A Line in the Sand

By Jennifer Hagman, M.D.

Last summer, I crossed an invisible “line in the sand.” A patient in whose care I was very involved committed suicide. Although it is well known that many of us will face this experience in the course of our careers, there is little preparation or education for what may be one of the most difficult experiences encountered in the professional life of a psychiatrist. The statistics say that 51% of psychiatrists have had a patient who committed suicide (Kaye 1991); other studies report that 33% of residents have experienced a patient suicide (Brown 1987). A 2005 article in the APA publication, Psychiatric News, quotes Robert Simon, M.D. stating, “There are three kinds of psychiatrists: those who have had a patient commit suicide, those who will have one commit suicide and those with both. If you practice long enough, someone will commit suicide. It’s inevitable.”

Little in my training or my career had prepared me for this experience. I began my psychiatry residency in 1986 and have been involved in the care of individuals with mental illness for 22 years. During my residency and child fellowship, I don’t recall any seminars or small group discussions about the likely experience of a patient suicide in the course of one’s career, nor do I recall any supervisor discussing this with me, or sharing their experience.

After the suicide, I felt as if I had crossed an invisible line, and found myself suddenly “on the other side,” in an unfamiliar place, unsure of how to navigate my way forward, yet having to do so. Due to the severity and persistence of the patient’s illness, many others had also been involved in interventions over several years. This fact broadened the depth and impact of the loss, but also provided a circle of support as we worked through the experience. The range of reactions and responses from colleagues who were aware of the death was widely varied. I greatly appreciated those who shared their own experiences freely and offered support. Still, I found the experience to be a solitary one. There was the challenge of being mindful of my own emotional responses, and the impact of the experience on my interactions in my clinical practice and personal life. There was the challenge of related administrative reviews and legal consultations. There was also the need to be supportive and aware of the wide range of responses and needs of others who were impacted. Some of the most difficult challenges came in being available to and aware of the needs of the patient’s family.

Many weeks after the event, I found myself in intellectualization – searching for information and articles. I called CPS to ask if we had any discussion groups or support groups for psychiatrists who had gone through this difficult experience. I was somewhat surprised to learn that we did not. However, Barbara Dygert was able to provide me with a very useful set of articles gathered up over the years on the issue of patient suicide. The articles she provided and my own subsequent literature search gave me helpful information for understanding my own experience. The APA also has a useful area on its website, under educational resources called “Helping residents cope with a patient suicide.” In addition, the 2003 APA Practice Guideline, “For the Assessment and Treatment of Patients with Suicidal Behaviors” includes a section on “management of suicide in one’s practice.” My hope is that this column will stimulate discussion of what CPS can do to support our members and trainees to be better prepared in the tragic event of a patient committing suicide, and to help CPS members with awareness of currently available resources.

The emotional impact of a patient's suicide cannot be minimized, and includes a range of emotions: guilt, shame, denial, disbelief, anger, fear, and depersonalization. The responsibility...
Resident’s Column
by Rachel Davis, M.D.

[Editor’s Note: We don’t usually print scientific information in the CPS newsletter. Please let us know if you want us to do this more often.]

As part of my rotation with Dr. Zilber in the University of Colorado Infectious Disease Clinic, I worked on compiling an up-to-date cytochrome P450 chart for psychiatric medications. The cytochrome P450 system includes the hepatic enzyme system responsible for approximately 75% of drug metabolism in humans (Guengerich, 2008). The level of activity in these enzymes is highly variable among individuals and is genetically determined. Awareness of drug metabolism is important in order to minimize potential drug interactions.

Due to the size of the chart, I’ve included just the SSRI/SNRI section in this newsletter, but I would be happy to forward the entire chart to those interested. Other sections include 1st and 2nd generation antipsychotics, benzodiazepines, non-benzodiazepine-sedative-hypnotics, TCAs, and miscellaneous psychiatric medications.

Drug development and drug metabolism research are very active fields so this chart will not remain up-to-date for long. Please feel free to send new or additional drug metabolism data as you come across it, so that I can continue to update this chart. Rachel.Davis@uchsc.edu.

Guengerich FP. Cytochrome P450 and Clinical Toxicology. Chemical Research in Toxicology. 2008;21:70-83. References available upon request. Contact CPS office (cps@nilenet.com) or Dr. Davis directly (Rachel.Davis@UCHSC.edu).

### CYTOCHROME P450 METABOLISM OF PSYCHIATRIC MEDICATIONS

<table>
<thead>
<tr>
<th>SSRIs - Selective Serotonin Re-uptake Inhibitors</th>
<th>SNRIs - Serotonin Norepinephrin Re-update Inhibitors</th>
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| **Fluoxetine**  
*Prozac* | 2D6 substrate (major)  
3A4 substrate (minor)  
2C9 substrate (minor)  
2D6 inhibitor (potent)  
3A4 inhibitor (mod)  
1A2 inhibitor (weak)  
2C19 inhibitor (wk to mod) | 2D6 substrate  
Mirtazapine  
*Remeron* |
| **Paroxetine**  
*Paxil* | 2D6 substrate  
2D6 inhibitor (potent)  
1A2 inhibitor (weak) | 1A2 substrate  
2D6 substrate (minor)  
2E1 substrate (minor)  
1A2 inhibitor (v. weak)  
2D6 inhibitor (v. weak)  
3A4 inhibitor (v. weak)  
Venlafaxine  
*Effexor* |
| **Fluvoxamine**  
*Luxox* | 2D6 substrate  
1A2 substrate  
1A2 inhibitor (potent)  
2C19 inhibitor (potent)  
2C9 inhibitor (potent)  
2D6 inhibitor (weak)  
3A4 inhibitor (potent) | 2D6 substrate  
Duloxetine  
*Cymbalta* |
| **Sertraline**  
*Zoloft* | 3A3,4 substrate (primary)  
2D6 substrate (minor)  
2D6 inh (weak to mod)  
1A2 inhibitor (weak)  
3A3,4 inhibitor (weak) | 3A4 substrate (minor)  
Desvenlafaxine  
*Pristiq* |
| **Citalopram**  
*Celexa* | 3A4 substrate  
2C19 substrate  
2D6 inhibitor (weak)  
2C19 inhibitor (weak)  
2C9 inhibitor (weak)  
1A2 inhibitor (weak) | 2D6 inhibitor (v. weak - not clinically significant at recommended daily dose of 50 mg) |
| **Escitalopram**  
*Lexapro* | 3A4 substrate  
2C19 substrate  
2D6 inhibitor (weak) |