The 3T's – Turning the Tide of Suicide

Coping With and Surviving Depression

Evening Lecture Series 2003

Transcript

Dr. Kay Redfield Jamison Lecture

Held On

Thursday 18th September, 2003

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Introduction by Professor Kevin Malone:

Good Evening and welcome to the 3T's autumn lecture series entitled '*Coping With and Surviving Depression*', our evening lecture series for 2003. Now I have to do a little bit of explaining first of all and that is what is the 3T's, everybody says "the what" and we say the 3T's – Turning the Tide of Suicide in Ireland. Let me tell you why it has been established.

Suicide is Ireland's number one new age killer of Ireland's young men, wreaking havoc on over 400 families a year for the past decade. Suicidal depression in young men has been shrouded in secrecy and shame but this national tragedy has sparked a new age and campaign to turn the tide of suicide in Ireland – the 3Ts.

My name is Kevin Malone, I am Professor of Psychiatry at St. Vincents University Hospital Dublin and I am involved in the 3T's project and I am proud to be involved. Ireland's golf superstar, seen behind me here, Padraig Harrington, and his two colleagues launched the 3T's campaign in January 2003 here in the Holiday Inn Dublin City Centre. '*There is not a community in Ireland that hasn't been touched by the tragedy of suicide in Ireland* ', said Harrington at the launch. The 3T's has brought together a group of suicide help charities and suicide research and education projects north and south in a brand new initiative to accelerate progress into suicide awareness and prevention through research, education and support.

Firstly, the campaign sent out an appeal to the golfing community of the island of Ireland to participate in the 3T's golf tournament launched by Padraig Harrington in 2003, through their local golf clubs in support of the new 3T's initiative - it was what we called a grass roots initiative. Over 800 golfers in 65 golf clubs responded with the Club Professional, the Club Captain and the winners of the Men's and Ladies May Medal making up the team in each Club. Following regional qualifiers the national final was held in the K Club South in August where the Achill Island Golf club from

the west of Ireland were the winners and secured themselves a trip to South Africa for the World 3T's final.

The 3T's golf event raised significant awareness around the country on regional radio stations as well as gaining high profile on national media, such as the Marian Finnucane show. The 3T's project is committed to turning the tide of suicide in Ireland through awareness, dedicated scientific research, education, and support for those in suicidal crisis and those bereaved by suicide.

The 3Ts annual event will continue on the island of Ireland for the next three years and is sponsored by The Holiday Inn Dublin City Centre, the Professional Golfers Association, the Louis & Zelie Martin Foundation, the K Club, in association with the Mater Foundation, St. Vincent's University Hospital ERC and the Ireland Funds. The beneficiaries of the 3T's project include AWARE, Schizophrenia Ireland, Samaritans, the INSURE Research Project, the National Suicide Research Foundation, the National Suicide Bereavement Support Network, the Irish Association of Suicidology and the Ireland Chapter of the American Foundation for Suicide Prevention.

The 3T's has a simple mission statement, a united, all Ireland approach has established the 3T's project, Turning the Tide of Suicide in Ireland through awareness, research, education and support.

But then it was on to the next 3Ts project because the 3Ts is a can-do, will-do, do-it-now, type of model and I'm sure you've heard a bit about that recently. This autumn series is an informal lecture series, a testimony of some of those who have coped with or are coping with and surviving depression.

We thought it appropriate and symbolic to hold the series in autumn, autumn is a time of risk, particularly in the whole realm of mood disorders, so therefore we thought it would be appropriate to give out a message from some people who were prepared to give a testimony about their struggle with depression and survival. Now, before I mention who we reached for when we put this programme together, we did reach for the stars and I believe we got the stars. But let me say a very brief word about our sponsors here at the Holiday Inn and I don't know if you've noticed it yourselves but certainly this is not just another gig for the Holiday Inn, really this is

more of an embrace. The staff have been so enthusiastic, warm and empathic and it really feels like they are proud to be part of this project and we are delighted that they have been so welcoming and so supporting of this initiative.

But now on to the stars and tonight's star really in some ways needs no introduction but I'm going to introduce her anyway. Dr Kay Redfield Jamison is Professor of Psychiatry at the Johns Hopkins University School of Medicine and Honorary Professor of English at the University of St. Andrews in Scotland. She is co-author of the standard medical text on manic depressive illness which I studied as a resident and which was chosen in 1990 as the most outstanding book in bio-medical sciences by the American Association of Publishers. She is author of Touched With Fire, An Unquiet Mind and Night Falls Fast. Her memoir about her own experiences with manic-depressive illness, An Unquiet Mind, was selected by The Boston Globe, Entertainment Weekly and the Seattle Post as one of the best books of 1995.

I know it changed her life but it changed the lives of millions of others also. An Unquiet Mind was on the New York Times Best Sellers list for more than 5 months and has been translated into 15 languages. Her most recent book, "Night Falls Fast – Understanding Suicide" was a national best seller, translated into 12 languages and selected by the New York Times as a notable book of 1999.

