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The Worst Best Place: Stories of Suicide in Montana

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This project tells the story of Montanans who, for now, have survived their battles against hopelessness in the state with the highest per capita suicide rate.
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Back from the brink: A journey through Montana's mental health system

One woman's struggle to survive and heal after attempting suicide

“When I go into the hospital I feel like I've done something wrong. Even if I haven't had a suicide attempt, I feel not only that I am a failure, but that I myself am a mistake,”

- Brooke Jaqueth

BrookeJaqueth sits in her wheelchair at the support group meeting slowly eating a peanut butter and jelly sandwich. She raises the sandwich to her mouth, bares her teeth and takes a slow-motion bite. If it looks like it's painful, that's because it is.

She's in her late forties, but that's impossible to tell by looking. Because she's so thin, the skin on her face is smooth. Her sandy-brown short hair, unstyled, is a bit out of control, another sign that her depression is worse this week.

Brooke is here to get help coping with her debilitating chronic pain and the depression that has taken over her ability to manage her life.

This is the most despondent I've seen Brooke since I started coming to these meetings a few months ago. She seems more gaunt than before, and makes no effort to hide her sadness.

Some weeks she could smile or offer counsel to other sufferers. This day, she is silent, slouched in her power chair.

I'm here because I want to hear the stories of those who most often confront suicide - people like Brooke who are struggling with mental illness. Everyone at the table knows about my project, and they know that I will keep the substance of the meetings confidential. They'll talk to me because I've already shared with them the story of my battle with anxiety disorder.

In support group lingo, I'm a 'consumer.' I consume psychiatric services - which can be doctor appointments, therapy sessions, or medications. I don't think I'd have these stories if I didn't have my consumer credentials, in part because of the common perception among consumers that mentally healthy people can't understand what mental illness feels like.

I fear for Brooke, but I know I can do little for her, other than listen and offer a kind word and a hug.

It is early September, and within a week Brooke will begin a journey through Montana's mental health system that she might say was inevitable. A suicide attempt at her home in Missoula will lead her eventually to the state psychiatric hospital in Warm Springs, the very place she wanted to avoid.

It won't be the first time she's attempted suicide, and it won't be her first stay in the state hospital either. Her friends and family will be left wondering what more could have been done for her, but they will also be comforted by the fact that she's still alive.

An overdose

A week later, Brooke's treatment team told her she needed to be in the hospital, and that they were
considering having her involuntarily committed. Because she posed imminent harm to herself, she could be escorted to a mental hospital, where a judge would decide if there was evidence enough to force her to stay.

She felt trapped. She was sure that committing herself would mean the loss of her Section 8 disability benefits that allowed her to live independently - and could take years to re-establish. But waiting to be involuntarily committed might mean being put in the state mental hospital in Warm Springs. She'd been to Warm Springs before, and said she'd rather die than go back.

Seeing no way to save her apartment, her job, and the life she had carved out, she took an overdose of her pain medication.

The next day, September 9, 2009, a personal care assistant found Brooke unconscious and barely breathing on her bathroom floor. An ambulance rushed her to Saint Patrick Hospital, where she was placed in intensive care. She survived for a week and a half hooked up to a ventilator, unable to breathe on her own. On the advice of the medical staff, Brooke's family would not allow visitors.

After nine days in the ICU, Brooke regained consciousness. She spent several more days there until she could sit up and go to the bathroom by herself.

She knew she'd given up everything – her apartment, her job, the service dog who was her best friend, and yet the overdose didn't kill her. In some ways, the slate had been wiped clean. She had no house, no job and no ability to provide for herself. Having given up power of attorney, she was completely at the mercy of others.

But in other ways, there was no clean slate. Rebooting her brain with an overdose of pain pills couldn't erase her host of auto-immune disorders, her chronic pain, or the depression that dominated her outlook since high school.

In a candid interview at her apartment about a month before her suicide attempt, Brooke discussed how her mental illness and her physical illnesses combined to overwhelm her ability to cope.

"As the pain goes so goes the depression because if I have a bad pain day, it brings me down a lot," she said. "If I have a lot of bad pain days in a row, it just really, really affects me. People tell me that I handle it really well, but I don't think I do."

I remember doing a double-take when she adjusted her wheelchair and, somewhat unsteadily, got to her feet. "Didn't you know I can walk?" she said with a slight smile. When I admitted that I assumed she was bound to the chair, she explained that a disease called neuropathy affected her arms and legs. Loss of feeling in her extremities and loss of muscle in her legs made walking difficult and dangerous, but possible.

She said the loss of muscle tissue meant less stability and risk to her ankles when she walks. She shuffled the short distance to the kitchen, filled a glass of water and brought it to me. Instantly I felt guilty. When she'd offered it to me, I didn't realize there was risk involved in getting it.

Until February of 2008, Brooke was functioning well. At Summit Independent Living Center, she worked as a peer advocate, helping people with similar mental illnesses and physical disabilities navigate the government systems designed to help them. "I helped them set goals and reach them, and
helped advocate for them,” says Brooke.

But then her depression reared up, accompanied by psychotic symptoms that caused her to hallucinate and hear voices. She took a leave of absence from her job at Summit in February and checked into Saint Patrick Hospital for a time before returning home.

For Brooke, visits to mental hospitals cause a deep feeling of failure. “When I go into the hospital I feel like I've done something wrong. Even if I haven't had a suicide attempt, I feel not only that I am a failure, but that I myself am a mistake,” she says.

Brooke is also fearful of hospitalization. Instead of a place of recovery and comfort, she sees treatment at a psychiatric hospital as invasive and therefore something to endure. She knows that the staff will ask about sexual abuse as part of a routine check of risk factors, and she'll have to talk about the abuse she suffered as a child.

She's still deeply affected by it, and though she knows that doctors and hospital staff are well-meaning, it's still difficult to talk about with people who are essentially strangers.

“When I'm in the hospital and I get psychotic,” she says, “I hear things that are really bad and I see things that are really bad and it's uncomfortable to tell people what I see and hear. But I have to tell them because they have to know for my mental health to be better.”

Diagnosed with severe depression in high school, she already knew the difference between treatment for physical illnesses and mental ones. “You don't always get better. You get so you can handle it.”

But you don't get cured, you don't get well, you get ... managed. You're always looking to get well and there is no well. The symptoms don't go away. They wax and they wane.”

