Back from the Brink

People with certain neurologic conditions are more likely to commit suicide than the general population. Here's how friends, family, and caregivers can reduce the risk.

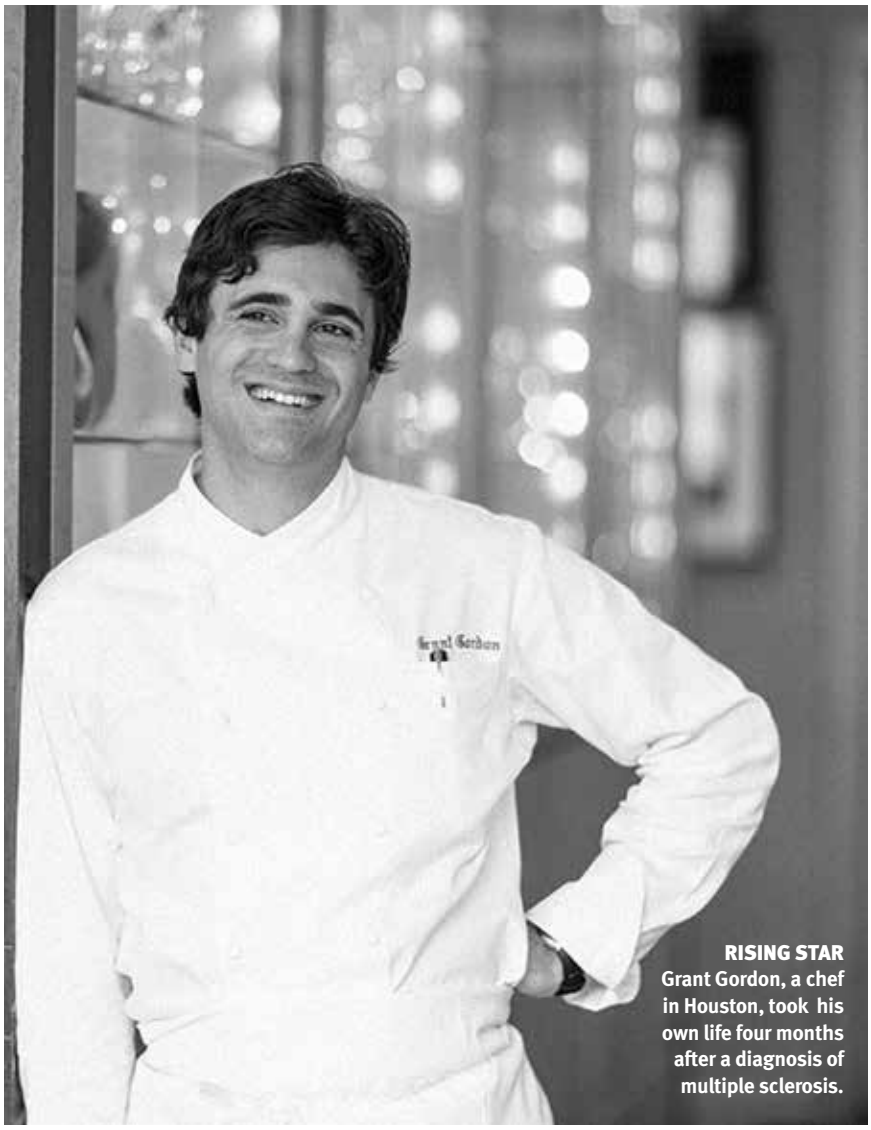
BY GINA SHAW

On Sunday, August 24, 2014, Grant Gordon, an up-and-coming chef in Houston, dined on beef ribs, chicken fried steak, and other barbecue at a restaurant owned by his friend Ronnie Killen. He later tweeted a photo of himself and Killen, praising the feast. The next day, as his roommate—Gordon's best friend since kindergarten—left the house, he heard the James Beard Award nominee on the phone, avidly discussing plans for his new restaurant, The Edmont, with the architect.

But later that afternoon, alone in his home, Grant Gordon picked up a gun and shot himself. He was 28 years old.