What about Dr. Jamison's background – she did her undergraduate and doctoral psychology studies at the University of California Los Angeles, where she was a National Science Foundation Research Fellow, University of California Cook Scholar, John F Kennedy Scholar, United States Public Service Pre-doctoral Research Fellow and UCLA graduate woman of the year. She also studied zoology and neuro-physiology at the University of St. Andrews in Scotland.

She was formerly a Director of the UCLA Affective Disorders Clinic and was selected as UCLA woman of science, has been cited as one of the 'Best Doctors in the United States'. She is recipient of numerous awards including the American Suicide Foundation Research award, the UCLA Distinguished Alumnus award, the UCLA award for Creative Excellence, the Siena Medal, the Endowment award from the Massachusetts General Hospital/Harvard Medical School, the Fawcett Humanitarian

Award from the National Depressive and Manic-depressive Association and it goes on and on.

She has been awarded numerous honorary degrees and was selected as one of five individuals for the public television series "Great Minds of Medicine" and she has been chosen by Time Magazine as a 'Hero of Medicine'. She was Distinguished Lecturer at Harvard University in 2002 and Lichfield Lecturer at University of Oxford in 2003.

Dr. Jamison arrived in Ireland at, left London this morning at 6am, arrived in Ireland at 8am, and will leave Ireland tomorrow at 6am to get a plane back to London and on to the US, where hopefully her house is still standing in Washington following Hurricane Isobel. But she is here for the day because she gave this commitment and she has honoured her commitment to be here to help us to launch the autumn lecture series, 'Coping With and Surviving Depression'.

With her pen, her voice and her personal testimony, she stands out as a beacon in her battle with those who have tried to relegate mental illness to the also-rans. We are privileged tonight to welcome Professor Kay Redfield Jamison to give our first 3T's autumn lecture – thank you.

Professor Jamison: Thank you very much. I'm delighted to be here. I'm sad to be in Ireland for such a short period of time but I'm not sure about getting back to Washington tomorrow, looking at the News this evening – it's an emergency alert. I would note that our President managed to get out of Washington but the rest of us don't have that option.

I wanted to say a couple of things, first of all I want to thank Professor Malone and University College Dublin for inviting me and I think it's a wonderful campaign, it's a very exciting thing to do and it's a very necessary thing to do and I have no doubt at all that it will save many lives.

I also would like to thank the Holiday Inn, what wonderful staff and wonderful people and kindness and generosity so thank you all, thank you for the flowers and the fruit and the kindness.

This evening I would like to talk about suicide from my personal point of view and also from a professional point of view and start off with the personal to illustrate how complex suicide is from many points of view and then talk a bit about what we know from a scientific and medical point of view. Because one of the things I would really like to emphasise over and over again is that we know a lot about suicide. There is kind of a notion in the general press and in the general public that suicide is kind of amorphous and vague and kind of beholden to all sorts of irrational forces and of course that's true but it's also something that we know a lot about from a scientific and clinical point of view. We know a lot about how to prevent it and we know a lot about the illnesses that are most closely related to it, so I would like to talk briefly about and summarise what we know about it in very short form and leave as much time as possible at the end for questions.

Summer evenings at the Bistro Gardens in Beverly Hills tended towards the long and languorous. My friend Jack Ryan and I went there often when I lived in Los Angeles and I invariably ordered the indigenous crab and a scotch on the rocks. Not so invariably but from time to time Jack would use the occasion to suggest we get married. It was an idea with such patent potential for catastrophe that neither of us had much of an inclination to take the recurring proposal with too much gravity, but our friendship we took very seriously. This particular evening I found myself knocking the ice cubes around in my whiskey glass, the conversation was making me uneasy. We were talking about suicide and making a blood oath - if either of us again became deeply suicidal we agreed, we would meet at Jack's home in Cape Cod. Once there the non-suicidal one of us would have a week to persuade the other not to commit suicide, a week to present all the reasons we could come up with for why the other should go back on lithium, assuming that having stopped it was the most likely reason for the danger of suicide. A week to cajole the other into a hospital, to invoke conscience, to impress upon the other the pain and damage to our families that suicide we knew inevitably would bring.

We would we said during this hostage week, walk along the beach and remind the other of all the times we had felt at the end of hope and somehow had come back. Who if not somebody who had actually been there could better bring the other back from the edge. We both in our own ways in our own intimate dealings with it, knew

suicide very well. We thought we knew how we could keep it from being the cause of death on our death certificates.

We decided a week was long enough to argue for life – if it didn't work, then at least we had tried and because we had years of cumulative experience with lifestyles of snap impetuousness and knew how quick and final a suicidal impulse could be, we further agreed that neither of us would ever buy a gun nor we swore would we under any circumstances allow anyone else to keep a gun at any house in which we lived. We sealed our foray into the planned and rational world. But still I had my doubts. I listened to the details, helped clarify a few, drank the rest of my whiskey and stared at the tiny white lights in the gardens around us.

