

R2R Transcript—The Silent Crisis: Understanding Suicide Risk

[00:00:00]

Content Warning Intro

Stephen Calabria: This podcast episode contains discussions and descriptions of suicide. Viewer discretion is advised.

From the Mount Sinai Health System in New York City, this is Road to Resilience, a podcast about facing adversity. I'm your host, Stephen Calabria, Mount Sinai's director of podcasting.

Meet Dr Galynker

Stephen Calabria: September is Suicide Prevention Month, a time to raise awareness, reduce stigma, and remind people that hope and help are available.

On this episode, we're joined by Dr. Igor Galynker, a psychiatrist, researcher, and director of the Suicide Research and Prevention Laboratory at Mount Sinai.

His work has focused on understanding the psychological states that can precede suicidal behavior and on developing new ways to identify people at risk before a crisis turns into tragedy.

In this conversation, we discuss warning signs, common misconceptions, what family and friends can do when they're concerned about someone, and how shifting paradigms are helping clinicians better prevent suicide.

[00:01:00] Dr. Igor Galynker, welcome to Road to Resilience, sir.

Igor Galynker: Thank you so much. It's a pleasure to be here.

Why Study Suicide

Stephen Calabria: You've spent much of your career focused on suicide prevention. What first drew you to this line of work?

Igor Galynker: In retrospect, I had two reasons for this. One was a conscious reason, and the other was a subconscious reason.

The conscious reason was that in about 2007, then the medical director of American Foundation for Suicide Prevention gave a talk, it was then Beth Israel, about suicide prevention.

And, there was very little there about suicide prevention. There was a lot about serotonin, radicals, chemistry, but nothing about suicidal mind, which surprised me.

So at the end of the talk, I actually asked Paula, "What do you know about the state of somebody's mind the day or the moment before they kill themselves that is different from the day before?" And she said nothing. There was no framework.

There's actually no [00:02:00] framework at the time. At that point, a light bulb went in my head, and I realized that here I am a doctor, and there's a giant gap in psychiatry and suicide prevention that we have a psychiatric syndrome or psychiatric condition that is lethal and with no description.

So that was the conscious reason. At that point, I changed my research direction from bipolar disorder to suicide prevention, and has been working on it ever since, describing that mental state and that condition.

The subconscious reason was that about seven years prior to that, I lost a patient to suicide and it was in my first year as a young attending.

And the person swore up and down that they were not suicidal, and then he died. And then he sent me a letter that received three days after he died, obviously, sent before he died telling me that it's not my fault, that I did everything I could, and also I got a gift from him.

[00:03:00] And that made an impact of me as a young clinician, and I was sitting there for several years until I heard Paula speak, and then it clicked.

Depression Versus Crisis

Stephen Calabria: Is there a difference between feeling depressed and being at imminent risk of suicide?

Igor Galynker: I can't say it is night and day, but I'm tempted to say it is night and day, because 50% of people that deny suicidal ideation to the last person they've seen. And because suicidal mental state is not actually a depression state.

It is not equal to depression. It may be related to depression. We, however, both the clinicians and general public, tend to think of suicide as a consequence of depression.

But a half to a third of people who die by suicide do not have any psychiatric diagnosis. And what they do have is acute suicidal mental state, which is closer to the state of psychotic panic than it is [00:04:00] to depression.

Stephen Calabria: Do you think folks all too often mistake being depressed with just being sad?

Igor Galynker: Yes. Depression is an illness with a particular progression, particular actually time course of which sadness and depressed mood is one of the symptoms and one of many, and not even the main one.

And the one that appears relatively late in this, in the episode progression in fact, the first signs of depression or depressive episode is not sadness but decrease in motivation and activity that a person may not even notice, but a person close to the depressed person would and ask him, "Are you okay?" Typically, that's how the story goes.

Rethinking Risk Assessment

Stephen Calabria: And how has our understanding of suicide evolved over the past several decades, particularly since you began this work?

Igor Galynker: In I would say significantly but insufficiently. Not enough to cause to result in [00:05:00] basically paradigm change in suicide prevention, which needs to happen.

What has evolved because of our work and other people's work, of course is understanding that suicidal mental process is not equal to suicidal ideation, that suicidal ideation is comes and goes, may or may not be there, can come in different kinds, and 25% of people, young people in the last, let's say last fall, seriously considered suicide.