By the beginning of fall 2008, Brooke had lost hope for the future. She couldn't go back to her job, couldn't prove to her treatment team that she could continue to live independently, and she dreaded what she saw as the probable alternative—a return to Warm Springs and a placement she likened to a nursing home.

She had exhausted her avenues of support. Her psychiatrists could recommend no more or different drugs, and one therapist told her there was nothing more she could do for Brooke. Her support groups weren't enough. The friends from those groups were at a loss.

A lifetime of mental illness had given Brooke ways to cope with depression, anxiety and pain, but she grew to think she was fundamentally different from most people. “I wondered how all the other people could be happy when I didn't have that feeling,” she says.

Asked why she thinks some people attempt suicide and others, despite depression or hopelessness, do not, she could offer a few reasons. Maybe they're scared of dying, she says, or they feel needed. “For some people, if you just wait a second, someone needs you — your pet needs you, a friend needs you, your sister or your mom needs you. You know, there's a reason.”

Asked if she had reasons not to attempt suicide, she admitted she's scared of death, but says, “No. I don't know. Not in the long run.”

Am I exploiting the sick?
This interview took me by surprise. I couldn’t believe that someone could be so miserable and yet so brave. Brooke was willing to tell me about her deepest struggles and what she saw as her biggest failures. For a time after this interview I had a feeling I was taking advantage of a very vulnerable person who wasn’t worried about the consequences of talking to a member of the media perhaps because she didn’t believe she would live to see them.

Though I had obtained consent to tell her story weeks before this interview, I wanted to make sure she understood that I wanted to publish what she told me. When we talked about this issue, she assured me that her hope was to help other people who are suicidal realize that they weren’t alone.

With this assurance, coupled with her history of advocating for people with mental illnesses, I decided I could continue to talk to her. Later, when we talked while she was in the hospital, I asked her each time if she wanted to talk that day.

Though this story, and perhaps others in this project, could be seen as an exercise in exploitation, I think this would be a narrow view that underestimates the desire of people with mental illnesses to combat societal stigma and help other sufferers.

“It’s a dark prison”

Clinicians who treat people with mental illnesses understand that those who are depressed are unable to see beyond the problems that have come to dominate their perspective. Just as Brooke couldn’t see a way out of a choice between death and the loss of her apartment and freedom, others with severe depression can’t envision life after loss of a job, loss of a loved one or exposure to a scandal.

“It’s a dark prison,” says Ken Welt, a psychologist and head of the University of Montana’s Counseling and Psychological Services. “If you’re depressed, you look out on a blue sky day, and you’re not heartened by it. You focus on loss, absence, emptiness, isolation, perceived lack of caring by others and that sort of thing. That’s the filter of depression that needs to be treated so that people are freed from that and can experience their life in all it’s nuances.”

To be sure, not all who suffer from depression become suicidal. But according to the American Association of Suicidology, 90 percent of people who attempt suicide are suffering from a mental illness. Further, the risk of suicide in people with major depression is about 20 times that of the general population.

Despite the fact that previous suicide attempts are the number one predictor of future attempts, Welt thinks that suicide may be easier to prevent among those with a history of coping with mental illnesses like depression. Welt says, “As a psychotherapist you can ask that person, ‘How did you survive last time? How did you get through this emotional crisis in the past?’”

Though treatment is different for each patient, the general strategy is to break the grip of hopelessness. By reminding people of healthier times, recalling what worked in the past and trying to shift the focus away from problems that seem all-consuming, Welt hopes to help patients along the path of recovery.

An Inpatient Stay

After her stay in intensive care, Brooke was transferred from Saint Patrick Hospital’s main...
Brooke began her stay in a room on the west side of the ward, still recovering from the effects of her overdose. I went to visit her there for the first time shortly after she was transferred. After surrendering my cell phone, keys, bag and Ipod, I was taken to Brooke's room.

It was much too big for the hospital bed and padded chair that were the only furniture. The tan walls were completely bare – no pictures or posters to look at, but no pictures or posters to destroy, either. Safety of the patient and potential liability to the hospital are paramount in this part of the unit.

Brooke was there, propped up in her bed. Awake but not alert, she croaked that she was happy to see me, and soon I found out that she had bruised vocal cords from pulling out her breathing tube during her ICU stay. I could tell by the hollowness of her face that she'd lost weight. We visited for a while, and then a nurse brought her dinner – a pureed veggie burger. Solid food would damage her esophagus. Anything she drank had to include a powdered thickener to make it easier to swallow.

A few days later, Brooke was transferred to the less restrictive east half of the unit. Patients in the west side have no contact with each other and must be escorted to the locked bathroom. Once Brooke graduated to the east half of the unit she could eat and watch TV in a common room.

Patients there have more freedom to move about and have a few more privileges. Still, the atmosphere can only be described as institutional. Patients must dress in hospital scrubs until shortly before being discharged. All food served is monitored, and leftovers are counted to make sure patients are eating enough. Visitors still have to surrender their personal belongings to make sure that nothing coming into the unit represents a hazard. Headphones could be used to choke, books can hide sharp objects, and cell phones can take unauthorized pictures.

On another visit after Brooke moved to the east wing, she told me she'd been well taken care of at Providence Center, and was glad that she could stay in Missoula for treatment instead of going to the state hospital in Warm Springs. It's at this point in her recovery that her doctors were deciding on the next step for her.

Could she safely go back home? Was her mental illness severe enough to warrant placement in an assisted living facility? Were there options that lay in between?

For her part, Brooke was despondent over the possibility of the assisted living facility. In her mind, this placement would be “forever.” When I suggested that this couldn't be so and that everything depended on how she recovered, she was adamant that her doctor told her it would be forever.

The role of stigma

What is behind Brooke's dread of psychiatric hospitals? Where does her association between hospitalization and having failed as a person come from?

Some clinicians say that the fear associated with psychiatric hospitalization has less to do with the conditions or level of treatment at the hospitals and everything to do with the stigma associated with hospitalization and mental illness in general.
Welt's colleague, Dr. David Brown, sees a strong sense of shame associated with psychiatric hospitalization. "We have a long history of looking at people who are institutionalized as having failed in some major way," he says.

The recent history of psychiatric hospitals is one of a shift, begun in the mid-1950s, from an emphasis on institutionalization and custodial care toward community-based mental health care that seeks to preserve a person's connection to family, friends, and other social supports.

Welt paints a bleak picture of a policy based on institutionalization. "When I was [younger], working at the state hospital for a short time, the population was enormous. There must have been thousands of people there, many of whom had been there for virtually their whole lifetimes – always contributing to stigma. That's all changed."

