The Suicidal Patient

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Objectives

- Example
- Statistics
- Risk Factors
- Assessment
- Management

Case Example

- 38 Chinese gentleman, married with two children, was admitted yesterday for overdose of 20 tablets of paracetamol.
- He said he was feeling very down for the past few weeks because his brokerage company owes many millions and he said he has “breached the trust” of his clients.
- He did it in his office when he was alone and he drank a bottle of hard liquor before he did it.
- He said its “God’s Will” that he is alive and he will not attempt to hurt himself anymore.

Which of the following are modifiable risk factors for suicide

- A: Mental illness
- B: Impulsiveness
- C: Low self-esteem
- D:All of the above

Which of the following should be done if the patient expressed suicidal ideations

- A: Document that you have done a risk assessment
- B: Consider Admission
- C: If depressed, to consider starting Antidepressants and then early referral to psychiatrist
- D: All of the above

Which of the following is false

- A: History of suicide in parents does not predict risk of suicide
- B: History of sexual abuse predicts higher risk of suicide
- C: Impulsive personality traits is a risk factor for suicide
- D: Eating disorders are associated with high risk of suicide

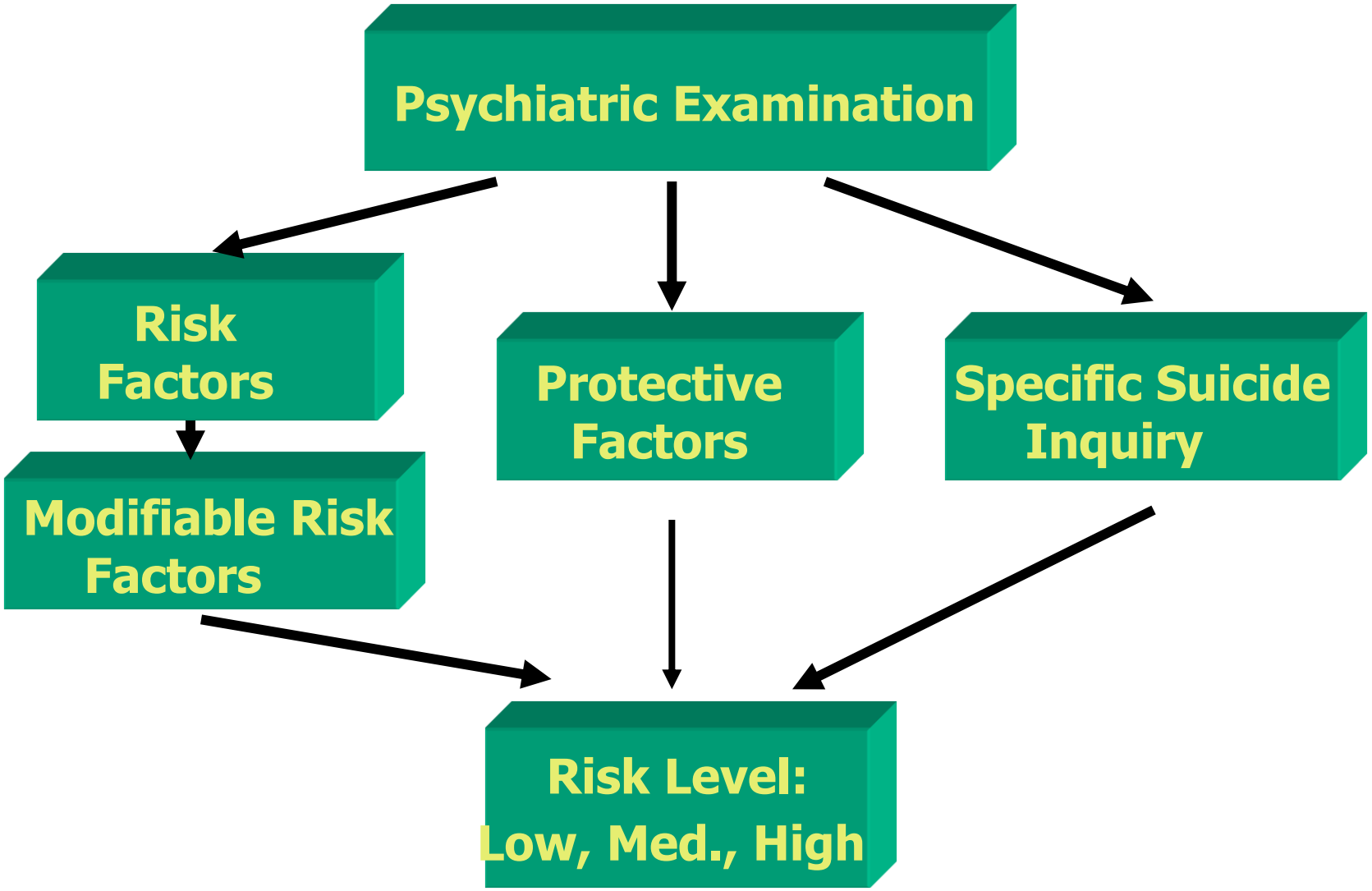
Suicide in Singapore

- 2008 – 364
- 2009 – 401
- 2012 – 467
- 2014 – 415
- 70% males
- Affects all age groups : students, working adults, elderly patients