Who were we kidding – never once during any of my sustained bouts of suicidal depression had I been inclined or able to pick up a telephone and ask a friend or a doctor for help – not once, it wasn't in me. How could I seriously imagine that I could call Jack, make an airline reservation, get to an airport, rent a car, and find my way out to his house on the Cape. It seemed only slightly less absurd that Jack would go along with the plan although he at least was very rich and could get others to handle the practicalities. The more I thought about the whole arrangement the more sceptical I became. It is a tribute to the persuasiveness, reverberating energies and enthusiasms and the infinite capacity for self-deception of two manic temperaments that by the time the dessert soufflés arrived, we were utterly convinced that our pact would hold. He would call me, I would call him, we would out manoeuvre the black knight and force him from the board.

It was never taken up as an option, however, that the black knight has a tendency to remain in play and so it did. Many years later, Jack had long since married and I moved to Washington, I received a telephone call from California, Jack had put a gun to his head, said a member of his family and put a bullet through his brain. No week in Cape Cod, no chance to dissuade, a man who had been inventive enough to earn a thousand patents for such wildly diverse creations as the Hawkins missile systems used even today by the United States department of defence, toys played with by millions of children around the world and devices used in virtually every household in America, a Yale graduate and a great lover of life, hugely successful business man.

This remarkably imaginative man had not been inventive enough to find an alternative solution to a violent self-inflicted death.

Although shaken by Jack's suicide, I was not surprised by it, nor was I surprised that he had not called me. I after all had been dangerously suicidal myself on several occasions since our compact and I certainly had not called him. Nor had I even thought of calling him. Suicide is not beholden to an evening's promises, nor is it always harkened to plans drawn up in lucid moments and banked in good intentions. I know this for an unfortunate fact. Suicide has been a professional interest of mine for many years and a very personal one for considerably longer. I have a hard earned respect for suicide's ability to undermine, overwhelm, out-wit, devastate and destroy. As a clinician, researcher and teacher, I have known or consulted on patients who had hanged, shot or asphyxiated themselves, jumped to their deaths from stairwells, buildings or over passes, died from poisons, fumes, prescription drugs, slashed their wrists, cut their throats. Close friends, fellow students from graduate school, colleagues and now children of colleagues have done similar or the same. Most are young and suffer from mental illness, all of them left behind a wake of unimaginable pain and unresolvable guilt.

Like many who have manic depressive illness, I have also know suicide in a more private, awful way and I trace the loss of a fundamental innocence the day I first considered suicide as the only solution possible to an unendurable level of mental pain. Until that time I had taken for granted and loved far more than I knew a temperamental lightness of mood and a fabulous expectation of life. I knew death only in the most abstract of senses, I never imagined it would be something to arrange or to seek. I was 17 when in the midst of my first serious depression I became knowledgeable about suicide in something other than in an adolescent sort of way. For much of each day during several months of my senior in High School I thought about when, whether, where and how to kill myself. I learned to present to others a face at variance with my mind, ferreted out the location of two or three nearby tall buildings with unprotected stairwells, discovered the fastest flows of morning traffic and I learned how to load my fathers gun. The rest of my life at the time, sports, classes, writing, friends, planning for college, fell fast into a black night, everything seemed a ridiculous charade to endure. A hollow existence to fake one's way through as best one could.

But gradually layer by layer the depression lifted and by the time my senior prom and graduation came around I had been well for months. Suicide had withdrawn to the back squares of the board and become once again, simply unthinkable.

Over the years my manic depressive illness became much, much worse and the reality of dying young from suicide became a dangerous undertone in my dealings with life. Then when I was 28 years old after a damaging and psychotic mania, followed in turn by a particularly prolonged and violent siege of depression, I took a lethal, massive overdose of lithium. I knew exactly how much to use and I used more. I unambivalently wanted to die and I nearly did. I was in a coma for many days.

Death from suicide had become a possibility, if not a probability, in my life. Under the circumstances, I was during this time a young faculty member in a department of academic psychiatry. It was not a very long walk from personal experience to clinical and scientific investigation. I studied everything I could about my disease and I read all I could find about the psychological and biological determinance of suicide. As a tiger tamer learns about the minds and moods of his cats, and a pilot the dynamics of the wind and air, I learned about the illness I had and it's possible end point. I learned as best I could and as much as I could about the moods of death.

It does tend to be very motivating to get a disease to learn about that disease. I don't recommend that you do it but if you have to, it's one way of coping.

I had no intention of writing a book about suicide, I had no intention of wanting to spend my time that way, waking up every morning confronting a day of reading about suicide, it wasn't my idea of what to do, but one of the things that struck me over the last several years after having gone public about my manic depressive illness, was how much suicide was a problem out in the community. Even though I knew the figures and I knew the statistics and I certainly knew clinically and personally to some extent, I had no idea how much pain and suffering there was out in the general public. So many people had been touched by suicide and so many people on campus', young people, had killed themselves and I had watched family

members bury their children. It's a kind of death like no other, it leaves a kind of pain and suffering and guilt like no other and people don't talk about it for whatever reasons, very complicated reasons, some of them very bad reasons some perhaps not so bad reasons.

