

SUICIDE AMONG PROFESSIONALS IN THE HUMAN SERVICES

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Published in Lifenotes
Feb 2001, Vol 6, No. 1

The phone rang yesterday afternoon (Jan.15, 2001) and I learned that a friend of mine died from Necrotizing Fasciitis (the flesh eating disease). He was 37 years old and last Thursday night he was at a hockey game and today he is dead. I am writing this grabbed by grief and sadness, pondering the irony of the topic before me: suicide among professionals in the human services. The choice to die, woven between the tragedy of a sudden death by disease; both born of circumstances, that for however brief a moment, seem unsurvivable. Suicide "kills in many instances because the pain is unbearable" (CASP Conference, 2000, Vancouver, BC).

I would like to focus on three particular moments of despair. In January, 1995, Peter, a social work colleague at the Children's Aid Society, died by suicide. In January, 1997, Tracey, another social work colleague, died by suicide. In October, 1999, Gordon, a social work professor, died by suicide. Peter, Tracey and Gordon were three people who dedicated their working lives to helping others. I remember Gordon's smile, like a photograph before me. I rarely had a week pass in three years that his voice didn't reach me; whether in class, at a meeting, in the hallway, or during our Wednesday evening "chicken wing" gathering. I equally recall the silence at his funeral; how the word "suicide" was never spoken. This is being written with the hope of giving voice to the many professional helpers and caregivers who have died by suicide and/or who may be struggling with suicidal thoughts at this time.

Professional helpers die each year by suicide. Social workers, police officers, physicians, nurses, therapists, and other helping professionals are not immune to experiences of pain, grief, stress, trauma, depression, nor suicide. During the Canadian Association of Suicide Prevention (CASP) Conference, in October 2000; Dick Ramsey, founder of the LivingWorks suicide intervention training, highlighted the prevalence of suicide among law enforcement officers. Ramsey noted the suicide rate to be 22-29/100,000 officers, a rate approximately twice the general population. Approximately, 300 police officers die by suicide, per year in North America; this statistic compares to death tolls of a jumbo jet crash. Ramsey indicated that a police Sergeant suggested that these deaths are an issue, but he emphasized that "it is a personal issue versus a police issue". When a police officer dies in the line of duty, this loss is revered and there is protocol around the death; however, when an officer dies by suicide very little attention prevails.

There is always a connection between the personal and professional; regardless of the boundaries that exist between the two. Professionals adopt various coping skills to manage the impact of traumatic stress and exposure to the painful and often overwhelming circumstances of other people's lives. As a medical social worker, I stood beside the body of a deceased 21 year old male, with his mother's hand in mine, explaining to her that her son was struck at an intersection and killed instantly only a _ hour before. This experience lingered past the end of my shift at the hospital; the memory of this mother's scream came home with me that night and

tucked into bed with me, as I closed my eyes to sleep. These professional experiences are known as critical incidents and they can result in secondary or vicarious traumatization.

Critical incident stress and vicarious trauma are among the occupational hazards relevant to work in the health and human services. Other issues, such as burnout, are also realities that helping professionals must protect against, in order to maintain presence and passion in both their professional and personal lives. While managing stress and buffering these potential hazards, professionals are also human beings with lives beyond the call of duty.

The humanity of helpers is often forgotten. Peers expect a certain level of constant optimism, resiliency, and mostly silence where pain roosts for the helper. Helpers are not supposed to need help and their competency as a professional is sometimes challenged. Professionals hear comments like “how can you help me with my marriage if you are divorced”? Or “if you can’t stand the heat, get out of the kitchen” (said by a supervisor to a coworker who was carrying a child protection caseload exceeding 55 client families). A recent tragedy highlighted the humanity of one helper; 37 year old Suzanne Killinger-Johnson, a physician, committed suicide in August of this past year. Killinger-Johnson also killed her six month-old son during this suicide, both died after being struck by a subway train in Toronto in August, 2000. Killinger-Johnson was suffering from post-partum depression at the time of this tragedy. In the August 14, 2000 issue of the London Free Press, an Ontario newspaper, another female physician acknowledged “we don’t want to admit we have problems just like everybody else...people still look at doctors as having extra special powers”. This belief system is entrenched within the health and human services. Furthermore, this attitude is perpetuated by societal beliefs in general, potentially leaving helpers quite vulnerable, isolated and at risk for suicide when personal crisis, mental illness or other difficult emotional states become part of the professional’s lived experience.

Professionals in the helping fields are dying by suicide and are often suffering in isolation and silence prior to their deaths; despite being in the company of other professional helpers on a near daily basis. There is often an inability for colleagues, friends and family members, to acknowledge such a crisis with someone who is a “professional”. In my experience, this is a common dilemma both before and after the suicidal crisis. The level of shame and apparent disbelief appears as survivors come to terms with death by suicide of someone they thought, “it (suicide) couldn’t happen to”.

It is obvious that professional helpers are dying by suicide. At the CASP conference this past October, Dr. Michael Myers spoke of physician suicide; as mentioned, Dr. Dick Ramsey spoke of suicide among law enforcement officers, and I spoke of suicide among professionals in the human services. Five years ago, in Banff, Alberta, I do not recall such topics on the CASP conference agenda. Perhaps we are beginning to give voice to suicide among this population. With voice comes awareness, with awareness comes prevention. I encourage us to continue to make visible suicide among helping professionals. There is a time when silence is like a loaded gun; in the moment we believe certain populations are untouched by all that it means to be human, including the experience of suffering, pain and desperation, we leave people vulnerable to suicide and other tragedies. We must create a chain link of resiliency in health and human service organizations. This can be accomplished by naming the reality and occupational hazards of caregiving work, while also acknowledging the humanity of helpers.

If you are reading this article and you are a caregiver, an emergency service worker, a therapist, or anyone else who chooses to make your life's work by helping others, give yourself permission to be all the parts of who you are. If you are the friend, the spouse, a family member, a neighbour, a client, or many of the above all at the same time, to someone who gets out of bed each day to help, to educate, to promote change, and to foster compassion in our communities: please make space and time to care for the caregiver in your life. If you sense that he or she is overwhelmed, struggling, or in pain, say so; because there is nothing worse than a person who is left invisible in their own darkness. People need each other, as colleagues, friends and family members, to support keeping the vastness of what it is to be human alive and accepted. In this context, suicide can be named, discussed and very importantly, prevented.

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