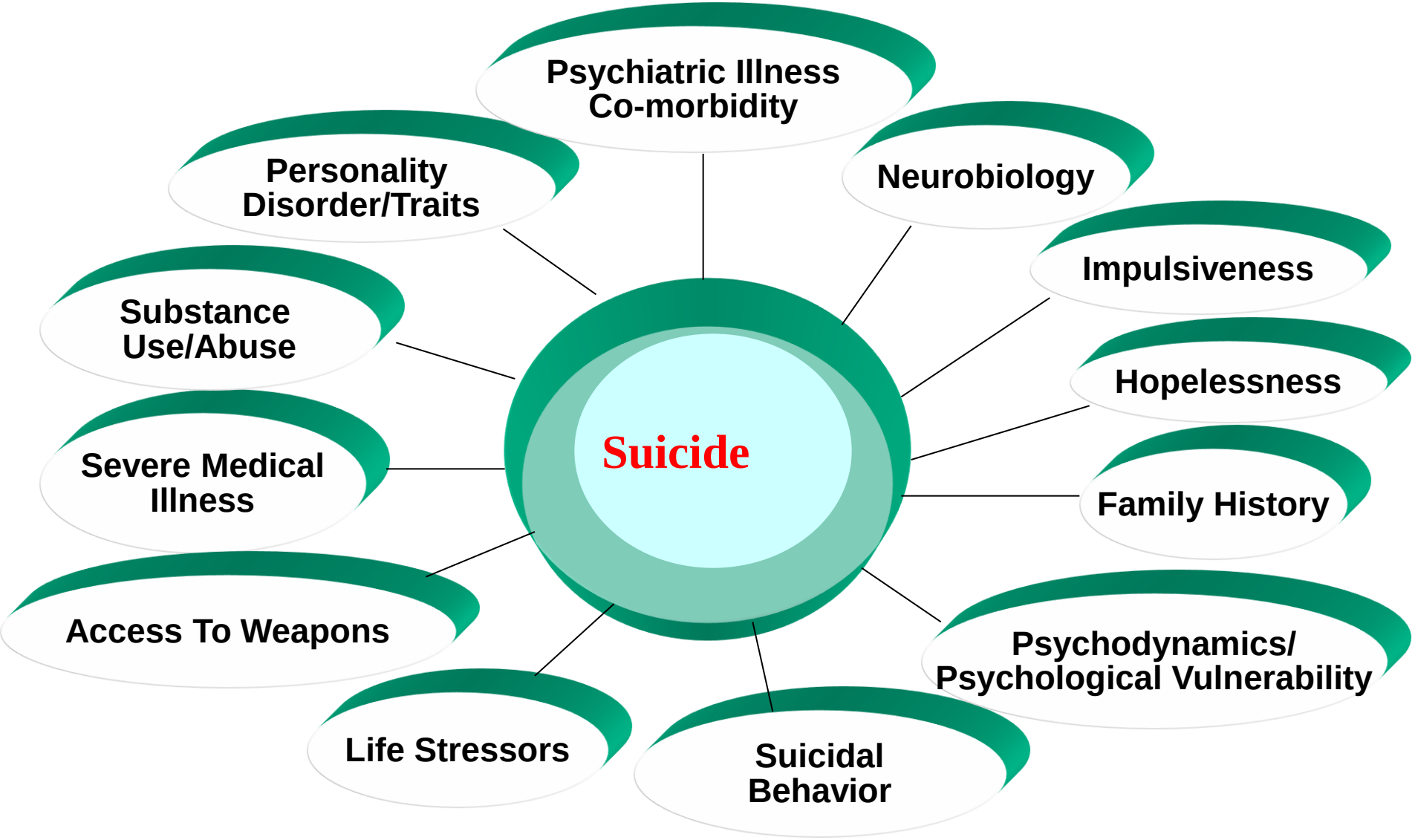
Suicide (risk) Assessment

- Clinical judgment of risk in the very near future
- Need to weigh a very large amount of available clinical detail
- Appreciate the complexity of contributing factors
- More than a guess or intuition
- Reasoned, inductive process
- Essential exercise

DETERMINATION OF RISK



SUICIDE: A MULTI-FACTORIAL EVENT



Areas to Evaluate in Suicide Assessment

Psychiatric Illnesses	Mood Disorders, Alcohol / Substance Abuse, Schizophrenia, Cluster B Personality disorders.
Psychosocial situation	Acute and chronic stressors; quality of support; religious beliefs
History	Prior suicide attempts, family history of mental illness, medical illness
Individual strengths / vulnerabilities	Coping skills; personality traits; tolerance of psychological pain
Suicidality and Symptoms	Suicidal ideation

Adapted from APA guidelines, part A, p. 4

RISK FACTORS (blue = modifiable)

Demographic	male; widowed, divorced, single; increases with age; white
Psychosocial	lack of social support; unemployment; drop in socio-economic status;
Psychiatric	psychiatric diagnosis; comorbidity
Physical Illness	malignant neoplasms; HIV/AIDS; peptic ulcer disease; hemodialysis; systemic lupus erthematosis; pain syndromes; functional impairment; diseases of nervous system
Psychological Dimensions	hopelessness; psychic pain/anxiety; psychological turmoil; decreased self-esteem; fragile narcissism & perfectionism
Behavioral Dimensions	impulsivity; aggression; severe anxiety; panic attacks; agitation; intoxication; prior suicide attempt
Cognitive Dimensions	thought constriction; polarized thinking
Childhood Trauma	sexual/physical abuse; neglect; parental loss