But suicide is a far more common problem than generally thought and the reason why it doesn't seem that common is that we don't talk about it. The sheer magnitude of the numbers is absolutely staggering, unimaginable. In the United States more than 30,000 people a year commit suicide, worldwide, a million people a year commit suicide, die by suicide. It's the second leading killer of university and college students but it's usually preventable, the illnesses that are related to it are treatable. There have been tremendous advances in the biological, clinical and psychological understandings of suicide in the last 10 – 15 years. What's truly awful is the breach between what we know about suicide and what we do about suicide is lethal and it's inexcusable – there is no excuse for society tolerating such unnecessary death – and we do.

We know a lot about suicide, we know first that it is a terrible killer. In 1996 more teenagers and young adults died from suicide that from cancer, heart disease, Aids, stroke and lung disease combined. Suicide kills the young dreadfully and it kills the young disproportionately. During the same years of the Vietnam war for example in the United States, suicide killed twice as many young men as the war did and across the world in those people between the ages of 15 and 44, suicide is the second leading killer of women and the fourth of men, so in the peak reproductive years of women's lives, suicide is the second leading killer across the world. In addition to actual suicide, studies conducted for the centres for disease control and prevention in Atlanta find that one in ten college students and one in five high school students say that they seriously considered committing suicide in the preceding year. Nearly one high school student in ten stated that he or she actually attempted suicide.

We understand up to a point the mental states of those who kill themselves, the despair, the depression, irritability, agitation and the sheer and utter hopelessness and we have learned a lot from suicide notes, diaries, psychological autopsies and clinical interviews with people who have survived very serious suicide attempts. We

have compelling and overwhelming evidence that the single most important factor in suicide is psychopathology – mental illness.

The major psychiatric and addictive illnesses, depression, manic depression, schizophrenia, alcohol and drug abuse, the severe anxiety disorders, personality disorders, are involved in more than 90% of all suicides worldwide. Combining depression and alcohol or drug use is especially lethal.

Clearly most people who are depressed won't kill themselves but of those who kill themselves the majority were profoundly depressed. We also know a great deal, although not nearly enough, about the underlying biology of suicide. We know for example that there is a genetic component which is probably independent of but interacts dangerously with the genetic factors implicated in the major psychiatric illnesses, in other words you may have a major psychiatric illness like depression or schizophrenia or manic depression and then have a second genetic hit and that combination proves lethal. We know that certain chemicals in the brain such as serotonin, etc. are deeply enmeshed in the volatility, impetuousness and violence which are part and parcel of the moody and explosive temperaments most closely associated with self-murder and violence is unquestionably an integral part of most suicides.

The igniting of a volatile temperment by a psychological stress or by the presence of a depressive illness or other psychiatric disorder is far too often deadly. We are extremely fortunate in this day and age to have very effective ways to treat the psychiatric illnesses most commonly associated with suicide. We have a wide variety of anti-depressant medications, wide variety of effective psycho-therapies and combinations with medications, lithium, anti-convulsive medications, drugs to treat anxiety, drugs to prevent psychosis. Of all of these study after study shows that lithium is the most persuasively tied to the actual prevention of suicide. But not everyone will respond to lithium, not everyone will take lithium and there are many other medications now that seem to have an effect on suicidal behaviour such as the anti-psychotic medication and anti-depressant medications.

Most medications are problematic and anybody who is on these medications know that these medications are problematic but the research literature is remarkably

consistent in showing that patients at high risk for suicide remain dangerously under diagnosed and dangerously under treated. We know many things about suicide but we do not know enough. We need to have far more public awareness of how prevalent a killer suicide is. We need to have far more public awareness of the symptoms and treatments for depression and other psychiatric disorders. Families, schools, churches, synagogs, university administrators, need to learn more and they need to do more. They need to do far more. A strictly pet peeve of mine is university administrators not doing enough – they get young people at a high risk time with a real chance of getting bad psychiatric illnesses and they don't do enough to educate and get treatment for their students.

We require a society that is much more aware of it's dangers out there and that there is danger in the midst. We need a society that does not tolerate this awful, awful thing. We need to do everything possible to prevent the kind of pain that went into this poem that was written by a 15 year old boy two years before he killed himself.

Once he wrote a poem and he called it 'Chops' because that was the name of his dog and that's what it was all about and the teacher gave him an A and a gold star and his mother hung it on the kitchen door and read it to all his aunts. Once he wrote another poem and he called it 'Question Mark – Innocent' because that was the name of his grief and that's what it was all about and the Professor gave him an A and a strange and steady look and his mother never hung it on the kitchen door because he never let her see it. Once at 3am he tried another poem and he called it absolutely nothing because that's what it was all about and he gave himself an A and a slash on each damp wrist and hung it on the bathroom door because he couldn't reach the kitchen.