Problems with institutionalization – isolation, stigmatization, lack of a societal role for the patient, little hope of living a normal life – have been replaced by the problems of community care. Chief among these is the difficulty people have with accessing care when they are suicidal.

Brown thinks that, as bad as a policy of easy institutionalization may have been, the pendulum has swung back too far in the other direction.

"We've had the experience often of someone who is talking directly about suicide, and having difficulty getting them admitted into local psychiatric units," says Brown. "And I don't think it's reluctance on the part of the psychiatric units to take somebody in, it's a matter of having enough beds."

Lack of funding for mental health care in Montana is at least partly to blame for sufferers not getting proper care, says Brown. "We're terribly underfunded," Brown says. "Montana has one of the worst statistics for suicide and one of the worst budgets for mental health funding out there. And those two things aren't necessarily correlated, but at the same time we have a lot of people with chronic mental illness or depression and needing some help that aren't getting help. Part of that is the funding."

Though he and other providers acknowledge that conditions could be improved at hospitals like the one in Warm Springs, Welt says most caregivers are caring people doing the best they can with limited resources.

**Dakota House and feeling better**

By Halloween, Brooke had been moved to Dakota House, a place for people to live who are transitioning from inpatient care but aren't ready to go home.

From there, she went home for three weeks, until the sight of her catheter started triggering flashbacks to the sexual abuse that haunted her. She says she became disoriented and was having hallucinations. She reached out to Dakota House, and they had a member of her treatment team call her and that person made the decision to call the police and provide an ambulance to take her to the emergency room.

Unfortunately, there were no available emergency beds for psychiatric care in Missoula, so she was taken to Warm Springs, where she stayed for 16 days.

There, doctors adjusted her medications, reducing many of them, and switched her main medication for
When she returned home, she went back to her schedule of meetings—support groups for self-esteem, anxiety and weight loss, as well as advisory board meetings for state and local mental health agencies.

Since her suicide attempt was an overdose of her prescription pills, she now gets a one-day supply of medication delivered to her every morning in a locked box. It's a daily reminder that she can't be trusted with enough pills to cause another overdose.

During a short interview after she returned from Warm Springs, I realize how much better she sounds. Her speech is quicker, she doesn't trail off at the end of a sentence like before, and she seems so much more in charge of her life.

Perhaps because she's been taking life one day at a time for so long, Brooke doesn't have much planned for her future. She still wants to get her job back later this year, after she gets re-certified.

I'm almost certain that she wouldn't say this, but she is lucky to be alive. She suffered little lasting damage from the overdose, and she seems to have put it behind her, sometimes talking about it as if it happened much more than a few months ago.

Soon she will begin a course of eye movement therapy, a new course of treatment for her. The goal of that kind of therapy is to desensitize patients to traumatic images and ideas from their past. She's cautiously optimistic. "I'm kinda hopeful," she said. "It's something new."
Breaking the cycle

Dr. Nathan Munn's fight against, and attempts to understand, his family's legacy of mental illness and suicide.

When Dr. Nathan Munn wants to explain how ideas are transmitted, he just says, “Hey Jude.”

Unless you've been living in a cave, Munn has just hacked into your brain. He knows you're thinking about the Beatles, and probably the image of Paul McCartney playing at the Super Bowl has already flashed across your mind's eye.

He knows what you are thinking because he's studied how ideas are transmitted through a culture. Beyond Paul McCartney and the Beatles, he studies particularly how ideas about suicide are transmitted and shared culturally.

From Socrates and Romeo and Juliet to the modern day debate about physician-assisted suicide the Western tradition often presents suicide as a noble, romantic, or rational choice. These stories about suicide are already informing how we feel about the decision to take one's life.

But according to Munn, the high rates of suicide in Montana and the Rocky Mountain West may be attributable to shared ideas among those in the region. Ideas about guns and individualism, coupled with shared myths about suicide, could be driving elevated suicide rates.

Ideas are like viruses or bacteria trying to invade cells in the body, says Munn, a physician and professor of psychology at the University of Montana-Helena.

He points to studies of suicide clusters in small communities, institutions and other restricted environments that show suicidal behavior spreading like an infectious disease.

All this might be just an academic exercise for Munn if his grandfather and his father had not killed themselves.

A body on the lawn

At the age of 13, Munn remembers, a gunshot woke him up in the middle of the night. When he went to investigate, he saw his father's body on the lawn. “The silence and the stigma starts immediately,” he says. “Mom told me to go upstairs.”

“I went out and touched his body. I had to do it,” says Munn.

Now 48 and a professor of psychology, he can joke about how his childhood probably drove him to psychiatry as a profession. He realizes now that his father had many symptoms of bipolar disorder — also known as manic depression.

And for a while, Munn could cope with treating suicidal patients. But during his psychiatric residency he became depressed. At the time he tried to pass it off. “I thought it was the effect of existentialism,” he jokes, “I had been reading Camus.”
He started on antidepressants, but despite what he knew about the way they work, he would stop taking them. And then came the "bold" thoughts. "I thought I could solve Montana's mental health problems all by myself," he recalls.

That was the grandiosity of manic depression talking. Soon he was out of control. "I started behaving horribly, lost my [medical] license, my house and my marriage," he says.

The Montana Board of Medical Examiners revoked Munn's license in 2003 following a complaint filed by a former patient, who alleged that the two had a sexual relationship while Munn was her therapist. Munn did not dispute the board's findings and it found Munn guilty of a serious breach of ethics.

He had ruined his career and cratered his already-struggling marriage.

And one night, in the depths of a depression that followed a manic episode, Munn was ready to pull the trigger. "One night I was pretty drunk," he says, "I had a gun to my head, but then I thought of my mother and my son and I didn't do it."

Choked up, he says, "I broke the cycle. I'm now 48, and my father was 47 when he killed himself."

**Correlates to contagion**

Munn's story gives a partial answer to the question of why suicide can be contagious. Although Munn admits that his behavior was "despicable," and he sees that his crisis was one of poor, if clouded, judgement, anyone who has had a family member die by suicide is at higher risk. Apart from genetic factors, children may think they are predestined for suicide or that suicide is a solution in hopeless times.

Adolescents seem especially likely to commit suicide as a way to get attention, especially if they see a member of their peer group get attention in death. They also are among the most impulsive when it comes to suicide.