Genetic & Familial	family history of suicide, mental illness, or abuse

PROTECTIVE FACTORS

- **Children in the home, except among those with postpartum psychosis**
- **Pregnancy**
- **Deterrent religious beliefs**
- **Life satisfaction**
- **Reality testing ability**
- **Positive coping skills**
- **Positive social support**
- **Positive therapeutic relationship**

SUICIDE RISKS IN SPECIFIC DISORDERS

Condition	RR	%/y	%-Lifetime
Prior suicide attempt	38.4	0.549	27.5
Eating disorders	23.1		
Bipolar disorder	21.7	0.310	15.5
Major depression	20.4	0.292	14.6
Mixed drug abuse	19.2	0.275	14.7
Dysthymia	12.1	0.173	8.6
Obsessive-compulsive	11.5	0.143	8.2
Panic disorder	10.0	0.160	7.2
Schizophrenia	8.45	0.121	6.0
Personality disorders	7.08	0.101	5.1
Alcohol abuse	5.86	0.084	4.2
Cancer	1.80	0.026	1.3
General population	1.00	0.014	0.72

Adapted from A.P.A. Guidelines, part A, p. 16

COMORBIDITY

In general, the more diagnoses present, the higher the risk of suicide.

Psychological Autopsy of 229 Suicides

- 44% had 2 or more Axis I diagnoses
- 31% had Axis I and Axis II diagnoses
- 50% had Axis I and at least one Axis III diagnosis
- Only 12 % had an Axis I diagnosis with no comorbidity

Henriksson et al, 1993

FAMILY HISTORY/GENETICS

- Relatives of suicidal patients 4x increased risk
- Twin studies -> higher concordance of suicidal behaviour between identical rather than fraternal twins.
- Adoption studies: a greater risk of suicide among biologic rather than adoptive relatives.
- Suicide appears to be an independent, inheritable risk factor

FAMILY PSYCHOPATHOLOGY

- Family history of abuse, violence, or other self-destructive behaviors place individuals at increased risk for suicidal behaviors (Moscicki 1997, van der Kolk 1991).

