Suicide assessment and managment

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Case Development 4:

- **During follow up, the psychologist in your team inform you that the patient discloses her deep wishes to die and refuse to elaborate more**

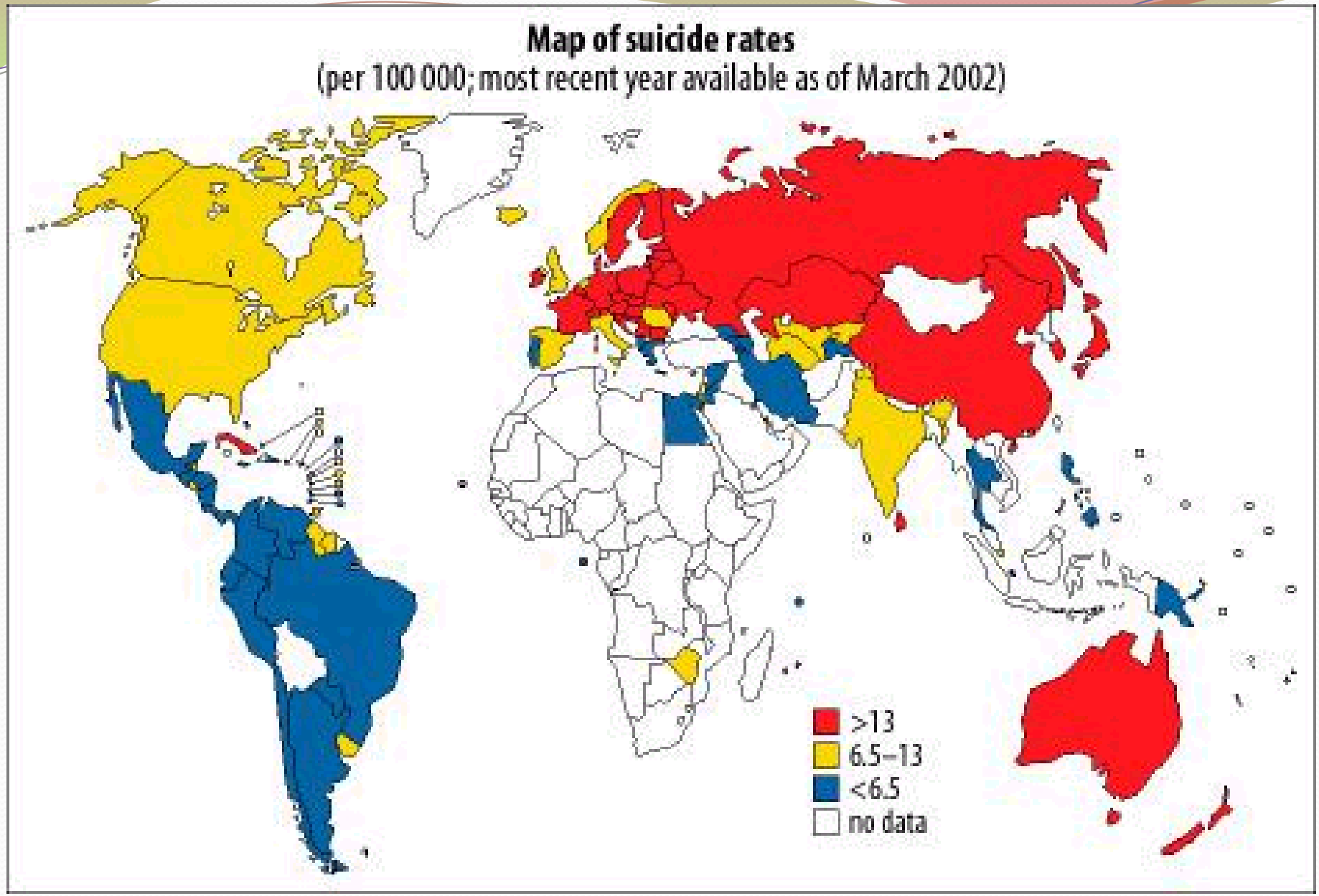
Definitions

- **Suicide:** intentional self-inflicted death
- **Suicidal ideation:** thoughts of killing oneself (i.e., serving as the agent of one's death)
- **Suicidal act:** intentional self-injury (can have varying degrees of lethal intent)
- **Deliberate self-harm or parasuicide:** An act of self-damage carried out with destructive intent but without the will to finish one's life.