Beyond clusters in isolated populations or individual families, however, Munn thinks that destructive ideas about suicide can spread over wider populations. "Individuals make up cultures," Munn says, "and they spread these cognitions from brain to brain, as it were. Talk and rumors do a lot to spread them."

Munn and other experts also believe that media coverage of suicides can have a large impact on the risk of suicide contagion in communities.

The American Association of Suicidology, which has published a set of guidelines for media coverage of suicides, warns against romanticizing stories of individual suicide deaths, putting a suicide story on the front page or beginning of a broadcast, putting the word 'suicide' in a headline, or describing a particular method of suicide in detail.

Research shows that each of these practices can increase the likelihood of copycat suicides and actually increase the rate of suicide in viewers or readers. Because television, newspapers and the Internet can reach such a wide audience, they can spread ideas faster and wider than mere word of mouth.

A recent study by a British sociologist looking at suicide rates in Britain and Wales may corroborate
Munn's theory. The study found that suicide rates dropped by 40 percent there after both the September 11 terror attacks and the London subway bombings on July 7, 2005.

The drop lasted for about a month in the case of 9/11, and only several days following the London bombings.

The researchers attributed the brief declines to a greater feeling of being bonded together by the tragedy. Britain's Daily Telegraph quoted the study's author, Dr. Emad Salib, saying, "There is greater social cohesion, the Blitz spirit," referring to the solidarity of those in the United Kingdom during the German strategic bombing offensive during World War II.

By contrast, Salib thinks that the greater duration of the drop in suicides following 9/11 is due to the greater amount of media coverage of the those attacks — specifically the repeated airing of the fall of the Twin Towers.

This phenomenon is not unique to the United Kingdom. Other authors have noted that suicide rates in many countries fell during both world wars, as well as in America following the Kennedy assassination.

This seems to fit with Munn's theory of cultural cognitions. The increase in social cohesion noted by Salib is nothing tangible, just a feeling of being closer to one's countrymen. This feeling may create a sense of being needed by others, but it doesn't directly affect what psychiatrists call proximal stressors.

Proximal stressors are those recent, possibly traumatic events that can trigger a person prone to mental illness to have a flare-up or relapse. Death of a loved one, divorce, and loss of a job top the list.

Even though the "Blitz spirit" cannot raise the dead, mend a marriage, or fix the economy, Salib's work suggests that this feeling keeps people alive, at least for a time.

A culture of fear

Other researchers also note a correlation between a tightly knit society and a low suicide rate. Dr. Spero Manson, a medical anthropologist and expert on Native American mental health issues, noted this connection across Indian tribes. In a 2001 episode of the radio program The Infinite Mind, Manson explained that suicide rates in Native communities have correlated with the level of social cohesion within the tribe.

He finds that tribes in the Rocky Mountain states have had less social cohesion than tribes in other areas, contrasting those cultures with societies in the Southwest. Manson says that the Rocky Mountain tribes did not have social controls that spread across the whole tribe, but instead left more decisions up to the individual family.

"In comparison to that, in the Southwest we have entire communities, such as the Pueblos, the Hopis, the Navajos, who had a much greater sense of social cohesion," Manson says. "And so there are much tighter social controls around deviant or abhorrent behavior, suicide among them."

And those differences in social control, Manson says, parallel the differences in suicide rates. The more interdependent the people, the lower the suicide rate.
For those in the business of suicide prevention, this is not a new insight. Maureen O’Malley, Missoula County’s suicide prevention coordinator, understands this as well, only she puts it in terms of isolation on the one hand and a sense of belonging on the other. And she’s acutely aware of the burden of being mentally ill in Montana.

If you can’t work and you’re reliant on Medicaid and other assistance measures, and you’re always being told, ‘No you can’t have that, you can’t have that,’ - how much do you feel you belong?” says O’Malley. “And we have all sorts of disenfranchised groups in our culture – and people die because of that. Of not having support systems, of not knowing where to go, of having to always be self reliant so much of the time.”

But there are no easy fixes for fostering a sense of belonging on a mass scale. O’Malley blames the lack of social connectedness on a culture of fear. “We kind of live in a climate of fear,” O’Malley says. “We don’t let our kids talk to our neighbors, our kids don’t play outside. This may sound simplistic, but each of those things that evolves distances us more.”

She is hopeful that the recent passage of mental health parity legislation at the federal level will eventually decrease the stigma and fear that go along with mental illness. “My hope would be that over time we see this as just another illness,” says O’Malley. “That we start to weigh things a little more evenly. Disease is nasty no matter what, but along with that do we have to stigmatize and ostracize those with a particular category?”

The cycle stays broken

Those social connections are part of the reason Munn didn’t pull the trigger in the depths of depression. He couldn’t leave his mother without a son, or his son without a father. His mother had already lost her father and her husband to suicide. As he puts it, “I couldn’t give my mother the trifecta of suicide.”

He credits support from his partner, Michelle, a correct diagnosis from his doctors and his own medical training for helping him recover. But he also thinks that making the decision to live was a powerful moment of clarity; a moment to return to and draw comfort from on the difficult road back to a productive life.

“Once I made that choice, in a way, the rest is kind of details.” says Munn. He went for long hikes around Helena, sorting things out in his mind, trying to uncover the patterns of thought reinforcing his illness.

It wasn’t easy to find his cognitive distortions, those faulty assumptions about the world and about ourselves that lie behind our thoughts. “Realizing that you can’t trust your own brain is a big conceptual shift,” he says. “You’ll get these underlying assumptions you didn’t even know you had.”

He had one of these conceptual shifts while sitting in a broken-down Lazy Boy, surrounded by a house being emptied of family and furniture by his divorce. Instead of dwelling on his misery and the emptiness of the scene, Munn remembers noting his feelings, but being able to think, “Here I am; suicidal. I might be able to do something with this.”

This idea, so uncharacteristic of someone who is depressed and feeling hopeless, became something to latch onto; another source of comfort.
Maybe this is how people break all destructive cycles. Maybe there is always a decision made in a moment of desperate clarity that needs to be built upon, bit by bit, until the struggle is over. Though the demons may return, they will come back weaker and less confident, the memory of their defeat fresh in their minds.

The specter of suicide will always be with Munn; it's part of who he is. But through his struggle and his research, he's done what he set out to do: make something out of it.
A reason to live

A look at Montana's crisis hotline and its efforts to keep people alive

"If it comes down to saving someone's life, I don't care if I offend them."
- Angela Hansen

[a sidebar to Nathan Munn's story]

The staff and volunteers who work the phones for Montana's crisis hotline know the importance of changing minds about suicide and removing the cognitive distortions that come with depression. They change attitudes and beliefs about suicide and mental illness one caller at a time.

