

I'm Eric D. Caine, Director of the Injury Control Research Center for Suicide Prevention (ICRC-S), at the University of Rochester Medical Center (URMC). AMA!

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### **Abstract**

Hi Reddit! I'm Eric Caine and I study risk factors for suicide and ways to prevent suicide. With colleagues in Rochester and from around the world, I've investigated many factors that contribute to suicide, with a recent focus on links to unemployment, the choice of specific methods, and the burdens of suicide and attempted suicide involving youth and adults in the middle years of life (20s-60s). The ICRC-S is devoted to developing community-based public health approaches to help people change their life trajectories so that they don't become suicidal, or if they do, so that they can reach out for help or accept it when offered. These approaches complement methods that we use every day to treat people who have survived an attempt or seriously considered killing themselves. I participate in the National Action Alliance for Suicide Prevention, which wrote the latest version of our national strategy to prevent suicide and also works with the CDC, states, and local organizations to reach out to vulnerable populations and individuals. Since 2001 I've led a series of collaborative initiatives in China that deal directly with suicide prevention, the delivery of mental health services in developing countries, and the potential for public health approaches to reduce injuries and prevent premature deaths. I'll start answering questions at 1 pm EST (10 am PST, 6 pm UTC), AMA!

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## Science AMA Series: I'm Eric D. Caine, Director of the Injury Control Research Center for Suicide Prevention (ICRC-S), at the University of Rochester Medical Center (URMC), I also serve as Chair of Psy

ERIC\_CAINE [R/SCIENCE](#)

### ABSTRACT

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I'm [Eric Caine](#) and I study risk factors for suicide and ways to prevent suicide. With colleagues in Rochester and from around the world, I've investigated many factors that contribute to suicide, with a recent focus on links to unemployment, the choice of specific methods, and the burdens of suicide and attempted suicide involving youth and adults in the middle years of life (20s-60s). The ICRC-S is devoted to developing community-based public health approaches to help people change their life trajectories so that they don't become suicidal, or if they do, so that they can reach out for help or accept it when offered. These approaches complement methods that we use every day to treat people who have survived an attempt or seriously considered killing themselves. I participate in the [National Action Alliance for Suicide Prevention](#), which wrote the latest version of our national strategy to prevent suicide and also works with the CDC, states, and local organizations to reach out to vulnerable populations and individuals. Since 2001 I've led a series of collaborative initiatives in China that deal directly with suicide prevention, the delivery of mental health services in developing countries, and the potential for public health approaches to reduce injuries and prevent premature deaths. I'll start answering questions at 1 pm EST (10 am PST, 6 pm UTC), AMA!

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Eric - A year ago I was 100% committed to ending my life. After a long conversation with a friend, he convinced me to try a mental health program. I didn't want to admit myself to a full-time psych hospitalization because that would have made me feel trapped, but 6 months later I finally found a partial hospitalization program that worked well for me.

During various interviews with mental health staff, one question I was often asked was "Do you have a [suicide] plan?" I had a *very* detailed plan, right down to the last second and afterwards, in terms of both getting my "affairs in order" and the actual method I was going to use (plus how I'd alert friends, prevent myself from calling 911, and how emergency services was going to be alerted to take my body away). My answer to this question was always "Yes, but I don't want to talk about it right now because I don't want to start thinking about it again."

They seemed to always dismiss me as "not really being suicidal/serious about it" whenever I gave this answer. They also didn't seem to really listen to my issues or address my concerns about my mental health. Needless to say this was incredibly frustrating for me as it led to me not initially getting the care I needed.

What are your thoughts on why this happened, and how can we (both patients and mental health professionals) prevent these sorts of situations to make sure people are getting the right level of care?