Quote, unquote, "seriously considered suicide." And 99.99% of them are alive and doing fine. And yet our reliance on suicidal ideation and on people telling you accurately about their suicidal ideation and suicidal plans at the worst moment of their life when they cannot think clearly and expect them to be correct in self-diagnosing their suicidal state is actually absurd, and people are actually getting to that point.

Because we never ask patients with schizophrenia to diagnose their psychotic [00:06:00] episodes. We never ask people with bipolar disorder to diagnose accurately their mania and then rely on our treatment and their diagnosis, and we ask people who are suicidal and about to die to accurately tell us what they're about to do, which makes no sense.

Stephen Calabria: That also leaves open a fair amount of subjectivity, doesn't it? The idea of somebody being, quote, "at serious risk of suicide." Who's to say what constitutes seriousness? Or is there a template for that?

Igor Galynker: There is a template which is incorrect, in my opinion. The template is what is called a risk stratification, and stratify people based on various criteria into low, medium, and high risk.

And like most people who are all suicidologists and most people who deal with suicide know that people who die by suicide are usually classified as low risk. And the main concern when people contact me and reach out to me from schools, from other institutions, from losing a [00:07:00] colleague is it came out of the blue.

The person was totally fine. We're not concerned about people who are telling us they suicidal. We're concerned of people who are not telling us.

Stephen Calabria: September is Suicide Prevention Month. Why is it so important that we continue having public conversations about suicide, do you think?

Igor Galynker: Within this current framework, meaning suicide actually being a preventable condition and that should be prevented in clinical setting, it is important because talking about suicide does raise awareness and does not increase uh, the instance or risk of people killing themselves.

Other things, such as celebrity suicides and imitation, et cetera, do, but this particular aspect doesn't. And in the last two years, the suicide rate in the United States, particularly in the young people, has flattened somewhat.

And the argument can be made that it is [00:08:00] due to 988 and the public awareness finally taking effect.

Stephen Calabria: From your perspective as both a clinician and a researcher, what do you think people most often misunderstand about suicide and suicide risk?

Igor Galynker: Most often, there's several things. One is a progression from ideation to intent to plan to suicide as an orderly progression, which is called ideation to action model.

Where there's a constant ideation, it gets worsens, worsens, worsens, and results in the plan in suicide. That's not how that works at all. It works in the minority of people, but the way it works is there is a storm that... a wave that people get swamped in, and it can... it's violent and quite short.

It can be quite short hours. And it can it doesn't come entirely out of the blue but it feels like people are drowning or [00:09:00] being swamped.

Stephen Calabria: And so in other words, it's not quite so linear in people- Not at all ... as a normal perhaps disease might be, like cancer, for example.

Igor Galynker: It's like a normal rational person would think and imagine suicidal process being because it is not a normal and rational process. What it is, it's a overwhelming, incredibly painful and unbearable syndrome, mental state that comes upon a person that becomes unbearable.

Suicidal Narrative Model

Stephen Calabria: What are some of the warning signs that family members, friends or workers or classmates you think should be aware of?

Igor Galynker: I would not call them warning signs. I know it's a very well-known term, and is accepted by SAMHSA and a lot of a lot of institutions and administrations. There is a particular order to developing suicidal mental state.

And we staged it, it's called narrative crisis model. There are four stages to [00:10:00] the model. The first is a long-term vulnerability. Some people just lifetime have higher probability of dying by suicide than others.

For instance, people who are fearless are like that. People who are pessimistic are like that. Perfections are like that. But they're totally okay, usually. But then something happens in some stress, and sometimes several and simultaneous in succession, and what they develop is what we call narrative suicidal narrative, and they talk about it.

And when they talk about it, first of all, of course, people need to pay attention to stressful life events such as final romantic rejection, catastrophic financial failure, onset of life-threatening illness.

All of these are. But once the people start developing what we call suicidal narrative, and I can describe it, they talk about it, and then, you don't even need to ask.

If you know what to pay attention to, you're gonna hear it. You're gonna construct it yourself. And that suicidal narrative, which is precede suicidal crisis, can be there [00:11:00] for weeks. And that would be actually a time to intervene and get help.