Less than six months before his death, Gordon had been diagnosed with relapsing-remitting multiple sclerosis (MS). To all outward appearances, he was handling his diagnosis well. He had kept the news about his disease private, sharing it only with his parents and older brother, Forrest, and sister, Devin Tomiak. The family knew Gordon had been in treatment for depression, a condition commonly associated with MS and many other neurologic disorders, but they saw no other obvious signs that he was in despair.

"He was an incredibly social person, with a million friends. He was at the height of his career, successful and well-liked," says Tomiak. "He was in the middle of pursuing the dream of opening his own restaurant. He was making all these plans for the future."



RISING STAR Grant Gordon, a chef in Houston, took his own life four months after a diagnosis of multiple sclerosis.

COURTESY GRANT GORDON FOUNDATION

HIGHER RISK OF SUICIDE

But as Gordon's family would come to learn, people with neurologic conditions such as MS are significantly more likely to consider suicide—a risk observed as far back as 1992 in a study published in the *Journal of Neurology, Neurosurgery & Psychiatry*. People listed in the Danish Multiple Sclerosis Registry died from suicide at nearly twice the rate that would be expected. A more recent study, presented at the 2015 European Committee for Treatment and Research in Multiple Sclerosis (ECTRIMS) meeting, found that people with MS were almost twice as likely to attempt suicide as those in the general population.

The risk is not limited to people with MS. An analysis of data from more than 220,000 stroke survivors in Sweden, published in *Neurology* in April 2015, found that they were also nearly twice as likely to commit suicide as people in the general population, with the risk being higher in the first two years after the stroke. People with amyotrophic lateral sclerosis (ALS) are nearly six times more likely to commit suicide than the general population, according to another large study from Sweden published in *Brain* in 2008.

Thoughts of suicide are also higher in these groups: people with dementia, especially men; those who were diag-

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nosed within the past year; and individuals who were younger than age 65 when first diagnosed.

ON THE EDGE

Gil Durban* has been in the same dark place Grant Gordon was on that day in August 2014. He was diagnosed with MS during his third year at Harvard Law School in 1994 and had climbed the legal ladder to become a partner at a prestigious law firm.

But by 2010, Durban's condition had begun to progress more rapidly. That spring, he took a neuropsychological examination and scored high in most areas, except for visual processing (the ability to focus on, process, or remember written information or anything else perceived visually). He scored a dismal 5 percent, far below what someone with significant cognitive impairments might score. "A lawyer needs visual functioning, and the disease took it," he says. "So I knew I had to step down from my job."

Durban was able to craft a small consulting position with his former company; that and a significant disability

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package meant that he had no financial worries, but the physical and emotional toll of MS was hard to bear. "You can be very fortunate and supported in lots of different ways and still just be completely devastated by your disease and by the depression," he says.

He took off that summer of 2010 and found himself spending a lot of time alone—too much, in fact. "Things got darker and darker," he says. "I was seeing psychiatrists and psychologists. Around Halloween, a psychiatrist put me on duloxetine [Cymbalta] for depression. That disclaimer about suicidal thoughts when you take antidepressants applied to me. It got worse instead of better. A morning came when I took my three beautiful kids to school, and I didn't think I would see them again."

Durban won't say what his suicide plan was, but he did have one. "I wasn't able to go through with it, not because I didn't want to die, but mostly because I was afraid of the pain and of messing it up and not succeeding. It wasn't a cry for help. I had all the help I could possibly have. I just wanted to escape from what had been happening and how I was feeling."

After his near miss that day in 2010, Durban's psychiatrist was able to identify the right combination of medications—in his case, aripiprazole (Abilify) and bupropion (Wellbutrin)—to control both his depression and overwhelming anxiety. "That brought me out of it. It was like flipping a light switch, and

Suicide Prevention Resources

In an emergency, call 800-SUICIDE (800-784-2433). For additional counseling or resources, try these groups:

- American Association of Suicidology: **suicidology.org**, 202-237-2280
  This association provides resources for families who have lost someone to suicide and people who have survived a suicide attempt. Their directory of searchable support programs is at **suicidology.org/suicide-survivors/sos-directory**.
- American Foundation for Suicide Prevention: **afsp.org**, 800-273-TALK
  This group has a national, 24-hour hotline with access to trained counselors as well as books, forums, and other materials for those affected by suicide. You can also get referrals to local or in-person support groups.
- Suicide Awareness Voices of Education (SAVE): **save.org**, **952-946-7998**
  SAVE has booklets and other resources for survivors of suicide loss and a searchable database of support groups.

