Suicide Assessment: A Clinical Model

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One of the most critical and ill-defined areas of the physician's practice is the evaluation of suicidal intent, particularly of the patient who has made no previous such attempts. Making the problem more complex is the attitude of the physician toward the self-destroyer, as determined by his/her upbringing and training. This article first confronts the issue of how the attitude of the physician can and does affect the potentially suicidal patient. Secondly, a conceptual model for a suicide evaluation is presented. This model has been designed for flexibility and practicality in order to help ensure that a complete evaluation can be done within the requirements and necessities of the practicing physician.

For the busy physician in general and family practice, one of the most critical and yet difficult tasks is the assessment of suicide risk, particularly in the patient who is only voicing a threat and in whom no previous history of suicide attempts exists. This is the gray area in which most potentially suicidal patients are found. Where the danger is clear and present, there the assessment and treatment plan are fairly straightforward; but where this danger is not clear, the physician must make critical decisions based on highly inconclusive information.

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The statistical incidence of suicide is well documented. It has been established that suicide is the tenth major cause of death in the United States, with 20,000 recorded suicides each year. It is estimated that at least ten times that number remain unreported.[1] Some 75 percent of all suicides have consulted a physician within a year prior to their act and ten percent consult a physician on the day of their act.[2] Richman and Rosenbaum comment: "Despite the frequency with which potentially suicidal patients consult a physician, the suicide potential is rarely recognized by the doctor."[3] The suggestion is that as many as 14,000 deaths each year could be averted or delayed.

At least two variables can account for this phenomenon: (1) incomplete evaluation procedures, and (2) physician's attitude towards suicide and the suicidal patient. Decisions regarding suicide risk are often based on "intuition" or such limited data as the presence or absence of a previous suicide attempt or psychiatric hospitalization, without due consideration of other equally critical factors. Given the state of the art of suicide assessment today, it is understandable that the

evaluation of suicide risk can never be entirely accurate. It is possible, however, to ensure that the major predictive signs are noted and considered.

Equally as important as the mechanics of the evaluation procedure is the physician's attitude toward the emotional problems of his/her patients in general and suicide patients in particular. This attitude will ultimately determine if some of the 14,000 deaths mentioned earlier can, in fact, be averted. It is the physician's sensitivity to and awareness of the emotional makeup of the patient that determine if a suicide assessment is even attempted.

Therefore, before a model for suicide evaluation is presented, it may be important first to consider the physician's attitude towards the suicidal patient and the possible effects of that attitude upon the patient.

The Attitude of the Physician

The societal taboo of suicide makes the task of even the most skilled and sensitive physician difficult. Patients are often reluctant to volunteer thoughts of self-destruction and may only hint at their presence. Somatic complaints and covert signs such as accident proneness and the increased consumption of alcohol and drugs are often the only indications. What the patient does not present directly in the pressureful atmosphere of an interview, often is ignored or not discussed. The societal taboo of suicide may also have an effect on the physician, decreasing his sensitivity or awareness to it.[4] Fearing his own power of suggestion, the physician may be reluctant to discuss suicide openly with his patient. One patient, who was referred to the Outpatient Psychiatry Clinic from the Emergency Room after a suicide attempt, reported having been sent from specialist to specialist during the previous two years for treatment of the somatic complaints of a serious depression. It was only after her suicide attempt that the emotional basis of her problems was recognized.

The suicidal patient may pose a threat to the esteem of the physician who prides himself in his ability to cure and to save lives. His knowledge and ability are impotent in the face of suicide. Physicians and other health-care professionals often have a negative and critical attitude towards the suicidal patient, perhaps in response to or in defense of feelings the patient evokes within them. Patel reports statements by a number of his colleagues: "Attempted suicide is of course the most unpopular of all complaints with the medical profession, and even the normally angelic nurses can turn quite waspy at the sight of a living attempt." "The fashion is to treat them with contempt and discharge them as soon as possible." "Their admissions may be regarded with disfavor, treatment may be narrowly confined to their physical condition, and provision for after-care or psychiatric investigation haphazard or ignored."[5]

Further, the suicidal patient, as described by Tabachnick, is often highly dependent in an almost infantile way, expecting others to make decisions for him.[6] For the overworked physician this type of patient can be very burdensome and emotionally draining. Experience with a few histrionic and repetitive suicide attempters can sour the attitude of the most well-meaning physician toward all suicidal patients. This attitude can strongly reinforce the cultural disposition to avoid and shun the self-destroyer.