Stephen Calabria: What does that narrative look like?

Igor Galynker: It looks like a life story. We all have our life story, life narrative, where we came from what our childhood was like, how we got where right now, where we are right now, where life is going. The suicidal narrative is a story that has no future, and the story is like that.

I had a goal, and the goal was out of reach, and I'm failing. I'm not gonna reach that goal, and becomes clearer that that I'm not gonna be a Bolshoi ballet dancer at 45, or that I'm not gonna be a Nobel Prize winner, that I'm not gonna be a billionaire.

And okay, I'm not gonna have a perfect family with perfect children, and it's not gonna happen, but people just keep clinging to that goal because that's the only thing that would make them happy, and they can't stop.

They cannot redirect. They cannot reset. They cannot change. And the farther it goes, the more humiliated and defeated they [00:12:00] become, and the more humiliated and defeated they become, the harder it is for them to connect with others, the more burdensome they feel, the more they withdraw.

And the future without that goal that they just failed to achieve is unacceptable, and that's the narrative, and they talk about it.

Stephen Calabria: You touched on particular life events that can increase vulnerability to suicidal crises. Could you delve into those a little bit more? And perhaps what they have in common?

Igor Galynker: I probably cannot say confidently what they have in common because I never asked that question to never asked myself that question.

What does final romantic rejection and financial failure and homeless have in common besides being devastating? But there's maybe seven or eight kinds of these events, and one of them is final romantic rejection, final underscored, which is associated with death by suicide within 48 hours.

So if somebody made it for two weeks, they're gonna be [00:13:00] okay. catastrophic financial failure. Catastrophic blow to ego identity, which is associated either with a career or family life.

Onset of life-threatening physical illness. Relentless, unremitting mental illness that doesn't respond to anything. bullying. Bereavement, losing somebody that was incredibly important to you. These are the main ones.

And there are others which fall under these categories, notably, let's say, impending homelessness. Losing a home, which is both financial failure and a blow to ego identity.

Things like that. These are the main categories.

Stephen Calabria: Sure.

Shame Resilience Screens

Stephen Calabria: Now, how do you think feelings such as shame contribute to suicide risk? It seems to exert an outsized impact when it comes to these sorts of conditions in a way that other medical conditions like bursitis or something, or even more serious conditions like [00:14:00] cancer perhaps don't. What are your thoughts on that and why it persists?

Igor Galynker: We just reviewed our own paper, which actually we're about to submit on that, and the two aspects to morality and suicide. One is moral prohibitions against suicide, usually religious, which is protective. It is the only thing that is really protective.

And the other side of it is shame, which is actually a risk factor. So shame is and being prone to shame for your behavior is generally is, I hate to use the word risk factor, but I would say it's a vulnerability.

Being prone to shame, and what that means is being what's called an internalizer in terms of a personality structure.

There are two types of people. Internalizers when something goes wrong, blame themselves and feel guilty. And the other one is externalizers. When something goes wrong, they blame others and generally don't [00:15:00] feel guilty and don't even feel bad.

So internalizers are prone to shame, and that obviously contributes to suicidality.

Stephen Calabria: Our show is called Road to Resilience, and I wanna make very clear to our listeners that resilience is a different concept than strength. Just because somebody is exhibiting suicidal thoughts or feelings does not mean that they lack strength. And perhaps you would agree that too often that is the conflation that people make.

Igor Galynker: I agree, and I actually deal with this in a, from a different from a different angle quite often. People email me or text me and said, "I had a friend who just killed himself." Okay, "And I blame myself for that."

And I listen to the story, and invariably, that person kept the [00:16:00] suicidal person alive for a very long time by being helpful, by helping them being resilience, by being resilient themselves, and it's it's incredibly important.

There's a separate issue, which is maybe not necessarily beyond this framework, and it is that our current upbringing of children, it's called gentle parenting, deprives them of resilience. And the mental health problem of the current generation and increased suicide rate more recently are probably related equally to increased exposure to social media and screens, and also to gentle parenting, and helicopter parenting, which does not allow people to develop regular resilience skills.

Since your show is called Road to Resilience that resilience is antifragile concept, and human mind is antifragile, if you know what I mean by that, as opposed to-

Stephen Calabria: I do not.

