Suicide

Theodore A. Stern, M.D.
Chief, Avery D. Weisman Psychiatric Consultation Service,
Massachusetts General Hospital
Director, Office for Clinical Careers,
Massachusetts General Hospital
Ned H. Cassem Professor of Psychiatry in the field of
Psychosomatic Medicine/Consultation,
Harvard Medical School
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General Facts About Suicide

• Ninth leading cause of death in the USA
• Results in more than 30,000 deaths/year
• Accounts for 1.3% of all deaths
• One of every 8-10 attempts are successful
• Average rate is 12.7/100,000
  – when > 65 years old, rate is 19.2/100,000
• Rate increases will social unrest
Problems of Prediction

• Predicting the future is problematic
• Most suicidal patients do not commit suicide
• Assessment of suicide risk can be complicated by the physician’s emotional reactions
• Awareness of risk factors does not make prediction infallible
• Some individuals effectively hide their true feelings and plans
Risk Factors: Major Depression

• Accounts for 50% of completed suicides
  – 15% of those with affective illness suicide
• Risk of suicide increases when psychosis co-exists
• Screening for neurovegetative symptoms is essential
  – Remember the SIG E: CAPS mnemonic
Risk Factors: Alcoholism and Drug Dependence

• Accounts for 25% of completed suicides
• Use and/or intoxication may disinhibit depressed patients and facilitate an attempt
• Substance abuse may co-exist with affective illness
Risk Factors: Schizophrenia

• Accounts for 10% of completed suicides
  – 10% of those with schizophrenia suicide
• Results in a deadly combination with depression
• Risk increased with delusions, paranoia, or command hallucinations urging self-destruction
Risk Factors: Character Disorders

• Accounts for 5% of completed suicides
  – and the majority of patients we evaluate for suicide risk

• Dysphoric patients frequently attempt suicide

• Impulsivity predisposes to suicide attempts and to suicide
Additional Risk Factors

• History of suicide attempts or threats
  – Nearly 50% have made prior attempts

• Male sex
  – Men attempt 3-4 times less often
  – Men succeed 2-3 times more often
  – Men tend to use more violent means

• Advancing age
  – Rates rise steadily with age, alienation, & debilitation
Additional Risk Factors

• Marital status
  – Never married > widowed > separated > divorced > married
• Being unemployed and unskilled
• Having chronic illness, pain, or a terminal illness
• Panic disorder
• Caucasian race
Additional Risk Factors

- Family history of suicide
- Organic brain syndrome
- Biological markers
  - Decreased CSF levels of 5-HT and 5-HIAA
- Recent hospital discharge
- Firearms in the household
## Rates of Suicide by Psychiatric Disorder

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affective illness</td>
<td>50%</td>
</tr>
<tr>
<td>Drug or alcohol abuse</td>
<td>25%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>10%</td>
</tr>
<tr>
<td>Character disorders</td>
<td>5%</td>
</tr>
<tr>
<td>Secondary depression</td>
<td>5%</td>
</tr>
<tr>
<td>Organic brain syndromes</td>
<td>2%</td>
</tr>
<tr>
<td>None apparent</td>
<td>2%</td>
</tr>
</tbody>
</table>
Who Needs Evaluation?

- Survivors of a suicide attempt
- Patients who complain of suicidal thoughts
- Patients with other complaints who admit to being suicidal
- Patients who deny being suicidal, but whose actions demonstrate suicidal potential
Why Do People Suicide?

- Murder in the 180th degree (Freud)
- Transition to a better life (Hara-kiri)
- Release, as from pain and suffering
- Response to hallucinations and delusions
- Anger, impulse, or to spite others
- Recent loss
- Feeling helpless or trapped
- “Rational” suicide
How Do People Suicide?

• Violent means
  – e.g., Shooting, stabbing, hanging, jumping

• Non-violent means
  – Drug overdose
    • e.g., acetaminophen, alcohol, aspirin, barbiturates, benzodiazepines, tricyclic antidepressants
Suicide Assessment

• Take all potentially fatal threats, gestures, and attempts seriously

• Consider the possibility
  – If you don’t, you won’t make the diagnosis

• Be empathic
  – Try to establish rapport before honing in on the issue of suicide

• Perform a mental status examination
Suicide Assessment

• Ask about suicidal thoughts and intent
• Ask about plans for suicide
  – Is there a detailed plan?
  – Are the means available?
• Determine if there are plans for the future
• Determine, “Why now?”
  – Is there a precipitant?
Suicide Assessment

• Obtain information from friends or family
  – Remember, the suicide assessment is often an emergency evaluation

• Review for the presence of risk factors
Suicide Assessment After an Attempt

• What was the risk?
• What were the chances for rescue?
• Did the person believe the method would work?
  – Was he disappointed he survived?
• Was the attempt impulsive?
• What is different now?
Decision Pathways

• Determine ongoing risk of suicide
  – If suicidal
    • protect and admit
  – If unsure about risk
    • protect, get consultation, and consider hospitalization
  – If not suicidal
    • decide on a reasonable plan that may not require hospitalization
High-Risk Patients

• Psychotic and suicidal
• Greater than 45 years old
• Survivors of a violent attempt
• Those who took precautions to avoid rescue
• Those who refuse help
• Those without social supports
Prediction of Risk: Results of an MGH Study

• None of 74 patients sent home from the ER after an overdose (OD) was readmitted for an OD or another suicide attempt within 6 weeks

• 1 of 26 patients admitted from the ER to Medicine after an OD was readmitted within 6 weeks

• 5 of 35 patients admitted to Psychiatry after an OD were readmitted within 6 weeks after hospital discharge
Treatment and Decision Options

• If not suicidal
  – Send patient home with follow-up
• If complications from an attempt are present
  – Admit to a general hospital and obtain further consultation
• If suicidal
  – Admit to a psychiatric hospital
    • voluntarily or involuntarily
Management Pointers

• Protect the patient
  – Throughout the evaluation and disposition process

• Document decisions in the medical record
Involuntary Hospitalization

• Know the laws and procedures in your state
• Often involves:
  – One physician, police officer, or judge
  – Simple documentation
  – Guaranteed transport to a facility for evaluation
• Treat the problem as specifically as possible
• Remember:
  – Even a week’s supply of some antidepressants can be lethal
Treatment of Suicidal Patients

- Psychopharmacology
- Psychotherapy
  - Strengthen relationships, be flexible, be active, demonstrate concern, listen for symbolic communication, emphasize options
- Social supports
  - Engage the help of others
- Protection
  - Prevent escape, avoid dangerous objects, consider use of restraints
Unusual Situations

- Rooftop evaluations
  - Be flexible
  - Be mindful of what you are wearing
  - Enlist the help of others
When Is Hospitalization No Longer Required?

• When the precipitant or crisis has resolved
• When supports are strengthened
• When psychosis has resolved
• When depression has abated
• When suicidal thoughts and intent have passed
Suicide in the General Hospital

• More common recently with greater numbers of psychiatric patients in general hospitals
• Jumping from a height is the most common method
• Often precipitated by medical illness
  – HIV infection, renal failure/dialysis, COPD
• Medical staff may focus on medical illness and avoid its psychiatric aspects
Know Your Limits

• Work with suicidal patients is stressful
  – Monitor your reactions
  – Monitor the behaviors of others
  – Determine when consultation and support are necessary
Reactions of Physicians to Suicide

- Anger
- Denial
- Depression
- Intellectualization
Countertransference Reactions to Suicidal Patients

• Hatred
• Restlessness
• Fear
• Helplessness
• Indifference
• Rejection
• Over-involvement
Conclusion

• Be prepared
Selected References


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