Family Practice Grand Rounds

The Suicidal Patient: Recognition, Prediction, and Intervention

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DR. DAVID B. ADAMS *(Director of Behavioral Sciences)*: There are many threatening aspects to the process of recognition and intervention in the case of the suicidal patient. Dr. Gregg Jowers, our chief resident, will be presenting a recent case for which he had primary responsibility. Dr. Tom House, clinical psychologist, will discuss with us some practical as well as theoretical considerations when treating suicidal patients. Contributions from other members of the health care team will help us with our understanding of this most complex issue. If Dr. Jowers could provide us with an expanded history, it would be helpful.

DR. R. GREGORY JOWERS *(Third year family practice resident)*: This patient, an 18-year-old, female college freshman was comatose when brought to the hospital by her roommate. The roommate stated that the patient had been drinking beer continuously for the last 24 hours and had ingested multiple oxazepam (Serax) and amitriptyline (Etrafon) tablets for the last hour prior to arrival at the emergency room.

Initial examination, in the emergency room, revealed a totally unresponsive patient without cardiopulmonary compromise. Vital signs were stable, pupils were mid-point and non-reactive.

A nasogastric tube was inserted and several undissolved tablets were retrieved. Toxicology studies revealed that the patient's blood alcohol was 0.179 grams percent. Qualitative analysis was positive for oxazepam, amitriptyline, and phenothiazine.

The patient remained comatose for approximately 12 hours and was fully awake and oriented by 24 hours without residual effects. By this time it was readily apparent that the patient was markedly depressed but responsive to inquiry. The patient stated that the origin of her problems was sexual in nature, having been rejected at age 16 by a 25-year-old male with whom she was having an affair.

She was diagnosed by her local family physician, subsequent to this rejection, as being depressed and was treated with a variety of antidepressants.

Because the patient lived in a small town she was also rejected by her peer group to the extent that she felt it necessary to complete her senior year in high school in another state. Subsequent to high school graduation, she entered college but failed academically, stating that she felt she was a "misfit." Since entering college she had been depressed, with low self-esteem, inability to concentrate, tendencies toward withdrawal, and frequent suicidal ideation. She admitted to alcohol abuse, becoming intoxicated at least twice each week. Final exams were approaching, and the patient

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was aware that there was no possibility that she would pass her courses. Additionally, on the night of the suicidal attempt, the patient was rejected by a recent boyfriend who failed to show up for a date. She stated that this was the final rejection she could tolerate; she felt that she could no longer continue to live in this manner, and admitted to taking both the Etrafon and Serax.

While hospitalized, the patient was initially quite resistant to psychological intervention but, after several short sessions, she became receptive and is presently undergoing outpatient psychotherapy.

DR. ADAMS: There are several issues one must address with this or any suicidal patient. Intent is an aspect of suicide frequently discussed, and lethality is another. Four main concepts always have a role in suicide: depression, aggression, helplessness, and hopelessness. I am wondering if Dr. Jowers found this patient to be clinically depressed.

DR. JOWERS: She displayed the recent history of involvement of vegetative functions. She had reportedly lost weight, shown a decreased interest in eating, was awakening several hours before dawn, and there were obvious signs of decreased libido. Although this patient was depressed, not all depressed patients attempt suicide. Another factor must be present.

DR. THOMAS H. HOUSE *(Associate Director of Behavioral Sciences)*: A mediator variable between depression and suicide, hopelessness, appears to be the key factor.

DR. ADAMS: We can operationally and behaviorally define both suicide and depression. What are the objective features, the measurable aspects of hopelessness, that permit us to similarly define this construct?

DR. HOUSE: Hopelessness is pessimistic thinking, and research has shown that it involves three components: a cognitive component, the individual's future expectations; an affective component, the person's feelings about the impending future; and a motivational component, the patient's loss in the drive to pursue future goals.

There are empirically validated scales which measure the hopelessness construct. In a situation where the clinician is concerned as to whether or not the patient is suicidal, and, of course, the clinician has already directly expressed this concern to the patient, the ability to assess hopelessness from the cognitive, affective, and motivational components will maximize the clinician's accuracy of suicidal prediction.[1]

DR. ADAMS: I believe we are also firmly committed to the realization that it is inappropriate and, indeed, dangerous to differentiate between suicidal gestures and suicidal attempts.

DR. JOWERS: We are presupposing, are we not, that the suicidal patient has sufficient sophistication regarding the lethality of the method chosen as to be able to do an accurate differentiation? Since the individual is agitated, depressed, and feeling some degree of hopelessness, judgment with regard to lethality would be significantly impaired.

DR. ADAMS: We have previously labelled some patients as suicidal ideators. We incorrectly assumed that they are not true threats to their own existence. We believe that they make suicidal *gestures*. In such patients, however, there is a competition or internal debate over the comparative wish to live vs the wish to die. One half of those who survive an attempted suicide report that they experienced such an internal debate.[2] Research has verified that suicidal intent and the wish to die are highly correlated, death being seen as an expression of the comparatively greater intensity of the wish to die. We are talking about an internal desire for death that is either more intense or is unchallenged by a competitive wish to live.