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I was back to myself," he says. "But it's hit or miss with these things, and they don't work forever. So far, I've never again been quite as bad as I was that day, but I've been close. I'm better at the moment, but I'm not quite as well as I was six weeks ago, and I'm starting to think they may need to up my dose again." He also knows to limit time alone and focus on what brings him joy.

FEW RED FLAGS

Neither Gordon nor Durban had exhibited any of what we may think of as "classic" signs of suicide risk (for example, deep depression or talking about or attempting suicide) in the days and weeks before Gordon's suicide and Durban's near miss. While they were both on medication for depression and seeing psychiatrists, neither had been diagnosed with severe depression, and their conversations with their families during those times seemed perfectly normal. Neither spoke of suicide or wanting to end it all; in fact, when Gordon's mother brought up Robin Williams' then-recent suicide in a phone conversation, he told her confidently, "No, mom, that's not something you have to worry about with me."

"I don't believe that Grant considered himself a suicide risk, and neither did we," says Grant's older brother, Forrest.

Many—maybe even the majority—of people with neurologic conditions who commit or attempt suicide don't have easily identifiable risk factors or fit a classic profile, says Daniel Weintraub, MD, associate professor of psychiatry and neurology at the Perelman School of Medicine at the University of Pennsylvania. "Some have even been assessed for suicide risk not long before attempting to kill themselves and denied thoughts of suicide. Even asking direct questions may not help identify the people most at risk."

iSTOCK/ SHAPECHARGE

WHAT TO LOOK FOR

The obvious signs may be missing, but there are other factors that caregivers, friends, and family members should be attuned to in anyone with a significant neurologic condition.

Depression and anxiety. Even if depression is diagnosed as mild, it raises suicide risk among people with neurologic disorders. And the more psychological conditions that accompany a person's disease, the higher their risk of attempting suicide, says Matthew Nock, PhD, a leading clinical psychologist on suicide and director of the Laboratory for Clinical and Developmental Research in the department of psychology at Harvard University. "If the person is depressed or anxious, for example, that doubles their risk of suicide. The presence of three psychological conditions—such as depression, anxiety, and alcohol or substance abuse—is associated with a ninefold increase in suicide risk."

Suicide history. If the person has previously had suicidal thoughts, attempted suicide, or had a close friend or family member—especially a parent, child, or sibling—commit suicide, he or she is at higher risk. "When patients tell me that they had a loved one commit suicide, I am particularly concerned about those patients and keep a closer eye on them," says Scott Hirsch, MD, assistant professor of neurology, psychiatry, and child and adolescent psychiatry at the New York University School of Medicine.

Changes in medication. Durban had recently started duloxetine. Gordon was also changing medications. "There's a danger zone when people first start taking a new antidepressant," says Richard Hughes, MD, professor and chief of neurology at Denver Health Medical Center. "The medication may motivate them to do things they couldn't before, but they're still so depressed that suicide seems to make sense."

Because antidepressant medications

ISTOCK/ JUANMONINO

have not been directly studied in people with neurologic conditions, Dr. Hirsch says they must be prescribed carefully. "These medications *are* appropriate for someone with a neurologic condition," he says. "But because we don't know exactly how they will affect such a person, they should always be prescribed by a doctor who is familiar with both the neurologic and psychiatric aspects of the person's illness, and must be monitored closely."

Age. A diagnosis at a young age can cause more depression and despair, says Dr. Weintraub. "The person may feel he's in the prime of his life, still working and raising a family, which can make the impact of the disease seem even greater."

Recent diagnosis. "When Grant was diagnosed, we did a lot of reading and saw that there was an elevated risk of suicide," says Tomiak. "I said to myself that this was something we'd need to be aware of down the line. We didn't know that the first year after diagnosis is actually a very critical year." The research about this is specific to multiple sclerosis, says Dr. Nock, but it may be true for other neurologic disorders as well.

