Evaluation and Management of Suicidal Behavior

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The danger of suicide is highest in depressed older people, especially men who have sustained a loss, who have an attitude of hopelessness, and who have not resolved feelings of grief. Factors associated with greater risk are chronic or serious illness, divorced, separated or widowed marital status, white race, drug abuse, excessive use of alcohol, unemployment, and poor living conditions. Commonly, those who commit suicide have made previous attempts and have directly or indirectly communicated their intention to others. The family physician is in the front line in the recognition and prevention of suicide. In the treatment of the suicidal, the physician should maintain a strong positive relationship to the patient and be consistently dedicated to his care including availability to see the patient frequently and to receive phone calls in the middle of the night. Those with the most serious risk should be referred to a psychiatrist and hospitalized to protect them from their suicidal impulses. Psychotherapy, antidepressant and tranquilizer drugs and electric shock treatment are the main therapeutic approaches. The physician's capacity for empathy and emotional commitment are of greater importance than his professional credentials.

The nonpsychiatric physician is in the front line in regard to the recognition of depression and the prevention of suicide. His decisions and evaluations are thus of the greatest importance in regard to the life or death of the patient. In this paper, our purpose is to inform nonpsychiatric physicians about the range and extent of suicidal behavior and to share some ideas which have proven to be useful in the evaluation and management of patients who have made suicide attempts and/or are suicidal.

Suicide is among the ten most common causes of death in the United States. For every completed suicide there are about ten suicide attempts.[1] Men outnumber women two to one in completed suicide, whereas women outnumber men two to one in attempted suicide. The suicide rate in men goes up with age. In women the rate reaches a peak in their 50s and then gradually recedes. The mean age of those who commit suicide is around 50, whereas the mean age of attempters is in the early 30s. An alarming recent change is the increasing rate of suicide in young people — persons in their teens and 20s. Other factors making for greater risk are divorced, separated or widowed marital status, white race, drug abuse, excessive use of alcohol, unemployment, poor living conditions and physical and emotional illness.

Suicide occurs most frequently in patients with psychoses, but patients with neuroses or character disorders also kill themselves. The psychodynamics or motivations for suicide are complex and vary from case to case. One Dutch psychoanalyst, Meerloo, has described 54 different motivations for suicide.[2] Common examples include the wish to

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die, the wish to be killed, the wish for punishment, the wish for reunion in heaven with a lost loved one, and the wish for spite or revenge.

Object Loss in Suicidal Behavior

Rather than discuss the various psychodynamic constellations, we would like to emphasize the vital importance of *object loss* as a predominating factor in suicidal behavior. In psychoanalytic terminology the term "object" denotes anything of value to the individual. It may be a person, a thing or even parts of one's own body. Although this paper will focus on the loss of individuals, similar psychodynamics are observed in suicidal patients who have sustained other types of object loss. In previous studies of attempted and completed suicide,[3,4] we found that some subjects committed suicide after the loss of money, others killed themselves after being discharged from their jobs. Next to the loss of loved ones, the most frequent loss was that of health. In our study of 114 subjects who had committed suicide, approximately half had a serious and chronic physical illness which was judged to have contributed to their suicide.[5]

Loss reactions also play a prominent part in suicide attempts. Attempted suicide subjects differ from those who complete suicide in that they more often are reacting to a *threatened* loss than an actual loss. For example, the most common event precipitating suicide attempts is a lovers' quarrel involving the threat of a disruption or separation in the relationship.

Since everyone experiences loss, the reader might ask the question, "Why do some people become suicidal whereas others are able to recover from their losses?" Patients in our studies were unable to overcome loss because they experienced the lost loved one as part of themselves and therefore as indispensable to their existence. They had an excessive dependency on the lost object for their lives and for the regulation of their self-esteem. Loss of the needed object brought the loss of meaning and purpose in their lives.