Only when a patient has a sophisticated and accurate conception of the potential lethality of the act does the threat to life become proportionate to this wish or intent.[2] Medical lethality has not proved to be, by itself, a valid predictor since in the vast majority of cases the patient inaccurately perceives the true potential lethality of the attempt.

A patient with a comparatively great wish or intent for death and an accurate conception of lethality would be the highest risk individual. With a comparable understanding of lethality but a low death wish or intent, the risk is the lowest. The intermediate risk categories include those individuals with high wish or intent for death but who have an inaccurate comprehension of lethality.[3]

DR. HOUSE: The wish or intent for death is also applicable to the social model of suicide. In this model an individual is conceptualized as an "island" surrounded by many islands where the well-being of any particular individual depends

upon the number of "bridges" between that individual and other individuals. This type of network provides an individual with a sense of community without which an individual typically feels as our current patient did—a feeling of rejection, of unacceptability. Loss of a sense of community increases the wish or intent for death.[4]

DR. JOWERS: This patient did report that she had been rejected by her peer group during high school. Would this suggest that she had, in the model that you are discussing, a limited number of relationships or "bridges"? And how about her boyfriend?

DR. HOUSE: Within the social model, every suicidal individual has a certain degree of vulnerability to the wish or intent for death. The degree of this vulnerability is directly related to the quality of individual developmental experiences.[5] Patients who experienced disruption during critical periods of development are at greater risks for suicide as adolescents and adults. Developmentally, these critical periods are ages six-to-seven, the time at which most persons within our society enter school.

The second critical developmental period is about 11-to-13 years for females and 12-to-14 years for males, the onset of puberty. If during these critical developmental times patients experience major disruption such as divorce of their parents, major illness either of themselves or significant others, or loss of important peers, their ability to form an effective network of friends and, thereby, a sense of community is drastically disrupted. It is impaired because of the imposed necessity to deal with their own internal feelings generated by the loss leaving little energy to either learn the social skills or to make community attachments, the aforementioned bridges. Thus, they are crippled in the development and skill level necessary for formulation of community attachments later in life.

DR. JOWERS: And the boyfriend, how does he fit into this model?

DR. HOUSE: In the social model as it applies to the wish or intent for death, the boyfriend would be considered a social provision but in a slightly different sense. The sense of attachment is more intimate with a boyfriend. The facts of a disruption in an intimate relationship or disruption in a community network present themselves differently. Loss or lack of an intimate heterosexual relationship creates in the patient a more acutely painful restless state. Lack of a community attachment, such as this patient reported when she was rejected by her peers, is experienced as a feeling of unacceptability. Both have in common feelings of rejection and isolation. The previously referred to bridges are perceived as being lost which in turn generates a sense of hopelessness and helplessness.

DR. COLLIN BAKER *(Director, Undergraduate Education)*: What should a physician look for then when utilizing the social wish or intent model for suicide?

DR. HOUSE: In the social model the actual suicidal act is, to the patient, an almost logical end. In this model, the physician in the history pays very careful attention to disruptions in the developmental history of the patient particularly during critical periods of development outlined earlier. In the history, the physician must note the patient's probable attachment (the bridges) ability.

A stable family unit, for example, would be recorded in the history as a support, and notation must be made of major disruption during critical developmental periods. With this patient there was a sequence of steady erosion, a loss of intimate relationships and sense of community which the physician would note and investigate to ascertain the degree of loss.

The physician must be particularly sensitive to the patient's feelings of rejection by important others. Perhaps the most classic example of erosion and rejection is seen in the pregnant adolescent female who may have had a poor developmental history which motivated her to seek intimate relationships by any means including sexual activity. The probable rejection by the boyfriend, the possible anger and rejection by the parents who typically restrict her at a time when she actually needs more peer and community support, and probable self-rejection and alienation contribute to poor adolescent adjustment. In this paradigm there is a steady loss of the emotional connections necessary for a feeling of value accompanied by an increasing sense of hopelessness and diminished feelings of self-worth.

Utilizing the social model where careful attention is paid to developmental issues, intimacy attachments, and sense of community combined with an understanding of lethality and the wish or intent for death provides for the physician a much greater understanding and higher probability of

accurately assessing the incidence of suicidal attempts in a patient population.

DR. BAKER: Should we not also be concerned that a patient frequently uses the drugs we prescribe in their suicidal attempt? Is this not part of the transference phenomenon?

DR. HOUSE: When patients turn to us for help and feel they have been rejected or, at least, unfulfilled, hurt and anger result. The use of medication prescribed, especially when perceived by the patient as being in lieu of true concern, can be an effective suicidal weapon and a means of communicating the frustration and disappointment, the hopelessness, even in the physician-patient relationship.

DR. ADAMS: It can be seen for this patient that critical developmental experiences increased the probability of this suicidal attempt. Her sources of support have often been inconsistent or absent. She fears the future and regrets the past, feeling hopeless and helpless. Her expectations, by her perceptions, are unfulfilled even by her physician who can assist her with her emotions but not save her from them. I feel that we agree that suicidal behaviors follow a predictable course and form a definable history. Support in the establishment of new relationships and exploration of potential future goals appear mandatory if the patient is to be supported and redirected from a self-destructive response to crises.

References

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