Suicide

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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

- Affective illness: 50%
- Drug or alcohol abuse: 25%
- Schizophrenia: 10%
- Character disorders: 5%
- Secondary depression: 5%
- Organic brain syndromes: 2%
- None apparent: 2%
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
Treatment of Suicidal Patients:
General Principles

• 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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