Evaluation of Suicidal Risk

How does one evaluate suicidal risk or suicidal intention? The best way to find out if a patient is suicidal is to ask him. The physician may fear that talking about suicide will result in an increase in anxiety, depression, or suicidal preoccupation in his patient. He may, therefore, avoid frank discussion of it. Instead of increasing the risk of suicide, talking about suicide is apt to relieve suicidal patients through giving them an opportunity to discuss their thoughts and feelings with a confidant. Verbal expression may actually lessen the need to take action. Questions can be broached gently and tactfully. For example, one could start: "Have your feelings about life changed?" or "Do you sometimes feel life isn't worth living?" With these openings, the patient often discusses suicide. Depending on the response, more specific questions can be asked, such as "Have you contemplated harming yourself?" or "Have you thought of definite plans to end your life?" and "What means of suicide have you considered?" and "What have you thought the reactions of others might be to your attempting to end or actually ending your life?"

We would like to discuss several generalizations which have helped us evaluate the degree and kind of suicide risk.

1. *People who commit suicide are depressed.* In our study of completed suicide, we found that all had some symptoms of depression. Not all patients had a clinical diagnosis of depression; some suffered from a depressive *mood* rather than a depressive illness. Clinical diagnoses in the group varied. The most common diagnosis in those under 40 was schizophrenia; in the 40 to 60 age group it was alcoholism; and in those over 60 the most common diagnosis was some type of psychotic depression.

Symptoms of depression include both psychic and physical disturbances. Especially in older people, signs of depression are often hidden behind somatic complaints. Physical complaints include fatigue, weight loss, insomnia, anorexia and constipation. Pain of whatever origin may serve to mask an underlying depressive mood or depressive illness. Among the psychological complaints are the following: sad or gloomy mood, decreased sexual desire, difficulties in memory, poor concentration and self-depreciation. Preoccupation with death or suicide strongly suggest suicidal intentions.

But depression is common, and not all depressed people kill themselves or even want to. What then distinguishes those who are suicidal from those who are not suicidal? This brings us to the second point.

2. *There is a risk of suicide in the depressed patients who have an attitude of hopelessness.* One can categorize depressed patients into two groups — those who complain of *helplessness* and those who feel and talk of being *hopeless*. Those who feel helpless can generally accept the aid and comfort of others. They are not usually suicidal. They perceive little in themselves which would help them overcome their difficulties but they view others as able to give them assistance. In contrast, those who talk of feeling desperate and hopeless generally see little value in themselves and they are also unable to perceive any value in the world around them.

3. *About one-third of those who commit suicide have made previous attempts.* A suicide attempt, even a pretense or gesture of suicide, is one way of communicating to others one's distress. It has been called "the cry for help."[6] When this "cry" is not heard — when there is not response — the risk of suicide increases. In our study of attempted suicides, we interviewed one depressed elderly man who had made a suicide gesture by nicking his wrists with a razor blade. He was discharged from the hospital with no provisions for follow-up care or treatment. Four days later he killed himself. After reviewing the case, we concluded that the failure of the hospital personnel to respond to this man's cry for help played a crucial role in his suicide.

In those who attempt suicide there is a broad continuum of suicidal motivation ranging from those on one end of the continuum who make suicide gestures to those on the oth-

er end who make potentially lethal, serious attempts. Those who make suicide gestures perform a pretense of suicide in order to frighten and manipulate others into giving them attention and love. In the middle range of this continuum of suicide motivation is a large group of patients who make what we have called "ambivalent" suicide attempts. Their motivation is mixed, vacillating and indecisive. They take some risk of dying, but at the same time they provide some means of rescue.