“We are a psycho-education resource,” says Angela Hansen, crisis coordinator for Voices of Hope, the Great Falls organization handling a majority of the calls to the hotline, available at 1-800-273-TALK.

Hansen says that after a recent advertising campaign that included a television commercial featuring survivors of suicide holding photos of their loved one, calls to the hotline have increased by two thirds to around ten thousand per year. She estimates that a third of the crisis calls are suicide related.

As a general crisis line, Hansen says the range of topics and situations is endless. “Research shows that people seek out anonymity,” says Hansen. “They look for people who can relate.”

That promise of anonymity frees callers from the fear of shame and rejection in confessing their suicidal thoughts to friends or family. It can also create tough situations for staffers, who may be taking calls from people who are carrying out their plan even as they reach out to the hotline.

“It's that ambivalent part of them that's picking up the phone.” Hansen says. And its her job to connect with that part of the caller that wants to live.

“You want to understand their reasons for dying first,” she says, “and then you uncover their reasons for living.” And as long as she can uncover just one reason, she's confident it will be enough.

By the end of the call, Hansen's goal is to help the caller create a plan to live – whether that means making a counseling appointment, agreeing to attend a support group, or even checking in to a psychiatric hospital.

If the caller remains committed to carrying out his or her plan, hotline staffers move quickly to use the information they have to identify the caller and stop the suicide. According to Hansen, the hotline has a legal obligation to preserve the life of those who call, and that obligation trumps the anonymity of callers who are a danger to themselves.

And Hansen is clear about her willingness to find those people who are actively suicidal. “If it comes down to saving someone's life, I don't care if I offend them,” she says.

She and her team have more than a few stories of going to great lengths to find those people who, despite reaching out, refuse help and remain suicidal.

One caller, a woman who was parked on the side of a Montana highway, called the hotline struggling
with the decision to take her own life. During the call, she told the operator her destination and other details of her trip. When it became clear that she had the means to kill herself with her in the car, and when she ended the call before the operator could persuade her to take suicide off the table, the staff took action.

Armed with those details about the woman’s trip, the call center alerted the Montana Highway Patrol who found the woman in her car unharmed.

Hansen is vague when discussing the methods of finding people that the center has at their disposal, saying only, “We can find them. I let people know that.”

Though callers often fear that the hotline will alert emergency services, most of the time it’s not necessary. People call the hotline to talk and be understood, and though they may be contemplating suicide, they are not actively carrying out a plan.

Hansen tells the story of a woman who called the hotline extremely distraught. Over two hours of listening, Hansen learned that the woman was married and had recently broken off an affair with a younger man with whom she was deeply in love. “He treated her like a queen,” Hansen says.

As in love as she was, she realized that the relationship couldn’t work. So after agreeing to break up, “they sat in a car for hours and just held each other and cried,” says Hansen.

But the shame of the affair, of which her husband knew nothing, became too great and she fled her home and moved back to Montana. “She said she never felt loved before,” Hansen says, “and now she’d abandoned a good life that wasn’t good enough after this relationship.”

The woman related how her husband had done everything he was supposed to do: he’d provided a big house, a stable life, and his love. All this only increased her feelings of guilt over rejecting him and the ‘good’ life that she’d had.

She called the hotline crushed by the self-inflicted loss of her lover, her rejection of her husband, and the guilt over cheating on someone who loved her. She wondered how she could go on after destroying her life.

During the call, Hansen learned that members of the woman’s extended family knew of the affair and were worried for her. After the woman reconnected with her family, she realized she was loved and that, in spite of what she’d done, she was still worthy of love.

When Hansen called the woman to follow up, “she was like a different person,” Hansen says. “She had that support.”

Not all calls end well, however. Sometimes people call the hotline in the middle of a suicide attempt. One woman called the hotline and said, “I’m saying goodbye. I’ve taken a bunch of pills and had a bottle of wine.”

Hansen’s colleague rushed to get her phone number and contact emergency services. Unfortunately the caller had used a cell phone, so his efforts to find an address from the phone number, known as a reverse lookup, were unsuccessful.
Complicating matters, law enforcement said they couldn't do anything to help find the woman. Desperate for a lead, the staff called the woman back and listened to her voicemail recording, which revealed her first name and the name of her employer. An Internet search revealed that she worked at a domestic violence shelter.

A call to the shelter asking after the woman was met with immediate suspicion. Women's shelters, as a rule, will not disclose information about their employees or the women in the shelter, for obvious reasons.

When the shelter called the staffer back and saw that he was indeed calling from the suicide hotline, the shelter provided the woman's address, and emergency services rushed her to the hospital after finding her unconscious at her home.

Though Hansen's job puts her in contact with so many desperate people, not to mention the occasional life-or-death situation, she seems remarkably unburdened by it. She trusts in her training and the efficacy of the hotline's intervention model to insure she knows what to do during a call.

"Even if you attempt this model poorly," she says, "You're still going to do OK." Her work doesn't trouble her because she knows she's helping people, no matter what may happen to them or what they might do to themselves. She can offer understanding and expertise, and most often, that's enough.
<table>
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Source: CDC Vital Statistics Wonder Code Gov
A matter of choice, or a slippery slope?

The debate over assisted suicide in Montana

[a sidebar to Nathan Munn's story]

“I have had patients who point out that they are in pain, albeit emotional pain, and [ask] why shouldn't they have the right to kill themselves with 'dignity' just like cancer patients.”

- Dr. Nathan Munn

Now that doctor-assisted suicide is legal in Montana following a district court decision that allows terminally ill patients to get a prescription for “drugs that hasten death,” Dr. Nathan Munn worries that suicide rates will increase.

“I have had patients who point out that they are in pain, albeit emotional pain, and [ask] why shouldn’t they have the right to kill themselves with 'dignity' just like cancer patients,” Munn says. “So again, yes, I think the idea of assisted suicide could worsen suicide rates and the cultural contagion as I put it.”

The recent decision by a Helena district court judge makes Montana the third state in the nation to allow doctor-assisted suicide, joining Oregon and Washington. The ruling affects all of Montana because the suit was brought against the state.

Washington passed its Death with Dignity Act in November, Oregon’s has been in effect since 1997. Suicide rates there, while relatively high, have held steady since 1994 – very close to 16 suicides per 100,000 residents. In fact, the 2005 data show a slight decrease.