These attitudes may also blind the physician to similar suicidal feelings within himself. Rockwell notes that the total annual output of an average-sized medical school is used merely to replace physician deaths by suicide each year.[2] Regarding suicide as a weakness or a crime against everything the medical profession stands for, the depressed physician may repress or disregard his own feelings. Further burying himself in his work, he becomes increasingly isolated from meaningful relationships with others. The self-destructive nature of depression can lead the physician into despair and the contemplation of his own suicide.[7,8]

Effects on the Patient

The hesitancy to directly face the problem of suicide is ultimately reflected in the underreporting of suicidal deaths in the United States.[9] Suicide remains, for many, within the realm of mental illness, and a diagnosis of suicide is made only where the intent is entirely clear. The existence of a suicidal death within a family is often a far

greater social stigma than would be a history of alcoholism.

In practice, the effects on the patient-physician relationship when suicidal potential is present are often subtle. Consciously or unconsciously, the physician may steer the conversation away from a "gloomy" topic to areas of physical complaints where he may feel more comfortable. Under the rationale of "cheering the patient up," the physician may completely ignore the patient's blank or depressed affect. This is often an understandable maneuver as the physician, due to his own psyche or to his own underlying depression, feels in danger of "picking up" the patient's depression. The patient may interpret this avoidance as disinterest. This seeming rejection may be the last of a long line of similar rejections and may prove to be the "last straw" that precipitates a suicide attempt.

The physician may respond to the patient's lethargy by giving good-natured and well-intended advice, "Join the Y," "Get busy in the garden," or "Start jogging." The physician thus avoids dealing with the true nature of the problem. Superficial advice giving does not help the patient understand or resolve his emotional problem. Furthermore, with the patient's energies so occupied in dealing with emotional conflicts, he is not likely to be able to follow "Get busy" advice. When the patient fails at following the physician's advice, feelings of guilt can follow, compounding the original problem. The patient may "forget" his next appointment or if he does arrive, he may get into a "Why don't you . . . yes, but" game with the physician.[10] He will resist acknowledging the guilt he feels as a "bad patient" by countering all advice the physician proffers with reasons why he could not possibly accomplish the suggested task. The physician often feels "defeated" after such an interchange while the patient feels "victorious." Ultimately, however, the patient may feel even greater despair as he realizes that he is able to "outwit" the very source of strength that he desperately needs.

The physician's timidity in initiating conversation about suicidal ideation may also be interpreted by the patient as an indication of an extremely serious situation. If the patient senses the physician's defensiveness and insecurity, he may feel increasing panic. He will certainly leave the physician's office with the uncomfortable feeling of having not been understood.

An overly conservative response to threats of suicide can be as detrimental as a superficial one. Without attempting to differentiate between weak or strong suicidal intent, but rather responding to all and any verbalizations relating to suicide as though the crisis were imminent, the physician may be too quick to prescribe medication or to hospitalize. Many patients who have been only mildly depressed have daydreamed about suicide without the slightest intention of carrying out the act.

Unnecessary hospitalization or over-medication based on the physician's own fears or anxiety rather than in direct relationship to the patient's problem can have a damaging effect on the patient's ego or self-image. The experience of being hospitalized on a psychiatric ward or of losing control of one's functions through over-medication can have a devastating and long-lasting effect on the patient. The end result may be that the patient becomes less secure in his ability to face future crises and may also be less likely to tell that physician or anyone else of similar inner thoughts in the future for fear of a similar repercussion. A hospitalization can also exacerbate already unstable economic, employment, marital, or family situations.

Overprescribing psychotherapeutic medications can provide the means for a future suicide attempt. Furthermore, the patient who may be able to resolve his emotional problems internally is denied this chance when medication is prescribed indiscriminately. Medication helps the patient repress or temporarily put aside the painful feelings that have led to the contemplation of suicide. They do not help him resolve internal conflicts that led to these feelings. After the immediate crisis has passed, for instance after the shock of divorce, business loss, or death of a loved one, when the patient begins to realize that he will be able to make a new life for himself, the medication can be discontinued. The patient can then deal with his emotional turmoil at a safer distance. The use of medication in this way strengthens the defenses momentarily at a time when they are being threatened by the massive assault of the trauma. For the patient who has sufficient strength to face the crisis at the onset, medication administered without regard to the patient's inner resources denies the growth experience of facing, address-

ing, and resolving challenges successfully. The physician's emotional support can be far more powerful and helpful than medication.