Isolation. Durban was no longer employed, and his wife was living in California while he was in New York, so he was home alone much of the time; although Gordon was planning his dream restaurant, he was working at home and was alone for long stretches while his roommate and friends were gone.

Impulse control. "Grant was making future plans for himself just hours before he died," says Forrest. "Everything points to the fact that suicide was an impulsive decision on his part." Changes in the brain caused by neurologic conditions, such as MS, stroke, and dementia, can affect a person's ability to control impulses, explains Nada El Husseini, MD, an assistant professor of neurology at Wake Forest Baptist Health in Winston-Salem, NC, who specializes in stroke. "The damage done to the brain by these conditions can lead to increased impulsivity, and that can put people at greater risk for suicide even if they are not severely depressed," she says.

"Patients who have any form of frontal lobe dysfunction, in particular, can be more impulsive and more likely to act without thinking things through," agrees Dr. Hirsch. "The frontal lobe is the 'CEO' of the brain, and you're more likely to have poorer judgment if the frontal lobe is impaired. The window between thought and action is shortened in many cases."

The Gordon family has channeled its grief into action to help better understand the connection between neurologic disorders and suicide. Last year, they launched the Grant Gordon Foundation (**thegrantgordonfoundation.com)** to support comprehensive research on specific risk factors and prevention strategies for suicide among people with neurologic conditions. They have partnered with Dr. Nock, who received a 2011 MacArthur Fellowship, or "Genius Grant," for his work on developing more objective ways of assessing suicide risk.

"We have learned many things about risk factors for suicide over the past decades, but we still don't know how to put them together in a way that tells us who is at greatest risk," Dr. Nock explains. He is analyzing enormous sets of data from Partners HealthCare, a major nonprofit hospital and physician network in Boston, to develop "risk scores" for suicide that are specific to neurologic conditions.

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ISTOCK/SOLOVYOVA

HOW TO HELP

Talk openly. "Ask people how they are feeling and if they've thought about hurting themselves," says Rosalind Kalb, PhD, vice president for healthcare information and resources in the advocacy, services, and research department of the National Multiple Sclerosis Society. "You aren't going to put the thought in someone's head. The thought is already there. When we can ask, 'How's your mood?' as easily as we ask about other symptoms of a neurologic disease, then we're more likely to know if someone's at risk."

Rely on professional help. First, understand what you can't do. "You need to know your limitations. Most family members, friends, or caregivers don't have the training to understand how these brain diseases may be affecting someone," says Grant's brother, Forrest. "The most important thing is to do everything in your power to get that person in front of a trained psychiatrist who also has experience with his or her particular neurologic disease, who can understand the complexity of what's going on," he says.

If a person tells you he is currently having serious thoughts of suicide, Dr. Nock recommends bringing him to the local hospital emergency department (ED) for an evaluation. "If a person is having serious thoughts of suicide but is not willing to go to an ED, call 911, and someone there can help you," he says. The dispatcher will ask a series of questions and take action depending on your answers.

If a person is having thoughts of suicide but you are unsure how severe those thoughts are or how at risk the person is—which will be true in most cases, Dr. Nock says—ask if he or she has a psychologist, psychiatrist, or social worker you can call. If not, call the 800-SUICIDE national hotline (see "Suicide Prevention Resources," on page 27). "Ask how you can get your loved one help," he says. "In some areas, they even have mobile crisis teams with trained clinicians who will drive to your home and check on the person."

Lean into joy. During bad times, Durban says the best piece of advice he ever received came from his psychologist: "I was in a pretty dark place again, and she told me to think about what has brought me joy, ever, in my whole life. It's such a great question. It's rare that you find someone who is so deep and dark that they can say, 'I guarantee you I will never feel joy again.' When people are deep in depression, try to find things that are close to what has given them joy. Maybe it's their dog. Maybe it's good food, or an intelligent comedy, or time with a grandchild—something to distract them from their despair and get them through that moment when they are close to hurting themselves."

Stay close. "Social isolation is not good for people who are depressed," says Dr. Weintraub. "Keep them socially engaged, talk to them, get them out of the house when you can. If you can keep them from becoming isolated and withdrawn and spending a lot of time alone with their thoughts, you can buy time until things improve."

