A Preventive Approach to the Suicidal Patient

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Physicians may have the opportunity to prevent suicide. An awareness of suicide risk factors, such as depression, alcoholism, drug abuse, schizophrenia, and chronic pain or disease, may facilitate suicide prevention. Recognition of acute and chronic suicidal vulnerability occurs through direct questioning. Psychiatric consultation is indicated for patients exhibiting clear self-injury risk, as exemplified by expressed suicide intent, an overt plan for death, or a "gesture." Hospitalization is usually recommended for socially isolated patients presenting with overt suicidal ideation, complicated by injurious self-harm, encephalopathy, or substance abuse. Family involvement and a "no-suicide" contract with the patient, coupled with close outpatient follow-up appointments, should suffice for those exhibiting milder or transient thoughts of suicide without manifest intent to die.

Suicide is an important social problem in this country. The suicide rate in the United States has been reported at 12.5 per 100,000 in 1978.[1] Discounting unrecognized instances, estimates of actual suicides are much higher, over three times this rate for men. Among people aged between 15 and 24 years the rate has nearly tripled within the past several decades.[2] Drug abuse has been hypothesized as the main contributor to this increase.[2,3] Many more suffer serious morbidity and use vast quantities of medical resources as a consequence of suicide gestures or attempts. The social cost of suicide to the person and family is enormous. A majority of subjects in one study had consulted a physician within three months of their self-induced death.[4] A physician, therefore, may have the opportunity to recognize and prevent a suicide. Recognition of patient vulnerability occurs through direct questioning, whereas suicide prevention requires a "no-suicide" contract, consultation, and either inpatient or outpatient treatment.

RISK FACTORS

Suicidal risk factors can be divided into acute and chronic endangerments. Chronic suicide vulnerability is enhanced by depression, recent divorce, past suicide attempts, unemployment, absence of a support system, poor interpersonal coping, and all types of alcohol or drug abuse. Among the younger population, substance abuse is a major diagnostic contributor to the rise in completed suicides.[2,3] A history of previous self-injury or of suicide in the family is very significant. Of particular importance are attempts by methods that are usually fatal (eg, guns). Recent job loss is for many individuals an especially grave sign. Individuals with poor social relationships often have diminished self-esteem and may view suicide as their only solution. Strong feelings of helplessness, pessimism, and rejection from a significant other are apparent in notes obtained from suicide victims.[5]

Studies of completed suicide cases substantiate previous diagnoses of depression, alcohol dependence, or schizophrenia in 70 percent of the victims. An actual psychiatric diagnosis, retrospectively based upon reconstructed histories, can be made in virtually all people who kill themselves.[6] Seventy-five percent of the suicide victims in one study were depressed, with two thirds of the study population having prior suicide attempts. Most often the suicide-attempt histories were unknown to the treating physician. A psychological explanation substituted in place of actual diagnosis and proper treatment of the depression. The great majority of the eventual suicide victims were unrecognized as being at high risk.[7] Misdiagnosing a depressed individual as one suffering primarily from anxiety, and treating with concomitant prescriptions of benzodiazepines, may worsen the illness. Depression has been underrecognized and often inadequately treated.

In approximately 15 percent of suicides, a history of alcoholism exists.[8] Suicide rates among alcoholics are ten

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times greater than those without alcohol abuse.[9] When a person dependent upon alcohol has suffered a recent separation or divorce, vulnerability is substantially enhanced.[10] Depressed or alcoholic patients expressing suicidal intent comprise 50 percent of all completed suicides.[11]

The prevalence of suicide among patients with chronic disease, serious disabilities, chronic pain, or fatal illness is higher than the normal rate, but much less than that in alcoholism, depression, or schizophrenia. Although one half of those who have successfully completed suicide have physical illness, 5 percent of those with terminal illness kill themselves.[11] In contrast to the 1 percent suicide rate of the general population, between 2 percent and 10 percent of schizophrenics end their own lives.[3,12] Evidence of brain atrophy or previous violence increases the risk, but, surprisingly, hallucinations about killing oneself do not increase vulnerability in schizophrenic patients.[13]

Additional long-term suicide risk factors are social isolation, male sex, and older age.[14] The elderly widower may be particularly vulnerable to fantasies of reunion with his spouse through death, especially around the time of anniversaries. He suffers doubly because of loss of family and occupational roles. In American society women frequently assume responsibility for maintaining contacts with friends and relatives. Without a spouse men tend to lose social supports and become isolated. Compared with women four times as many men kill themselves between the ages of 65 to 69 years, and after the age of 84 years, the ratio of male to female suicide is 12 to 1.[15]

Biological data have been reported in relationship to suicide. Both depressed and nondepressed patients who have attempted suicide have had low levels of cerebrospinal fluid 5-hydroxyindoleacetic acid.[16] Increased suicide mortality has been associated with below-average cerebrospinal fluid 5-hydroxyindoleacetic acid. Postmortem studies have revealed reduced brain serotonergic activity in suicide victims.[17] These findings, while interesting, are not yet clinically useful. It would be premature to recommend 5-hydroxyindoleacetic acid determinations to assist in the evaluation of suicide risk.[16]