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### [mharrizone](#)

Mental health professionals typically are taught to think in a gradient -- ideation to plan to attempt -- with the notion that one is more severe/threatening than the next. I would guess that some clinicians interpret a refusal to discuss any plan in detail as suggesting that a person is not as "at risk" as others. Of course, this can be incorrect. At the same time I would suggest that our "talking therapies" require all of us to stretch enough to reach one another, and it is important to recognize the fallibilities/limitations of clinicians. For one, talking about suicide can be scary -- someone is trying to discern another person's life-and-death thinking. It is not an easy matter and there are times when I have seen evaluators 'turn away' from following the most direct route in evaluation because of such difficulties. So, it always is helpful, even when not wanting to talk about painful matters, to try as much as possible to indicate the gravity or seriousness of one's thoughts, concerns, and plans.

I have major depressive disorder/ anxiety; was diagnosed about 17 years ago. Ten or so years ago, I started to have unwelcome thoughts of suicide. (I would be in so much wretched pain, and ending it all would bring such relief. But it would destroy my parents, so I work hard to stay alive for them.)

This summer I was in the middle of an especially bad depressive episode and these suicidal thoughts were out of control. The best way to describe it is that I felt a stranger's voice inside my head, urging me over and over to do it. I felt like I could almost *hear* these thoughts, but they weren't mine. A handful of times I found myself screaming, like an animal, because I just had this terrible, horrific need to put myself down, but knew that I couldn't.

1. I guess what I'm asking is, like ... are those "voices" normal? (For a depressive person, I mean.) They've gotten clearer and louder as I've gotten older. They really freak me out.
2. I can't end my life, at least not when it would destroy someone else's. But I'm terrified because I know these feelings will happen again sooner or later. I wish I could convey better how awful it is, but I don't have the words. What should I do when they come back?

Thanks so much for your time, it really means a lot.

PS: I'm on a good regimen of meds now and doing pretty well.

### [curious\\_umbrella](#)

Voices suggest a more serious depression, especially if they are telling you to harm yourself. They are NOT normal, and are a sure sign to seek care. I am glad to read that you are on a good regimen of medications, surely something that is indicated when one has persisting negative voices, and are doing better.

Hello Dr. Caine, I am a psychiatry resident in my first year. What would be your advice when confronted with patients who are suffering from, for example, a borderline personality disorder and might come to the ER several times a week after a suicide attempt, despite already living in a protected environment and getting intensive treatment. Admitting these people to a psychiatry ward is often counter-productive and it often gives a feeling of helplessness to have to send the patient home again. What would be your advice for dealing with these situations, especially for the residents who see these patients?

### [H--K](#)

As a first year resident, I certainly would not want you to be alone making such decisions. Ours are not! It always is both difficult and personally trying -- a time filled with fear about what happens "if I am

wrong about this patient and s/he dies" -- and the first year of training is a time when this is especially challenging. That said, my focus over the years has been to try, once it is clear there is a pattern, to use a boarding bed long enough to talk with such persons in an effort to explore what is happening now that is tied to coming to a place like an ER so often [ERs don't tend to be the most welcoming and comfortable spots to spend one's time]. Finding a way to connect while not ever encouraging such maladaptive behavior is key.

What is the most effective way (diet, exercise, medication) for someone who is chronically depressed to avoid serious feelings of suicide?

[ZapoiBoi](#)

It did not take a medical degree for me to say this to you. It appears that the most effective buffer and shock absorber for persons with depression involves strong personal relationships -- connectedness that makes community, shared interests, affection, thoughtful consideration of others, sharing, and going beyond oneself. Being physically active, eating well, mindfulness, engaging in active interactions and (if possible) fulfilling work all are positive self-protective and healing measures. Getting the proper professional help certainly can be life saving.

Hi Eric - Meliora and thank you for your work and for doing this AMA! My question is a bit more basic in nature:

How common is suicide across the animal kingdom? Are there animal models of suicide? What about GWAS/linkage analysis studies? Have these revealed genetic risk factors for attempting suicide and have people attempted to model suicide using animals carrying the alleles associated with attempting suicide?