Don't dismiss feelings. "You need to recognize their frustration and their despair," says Dr. Hughes. "Don't just say, 'Oh, you can't do that, you have so much to live for.' Acknowledge what they're go-

Healing from Suicide

Processing the suicide of a family member takes time, compassion, and support.

For each of the approximately 41,000 people who commit suicide in the United States every year, there are at least six survivors—family members and loved ones—according to estimates from the American Association of Suicidology.

How do you navigate the shock, guilt, grief, anger, and other emotions that affect survivors of suicide? Everyone is different, says Devin Tomiak, whose brother Grant Gordon committed suicide at age 28, four months after being diagnosed with multiple sclerosis (MS). "Coping with this kind of loss is so personal. There doesn't seem to be a magic formula for getting through it." But people with expertise in dealing with suicide say there are some things to keep in mind when going through the grieving process.

1 Don't put a time limit on healing. Grief does not always take the same path, and sometimes you take two steps forward and three steps back. Don't let anyone tell you how you "should" be feeling, says Rosalind Kalb, PhD, vice president for health care information and resources in the advocacy, services, and research department of the National MS Society.

2 Understand that you could not have prevented this. "Families often feel guilt or remorse that they didn't see this coming or couldn't seem to do anything to prevent it," says Dr. Kalb. "It's important for people to understand that the feelings of depression that generally drive suicidal thoughts and impulses are very complex and strong, and that suicidal behavior is often impulsive and virtually impossible to predict, even by trained mental health professionals."

3 Seek out counseling and/or support groups for survivors of suicide. "The counseling and connection with others is extremely important. Healing in the aftermath of a suicide can take a very long time, and no one should try to do that alone," Dr. Kalb says. "Counseling and support groups can also help families deal with the anger they often feel—at their loved one and his or her health care providers. Family members who are dealing with their own depressive feelings or symptoms should be sure to seek treatment for themselves."

ing through and why they would have feelings like this. They'll be more likely to keep talking and confide in you."

Take talk of suicide seriously. "We know that about two-thirds of people who have committed suicide told someone ahead of time that they were thinking about death or killing themselves," says Dr. Nock. "Not everyone talks about it, and in most cases people who do talk about suicide don't attempt it. But don't take chances. If someone mentions suicide to you, tell them how concerned you are to hear them say that, and suggest finding someone professional to talk to in order to get them to a better place."

Encourage engagement. "Many people who have lost function due to a neurologic condition feel like they've lost their purpose in the family and society," says Dr. El Husseini. "There's a sense of not being important anymore, of having nothing to do—just being someone who is cared for. Help them to remain involved and find ways to do things that matter." Durban, for example, cannot work in his old capacity, but he still consults for his law firm and writes a blog about living with MS.

Keep guns out of reach. The risk of suicide triples when people have access to a firearm—whether they have a neurologic condition or not, according to a study published in the *Annals of Internal Medicine* in 2014. The Gordon family strongly believes that if Grant had not had access to a gun, he would still be alive. In fact, although only 9 percent of suicide attempts result in death, when the attempt involves a firearm, it is fatal 85 percent of the time, according to the US Centers for Disease Control and Prevention. Other means of attempting suicide—like taking pills or cutting wrists—are more likely to fail, and they also allow the person time to reconsider and call for help. Having a gun nearby can turn what would have been a brief period of despair into an irreversible act.

Discuss safety measures. Don't remove guns without talking to the person first. Discuss the idea when the person is in a calm and relatively positive frame of mind and explain that limiting access to lethal means can keep them safe in their worst moments, even if they might not want to do anything now. "Be frank that you are worried about their safety, because they are so important to you," says Dr. Hirsch. "If they don't agree to precautions—for example, putting guns in a safe to which they don't have the combination—then you have to decide if you think they are an imminent threat to themselves. If you do, then you have to call 911."

The Gordon family hopes that talking about what happened to Grant will encourage other people with neurologic conditions who are struggling with depression and thoughts of suicide to reach out. "There's such stigma surrounding suicidal thoughts and suicide attempts. Nobody wants to talk about it," says Forrest. NN

**Gil Durban is a pseudonym.*

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