There is a lot of pain out there, I spend a lot of my time on university campus' talking to students and you learn a lot of things, you learn about the level of pain, you learn that they don't talk to their parents about it, if you ask a group of students about suicide attempts and you say how many of you told your parents about it, maybe one person in ten will have told their parents about a suicide attempt. It's horrifying, really horrifying and I think all of us do so little and I include particularly

the medical and psychological community in that. We have not been pro-active enough.

I would like to just end with a few remarks about - the whole process of writing about suicide in such an intensive way makes you think about suicide a lot more than you ever wanted to I can assure you. I was very naïve to under estimate how disturbing it would be to write about. I knew it would mean interviewing people about the most painful and private moments of their lives, and I also knew that I would inevitably be drawn into my own private dealings with suicide over the years. Neither prospect was an attractive one but I wanted to do something about the epidemic of suicide and the only thing I knew was to write a book about it. I am by temperment, a huge optimist and I thought from the beginning there was much to be written about suicide that was strangely heartening. As a clinician I believed there were treatments that could save lives, as one surrounded by scientists whose explorations of the brain are elegant and profound, I believed our basic understanding of the brains biology was radically changing how we think both about mental illness and about suicide. As a teacher of young doctors and graduate students I felt the future held out great promise for the intelligent and compassionate care of the suicidal mentally ill.

All of these things I still believe. The sciences of the first water, it is fast paced and it is laying down pixel by pixel, gene by gene the dendritic mosaic of the brain. Psychologists are deciphering the motivations for suicide and piecing together the final straws, the circumstances of life that so dangerously ignite the brains vulnerabilities and throughout the world from Scandinavia to Australia, public health officials are mapping clearly reasoned strategies to cut the death rate of suicide.

Still the effort seems remarkably unhurried. Every 17 minutes in America someone commits suicide. Where is the public outrage, where is the public concern. I have become more impatient, it has to be said patience has never been my middle name, I have become less patient over the years watching people not engage with the issues of suicide prevention. We have become a lot more impatient and I am acutely aware of the problems that stand in the way of denting the death count. I cannot rid my mind of the desolation, confusion and guilt I have seen in the parents, children, friends and colleagues of those who kill themselves. I'm tired of writing

eulogies for medical students who have killed themselves. Nor can I shut out the images of autopsy photographs of 12 year old children or the prom photographs of adolescents who in a years time will put a pistol in their mouths or jump from the top floor of a university building. Looking at suicide, the sheer numbers, the pain leading up to it and the suffering left behind is harrowing. For every moment of exuberance in the science or in the success of governments, there is a matching and terrible reality of the deaths themselves, the young deaths, the violent deaths, the unnecessary deaths.

Like many of my colleagues who study suicide, I have seen time and again the limitations of our science, been privileged to see how good some doctors are and appalled by the callousness and incompetence of others. Mostly I have been impressed by how little value our society puts on saving the lives of those who are in such despair as to want to end them. It is a societal illusion that suicide is rare – it is not and certainly the mental illnesses most closely tied to suicide are not rare. They are common conditions and unlike cancer and heart disease they disproportionately affect and kill the young.

When I was writing my book I kept on my desk a photograph and a fragment of a poem. The photograph is of a young, good looking cadet at the united States Air Force Academy, standing next to a jump fighter. Writing about this young man's suicide who had been given the leadership award in his senior class at the Air Force Academy, charismatic, good looking, charming as the day is long, absolutely wonderful young man, writing about this young man's suicide was the most difficult part of writing my book. I started the essay on a clear winter day in the library of the University of St. Andrews in Scotland where I teach each year. I was able to read his medical records for brief periods of time only before I had to get up, walk over to the window and look out at the North Sea in a futile attempt to pull from it a meaning that would make more tolerable the awfulness of it all. I would then return to the medical charts that charted out the inexorable course of the manic depressive illness that would kill him.

The fragment of the poem I kept on my desk was one that drew me to life. It is the last line from Scottish poet Douglas Dunne's poem "Disenchantments" – "Look to the Living, Love Them and Hold On". Thank you.

Prof. Malone: Now we have a roving mic and we're going to allow some questions but first of all I'd like to thank Kay Jamison for, I mean it isn't as if we needed a wake up call but she certainly delivers her message in such a compelling and blunt way about the difficulties and successes. I mean Kay could be a statistic on the death register in the US instead she's not, she's here with us sharing her experiences and is pursing the life option and I guess from our point of view there is no question the darkest hour is before the dawn and really I hope that this is the beginning of a more concerted effort across groups and charities and research to advance it and certainly we'll hold on to Kay's words, in fact we've taped them and we'll play them back just in case we forget them, it's unlikely we will.

If you have specific questions for Prof. Jamison about her presentation keep them to that for now and we can have informal conversations later.