Epidemiology

- Suicidal behaviors are the most common psychiatric emergency
- The 11th leading cause of death in U.S.
- About 30,000 suicides annually in U.S.
- Over 90% of suicide victims have a diagnosable psychiatric disorder—over half have a depressive disorder

Scott Stroup, 2004


Map of suicide rates
(per 100 000; most recent year available as of March 2002)
>13
6.5–13
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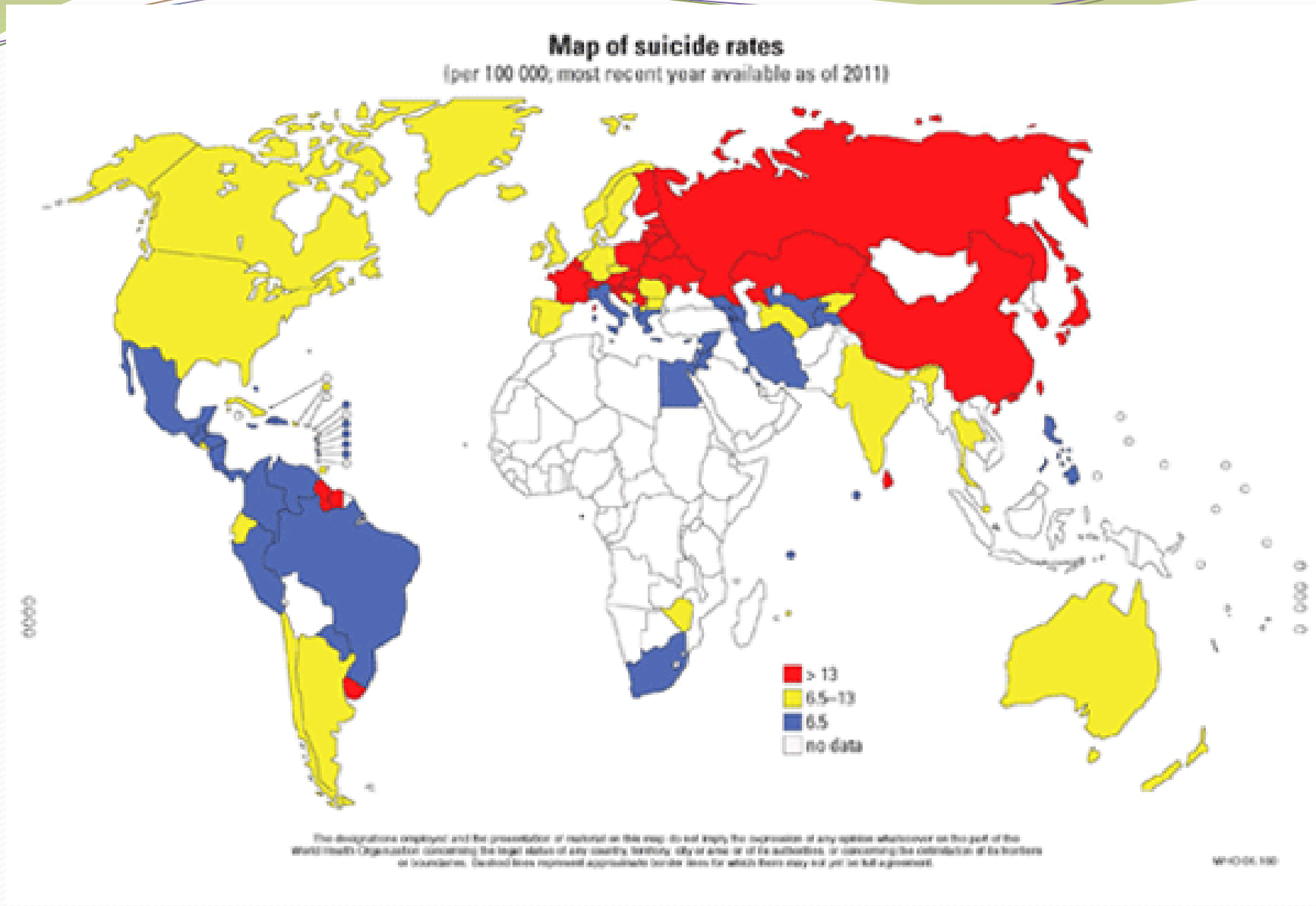
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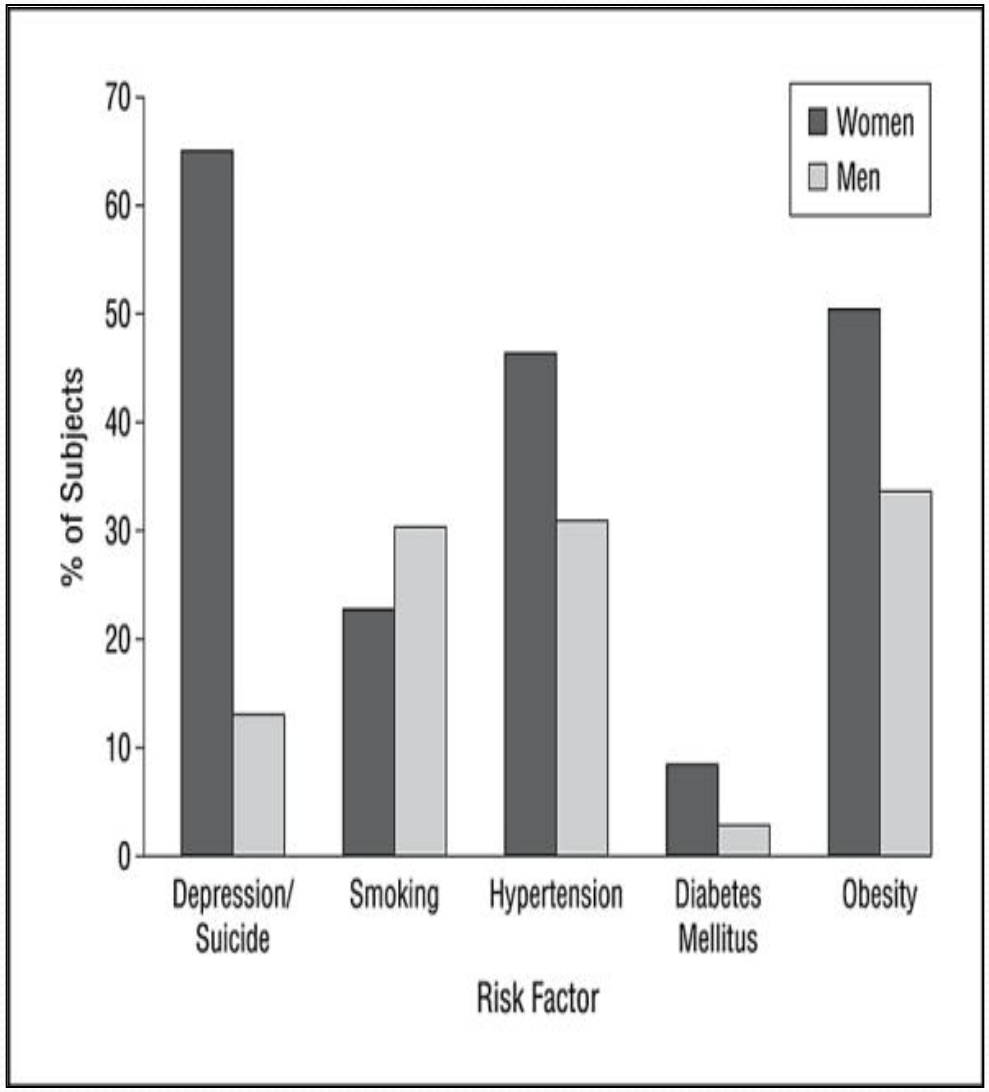
Depression and History of Attempted Suicide as Risk Factors for Heart Disease Mortality in Young Individuals.