Thus, the first requirement in performing a suicide assessment is the physician's responsibility to know himself, to be aware of his own attitudes and feelings about suicide. Considerable introspection may be necessary in bringing about the degree of openness required if the physician is to uncover carefully masked and guarded thoughts of suicide in his patients.

The physician's awareness of similar feelings within himself is, of course, important. For the troubled physician often all that may be required is the opportunity to discuss problems or concerns with a trusted colleague. Simply talking about the pain can relieve the immediate pressure or stress that has driven the individual to despair. It becomes a professional's responsibility to be actively aware of the mental status of his or her colleagues, to be available to them, and to offer assistance.[11]

The Clinical Evaluation

The physician's second responsibility, of course, is in knowing his patient. Unfortunately, there are very few guidelines in suicide assessment that reliably indicate weak or strong suicidal intent. A thorough and intensive evaluation is generally recommended. This can involve a lengthy interview. Although an enviable goal, this is not always a realistic expectation of the physician in practice. For this reason the following model is proposed. This model stresses the need for a complete evaluation, one that considers both the patient's strengths and his/her weaknesses. This model emphasizes the need for consideration of multiple areas in an evaluation of suicide risk rather than basing a decision on only one or two areas. Though presented in a simplified manner it provides room for in-depth investigation as necessary. The four basic areas described lend themselves to easy recall and application.

1. The Feeling Tone of the Interview

One of the most important aspects of suicide evaluation is the manner in which the patient relates to the interviewer, or what may be called the feeling tone of the interview. The nonverbal aspects of the interview include the pattern of communication and the patient's body language. Direct or indirect communication of feelings of hopelessness, despair, or resignation are all serious signs in a suicide evaluation despite the patient's verbalizations to the contrary.

A feeling of euphoria following a serious depressive episode may indicate that the patient has given up the struggle and is finally at peace with his decision to die. A talented artist, suffering from a lingering and fatal illness, was referred to the author by his physician as the patient was becoming increasingly depressed. He was followed on and off over a period of years and kept the author posted as to his emotional well-being by occasionally bringing in oil paintings he had done. When very depressed, his paintings were usually glum, stark portraits of older people done in dark oranges, browns, and blacks. He appeared after one lengthy absence with a painting of starbursts, almost like a fireworks display in vivid whites and yellows. It was a very beautiful work and highly uncharacteristic. It could have almost been described as an "explosion of life." The artist related that the painting had been done a few hours prior to a very serious suicide attempt. Although "overnight" recoveries may come as a welcome relief to both physician and patient, there is a need to remain cautious.

The patient's interest or disinterest in discussing his problems as evidenced by facial expressions, voice tones, and signs of relief derived from the interview can indicate whether communication with the patient has been severed or whether the patient has any hope of being understood and helped. Nonverbal cues such as body language and facial expressions should be considered in relation to the verbal content of the interview. Agitated movements, psychomotor retardation, and a generally lethargic bearing are important signs to note and evaluate.

2. Suicide Planning

The degree of suicide planning the patient has done is one of the most reliable indicators of true suicidal intent.[12] A specific and detailed plan

Figure 1. A Model for The Evaluation of Suicide Risk*

	Low Risk	Moderate Risk	High Risk
1. Feeling tone (Including pattern of communication and body language)	——	——	——
2. Suicide planning (Including lethality, availability, and specificity)	——	——	——
3. History (Including previous attempts, mental status, and medical history)	——	——	——
4. Strengths** (Including future plans, feelings of pride, relationships with others)	——	——	——

*A self-instructional videocassette program has been developed by the University of Arkansas for Medical Sciences that provides practice in the application of this model with potentially suicidal patients.[14]

**It should be remembered that good strengths would mitigate *against* suicide risk and therefore, for consistency, the low risk column should be checked. A patient with only minimal strengths would indicate a high risk.

would certainly indicate seriousness of intent as compared to a vague "pipe dream" such as, "Oh, maybe someday I'll just jump off a bridge." Even though a plan may include an unconscious "escape mechanism," such as a husband who will be in the next room watching television or a busybody neighbor, the potential for death is still great. Accidents do happen. A gesture can turn into a real suicide should the husband step out for a beer or the neighbor become ill.

The physician needs to determine how relatively lethal the intended means are. A threat involving a gun would be a far more serious sign than a bottle of aspirin. The less amenable to treatment the means, the greater the risk. If the patient did not choose a very lethal means in his attempted suicide, the physician can make a determination, based on the patient's intelligence and sophistication, of whether the means were chosen out of ignorance or from an unconscious plan. One very naive and also very disturbed young woman, whom the author saw briefly on intake service, described having first attempted to kill herself that morning by ingesting a small bottle of aspirin. Later that day she tried to stab herself, with limited success. She was finally brought to the Outpatient Clinic by the police who found her roaming among the lanes of a busy thoroughfare.