Igor Galynker: Okay. [00:17:00] Antifragile is an interesting concept. It means that some function does not develop if it's not challenged. Like immune system is anti-fragile. If you don't challenge immune system, if you protect people, it doesn't build up and people die from infections.

Same as the brain and emotional system, if you don't challenge it with adversity, people are deprived with opportunity to build resilience and life skills.

And when we protect our children and when we practice gentle parenting, when we schedule everything for them to not allow unsupervised play, what happens is that children grow up having no resilience because their mind has not been practiced.

Stephen Calabria: Could you please touch on the role of social media in all of this and how it correlates to and perhaps even contributes to increases in suicide risk?

Igor Galynker: There are facts. Let me deal with the facts as opposed to my [00:18:00] personal actual feelings about. The facts are exposure to screens of any sort increases suicidality.

Exposure to screens plus social media further increases suicidality. Exposure to screens and social media for girls selectively increase suicidality for girls, and they spend more time on social media than boys.

And finally, to cyberbullying on top of that amplifies all of it. So I'll give you five steps of increasing screen time and social media that makes things worse, increases I guess chances of suicidal behavior, vulnerability, and all of this is worse for girls than boys, and this is why the rates of suicide have been closing.

Suicide Crisis Syndrome

Stephen Calabria: You've studied what you call Suicide Crisis Syndrome. Could you tell us what that is and how it differs perhaps from traditional ways of thinking about suicide risk?

Igor Galynker: Suicide crisis syndrome is [00:19:00] a medical syndrome, a psychiatric syndrome called suicidal mental state, acute suicidal mental state. When people are in that state they kill themselves. It's an objective state. It's not self-report.

It is something that has fourteen symptoms grouped into five criteria. They're not a hundred percent exclusive because, not all criteria for depression do not cover all symptoms of depression.

But if they're there, if people has the syndrome, the chances of dying in the next, let's say, days or weeks are much higher, by an order of thirty.

Stephen Calabria: What advances would you say, either technological or otherwise, are helping clinicians assess suicide risk more effectively these days?

Igor Galynker: I would let me pull out the word technological. And focus with that for a minute. And Technology, in my opinion, particularly recent technology, does not make things easier. Technology actually has made everything harder and will continue to make [00:20:00] everything harder.

Paper is easier than clicking. Dealing with people is easier than dealing with the computers, with computers, and it's like abundantly, clear to everyone.

So with, specifically with technology, there is a temptation to move away from people, suicidal people, and try to deal with it long distance using medical records various notes, and analyzing them and predicting them as opposed to dealing with real people. And one of the reasons for that is obviously fascination with technology.

That's a usual human thing. But also people have very negative emotional responses to suicidal people. They're scared. Suicidal people make them anxious. And it cause incredible distress, and I think technological advances allow clinicians and also others to hide behind technology and step away from suicidal people they're scared of.

So I'm skeptical [00:21:00] about advances because I think they I didn't see any, really, significant improvement from advances.

But I see damage in people misdirecting their research efforts and from clinical encounters and actually talking to people and understanding how that work and getting involved, to trying to predict and save people from looking at the numbers.

Stephen Calabria: And to that point, for a loved one who is encountering something like this in a family member or close friend, and it does make them anxious or it does make them scared, what's the best way for them to begin the conversation? How do you that?

Igor Galynker: They said there have been advances but there hasn't been a paradigm shift. In my opinion, the suicidal narrative and suicide crisis syndrome need to be known to everyone like choking victim, signs of angina, heart attack or stroke. Everybody needs to know what it is. [00:22:00] And once that's there, you're empowered to know what to do.

You're not scared anymore. You're not relying on the person telling you what they're like. You actually can turn on your brain and your mind and be informed. You know when somebody's choking and you don't know what it is, you panic.

And you can still panic, but you vaguely know what the Heimlich maneuver is and you know what to do. And it should be the same thing. It should... Everybody should know about it.

This is why we want suicide crisis syndrome in DSM which is Diagnostic and Statistical Manual for psychiatric conditions, so it is taught everywhere and everybody knows it.

And when somebody tells you, "I can't sleep, I can't think," and I don't know what I feel, and I'm jumping out of my skin," that would know, the way actually, these are four out of five symptoms of suicide crisis syndrome.