Question: Five years next November I attempted to take my life – I read your book in 1997 and I had dealings with schizo-effective ………..a mood disorder but primarily manic-depression. I survived against pretty much all the odds, you described your coma after your lithium overdose. I was in a coma for 2 months after my burn – I am delighted to be here this evening, I got a call from a psychotherapist who referred me here – I'm delighted that you are here. It is very important work. I'm trying to discover what areas I could work towards contributing a bit more. I'm alive, I'm very glad to be alive, I don't want to go back. The medical facilities are in place there, psychiatric consultancies, but you know what can be done – it's just talk, talk really, talking is the main thing. I have seen three of my friends go before me and I know they just had mental health concerns as well. There is a lot here to give thanks for.

Prof. Jamison: You ask what you could do, I mean, speaking up is an enormous thing and I know there are advocacy groups in Ireland, one I know best is AWARE and I don't know if you have been involved with any of the support groups but there's certainly things, Prof. Malone might have some suggestions as well.

Prof. Malone: No I think the fact that you have said what you've said and that you're here to bear witness is a point of hope for people who've suffered.

Question: Thank you to Professor Jamison for her wonderfully passionate speech as somebody who has contemplated suicide myself – I'd call it a par-attempt as I didn't actually want to die. The question I would have is that to what extent do you think that the individualism and materialism of western culture and the loss of communal values is responsible for the high figures we are experiencing in the west.

Prof. Jamison: I think it's very hard to know those things, because it's an amorphous concept. Certainly suicide rates were very high even in times where communities seemed to be more closely together so I think it's not the most important thing, I think the most consistently most important thing is untreated mental illness, overwhelmingly. I mean, we do have stress now but when you think about the kind of stresses in the 19th Century or sheer poverty, terrible disease, long working hours, very young people in the fields and so forth, it's hard to make the case that our lifestyle is so much more stressful or fragmented it might be, it certainly is not helpful. Certainly one of the things that seems to go on here in Ireland which is not unusual by any stretch, except in extent, is drinking, there's been a real sharp increase in drinking. We know that it's just like adding fire to fire, it's just a terrible increase risk factor – if you have a depressive illness and you drink, you're just upping the odds astronomically of suicide, so it's a terrible problem and I know it's just been on the news in the last day or so here and it is a huge problem here in Ireland. I was struck, I thought well how much worse could it be here than it is in the States, I mean it's a big problem in the States, it looks like it's a big problem here, unfortunately.

Question: There seems to be a big difference between the rates of success for suicide between males and females in Ireland. Is that down to the methods they use or is there a real difference ?

Prof Jamison: Probably both, the question is why so many more male suicides than females. First of all it's absolutely true here as almost everywhere else, although in places like China there are actually slightly more women who kill themselves, and interestingly that gets us to the issue of methods because in China a lot of the young women who kill themselves kill themselves with insecticides, and they are out in the middle of the fields and they are lethal agents and of course they

are not near an emergency room and they make a suicide attempt and that suicide attempt immediately translates itself into a completed suicide. But males are more likely to use alcohol, more likely, in the States anyway I'm not sure here, but violent methods and certainly in the United States although women are unfortunately catching up to males in terms of using guns, so 60% of our suicides are guns.

Question: You mentioned that a potential suicidal person doesn't broach the subject with parents. Is it a good thing then in situations where there is a person suffering from depression or who may suffer from depression on and off that the subject of suicide is discussed without it ever coming up in the first place, or does that lead to more problems ?

Prof. Jamison: I think one question you are asking is that if you talk about suicide are you in a way planting an idea in somebodys head, are you making it more likely, I think the evidence on that is no, you're not going to make somebody suicidal or commit suicide because you straight forwardly discuss suicide. Are there ways of romanticising suicide – absolutely, we know them all through the media and so forth. I think one of the things that parents can do and one of the things that is always shocking to me is that, and I was talking to a reporter this afternoon about this, if you look at the books that are written about children's health for parents or parents to be, the cover of these very mondo-bizarre diseases that nobody gets, you know very rare diseases and mothers worry about it and so forth. What they don't cover are the very common psychiatric diseases. Depression is very, very common and manic depression. One person in 100 is going to get manic depression, 15% of the population is going to get depression so if you don't get depression somebody in your family is going to get depression, your friend is going to get depressed, somebody is going to get depression that you know – really common.

We know that these diseases are hereditary, so you know, parents minimally before they send their children out of the household and hopefully long before that, should if they have mental illness in the family, talk about it in a straight forward way in the same way that if you had a heart condition that was hereditary, you wouldn't send your kid off without telling them what the symptoms are, who the specialists are if they are going to another city, what to do if they get ill. Yet parents routinely send their kids off without discussing mental illness or suicide in the family, they don't line

up specialists for them to see if they need to and you can say the odds are overwhelming you won't get this illness, it does run in the family, just be very straight forward about it, and these are the symptoms, it seems scary but these are really very treatable illnesses, these are illnesses that you can in all honesty extend a great deal of hope about. There are a lot of illness that you can't treat now and that's not true for these illnesses so you can say in all honesty and the school system should be educating children about what the brain does, you know people probably know more about what their pancreas does than the brain does and it's horrifying – we have this great science this staggering, beautiful, incredible great science on the brain but that doesn't get put into the school systems for whatever reasons.