Between 25 and 50 Oregonians end their lives each year under the Death with Dignity Act, and when they do, they don't count toward the total number of suicides in the CDC data. The fifty doctor-assisted suicides in 2005, even if added to the state’s totals, would not significantly increase the overall rate.

Even though Oregon's per-capita suicide rate has stayed close to the levels before the Death with Dignity Act, those in the business of suicide prevention still fear anything that removes barriers.

Pat Tucker is the Montana spokesman for the advocacy group Compassion and Choices, a plaintiff in the landmark case. She sees the fears of opponents of what she calls “aid in dying,” as simply unfounded.

Opponents worry that once the door to assisted death is opened, the rules may be relaxed to allow people with severe disabilities, the aged who are not terminally ill, or others to choose to end their lives.

“Well, look at Oregon,” says Tucker. She points to the 10-year span of the law, with little if any record of abuse or expansion. “All those things have turned out to absolutely be not true,” she says.

And for the terminally ill, this right is critical to stop suffering, she says, and to deny it is shameful. “You can get so worried about slippery slopes that you don't give anyone any rights,” says Tucker.
That fear is the reason advocates like Tucker want to change the language of the debate. They resent the word 'suicide' in the term 'physician-assisted suicide,' and question why we use the same word to describe two acts that they see as qualitatively different.

She uses as an example a 94-year-old terminally-ill man she knew who was growing steadily weaker and closer to death. He hated the thought of losing the ability to take care of his basic needs. "He just didn't want someone wiping his butt," says Tucker.

So the man quit eating and drinking, and passed away. Tucker contends that we don't call his case a suicide because of his illness. She points out the possibility that he may have lived longer if he'd had access to a lethal dose of medication. What he feared most was the loss of autonomy and dignity, and he wanted to make sure his wishes regarding his care were respected. Tucker says that people in his situation take the steps he did because they want to die lucid and avoid a situation where their lives are being extended against their will.

She wonders if he might have hung on longer knowing he could have ended his life quickly when he felt his mind slipping.

Tucker knows that some terminally ill people want everything possible done to extend their lives, but says about those who don't, "I think we do know when it's crazy to keep on keeping on, but what's difficult is getting it written down in a law."

The week after the court decision legalized assisted suicide in Montana, Britain was struggling with the same debate after a documentary aired that featured the recorded assisted suicide of a 59-year-old man with Lou Gherig's disease. Though assisted suicide is illegal there, Britons can travel to Switzerland where it is legal and end their lives at a charity clinic called Dignitas.

The man's wife was present during the procedure, which took place in 2006, and told the filmmaker that it was her husband's wish to have the footage broadcast because he hoped it would lead to a dialogue about death and end of life issues.

And the broadcast did succeed in that. The day before the broadcast was to air, British Prime Minister Gordon Brown told the BBC, "I believe that it is necessary to ensure that there is never a case in this country where a sick or elderly person feels under pressure to agree to an assisted death or somehow feels it is the expected thing to do. That is why I have always opposed legislation for assisted deaths."

It seems the British government would like to keep assisted suicide illegal at home while tacitly allowing those who are willing to make the trip to Switzerland the freedom to do so without consequences. Although British law provides for prosecution of family members who travel with the deceased upon their return, none have been charged so far.

The case of 23-year-old rugby player Daniel James stretched the bounds of assisted suicide beyond the realm of terminally-ill people and into those with permanent disabilities. James was a top-tier rugby player who had a promising future in the sport before an injury on the field left him permanently paralyzed from the chest down. He traveled to Switzerland accompanied by his parents and ended his life at Dignitas on September 16th, 2007.

His parents initially opposed their son's wish to die, but after he attempted suicide several times,
eventually acquiesced and accompanied him to Dignitas. Recently they told the BBC that his death was “no doubt a welcome relief from the 'prison' he felt his body had become and the day-to-day fear and loathing of his living existence.”

James' despair exactly mirrors the concerns most often expressed by those who end their lives under Oregon's law. A 2007 survey of Oregon's Death with Dignity Act gave the most common reasons patients gave for wanting to end their lives. “As in previous years, the most frequently mentioned end-of-life concerns were: loss of autonomy, decreasing ability to participate in activities that made life enjoyable, and loss of dignity.”

Disability advocates and religious groups that oppose physician-assisted death see their fears of a slippery slope realized in James' case. He was so young and not terminally ill. He was, however, facing a life that he felt would be empty of meaning.

The disability groups resist because they believe that James' life could still be meaningful, and Catholic groups, for example, believe that physician-assisted death cheapens human life. A press release from the Diocese of Helena quotes Bishop George Thomas saying, “We are extremely disappointed in Judge McCarter's decision. This decision echoes disturbing actions taken in the states of Oregon and Washington, and sadly this blatant disregard for human life has now been imported into our own region.”

The Catholic Church believes that physician-assisted suicide cheapens human life because it is still suicide, and as such, it destroys something humans have no right to destroy. “The Church position is, each of us was given the life we have, and since we didn't create it, it doesn't belong to us,” says Moe Wosepk, executive director of the Montana Catholic Conference. “This [life] doesn't belong to me, it is God's.”

Wosepak describes life as something to safeguard and nurture until it takes its natural course. And when we end life prematurely, we act as if we have authority to do so. But, he adds, “We don't have the right.”

Hospice providers like Kathy Wise, a social worker with the Billings-based Rocky Mountain Hospice, consider it their mission to make sure people are aware of all their end-of-life choices. She says that most people have access to hospice care through Medicaid and Medicare, private insurance or other government programs. She acknowledges that the homeless need to check into a shelter to be eligible for Medicaid, and that young people without insurance who are suddenly stricken with a terminal illness will need the help of a hospital social worker to access care.

The majority of people who need hospice care are either elderly or disabled and are covered says Wise. Once in hospice care, “people have a lot of choices,” Wise says. “They always have the right to refuse treatment.”

Patients with diabetes can go off dialysis, those who suffer from lung disease can refuse oxygen, and patients with advanced Alzheimer's often succumb to untreated pneumonia—all painless ways to go according to Wise. Many families of those in hospice care react with disbelief when told, for example, that refusing food causes little discomfort. In fact, refusing treatment is often less painful than the late stages of terminal cancer or diseases like Parkinson's or ALS.

And now physician-assisted suicide is another option. When patients want to discuss the issue, Wise
simply tells them that it is legal, and they they are free to pursue the issue with their physician if they wish.