- Histories of childhood physical abuse and sexual abuse, as well as parental neglect and separations, may be correlated with a variety of self-destructive behaviors in adulthood (van der Kolk 1991).

PSYCHOSOCIAL SITUATION: LIFE STRESSORS

- Recent severe, stressful life events associated with suicide in vulnerable individuals (Moscicki 1997).
- Stressors include interpersonal loss or conflict, economic problems, legal problems, and moving (Brent et al 1993b, Lesage et al 1994, Rich et al 1998a, Moscicki 1997).
- High risk stressor: humiliating events, e.g., financial ruin associated with scandal, being arrested or being fired (Hirschfeld and Davidson 1988) – can lead to impulsive suicide.

COMPONENTS OF SUICIDAL IDEATION

- Intent:

  Subjective expectation and desire for a self-destructive act to end in death.
- Lethality:

  Objective danger to life associated with a suicide method or action. Lethality is distinct from and may not always coincide with an individual's expectation of what is medically dangerous.
- Degree of ambivalence - wish to live, wish to die
- Intensity, frequency
- Rehearsal/availability of method
- Presence/absence of suicide note
- Deterrents (e.g. family, religion, positive therapeutic relationship, positive support system - including work)

Beck et al. (1979)

CHARACTERISTICS OF A SUICIDE PLAN

- Method
- Time
- Place
- Available means
- Arranging sequence of events

Jacobs (1998)

Before the act

- Problems?
- Planning? Impulsive?
- Final acts?

The act itself

Method used – was it dangerous?

- Safe method / dangerous intent
- Dangerous method / dangerous intent
- Dangerous method / no intent

Open / concealed?

Intention? - why did you do it?
- did you hope to die?

After the act

- Seek help?
- Inform anyone?
- Discovered by others
- What happened?

PSYCHIATRIC SYMPTOMATOLOGY: COMMAND HALLUCINATIONS

- Existing studies are too small to draw conclusions, patients with command hallucinations may not be at greater risk, per se, than other severely psychotic patients.
- However, the majority of patients with suicidal command hallucinations should be considered seriously suicidal
- Management of patients with chronic command hallucinations requires consultation and documentation

Adapted from A.P.A. Guidelines, Part A, p. 20-21

TREATMENT SETTING AND PLAN

- Admission or outpatient
- Somatic treatment modalities:
  - ECT – used to treat acute suicidal behavior
  - Benzodiazepines – may reduce risk by treating anxiety
  - Antidepressants
  - Lithium, Anticonvulsants
  - Antipsychotics, recent study on Clozapine
- Psychological therapy– widely viewed as helpful but evidence is limited
- Provide education to patient and family
- Close monitoring
- Reassess suicide risk frequently.

TREATMENT

ECT	Evidence for short-term reduction of suicide, but not long-term.
Benzodiazepines	May reduce risk by treating anxiety
Antidepressants	A mainstay treatment of suicidal patients with depressive illness / symptoms. No conclusive evidence of suicide reduction
Lithium and Anti-convulsants	Lithium has a demonstrated anti-suicide effect; anticonvulsants do not
Antipsychotics	Evidence for Clozapine reducing suicidality in schizophrenia and schizo-affective disorders

Psychotherapy

- **Key is to provide a positive and sustaining therapeutic relationship**
- To target issues
  - Denial of symptoms
  - Lack of insight
- To manage high risk symptoms
  - Hopelessness
  - Anxiety
- Effective treatment for
  - Depression
  - Personality disorders

WHAT TO DOCUMENT IN A SUICIDE ASSESSMENT

Document:

- The risk level
- The basis for the risk level
- The treatment plan for reducing the risk

Key Learning Points

- Suicide risk assessment involves the consideration of a plethora of factors
- Risk factors, modifiable risk factors and protective factors
- Assessment of the suicide
- Treatment plans include consideration for admission, medications and therapy

References

Jacobs DG, ed. The Harvard Medical School Guide to Suicide Assessment and Intervention. San Francisco, CA. Jossey-Bass Publisher, 1998.

Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors. American Journal of Psychiatry (Suppl.) Vol. 160, No. 11, November 2003