[SirT6](#)

There are no animal models of suicide, although researchers have analogs to depression, stress, and anxiety. Gene studies have some interesting leads, but they all have been in relatively small groups of participants vs. controls. The major problem for this type of study is a signal that is not specific -- a similar case serves as an example: Significant depression is common among persons who kill themselves, but more than 99% of persons with depression do not die by suicide in any year.

Is there a genetic predisposition to being suicidal?

For example, are the children of a person who kills himself more at risk of being suicidal themselves?

Is it possible predict, say as early as in utero, who will be likely to become suicidal?

And this is a big if, but if identification of at risk people could start before birth, or perhaps more reasonably, say around 4-6 years old, what would be the most effective method of prevention -- counseling, pills, trust fund providing unlimited money, etc.?

[SocraticSwagger](#)

It has been long apparent that suicide is higher in families where there have been past suicides. Whether this is genetic or environmental or both remains a major topic of research. Clearly there are suggestions that genes affect temperament and may be associated with the frequency in families of depression, alcohol or drug misuse, or anxiety -- and all of those certainly have been contextual or risks associated with suicide. BUT the vast, vast majority of such affected persons never attempt, let

alone kill themselves. There are no in utero tests. Moreover, it is likely that there never will be a specific "suicide gene." I foresee that we will learn someday about genes that contribute to aspects such as mood and emotion, thinking, personality, and disposition, but none of these alone make for suicide, and life has many protective factors (e.g., good relationships) that can buffer even in the presence of adversity, or less than perfection in one's genes. (Many of us already know about less than perfection in our genes!)

With euthanasia (or physician assisted suicide or assisted suicide) coming to more places via the courts and legislation and noting the fact that depression can be a terminal, incurable, often untreatable and recalcitrant disease with a potential for an enormous effect on quality of life, why does suicidality stemming from depression not merit the same protection and freedom as other diseases to end one's life?

The follow up question which you may feel more comfortable answering is what effect would permitting assisted suicide for depression have on the field of psychiatry and psychology.

[AtticusWolfstein](#)

For those of us who have worked with countless patients, and populations, it is very clear that what we call "depression" or "clinical depression" is very diverse. Central to what I have seen has been an inability to realistically weigh life's many options; one person once said to me, "This is my depression speaking" when suicidal, and I have thought that it was a powerful insight. Clearly there are persons who do not seem now to respond to available treatments, and that surely must be deeply discouraging. But I would not support legislation or regulations that allowed "depression" as a category to be viewed in the same context as end-stage cancer, for example, as I see many possibilities for future care and quality of life.

I'm a new PA and I work in family medicine. If I see a diagnosis of depression in a chart or depression meds I ask the patient if they have suicidal or homicidal thoughts. It's what I've been taught to ask. When someone actually says yes I'm caught off guard- I don't feel adequately educated on when a "yes" is a call for help and when it's ideation without a plan and isn't something I need to worry about. I feel like I'm asking but I don't actually know what to do with the answer. Plus, I have no idea what I would do to help if someone said yes and meant it. Often there are so many other confounding mental disorders it's hard to figure out what to treat and how in just 15 minutes. Any advice is appreciated.

[dizzyizzie](#)

I practiced beginning many years ago, and have said for decades to medical students, that one of the most essential statements in all of medicine is: "I don't know!" One should say this without any queasiness or hesitation. So...when you ask important questions about suicidal thinking, plans, or past history of attempts, and get an affirmative, ASK FOR HELP! No one of us has to know all things in medicine but we do have to ask our patients about issues that will affect their lives, especially about their most important concerns when coming to us for care. As you gain experience, you may not have to ask for help as much, as your depth of knowledge and your know-how grow, but as a new PA, you want to approach complex clinical situations without fear and the best medicine for that is great backup help. Suicide always is scary, even for those of us who spent many hours and years working with suicidal individuals. No clinician wants to see her/his patients die -- from whatever disorder or condition. If you were faced with a complex heart condition, you surely would ask for help. This is another one of those situations.