Question: Do you think that psychiatrists are more enamoured by the beauty of the brain than with the patients at times ?

Prof. Jamison: I've never been impressed psychiatrists are particularly enamoured by the beauty of the brain – that they know that much about it – I would be a little more sceptical on that front – I think the scientists do and some doctors do. I think doctors vary enormously – I'm a big fan in general of doctors and psychiatrists but there are a lot of incompetent and insensitive doctors out there, nobody would question I don't think if they are really being honest – it's true. But there are a lot of really fabulous doctors and what you want is ideally somebody who knows the clinical science of an illness and who's an extraordinary human being who can empathise who can understand what the pain is, what the options are and present them in a way that is compassionate yet well reasoned and some people get that kind of doctor and some people don't.

Question: I've had three or four admissions in the last number of years and what struck me as remarkable about the whole thing was the complete lack of contact with the psychiatrists, they were just absent for the whole duration. I mean you would have a 5 minute interview over a period of 2 weeks and the only indication you would have as to the condition you were supposedly condition that you have, the only literature that is available it undermines everything that you think, I mean it's all presented in a negative light, the psychiatric literature on if you read DCM4 the human being is presented in such a way it makes you feel as if you were nothing and I felt at my lowest ebb during the period when I should have been receiving,

maybe the fact that it was that you were high then low, I just feel there is no contact whatsoever, you're just left there like a wet rag – it's remarkable – and at the time you feel at your worst is when you come out of there and you feel as if everything you ever were, up to the time you were hospitalised, everything you ever were has been swept from underneath you and the simplest target you can find is the whole of psychiatry and I jumped into every anti-psychiatric, as I felt they were at least approaching not as a delusional matrix but looking at it as something that had worth and value in itself.

Prof. Jamison: Well you know you won't get me to defend bad doctoring okay I just wouldn't do that. I think you can make general arguments I don't know the Irish system so it wouldn't be fair for me to comment one way or the other. I can say in the States the resources are very limited and it's because society has not put a premium on treating these kinds of illnesses and I think from my point of view as a patient, it's because society has not made a decision that the lives and health of psychiatric patients are as important as the lives and health of non-psychiatric patients and we have it had it conified in the sense that we don't even pretend to have parity in terms of health insurance. If you have a psychiatric illness in the US you don't have parity, you don't get the same medical coverage that you do if you have another kind of medical illness.

Question: The law here doesn't apply to parity yet …….it hasn't been enforced…. general and mental illness and we have a wonderful two tiered system where the public system – whatever hope you have if you have private health insurance you may be able to demand to see your consultant and you may have some chance of getting a doctor. When you are on a public system you are very much at the risk of your doctor you may see your consultant as this man says for 4 minutes once a month but you are probably going to see a Registrar who is going to be in place for six months, who may only have that six months of psychiatry and then you will see another Registrar who may only have six months of experience or a year and time and again we come across people and that's what they are getting and they are getting nowhere fast.

Prof. Jamison: I can only say that it is horrifying and inexcusable and it's a violation, I think, of human rights at some basic level. I think it's changing gradually

for some of not so great reasons, I think that the Government is now aware of how economically costly psychiatric illnesses are so they are more interested now in dealing with them because of the economic cost –that's certainly a consideration – it's not one you would as a human being say is the most important thing. I think what it's going to take is journalist's kids committing suicide, enough people's kids committing suicide, enough people really protesting before it happens. I mean I often look at the AIDS movements, AIDS has been around for a relatively short period of time, suicide has been around as long as we know, thousands and thousands of years. If you look at what the AIDS community has done in terms of advocating and political power. I mean I'm always going to the American advocacy groups and saying you vote, you've got a vote, you know if all people with mental illness starting asking their politicians how do you stand on parity, how do you stand on getting decent health care out there for people with psychiatric illness, and I am going to vote accordingly or at least consider it, things will change. They don't.

The AIDS community, which is a tiny, tiny fragment of the mentally ill community, does vote and in cities like San Francisco and Washington, not that Washington is a totally democratic city, but San Francisco and many large cities in the US, that AIDS vote is tremendously important and politicians now can't act fast enough to ensure that there is AIDS research and good care for AIDS people.

Now people with mental illness have a much larger community from which to draw on and we just don't do it, we don't think of ourselves as voting citizens, it's just not in our conceptual framework and I think it is a political issue. At some level the amount and quality of healthcare that you get is a political issue. You would like it not to be but it really is.