So let's go somewhere. Let's call your doctor. I cannot leave you alone. It's not gonna go away. We need to act. As opposed to when somebody says, I wanna kill myself [00:23:00] because I would rather live with my father than with my mother."

Which, is not an issue really and no, no suicidal danger despite the words.

Family Support Protection

Stephen Calabria: We've been talking about the role of close friends and family in all this, which is perhaps often a great deal of responsibility to place on a few individuals. How do you think other institutions, like healthcare providers, schools, workplaces, or even entire communities could play a role in suicide prevention?

Igor Galynker: I wanna actually come back to family, because as you may or may not know, I have two clinical centers in Midtown. One is the Family Center

for Bipolar Disorder, and the other one is the Family Center for Suicide Prevention.

And the family component is as essential as suicide crisis syndrome and narrative crisis model because it does so many things. If family alone is responsible, for a suicidal person, it's [00:24:00] incredible pressure.

But if family works with a clinician being responsible, okay, and knowing what to do, that removes the pressure, and we do it all the time.

And the teamwork between the family and treatment partners and the clinicians in open communications and chats that we do, drastically changes the picture because nobody is ever alone.

And nobody ever feels responsible. Everything is spread. And, there's trust, and people can communicate, and that happens, all the time.

That's a key to suicide actual prevention. By the way, treatment partners, I mentioned. Not all treatment partners are family members. Some of them are friends, some of them are caseworkers, some of them are coworkers

Stephen Calabria: Would you say there are protective factors that help reduce risk and strengthen resilience during particularly difficult periods?

Igor Galynker: The main protective factor that works, the main protective factor on an [00:25:00] individual level is actually moral and religious objections to suicide. That's critical. Somebody who is a Catholic somebody who goes to church, somebody who has a priest, somebody who talks to the rabbi and that's really very important.

When somebody says, "If I kill myself, I'm gonna go to hell," that's one thing. And the other person says, "If I kill myself, I was organic matter, and now I'm an inorganic matter, merged with the universe," it's a very different story. That's really what works.

That's the best protection. The other protective factor and it's really critical, is just not being alone. Very few people die by suicide in front of other people, particularly their loved ones, in front of them, unless there is a conflict. But that's an exception.

Stephen Calabria: How does substance use, oftentimes termed substance abuse, factor into this? Does it [00:26:00] heighten an individual's risk on average?

Igor Galynker: Yes. Heightened in several ways depending on the substance use. The worst actually problem at the moment as I see it is marijuana.

And the legalization of marijuana has been one of the disasters, if you ask me recently, because now twenty-five percent of men who develop schizophrenia do it because of marijuana use.

And it makes people psychotic, and it does so unpredictable in insidious ways, and its psychotic panic state is suicidal state. And I've seen many people who actually attempted suicide in that state high on weed. Opiates is an overdose.

Just in a way that's most well known. And alcohol is also contributing factor significantly in increasing alcohol abuse because I've seen this is when people kill themselves without being consciously [00:27:00] suicidal.

Because there is a like a death awareness in a lot of people which is underneath, like actually pretty close to the surface, but may not be conscious, and when people get drunk, it comes up and these inhibitions drop, and people can jump, and people can stab, and people can shoot.

Stephen Calabria: Around the issue of marijuana, there is a debate about causal versus correlative. Some folks believe psychosis already existed within that person and it was only the marijuana perhaps that caused it to flare up or come out even further. But, you would disagree with that.

Igor Galynker: There is unequivocal studies that shows that actually marijuana causes schizophrenia. Marijuana does not cause schizophrenia in everyone. Some people have vulnerability, genetic vulnerability, genetic [00:28:00] loading.

The way the genetics work in psychiatric illness is not particularly genes, but the number of them that's that's an issue. If you have, let's say, 100 genes that cause schizophrenia if you have all 100 of them, no matter what, you're gonna have schizophrenia.

If you have zero, no matter what, you're not gonna have schizophrenia. You can use weed from, birth, you're not gonna develop schizophrenia. But if, let's say, if you have 20 to 80, schizophrenia's gonna depend on how much weed you use

Stephen Calabria: Now, it's a topic for perhaps a whole separate podcast, but I did want to touch on assisted suicide, which I don't imagine is what you're really talking about here.

