Letters

Reaching for the Golden Goose Egg

TO THE EDITOR: Recently, three years out of psychiatry residency, I lost my first patient to suicide. He was habitually overextended, maneuvering an out-of-town job, a disintegrating marriage, and a severe depression exacerbated by excessive alcohol use. His horizon was contracting. Alert to his precarious stance, he sold his guns, tempered his drinking, and agreed to therapy. But shortly afterward, he bought another gun, and in the tempest of a domestic dispute fueled by whiskey, he fled police, doubtless panicked, and shot himself in the head.

I was shaken but also knew I had provided good care. I phoned his distraught widow, who offered this: "He liked you. He would talk about how you helped him. Thank you." That meant everything, but of course it could not bring him back, nor did it stave off the inevitable self-scrutiny that follows a bad outcome. And while I received only comfort from my colleagues, I work for the U.S. Department of Veterans Affairs (VA). This isn't supposed to happen at the VA.

Bringing veteran suicide to zero is now among the VA's top clinical priorities. David Shulkin, M.D., the former VA Secretary, publicly asserted, "The issue of veteran suicide is our number one clinical priority . . ., and it's really the only clinical priority that I talk about as our major focus. . . . I can't commit that I know exactly everything that's going to work, but I can commit that we're going to do everything possible to try to get that number down to zero" (1). The VA wants a zero, a golden goose egg, in the suicide column.

Those of us who work with veterans know just how daunting a task this is. Veterans disproportionately die by suicide in the United States, and they do so in the context of an increase in the general suicide rate (2). The most recent publicly available data show that on average, 20 veterans per day die by suicide (about a third of whom use VA services) (3).

Saying we are pursuing zero suicide creates an uneasy expectation, particularly for a nation clamoring for favorable news from the VA. But is it even reasonable to talk like this? While asserting that the pursuit of zero suicide is a worthy aspirational goal, the Group for the Advancement of Psychiatry's Committee on Psychopathology (4) also pointed out that, "Given the present state of our science and community practices, most would agree that zero [suicide] is not yet obtainable." And, importantly, they highlight that an overzealous push for zero can have unintended consequences, namely augmenting the guilt of survivors and potentially compromising postvention work. Respecting the essential autonomy of our patients while affirming life when they want it to end is complicated. The will to live cannot be forced, even by government mandate.

The catastrophic impact of suicide on survivors demands that we exercise appropriate evidence-based caution and ensure that we are not simply shouting slogans. The evidence that we can achieve zero suicide in the veteran population unfortunately does not yet exist, particularly when two-thirds of veterans who die by suicide are choosing to stay out of VA's clinical reach. This shouldn't stop us, however, from reaching for the golden goose egg (zero suicide) and doing everything we can to affirm life, so long as in our efforts we become more united and more compassionate and look to the evidence to inform our approach.

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The Healing Relationships in Public-Sector Psychiatry

TO THE EDITOR: Family medicine attends to the possibility that relationships can have healing effects (1). Historically, psychiatry has recognized psychological healing (2), but lately psychiatry has not emphasized the concept. Yet healing relationships may have special value in public health.

Healing is defined as curing when possible, relieving suffering, and finding meaning beyond the illness (1). The concept of healing relationships, typically occurring between

two people, is a time-honored and venerable social construct across cultures. One person is a help seeker who is ill, possibly disabled, and often demoralized. The other is a professional caregiver who wishes to heal and has special knowledge and skills.

Consistent with person-centered therapy, the concept of healing relationships emphasizes the qualities of clinical relationships for which professional caregivers may strive. Core characteristics are being nonjudgmental, understanding, accepting, respectful, and empathic and instilling a sense of hope and empowerment within the help seeker (3). Healing relationships develop during skillful, semistructured interviewing; focused listening; and iterative, collaborative formulations of illness and recovery narratives that reflect personal experiences beyond diagnosis.

Healing relationships are interpersonal nuclei for person-centered care (PCC) in recovery-oriented systems of care. PCC provides principles, strategies, and structures—a process for actualizing recovery plans. PCC emphasizes personhood (versus patienthood); recovery goals (beyond the relief of suffering); partnership among help seekers, their families, and professional caregivers in planning care; and facilitating help seekers in taking an active role in their care (4). All of these are instrumental in supporting help seekers (1) in achieving recovery within a healing context of shared meaning. Recovery orientation incorporates the attitudes, behavioral professionals (including peers), and resources (including residential services) necessary for people to shape their care and their lives (5).

To illustrate, AB was a 29-year-old Greek-American man with intractable schizophrenia, whose treatment included multiple hospitalizations and a recent clozapine trial that caused myocarditis. Living in a low-supervision residence and demoralized by failure to achieve his goals of marrying, working, and owning a home, he suffered from persistent paranoid delusions and alarming suicidality. An interdisciplinary team engaged him with nonjudgmental understanding and acceptance, instilled hope, and collaboratively formulated a recovery plan. Fundamentally at stake for him was having a reason to live. The plan, made while AB was taking risperidone, included publishing poetry and participating in peer groups and supported work. To everyone's satisfaction, the psychotic symptoms subsided, and he joined a narrow community.

In addition to their intrinsic therapeutic value and consistent with the variance explained by the attributes above in therapeutic trials (3), healing relationships engage help seekers and hold them in care, thereby facilitating PCC and treatment interventions. They serve as essential criteria for quality of care, and they mitigate behavioral professional burnout. Healing relationships work best in a framework of a comprehensive, biopsychosocial model of practice.

Healing concepts, which are rooted in medical and social sciences, are particularly important for a target population of people with chronic, disabling, and demoralizing behavioral disorders. They complement macroscopic system perspectives for understanding public-sector practice. For these reasons, public psychiatry ought to renew interest in healing relationships as clinical, interpersonal nuclei in the process of care.

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PHQ-9 Administration in Outpatient Adolescent Psychiatry Services

TO THE EDITOR: Depression is a major public health concern among young people within the United States, yet 60% of adolescents with depression do not receive the necessary treatment (1). Increasingly, universal screening for depressive symptoms is being recommended across health care settings (2). One of the most popular depression screening instruments is the Patient Health Questionnaire (PHQ-9) (3), a freely available, psychometrically sound measure recommended by the U.S. Preventative Services Task Force for depression screening (4). The utility of the PHQ-9 has been well established in primary care (4,5), but there is a paucity of research detailing the extent to which the PHQ-9 is effective in adolescent psychiatry settings.

Beginning in 2016, the outpatient psychiatry clinic at Boston Children's Hospital implemented universal depression screening with the PHQ-9, allowing us to preliminarily evaluate the instrument's feasibility in an adolescent outpatient population and to examine associations with clinical management of depressive symptoms. From September 2016 to March 2017, 325 patients over the age of 12 were administered the PHQ-9 upon their visit to the clinic. Sixty-two percent of patients were male (N=202; some patients did not report) and 63% (N=205; some patients did not report race-ethnicity) were white, with a mean±SD age of 16.03±2.42 years. Session notes for clinic visits wherein the PHQ-9 was administered were reviewed for documentation of psychiatric diagnoses, referrals, safety planning, readministration of the PHQ-9, and emergency assessments for possible hospitalization. The proposed project was approved by the Psychiatry Scientific Review Committee at Boston Children's Hospital as a quality improvement initiative.