Depression and History of Attempted Suicide as Risk Factors for Heart Disease Mortality in Young Individuals.
Shah, Amit; Veledar, Emir; Hong, Yuling; MD, PhD; Bremner, J; Vaccarino, Viola; MD, PhD

Archives of General Psychiatry. 68(11):1135-1142, November 2011. DOI: 10.1001/archgenpsychiatry.2011.125

Figure 2. Population-attributable risk of ischemic heart disease mortality due to depression and a history of attempted suicide and traditional risk factors. Risk is based on hazard ratios in a multivariate model that included depression/attempted suicide, age, race/ethnicity, smoking, hypertension, hyperlipidemia, diabetes mellitus, and obesity.

Attempts vs. Completions

- Ratio of attempts to completions may be as high as 25:1
- Women more likely to attempt suicide
- Men more likely to complete suicide
- Men use more lethal means

Psychiatric disorders are the primary underlying risk factors

- Major depression
- Bipolar disorder
- Schizophrenia
- Substance use disorders
- Personality disorders: borderline, antisocial
- Panic disorder

Highly important underlying risk factors

- **History of previous attempts**
- **Depression**
- **Alcohol or drug abuse**

Other underlying risk factors

- History of psychiatric hospitalization
- Chronic medical illness(serious, painful or disfiguring)
- Family history of suicide
- History of childhood abuse (physical, verbal, or sexual)
- Impulsiveness

Underlying sociodemographic risk factors

- Social isolation:
  -Living alone
  -Not currently married (never married, separated, divorced, or widowed)
- Unemployment
- Male gender
- Increased age
- Certain occupations: police officers, physicians

Biological Factors

- Serotonin abnormalities
  - decreased CSF 5-HIAA
  - increased 5-HT_{2A} receptors
  - linked with impulsivity and aggression
  - PET: abnormal metabolism in prefrontal cortex
- Genetics
  - familial association beyond risk for specific diagnoses

Precipitating (proximal) Risk Factors

- Intoxication especially with Alcohol
- Stressful life events:
  -loss of job
  -death of a loved one
  -divorce
  -migration
  -incarceration
- Is suicide contagious?!!
- Role of media?!!

Most common methods of completed suicide

Men

1. **Firearms (61%)**
   - Presence of a gun in the home increases risk of suicide 5X
   - Readily accessible firearms facilitate lethal impulsive acts and leave little chance for rescue
2. **Hanging**

Women

1. **Firearms (37%)**
2. **Self-poisoning**

Psychological factors/theories

- Hopelessness, despair
- Freud: aggression turned inward
- Escape from rage
- Guilt; self-punishment or atonement
- Rebirth or reunion fantasies
- Control over a relationship
- Revenge

Religion and Suicide

- Lower rates among Muslims, Jews and Catholics, presumably due to religious prohibition
- Lower rates in predominately Catholic countries, but this is not consistent
- Religious affiliation is apparently less important than religious involvement and participation in affecting risk of suicide
- No major studies about suicide in Islamic countries

Suicide and Schizophrenia (I)

- 33-50% with schizophrenia will attempt suicide
- Approximately 10% with schizophrenia die by suicide
- Gender: equal attempt ratio, more men die by suicide
- Risk factors :