A person who undergoes assisted suicide, at least according to the legal ramifications in some places, is a person who is terminally ill and has perhaps no hope.

Igor Galynker: That's not- Yes ... that's actually not the case. And I'm glad you brought it up. So it used to be the case [00:29:00] that a person needed to be terminally ill and six months prognosis, and needed to be assessed, and was in unbearable pain.

So recently, including in New York State, I believe they're trying to pass laws when people, for instance, do not need to be terminally ill.

Some people may have mental illness and may not even have a capacity to do that. And to me, this is one of the most dangerous slippery slopes humanity has entered comparable to AI.

Because at some point, if you follow the money, because this is what usually drives the world, this is a really great way to get rid of a lot of people who need to be on Social Security.

Death with dignity assisted suicide if you're ill, if you're mentally ill, if you're sad, if you're depressed, or generally, if you're not wanted to be around. And to me, this is incredibly dangerous, and I [00:30:00] hear more and more conversations about this.

And the way I see the world works, these conversations are fueled by those people who won't cut down on social security.

Hope Treatment Takeaways

Stephen Calabria: For someone who is currently struggling and feeling hopeless, what would you want them to hear?

Igor Galynker: For people who are who are struggling, meaning people who are struggling with being consciously suicidal. Is that the question?

Stephen Calabria: Yes, sir.

Igor Galynker: Okay. That suicidal mental state is an illness. Suicidal narrative is an illness. Both of them are treatable illnesses. You need to know the symptoms. Once you know the symptoms you need to see the doctor who knows the symptoms.

And crisis is, in somebody who is not on psychiatric medication can be treatable with- s- within forty-eight hours, twenty-four, forty-eight hours.

And after that, a person feels differently and they can talk, they can do therapy.

If it's more complicated when [00:31:00] somebody is already on medications, but again, the other medication can be added or changed.

And this is, by the way what is missing at the moment is a clinical trial for acute suicidal mental state with medications that work.

And let me now plug what we're doing is that's what we need funding for research. That's the thing that is missing. We need a clinical trial of certain medications, which are not ketamine, by the way.

That's a different story. I think ketamine actually is a ve-very dangerous drug in my opinion.

And but again, that's my personal opinion. And o-other medications work and work more effectively with few side effects.

Stephen Calabria: If you could change one thing about how society approaches mental health and suicide prevention, what would it be?

Igor Galynker: I think we need to literally move away from suicidal ideation, have a medical model like we do with any other illness, [00:32:00] consider it a separate illness, suicidal mental state and its progression, and treat it accordingly

Stephen Calabria: Sir, you mentioned at the top of the interview your patient who passed away by suicide gave you a gift. If you're comfortable sharing it, what was that gift?

Igor Galynker: I'm Russian. I'm a Russian Jew, but and so he gave me a spoon and a dish for caviar.

Stephen Calabria: What have your patients taught you about resilience?

Igor Galynker: What I've seen people struggle with and what I've seen people survive and deal with, and the pain that they deal with made me feel so much respect for people in general, what they can handle, and taught me, myself, and also others, gave me an example of what to do when I hit a rough spot or friends around me do.

[00:33:00] And that's incredible lesson for me. I've been a psychiatrist some seventy-two, so I've been doing it for a very long time, and every patient is still interesting to me.

And I've seen thirty-five thousand people probably and treated, and I learned tremendous amount, and I continue to learn every day from people who suffer and are resilient and get through it.

Stephen Calabria: Last question. Sir, as we close, what is the single most important message you'd like listeners to take away during Suicide Prevention Month?

Igor Galynker: It's an illness and it can be prevented. It's not a weakness. It's not depression and its own illness that people need to know what this is.

And once you know what this is, you can withstand you can fight you can get treated and help others.

Stephen Calabria: Dr. Igor Galynker, thank you so much for your time, sir.

Igor Galynker: Thank you.

Stephen Calabria: Thanks again to Dr. Igor Galynker for his time and [00:34:00] expertise. That's all for this episode of Road to Resilience. If you enjoyed it, please rate, review, and subscribe to our podcast on your favorite podcast platform.

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