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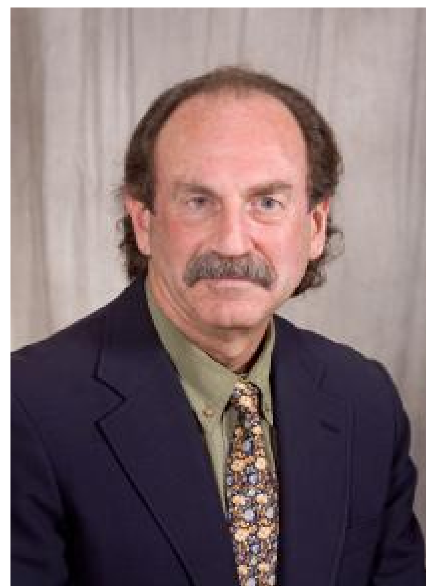

Biographical Sketch: I joined the faculty of the University of Rochester in 1978, following medical school at Harvard, residency training at the Massachusetts Mental Health Center and the National Institute of Mental Health, and further postdoctoral research at NIMH. During college at Cornell and medical school, my interests focused primarily on substance abuse treatment, suicide, and end-of-life issues. The first two were tied specifically to fundamental concerns about public health, prevention, and public policy development.

My path changed radically as I progressed through medical school and my psychiatry residency. I focused on the relationships between organized brain functioning and behavioral disorders. In addition to the standard residency I pursued informal training in neuropsychology and neurology as a means of grounding my interests in “neuropsychiatry.” My research initially dealt with Huntington's disease and Tourette's syndrome, and to a lesser extent, Alzheimer's disease. Questions arising in clinical settings drew attention to the cognitive impairments of psychiatric patients, especially those with depression and “pseudo-dementia.” This led to a series of studies of depression in later life, especially related to its neuropsychological features, and the interface between mood disorders and general medical conditions. In the midst of these projects, I began to consider the factors that contribute to suicide among elders together with what has grown to become a diverse group of outstanding colleagues. Suicide research and prevention emerged during the past two decades as my central interest for investigation, now reaching across the life course and involving collaborations throughout the US and internationally. This is an area where it has been possible to integrate biological, psychological, pathological, social, cultural, public health, and international perspectives in a single problem focus. Reducing the mortality and morbidity of suicide also has become my entry key to the nascent field of “public health and preventive psychiatry.”

From the 1970s to the mid-1990s, my clinical work involved inpatient general psychiatry and neuropsychiatry (from adolescence to old age), general outpatient psychiatry and psychopharmacology consultation, and specialty work in geriatrics and neuropsychiatry. During the 1980s, I clarified my ‘most favorite’ role as an educator; specifically, working as a mentor with post-doctoral fellows and junior faculty, viewing the time after residency training or receipt of a Ph.D. as a critical period in the life of a would-be academic. My greatest personal career rewards in medicine, in addition to those related to patient care, have come from supporting this developmental process and seeing several generations of faculty emerge in their own right as outstanding researchers, educators, and clinicians. My role as a department leader has allowed me to forge with others an environment and community that serves to support the development of professionals from multiple disciplines and to foster institutional excellence in clinical care, research, and education.

Looking Beyond “Risk Factors” in the Evaluation of Persons Who are Seriously Suicidal—A Practical Clinical Approach

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Deciding "what do I do next" when evaluating a seriously suicidal individual, particularly one who has a well-established mental disorder, poses one of the most challenging and difficult tasks for all mental health professionals. This is especially true because such persons, often seen in emergency rooms or in hospitals after they have made serious attempts to kill themselves, present all of the so-called “risk factors” that are put forward as useful for identifying potentially suicidal patients.

This plenary lecture outlines a methodical approach for evaluating patients in acute care clinical settings—at a time when decisions must be made. It invites clinicians to look beyond risk factors in order to develop an informed decision that considers contextual factors, life events, and the natural history of suicidal episodes, in addition to thinking about psychiatric disorders and their treatments.

Ultimately we must integrate diverse information in order to make immediate yet informed clinical decisions. Such integration is a focus of this discussion.