Question: I would like to know how easy it is for a psychiatrist to diagnose and therefore intervene in depressive illnesses that have a suicidal ideation connected with them and I would like to place that question in the context of my own experience. I am a carer for somebody who is severely depressed and who lives on a daily basis with suicidal ideation. My job is to try and keep that person alive and part of what I do daily and what I have done is to ask the medical profession for help and much like the frustration I have been hearing here, I have spent the last six months trying to get a proper diagnosis and trying therefore to get proper care and I

am just wondering, my last interview with a consultant I was told this person basically just needs to pull themselves together and get a grip on themselves and go out and enjoy life ….

Prof. Jamison: That's always helpful….

Question: Yeah, my position as a carer for somebody with severe mental illness, how do I go about getting a proper diagnosis, what do I need to tell them, what do they need to hear to make the proper diagnosis ?

Prof. Jamison: Well of course my first answer would be that it is not really your role to get the correct diagnosis for somebody but given that in an imperfect world I think again advocacy is very important and I am not sure quite what the advocacy groups do here but certainly many advocacy groups will know good doctors, know good consultants, know where to go, there is a lot of information on the internet, some of it's terrible some of it's very good. I am a great believer in the badger factor, badger, badger, badger, you go in with a list of questions and you badger. It doesn't always work, it's very hard to answer the question if you are not getting good medical care how can you get good medical care because it's very easy for me to say get a second opinion, get a consultation but second opinions cost money, you can't always get second opinions, it depends on the healthcare system you are in. I think reading and educating yourself which it sounds like you are doing.

In terms of how easy it is to make a diagnosis, generally making a diagnosis on a depressive illness is very straight forward if the person knows what he or she is doing, it's usually pretty straight forward, now there are a lot of cases that are complicated for different reasons but by and large it's relatively straight forward and a reliable diagnosis. As far as pulling yourself up, it's beyond comprehension to me that anyone could get those words out of their mouths in this day and age – this is 2003.

To make a general point, I can understand frustration and I can understand that people get badly diagnosed or not getting the correct treatment, I am a great believer that you learn from the exemplary as well, from what people do right and what doctors do right and what clinicians do right, what advocacy groups do right

and look to the ones that are really good and learn from them and try and hold other people up to those standards. I am also a great believer in documenting things and if you have concerns about a doctor send them a letter put it in writing and keep a copy.

Professor Malone: Well, first of all I hope I didn't neglect the people in the overflow room, I didn't see any hands go up but hopefully you'll get a chance if you have a specific question for Kay Jamison that you will be able to ask her after, if she's got enough energy, she's been lecturing and touring all day with us and has really thrown in her two cents worth here in terms of the debate and I think one of the things that came out loud and clear and which I think is an important component of the 3Ts, is that we have advocacy groups in this country and if you can at all bottle anything of what Prof. Jamison said here tonight you should feel more empowered after her presentation and you should be going back to your advocacy groups that are supported by the 3Ts or if not let us know about them, but the advocacy groups that are associated with us at the moment include any of you who are in AWARE, Schizophrenia Ireland, the Samaritans, that National Suicide Research Foundation, the National Suicide Bereavement Support Network, the Irish Association of Suicidology so you should be getting back on to your advocacy groups and we have a website www.3Ts.ie and we hopefully will get the script of Prof. Jamison's presentation on to the website in due course so it will be there for people to see because I think, it shouldn't, but sometimes it takes an outsider to come in and present a wakeup call in a different way and certainly I am quite sure you would agree that tonights presentation was a unique presentation to say the least.

I would like to, first of all can we show our appreciation for Prof. Jamison.

Applause…………

If ever anyone told it as it was Prof. Jamison did. So she is flying out to the States tomorrow morning, we hope that she will land in Washington and Washington is still there, apparently they closed Johns Hopkins this afternoon so they are expecting Hurricane Isobel to do something awful in Washington but hopefully your house will survive Kay and certainly you showed enough hope tonight that hopefully that will translate into tomorrow.

Two final points, first of all we are incredibly excited at the turn out, you voted with your feet in terms of coming here. We put this series together with reasonable speed along the lines we are going to do it, not talk about it type model and we've done it and in a micro field of dreams moment, we built it and you came and that is really fantastic from our point of view.

I would remind you of the two further lectures that will be happening, one in October and one in November that I think you will enjoy both of them and I would invite you back to the Holiday Inn on Thursday the 9th October when Gareth O'Callaghan will present at 8pm and then on Thursday 20th November when Johnny McEvoy at 8pm will present.

One more announcement is that our sponsors who have been so fantastic in terms of this whole event are inviting you to tea and coffee and biscuits in a corralled area at the Bar when you come in the Hotel on the left had side, where hopefully you can mingle over a cup of tea, coffee and biscuits and meet each other and Professor Jamison if she has any energy left might be willing to engage with you as well.

So, unless there is anything else, I have to thank John Moran who is the General Manager if the Holiday Inn, Trevor and Sabrina who were absolutely fantastic in terms of courtesy, respect, organisation, efficiency, empathy, all the things you would hope for in a meeting like this was just so apparent, we are just delighted with it.

So, go forth enjoy your cup of tea and I hope to see you all in October.

Thank you very much.