Under what circumstances, if any, do you believe that suicide is a rational act? Are there any circumstances in which you think it would be unethical to *prevent* a suicide?

[HagbardCelineHere](#)

The term "suicide" is used in a somewhat muddled way in our language. Technically it is undertaking a self-injurious action with the intent to die. However, we also hear about "suicide by cop," when someone acts in such a fashion to force police to shoot him/her. Some talk about "suicide bombers." I certainly don't lump them with people who kill themselves in the midst of tragically deep despair, lost hope, and a sense that there is nothing to live for. We didn't call the early Christians "suicides," even as it was assured that they would be crucified by the Roman state for not saying that the Emperor was a god. We call them martyrs. I have no doubt that there are persons who -- with clarity of thought, a settled and calm and hopeful state of mind, and a perspective that they have lived a full life and don't want to suffer the end-stages of their terminal illness -- can be rationale in deciding the timing of their life's end. How we deal with such situations socially and legally is another matter, but I certainly have encountered persons who fit the description.

It is one thing to think about the ethics of prevention and another to consider the ethics of assistance. Those are topics for many hours of discussion.

What is your position on people who are not suffering from high amounts of stress, clinical depression or mental disorders, but have analyzed their life so far and came to a conclusion that it simply isn't worth living? Provided that they have consulted a therapist on the matter and have not changed their mind. Do you believe that suicide should still be prevented in such cases or is it their right to end their life if they are not satisfied with it?

[Karegohan and Kameha](#)

"Satisfied with" is a tricky term. I suspect that we all would acknowledge that there have been times when we have not been satisfied with what we face, what we feel, and those around us. I admit to be a congenital optimist; but I also know that things change, and that for many, many persons, things get better. So, I cannot dictate what people do but have seen many persons deeply caught in disillusionment and despair who go beyond surviving to thriving. Hope is the winch that drags us throw an awful present to something better beyond now...

Dear Eric, to what extent do you think that suicide can be contagious? I've read about the Werther effect, whereby a widely reported suicide leads to copycat acts, but this seems rare. Is digital media enabling suicidal ideation to spread faster and further than ever before?

[ViennaFamous](#)

These are fascinating questions that don't have a definitive answer. There certainly are indications that some people are influenced by knowing about suicide in another person. This has happened after celebrity suicides and occasionally there are local clusters. A cluster, however, does not prove "contagion." Indeed, the analogy to infection has many limitations. There now is a great deal of attention to whether social media have a negative effect, or for some, a protective effect. It is complex and we are at the beginnings of such research. For example, while there are anecdotes and some data at the level of broad populations, it is still to be explored how much media exposure has influenced individuals who have made serious attempts but are alive after to talk with us about what media they had seen and whether it had any impact. (Remember, they may have searched social media AFTER deciding to attempt suicide rather than being swayed before coming to that conclusion.)

Good morning Eric!(afternoon when you might read this)

My question is: In your opinion should general physicians be encouraged to refer patients needing anti depressants or other types of medications which affect brain chemicals to a Psychiatrist instead of taking it on themselves?

In my personal experience I was prescribed several different anti depressants through my GP on and off since the age of 14. My first experience on them I attempted suicide within 8 months. Fast forward to age 32 after trying several anti depressants just to experience odd behavior and elated moods was I finally under the care of a Psychiatrist who diagnosed me as bipolar 1 with adhd and I was explained that anti depressants are the worst thing I could have taken.

[adamedia](#)

As I noted in responding to another comment, what we call "depression" is very diverse. Primary care providers prescribe more psychiatric medications than psychiatrists. Perhaps 30% of the problems coming to PCPs involve mental health and substance-related conditions. It is inevitable that PCPs have to deal with some issues directly; there are not enough psychiatrists to handle all of them. At the same time, one would have hoped that after a person's suicide attempt -- IF NOT BEFORE -- there would have been a psychiatric referral for a consultation to further explore what contributes to one's distress and depression. However, it certainly can be challenging to make the initial diagnosis of any type of bipolar condition, given the changing nature of its presentation. Time may have to pass in order to understand the full range of problems that are experienced, though I am not sure that 18 years would have been necessary to see the pattern if more expert clinicians had been involved.