One patient who made an ambivalent suicide attempt was a middle-aged depressed woman whose main complaint was that her husband did not pay attention to her. He returned home promptly at 6 p.m. each evening. One night, he found her unconscious with her head placed on the oven door and the gas turned on. By placing her head near the oven just before she expected him to return home she compelled him to pay attention to her and to rescue her. She recovered and her husband, partly through the benefits of conjoint therapy with both wife and husband, was able to pay more appropriate attention to her. We cite this case to illustrate the point that death is not the only aim in suicide attempts. Wishes to be reconciled with others, to compel attention, love, sympathy and rescue are often prominent motives. If the patient has been ridiculed or rejected after a suicide attempt, he is more likely to make a more serious, possibly successful effort to end his life. Particularly, emphasis in suicide prevention needs to be placed on efforts to understand and treat those who have been identified as high suicide risks.[7] The prognosis is better if the patient obtained some gratification from the suicide attempt. The vast majority of suicide attempts are designed in such a way as to bring about rescue. The unconscious meaning of such behavior can be paraphrased in this way: "If they save me, if they rescue me from death, I must be worthwhile and loved."

The evaluation of suicidal intention in a past suicide attempt is some help in evaluating current suicide potential. Here the crucial question is: How great a risk did the patient take? One who has merely nicked his wrists obviously has taken no risk, whereas the patients who attempt to shoot or hang themselves fully expect to die.

The evaluation of the seriousness of a past attempt is not a sure guide to current suicidal risk. We have already mentioned the elderly man who made a suicidal gesture and then, after he failed to receive help, killed himself. We could cite other cases of patients who have made very serious suicide attempts and then have recovered from depression with no repeated attempts. In our experience the supportive and helpful response of the patient's family and the medical community are crucial in determining whether the patient gains a constructive outcome from his suicide attempt or if he goes on to more self-destructive behavior.

4. *People who commit suicide communicate their intention to others.* In our study and in the studies of others, about 80 per cent communicated their suicidal intention. Most often this is communicated in a direct way. The patient says, for example, "I'm going to shoot myself." The surprising thing is that people do not believe them. There is a popular saying that those who talk suicide do not do it. Nothing is further from the truth! In our study of committed suicides, we interviewed surviving family members. The wife of one of our subjects told us that her physician had told her, "Those who threaten suicide don't do it." Her fears were relieved but three days later her husband killed himself. Not all communications of suicidal intent are direct and explicit. Indirect communications of suicide intent include: the purchase of lethal weapons, making a will and the hoarding of drugs. Because drugs are so often used for suicide, we have sometimes found it helpful in dealing with suicidal persons to have relatives control and manage drugs used by the patient.

5. *Unresolved grief may lead to suicide.* Over 40 percent of the patients in our study of completed suicide were unable to resolve the loss of a loved one. Most of the losses occurred in the year before the suicide, but in some cases these subjects had been going through a malignant grief reaction for as long as five years. They were unable to complete the so-called "work" of mourning — that is, the task of giving up or relinquishing their emotional ties to lost loved ones. They had not made the transition from the sadness, anxiety and anger which came with the loss to a position where they could look for and find new love objects. Physicians prevent suicide by serving as substitute objects for those who are grieving. For them we are a sort of bridge between the lost hopes and lost love objects of the past and the new relationships in the patient's future. Emotional expressions of grief relieve depression and help prevent suicidal behavior. Let the patient *cry* over his loss. We have often observed dramatic improvement in depressed patients when they are able to cry or express previously repressed anger over the loss of a love object. Just as sex was a taboo subject in the 19th century, so until recently in this century subjects related to death have been avoided. In the past decade, there has been more interest and receptivity to psychological and sociological studies of grief, dying and death. Grief is the emotional reaction to any significant personal loss. Indeed, grief is the most appropriate response to loss and, if fully completed and resolved, has the virtue of being a healing response.

6. *A subtle and usually ignored indication of suicide potential is the physician's subjective response of anxiety and guilt.* The prospect of death, the possibility of being blamed for another's death evoke strong feelings of guilt and/or anxiety in the treating physician. Sometimes when the objective evidence is unclear, we find our subjective sense of foreboding a tell-tale clue to the presence of significant suicidal motivation in a depressed patient.