❑ Isolation (single, living alone, unemployed)

❑ Substance abuse

❑ Akathisia

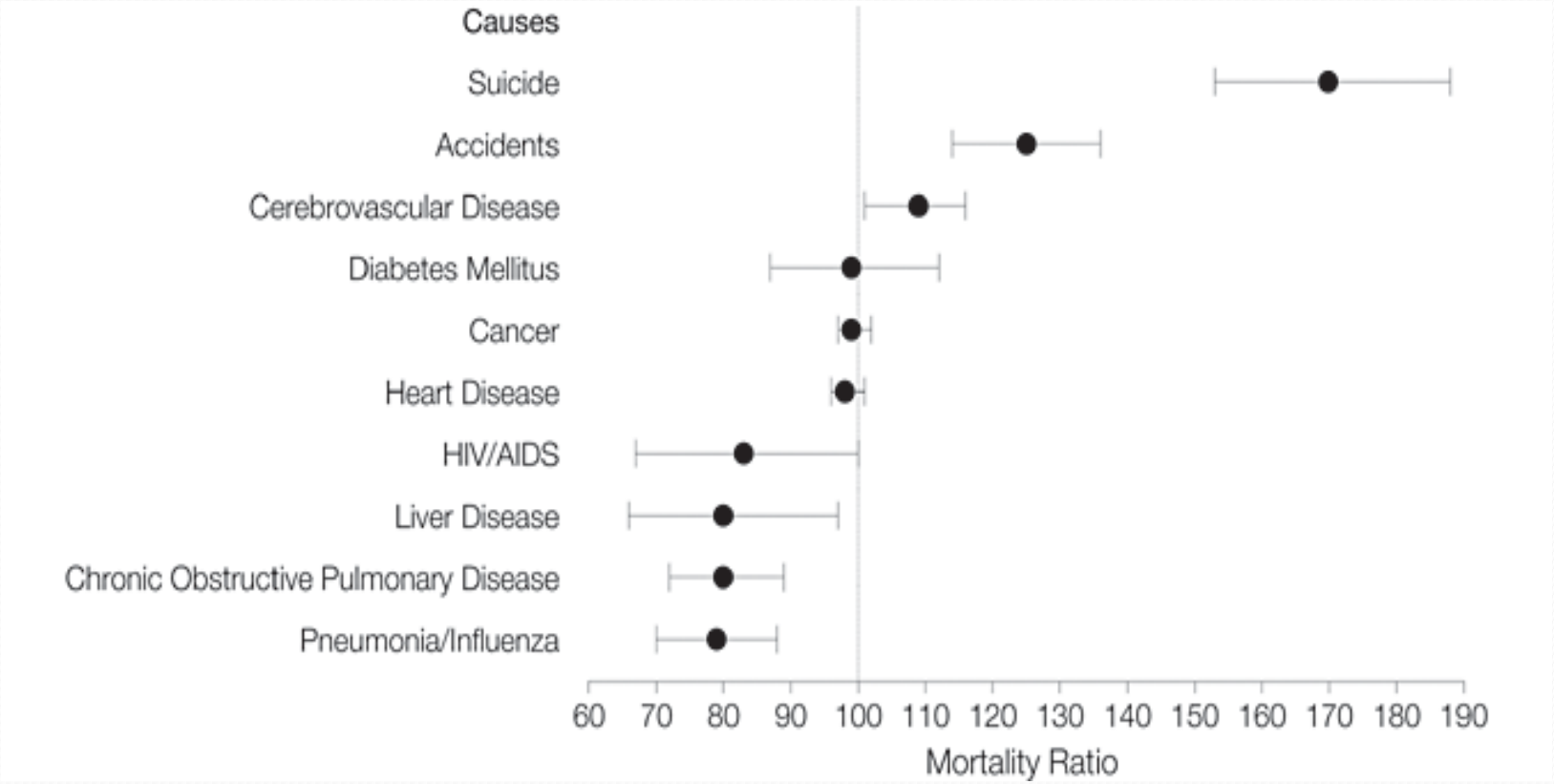
Suicide and Schizophrenia (II)