For her part, Wise is not against physician-assisted suicide, but notes that the hospice does all it can to make their patients as comfortable as possible and to give them maximal quality of life to make sure physician-assisted suicide is truly the last resort. Pain control is a key part of hospice care, and if done correctly, Wise says that physician-assisted suicide would be most often unnecessary.

The director of spiritual services at Rocky Mountain Hospice, Richard Vettel-Becker, has worked as a chaplain for 30 years. He cautions that this issue is more complicated than the rhetoric on either side. In his work as a hospice chaplain, he finds himself often confronted by the complexity.

"Death is messy," says Vettel-Becker, referring to the emotions that arise and decisions that need to be made during hospice care. And he says the option of assisted suicide will make it even messier.

If anyone could be said to be comfortable in the midst of the mess, it would be Vettel-Becker. In his work, he says, he approaches the issue pragmatically. He says he is for the decriminalization of the act for the sake of the physicians involved, but worries that advocates are "pushing" assisted death.

"I'm against the rhetoric that if you don't have this option, then you are going to die a horrible death," he says.

It looked as if Montana legislators were moving to address the issue during the current legislative session, with bills being crafted to either codify McCarter's decision or to ban the practice of assisted suicide. However, Dick Barrett (D-Missoula), who was crafting a bill to make McCarter's decision law, and opponents of the decision didn't introduce bills either. Barrett confirmed that he and other legislators had agreed not to introduce legislation ahead of the Supreme Court decision, saying that would make meaningful debate on a controversial issue difficult.

It seems that lawmakers on both sides are content to wait for the Montana Supreme Court to issue their decision before addressing the issue.

Mark Connell, the attorney for the plaintiffs in the recent case, says the state filed its appeal on January 27th. He is looking forward to arguing the case before Montana's high court.

"If a person can refuse life-saving treatment," he says, "all we're asking is to provide this additional method to reduce suffering."
Moving from illness into advocacy

After mastering one method of dealing with mental illness, Monique Casbeer brings it to others

"And my impulse was to walk out of the dinner. But I thought, I don’t have to get worked up. I can work this up or I can work this down."

- Monique Casbeer

For many people suffering from mental illnesses, outpatient treatments can be hit or miss. Though studies show that the combination of talk therapy and medication is more effective than either alone, finding an effective therapy can involve some shopping around, especially for those who have multiple diagnoses.

Monique Casbeer has shopped for everything: doctors, diagnoses, medications and therapies. About four years ago, she finally found a therapy that worked to keep her flaring temper and manic instability under control. After mastering its method, she dedicated herself to teaching the techniques to others.

Today she looks comfortable in the midst of the antique-store chaos that is her living room.

She is wearing sweatpants, slippers and a pastel top, and she is casually slouched down into her ancient couch. The living room around her can’t have been updated since the 70s – wood paneling and all. Two massive organs stand out from the piles of dusty books, old electronics, knick-knacks and garage sale items that she’s saved. A home-built computer, with its insides showing, hums on a small desk next to of the organs. One path through the mess leads from the front door to the couch, and from the couch to the kitchen.

The symptoms of her obsessive compulsive have changed over the years: first a paralyzing perfectionism, then an obsession with checking and re-checking things like locks on doors, and now a compulsion to hoard.

Her Asperger’s - a mild form of autism - makes the complexity of social situations hard to navigate. When someone greets her, for example, she’ll take about one and a half seconds too long to respond. Her flat affect and monotone voice sometimes leave people thinking she’s uninterested in what they have to say. The condition also hampers her ability to recall faces. "I think that is processed in a horribly inefficient part of my brain,” she says.

Despite all that, Casbeer can be an effective communicator. After a lifelong struggle with mental illness, she has found a treatment system that is working for her, and is now teaching that system to others with mental illnesses, and just about anyone else who will listen.

Before she found Recovery International, the system that changed her approach to her illness, she was unable to control her frequent emotional outbursts. Arguments with her father would quickly escalate, often with Casbeer threatening suicide.

“Dad was getting me so upset that I would lock myself in the bathroom with a gun and threaten to kill myself,” she says. "These arguments didn’t start off big; they might be arguments about taking care of the house or about Casbeer’s tense relationship with her stepmother."
“Just about everything he said was upsetting me,” Casbeer says. These episodes went on for about a year until doctors put her on mood stabilizers used to treat bipolar disorder.

Indeed, once she was taking the stabilizers, she found her moods much more manageable. But it wasn’t until she joined a Recovery International support group that she began to feel she had a handle on her tendency to “get worked up.”

Developed in the 1930s and 40s by Dr. Abraham Low, the thinking behind Recovery International is his early brand of cognitive behavioral therapy. The idea is that people may not be able to control events, but they can learn to control their thinking about them.

For example, a driver cannot control the other motorists on the road. She also cannot control the rush of adrenaline and flash of anger that comes with being cut off in traffic. Low’s premise, however, is that through mental training, she can prevent that initial fear and anger from turning into road rage.

He aimed his method at those already struggling with bipolar disorder, depression, and anxiety, as well as schizophrenia.

“He just got tired, as a psychiatrist, of seeing the same people coming out of the hospital over and over, and he found that with this method, people stayed out of the hospital,” Casbeer says.

Practitioners of Low’s method use ‘spottings’ – short memorized mental cues that aim to shortcut the initial impulse. They are Post-Its for the brain that, to the uninitiated, sound a bit like Biblical passages. Examples:

• Excuse rather than accuse for the sake of our mental health.
• People do things that annoy us not to annoy us.
• We are all apprentices.
• Don’t dig, probe, and analyze.
• Fumble all you want as long as you continue to function.

As a newcomer to the group, Casbeer found it had a bit of a learning curve but sensed that it could help her control her outbursts. “It was confusing at first, but the people were nice, and it seemed to be all about how not to get upset,” she says. “And I knew I had been bouncing around a lot.”

It wasn’t long before she had chosen a few of her favorite spottings and was trying to use them in stressful situations. The phrases “You are entitled to your initial startle,” and “You can’t do too much about your true feelings, but you can change your thoughts and control your impulses,” resonated.

Soon she was able to recognize her angry flares for what they were and at least try to invoke a spotting appropriate to that situation. “The first time I used Recovery we were at dinner at a restaurant, and [her stepmother] said one of her things, and all I could think about was, this is one of the things that really bugs me. Really really bugs me,” she says. “And my impulse was to walk out of the dinner. But I thought, I don’t have to get worked up. I can work this up or I can work this down. And I was trying to think of the spotting for this situation, but by then she had moved on to another topic, and by then I was over my angry flare – which was good because I realized I hadn’t driven there, and it would be a long way home.”