The availability of the means is an important criterion. Does the patient own a gun or is he/she capable of getting one? A threat to jump off a bridge would be a far more serious threat from a San Franciscan than it would be from a resident of Las Vegas.

It is always good practice to ask the patient if he or she is taking medication as prescribed as well as if any prescriptions are being obtained from other sources, in order to determine if medication is being "stockpiled."

How specific the patient has actually been in

planning his suicide will provide further clues. A patient who has decided upon a time of day, a place, and who has made out a will or suicide note presents a particularly high risk.

Asking about the contents of a note, either real or intended, can provide important information. A "now you'll be sorry" note indicates underlying anger, that, if expressed in the safety of the physician's office, can quickly diffuse a potentially fatal threat. A note of true despair ("To whom it may concern. . .") indicates a far deeper and more serious problem. Actively and aggressively asking the patient to describe in minute detail the specifics of the intended plan along with the fantasied reactions of significant others will not only provide valuable data, but can also be highly therapeutic. If the patient is able to talk out the threat, he may not have to act it out. Questions such as, "Who will be at your funeral?" Who will cry the loudest?" "Who will feel the most guilty?" "What will you be 'thinking' as you see everyone surrounding your casket?" are not only entirely appropriate, but also are helpful diagnostically and therapeutically. Facial expressions such as a sly grin or an averted glance can be more telling than the actual verbalization.

3. History

A good medical and psychological history is essential. Particular areas of concern include the precipitating event that brought about the patient's current crisis. Loss or the threat of a loss such as a divorce, a death, a job reversal, or a financial setback are common examples. Chronic and debilitating illnesses and surgical procedures which have altered or threaten to alter the patient's body image or self-concept can precipitate a suicide.

Previous suicide attempts by the patient and/or members of his family may indicate a likely disposition to repeat the act. The way the patient has handled stressful situations in the past can provide clues. A history of alcoholism, drug abuse, impulsivity, or psychosis are danger signals. The depressed patient should certainly be asked about suicidal ideas.

The patient's relationships or lack of healthy relationships with others is a significant factor. It is unlikely that a patient who has habitually been a loner will turn to others for help in a crisis. The interviewer needs to discover if the patient's friends or family are unconsciously supporting or encouraging a suicide attempt. One member of a family can become the "sickie," "weakling," or "scapegoat," upon whom all the inner hostilities and frustrations of the family are unconsciously focused.[13] Typically, the scapegoat is the most defenseless member of the family by virtue of age, or emotional or physical strength. The undermining of the patient's ego may be very subtle, taking the form of criticism, rejection, or the withholding of love. The patient who has suffered this type of emotional abuse over a number of years can be truly at the point of despair when he reaches the physician's office. Immediately returning the patient to this environment could be disastrous.

Inquiring of a family member as to the availability in the home of a gun or potentially harmful medicines may bring to light unconscious mechanisms. The family's awareness of the severity of the patient's problems can also provide clues as to concern or real interest.

A person whose general life style has been relatively stable, but who is experiencing an acute crisis presents a serious risk, although if the initial impact can be weathered, recovery will generally be rapid. The inner strength that has enabled the patient to lead a relatively stable life up to the crisis will reassert itself if the patient can be helped through the initial impact, either through the emotional support of the physician, the use of medication, or a hospitalization. Recovery for a person whose life style has been chronically unstable may not be as rapid or long-lasting.

4. Strengths

An assessment of the patient's strengths, an often neglected factor, can provide important information that might help balance what otherwise might appear to be a hopeless situation. Does the patient have constructive and realistic plans for the future? Is there something he takes pride in, ie, his children, his job, or a hobby? Does he have friends or family members who are truly concerned about his welfare and upon whom he can depend? Does he or she hold strong religious convictions condemning suicide? Although these factors do not negate the possibility of suicide, they often provide an opening for beginning the therapeutic support of the patient.

Risk Assessment

In order to avoid the danger of basing an evaluation solely on "history" or any other single element, it may be helpful to mentally organize the assessment as shown in Figure 1.

Theoretically, an independent judgment can be made regarding the risk of suicide in each of these four areas. This can help ensure a proper weighing and balancing of all the factors involved. Although this model has been simplified for the sake of clarity and retention, it is hoped that the physician using it will be able to determine the overall risk of suicide in his patients more readily and accurately.

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