- Periods of increased risk:
  - Highest risk in first 10 years of illness
  - When depression
  - When hopeless
  - After resolution of an acute psychotic exacerbation
  - Days, weeks, months after hospitalization
- Persons with more “insight” thought to be at higher risk of suicide

Suicide among physicians

- Rate higher than general population, particularly for women doctors (same rate in male, female MDs)
- Unrecognized and untreated depression a common theme
- Physician help-seeking highly suboptimal:
  - 1/3 of physicians have no regular doctor
  - Low rates of seeking help for depression
  - Professional attitudes discourage admission of health vulnerabilities
  - Concerns about confidentiality, licensing, privileges, medical insurance, malpractice insurance
  - When seek help often quite ill

Figure. Proportionate Mortality Ratio for White, Male Physicians vs. White, Male Professionals, 1984-1995



Center et al, JAMA, June 18, 2003

Profile of a Physician at High Risk for Suicide

- **Sex:** Male or female
- **Age:** 45 Years or older (woman); 50 years or older (man)
- **Race:** White
- **Marital status:** Divorced, separated, single, or currently having marital disruption
- **Risk factors:** Depression, alcohol or other drug abuse, workaholic, excessive risk taking (especially high-stakes gambler, thrill seeker)
- **Medical status:** Psychiatric symptoms or history (especially depression, anxiety), physical symptoms (chronic pain, chronic debilitating illness)
- **Professional:** Change in status—threats to status, autonomy, security, financial stability, recent losses, increased work demands
- **Access to means:** Access to legal medications, access to firearms

Center et al, JAMA, June 18, 2003

Assessment of suicidality

- Ask about suicidality in every initial psychiatric assessment
- Asking about suicidality does not suggest it
- Do not dismiss someone’s suicidal comments
- Spectrum of suicidality: passive thoughts, plan, intent, attempt
- Intent is not always communicated
- No absolute predictive test or criteria

When assessing suicide risk, consider:

- Pervasiveness of thoughts
- Plan
- Lethality of plan/attempt
- Availability of lethal means
- Likelihood of rescue

Markers of increased suicide risk

- Preparations for death: Settling affairs, giving away personal items, writing a note
- Sudden change of mood
- Lack of future plans
- Recent loss
- Symptoms: Insomnia, hopelessness, severe anxiety, extreme restlessness or agitation

The chronological assessment of suicide events (CASE)

1. The presenting suicide ideation and behaviors.
2. Recent suicide ideation and behaviors over the preceding 8 weeks
3. Past suicide ideation and behaviors
4. Immediate suicide ideation and future suicide plans

(Shea, 2002)

Assessment of the suicide

- The present attempt:
  - Situation
  - Mean
  - Suicidal note
  - Planning
  - MSE
- Past History:
  - Past attempts
  - Past psychiatric disorder
  - Medical disease
  - Present factors
  - Living status
  - Social support

Suicide risk categories (Psychosomatic medicine, Amos, 2010)

Baseline: absence of acute overlay without significant stressors, appropriate only for ideators and single attempters

Acute: presence of acute overlay and significant stressors and/or symptoms, appropriate only for ideators and single attempters

Chronic high risk: baseline risk for multiple attempters, absence of acute overlay, no significant stressors or symptoms

Chronic high risk with acute exacerbation: acute risk for multiple attempters, presence of acute overlay, significant stressors and/or prominent symptoms

SAD PERSONS Scale

Table 4. SAD PERSONS Scale.