After that, it became easier. “It worked when I got a [traffic] ticket.” And also when she got into a car
accident. "I was a lot more calm and collected than I would have been," she says.

The difference between the untrained and unmedicated Casbeer and her psychically armed counterpart was one of night and day. She needed the medication to escape the roller coaster of her manic swings, and she needed the Recovery training to control emotional outbursts. She credits the mood stabilizers with helping to end the fights with her dad. "Sometimes the meds were at a high enough level, I could tolerate what dad said," she says. "But when they weren't, I'd be crashing."

And for Casbeer, crashing meant staying up for nights at a time and often having suicidal thoughts, "Besides the gun thing, I had other creative plans," she says. Drowning and jumping from a bridge were among the methods she favored. "I wasn't just a one method thinker," she says. "I was definitely thinking seriously about it. Ways that weren't so gross."

She talks about her desire to disappear, not her desire to die. In dark moods she would fantasize about jumping into a river and drowning, leaving her family to wonder where she was.

She says she's only attempted suicide once, when she was at college. "I was really confused, and having trouble in school, and just felt wretched," Casbeer says. "I came home from school and took a bunch of pills."

A hazy memory makes it difficult to recall her hospitalization and recovery, but she does remember being angry at having failed in her attempt. "At the time I thought, 'Next time I will think of a better way.'"

For a time after she physically recovered, she says she was unable to feel much emotionally. She's not sure if that was because of her mental illness, the medications she was on or "just because."

Her then-undiagnosed mental illness, coupled with severe allergies that doctors couldn't pin down, left her feeling hopeless. "I wasn't functioning mentally well," she says, and I wasn't functioning physically well."

Casbeer is quick to counter the myth that manic symptoms are desirable or fun, though it may seem that way. "When I'm at my most manic I laugh more," she says. But she finds herself laughing at odd times, or even completely inappropriate times. It seems more like a nervous reaction than a reaction to something funny. "Mania is no fun at all," she says. "It's not fun to laugh at things that aren't funny."

Since her doctors at the time weren't able to manage her mental illness, she thought she was doomed to be miserable forever. That feeling of hopelessness triggered her suicide attempt.

That's the plight of those with chronic mental illness. However well they may have coped in the past, the only place humans feel anything is in the now. It's easy to believe that tomorrow will feel like today, especially if today felt as miserable as yesterday.

It's these cognitive distortions that psychiatrists and therapists help their patients fight. Distortions like, "My family would be better off without me." or "I will feel miserable forever," or "Suicide is the only option." Most non-depressed people can argue against these ideas; sufferers often cannot.

Clinicians like Kevin Welt and David Brown, both psychiatrists at the University of Montana, recognize the difficulty of someone pulling themselves up by their own bootstraps, something that,
with the aid of medication, Casbeer seems to have done.

“When you are depressed and despairing, it's very hard to instill that hope in yourself.” Brown says. “One thing I ask is 'Why not delay?' to get suicide off the table. We may be bargaining, but it's just to buy time for medication to help or things to change.”

**Taking over at River House**

Three years of practicing what she learned in the support group has made Casbeer into a much calmer person. It has also enabled her to co-facilitate the group she had joined three years before.

The goal, she says, is to reprogram your brain. And she's had success helping a group of people who meet at Missoula's River House and a group of patients at the state hospital in Warm Springs do just that.

“We have seen some of the biggest improvements in some of the sickest people,” she says, referring to herself and her supervisor and co-facilitator, Charlotte Moran.

Casbeer relates how, at the state hospital, several patients who were routinely getting in physical fights were able to be discharged after going through the Recovery program there.

Cheryl Eamon, manager of recreation and rehabilitation for the state hospital, says that the group not only helps people to leave the hospital, it keeps them from coming back. “It helps them stay discharged, because they have support in the community where they live,” Eamon says. “They have a peer group, which a lot of the people who leave here don't have.”

At River House, a day treatment center for the mentally ill, Casbeer is challenged by the differences in cognitive ability within the group. But, she says, even those who are quite low-functioning can improve their quality of life.

One woman with whom she has worked is nearly non-verbal. Casbeer discovered that she was scared by the sight of blood on television, and was becoming increasingly fearful that there was going to be a war close to home. This woman watched a lot of TV, and perhaps was confused by the images she saw of U.S. servicemen at war in Iraq and Afghanistan.

Treatment for her, according to the Recovery model, was to train her not to dwell on disturbing images.

“Once we realized that she thinks in images, we were able to work with her and find images that were comforting,” says Casbeer.

The woman's fearful episodes became less frequent the less TV she watched - and the more she worked with Casbeer and Moran.

Besides helping others deal with their mental illnesses, Casbeer's role as a facilitator in both groups has increased her confidence and ability to relate to people, according to Eamon. “She's really improved herself,” she says. “When she first came she was really quiet, now she really interacts with the patients.”

When asked if others with mental illnesses see her as an inspiration, Casbeer admits having heard that a
few times but remains humble. She says her priority now is to keep functioning well so she can finish her master's degree in computer science and continue working with the Recovery group.

Her emphasis on 'functioning' mirrors the Recovery International literature, which stresses that 'functioning' in the world is the goal. For some with serious mental illnesses, functioning can just mean being able to leave the house, get groceries, and return home. For Casbeer, it might mean being able to handle life's disappointments without having a meltdown.

Functioning does not mean the absence of symptoms, and it doesn't necessarily correspond to feeling happy or content.

But functioning is necessary for having a full life outside of an institution, and that's a life that Casbeer is determined to help her peers achieve for themselves.
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Brown, David, Ph.D – Psychologist at Curry Health Center
Carolla, Bob – director of NAMI Stigma Busters network
Carolla, Sylvia – NAMI member
Casbeer, Monique – NAMI member
Eamon, Cheryl – manager of rehabilitation and recreation programs at the Montana State Hospital
Hansen, Angela – suicide hotline coordinator for Voices of Hope, Great Falls
Jaqueth, Brooke – National Alliance for the Mentally Ill member
Kendall, Pat – mother of suicide victim
Kuntz, Matt – NAMI-Montana executive director
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Stewart, Geri – NAMI member
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Vettel-Becker, Richard – hospice chaplain at Rocky Mountain Hospice in Billings
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