7. *Approximately one-half of those who commit suicide have a depression connected with a chronic and serious physical illness.* Here too, there is an object loss — the lost object being some physical structure or function. Physical illness brings about changes and losses in one's interpersonal relationships. It isolates the sick from the well. Persons who depend on physical activity for their security and self-esteem become depressed when they are disabled. This

may be observed, for example, in patients who have strokes and those with arthritis. As a contributing factor to the development of depression and suicide, physical illness is much more common in patients over 60 years old.[5]

Family physicians, internists and other physicians are making a notable contribution to suicide prevention by their treatment of depressed elderly people with chronic illnesses. Statistics indicate that before making a suicide attempt, most people ask for help, usually from a doctor.[8] Few of these individuals see psychiatrists. This is also the experience of the suicide prevention clinics and crisis clinics who provide emergency care for the suicidal. Their work is predominantly among younger people. Probably the greatest improvement in our prevention of suicide could be made through earlier detection and treatment of depressive reactions — especially in the aged.

Management of the Suicidal Patient

The serious suicidal risk should be referred to a psychiatrist and be hospitalized in a psychiatric hospital or the psychiatric ward of a general hospital. Frequently, physicians find it impossible to take these steps. Many suicidal patients will not accept psychiatric treatment, and if the patient is not psychotic, he is probably not committable to a psychiatric hospital. In such crises, the patient can be treated in a general hospital or by office visits.

If the patient is treated in a general hospital, a number of precautions should be carried out. The need for such precautions is demonstrated by the fact that recent studies show that more suicides occur in general hospitals than in psychiatric hospitals. The patient should be placed in a room which is in all ways safe. Since many suicides involve jumping from windows, precautions should be taken to insure that there is no access through the window. Objects which could be used for suicide should be removed from the room. It is particularly important to remove sharp objects and objects which could be used for hanging. These include: knives, blades, drinking glasses, ropes, and belts. Patients should have frequent surveillance by nursing personnel.

The specific treatment measures used will depend on the patient's needs and the clinical diagnosis. Psychotherapy, electric shock treatment, antidepressant and tranquilizer drugs are the main therapeutic approaches to the treatment of the suicidal. Electric shock treatment should be reserved for those who are refractory to other treatments.

So far as office treatment is concerned, our advice is to not become involved if you do not want to treat the patient or if you do not have time to treat him. One should not feel guilty over not assuming professional responsibility for treating their suicidal depression. They are difficult patients. In treating and supervising psychiatrists, we have observed that the care of suicidal patients is one of the most stressful and wearing aspects of their work. Frequently, it has been observed[9] that the most common mistake made by physicians (including psychiatrists) who treat suicidal patients involves an initial therapeutic involvement with the patient followed by rejecting the patient or withdrawing from him. Patients then react to the rejection and withdrawal by suicidal behavior — suicide attempts and even actual completed suicide. Physicians may unwittingly withdraw or subtly reject the patient because of the unusual stresses they endure in treating the suicidal.

We suggest that you either make a commitment to become heavily involved with the patient or make arrangements for someone else to assume the professional responsibility. If you do not assume professional responsiblity for treating the suicidal person, you can refer him to a psychiatrist, to a suicide prevention center or crisis clinic, or you can inform the family members of the suicide risk and the need for professional care. If you do assume the treatment responsibility, you must offer all the resourcefulness and dedication you would give to any life-or-death crisis.

Suicidal patients are vulnerable to loss, so that the loss or threatened loss of the patient-physician relationship may itself be the final trauma engendering suicidal behavior. Since deeply depressed patients commit suicide when they lose hope of any meaningful relationship, we should above all maintain contact with them. This means being available for phone calls in the middle of the night. Home visits may be required. Frequent, even daily office visits are often needed. Whenever possible, relatives should be included in the treatment either through individual interviews or conjoint interviews with the suicidal patient.

Professional credentials or expertise matter not so much as the practitioner's capacity for empathy and emotional commitment to the patient. The more concerned and caring family physician best serves the suicidal patient. Provide emotional contact for the patient. Hold on to him, and let him hold on to you so that he may choose life rather than death.

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