Factor		Points
S =	Sex (male)	1
A =	Age (<19 or >45 years)	1
D =	Depression	1
P =	Previous suicide attempt	1
E =	Ethanol abuse	1
R =	Rational thinking loss	1
S =	Social supports lacking	1
O =	Organized plan	1
N =	No spouse	1
S =	Sickness (chronic debilitating disease)	1

Score less than 2:
discharge with outpatient psychiatric evaluation

Score of 3-6:
consider for hospitalization or at least very close follow-up

Score of 7 or greater:
hospitalization

Source: Patterson WM, Dohn HH, Bird J, et al. Evaluation of suicidal patients: the SAD PERSONS scale. *Psychosomatics* 1983 Apr;24(4):343-345, 348-349.

Management of suicidal patients

- Determine treatment setting: Inpatient or outpatient
- Caution regarding use of “contracts for safety”
- Better to use (commitment to treatment statement) (Rudd,2006)
- Medications
- Limit availability of firearms, lethal drugs, other means
- Access to crisis services needed
- Therapy

Management of suicide

- Immediate:
  - Admission: psychiatric vs. medical wards
  - Instructions to nurses
  - Management of medical problems
  - Involvement of family
- Short-term:
  - Transfer to psychiatric ward
  - Treat psychiatric disorder
  - Manage social stress
  - Psychological treatments

Management of suicide

- Long-term:
  - Maintenance of treatment
  - OPD follow-up
  - Social support
  - Samaritans (easy contact to service)
  - Watch of relapse

Myth vs. Fact about suicide

Myth: People who talk about suicide don't die by suicide.

Fact: Many people who die by suicide have given definite warnings to family and friends of their intentions. Always take any comment about suicide seriously.

Myth: Suicide happens without warning.

Fact: Most suicidal people give many clues and warning signs regarding their suicidal intention.

Clayton, J. *Suicide Prevention: Saving Lives One Community at a Time.* American Foundation for Suicide Prevention. http://www.afsp.org/files/Misc_//standardizedpresentation.ppt

Myth vs. Fact about suicide

Myth: People who are suicidal are fully intent on dying.

Fact: Most suicidal people are undecided about living or dying – which is called suicidal ambivalence. A part of them wants to live; however, death seems like the only way out of their pain and suffering. They may allow themselves to "gamble with death," leaving it up to other to save them.

Myth: Males are more likely to be suicidal.

Fact: Men *die by* suicide more often than women. However, women *attempt* suicide three times more often than men.

Clayton, J. *Suicide Prevention: Saving Lives One Community at a Time.* American Foundation for Suicide Prevention. http://www.afsp.org/files/Misc_//standardizedpresentation.ppt

Myth vs. Fact about suicide

Myth: Asking a depressed person about suicide will push him/her to kill themselves..

Fact: Studies have shown that patients with depression have these ideas and talking about them does not increase the risk of them taking their own life.

Myth: Improvement following a suicide attempt or crisis means that the risk is over.

Fact: Most suicides occur within days or weeks of "improvement" when the individual has the energy and motivation to actually follow through with his/her suicidal thoughts.

Clayton, J. *Suicide Prevention: Saving Lives One Community at a Time.* American Foundation for Suicide Prevention. http://www.afsp.org/files/Misc_//standardizedpresentation.ppt

Recommendations to Saudi health care policy to deal with suicide

- 15% of healthcare budget should go to psychosocial services. (currently, ? Less than 1%)
- Force medical insurance companies to cover psychiatric treatment in the insurance pill (currently, the insurance does not cover plastic, dental and psychiatric services?!!, despite 25-33% of population will have psychiatric disorder anytime in their live).
- Integrate psychiatric services as part of general medical hospitals (currently, we have only isolated neglected stigmatized mental hospitals).

Recommendations to media

- Reports should be factual, concise, non-repetitive
- Reports should avoid oversimplified explanations of cause
- Detailed descriptions of method should not be provided
- Reports should not glorify victim or imply that suicide was effective in helping the person to attain some goal
- Reports should provide information on how to get help

Thank you

لماذا ينتحر السعوديون؟

فهد العصيمي

http://bit.ly/18dU1YN