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

<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
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


Selected References


Selected References


Thank You

• Questions?