I lost my best friend in 7th grade to suicide, it will always haunt me and be with me.

What advice do you have for people who have already felt that grief and heartache that comes when you lose a friend? How can I help others who aren't in such a good place? In other words, how can I help?

[Deadpker56](#)

The American Foundation of Suicide Prevention sponsors many support groups and now has chapters in all states. I would seek out AFSP locally and see what you can do! There are many activities -- from groups to community walks that shine a light on all that we can achieve together.

Hello Dr. Caine - thank you for doing this AMA. Do you know if any work is being done examining the effects of parental suicide attempts on their adult children (or really any close adult relationship - I am familiar with some work on children). Further, do you know if there are any supports/resources available for these adults to help them cope with this particular type of traumatic and complex experience?

[firststop\\_svalbard](#)

There is a growing body of literature on the impact of suicide on offspring, though I cannot give you specific information about adults whose older parents have tried to kill themselves or who have died by suicide later in life. Years ago, when colleagues and I were talking with families of persons who died by suicide, it was clear that adult children most often were profoundly shaken by their parent's death. The American Foundation of Suicide Prevention offers many support activities, and I would be confident that there will be individuals and families among the members who have faced such painful challenges in the past. That may be a useful resource, even as a parent who has attempted still lives. Moreover, this may be a setting for one's own treatment/therapy or for a family interactive approach to therapy. In

any case, it should not be one of those unspoken, festering family matters that may corrode important relationships.

How does gun control affect suicide rates across a population?

How does gun access affect suicide risk in an individual?

[nezumipi](#)

The firearm discussion is a most important -- yet most difficult -- topic to discuss. It really is hard to find space that allows for thoughtful exchange these days. About 20,000+ suicides annually in the US relate to firearms, which comprises half of the total...which now is greater than 42,000 lost lives annually. This far exceeds the number of gun homicides (those have been declining), and while mass shootings terrorize, they are very small in number by comparison. SO, we need a discussion nationally about how to create a culture of safety and caring so that homes are "gunfire free," just as you would child-proof a home with a toddler in residence or remove the throw rugs when an unsteady older person lives under the roof. How we foster responsible and safe storage is everyone's business. NO, such safety measures won't prevent all suicides but they can be an important part of a collaborative discussion that draws together many people with apparently unreconcilable positions. There are ample data that access to handguns is a powerful factor that differentiates households with suicides from others in the community. In Upstate NY, where I live and where there are many long guns for hunting, the suicide rate is very low. Limiting firearm access to persons with unstable mental disorders seems sensible even as it arouses understandable concerns from persons worried about any limitations on gun access.

Thanks for doing this work and this AMA! Earlier this year the American Psychological Association Survey showed that [money stress is weighing on Americans' health](#). It turns out that [most Americans have less than \\$1,000 in savings](#). It's quite clear that high levels of stress (and the problems that come with that) are related to economic prosperity. My question is whether and how scientists and clinician experts are influencing economic policy and the political process.

[freethinker](#)

This is complicated even as it appears to be straightforward. There is a large scientific literature that repeatedly points to the population level impact of increasing unemployment rates and increasing suicide rates in many countries. These tend to be short term effects, where there can be a decline as the economy improves. However, when looking more closely we can see that times of economic hardship may hit employed people as well, perhaps because they too are under economic pressure. Increasing rates of housing foreclosures also have been related to increasing suicide rates. Here the glitch: In a nation such as S. Korea, where there has been substantial economic growth over the course of decades, there also has been extraordinary increases in the rate of suicide (even as short term fluctuations follow the expected patterns). It may be that other forces, such as major trends in internal migration and their effects on traditional patterns of family relationships that occur during rapid economic development as happened in S. Korea, also have powerful effects that we now are only beginning to understand.