Acute indicators of endangerment include pervasive suicidal fantasies with an organized plan for death involving lethal means.[14] Similarly, sudden worsening of depression with features of psychosis or hopelessness are grave indicators.[5] Patients who are both depressed and have delusions are five times more likely to kill themselves than those depressed persons without psychosis.[18] For schizophrenics, however, it is the presence of depression rather than delusions that greatly increases the suicidal risk.[19]

There are both similarities and differences between those who make suicidal gestures and those who complete a suicide attempt. Most people who engage in suicidal behavior suffer from mental illness. The predominant disorders of those who commit suicide are depression and alcoholism. Suicide occurs primarily in white, elderly men. Survivors of attempted suicide usually have personality or adjustment disorders. They are mainly nonwhite, young women. The early diagnosis and adequate treatment of depression would significantly decrease suicide.[20]

CLINICAL EVALUATION

When depression is recognized, its intensity must be evaluated. Questions pertaining to feelings of helplessness, hopelessness, guilt, self-esteem, and outlook for the future are appropriate. Direct inquiry about the existence of suicidal ideas, intentions, and a suicide plan is mandatory. If a plan for suicide is revealed, its seriousness and the availability of means to carry it out should be examined. The plan's method, timing, and circumstance should be explored. Questions pertaining to the patient's expectation of a fatal outcome from a chosen method for death as well as safeguards taken against discovery are pertinent. The seriousness of past suicide attempts must be assessed. Marital history, living arrangements, and recent life changes should be appraised as to their reflection of stress, interpersonal isolation, and social or occupational support.[21] Information from the family can be most enlightening.[22] Relatives of the patient are asked about suicide notes, previous attempts, recent procurement of a lethal means for suicide, or other warnings.

MANAGEMENT

Psychiatric consultation is indicated for patients exhibiting clear suicidal risk. Expressed suicidal intent, an overt plan, or a significant gesture constitute substantial risk. Similarly, suicidal ideation accompanied by psychosis, substance abuse, or past suicidal behavior warrants consultation. In questionable cases discussion with a psychiatrist can help ascertain the need for direct psychiatric intervention.[23] Hospitalization is mandatory for patients presenting with overt suicidal ideation complicated by injurious suicidal behavior, encephalopathy, and substance abuse or intoxication. It is usually necessary to confirm the seriousness of suicidal behavior by talking to relatives or friends and obtaining toxicology surveys in cases of drug overdose. If family intervention is refused, the family should be contacted above the patient's objections only, but always, if the risk for suicide is judged to be high.

Some patients exhibiting mild, transient thoughts of suicide without serious intent may not require consultation or hospitalization. Family involvement, though, is

always recommended. After obtaining the patient's permission, the physician should call the closest available relative. A family interview should be arranged to increase support and gain information. Follow-up appointments ought to be specific and within a short time interval. It would be unwise to dismiss a patient recently contemplating suicide without involving significant others or without making close follow-up arrangements. When a serious likelihood of suicide is noted, patients lose their right to absolute confidentiality.

Establishing emotional attachment with the physician is central to the helping effort for the suicidal person. Many suicidal patients despair over the possibility of mastering a crucial life task, such as recapturing a loved one, a job, or a position of esteem. This task is viewed as essential to survival. The physician-patient relationship can be a primary factor in treatment by providing hope. The physician helps the patient see the irrationality of a hopeless outlook by widening the number of available options and enabling a search for alternative solutions. The physician reduces anxiety by attending to worrisome matters that can be changed. Telephone contacts to the patient's spouse, employer, or significant other may reduce feelings of hopelessness and helplessness.[24] Informing patients about the relationship of depression and hopelessness and the improvement once depression has remitted can be of great reassurance.

Most depressed patients do not present with an acute suicidal crisis, but many have increased long-term vulnerability to suicide. The clinician, by exercising caution in his or her prescribing practices, may render eventual suicide a less-probable event. Depressed patients who are irresponsible, substance abusing, or potentially suicidal should not be given antidepressant prescriptions in dosages exceeding 1.5 g in total amount. An overdose of 2 g of many antidepressants is potentially lethal, especially in combination with other drugs or alcohol, particularly in the ill or elderly. Prescriptions for greater quantities of antidepressants may be prescribed only for those patients who are stable and not at risk for suicide.[25]

Contracts against suicide are an effective preventive therapeutic strategy in which the physician attempts to obtain an agreement from the patient not to kill himself for a specified time, and the patient agrees to contact the physician should irresistible suicidal urges recur. People usually respect their agreement and refrain from a betrayal of trust.[26] The contract against suicide can best be used for outpatients when supportive, reliable family members are present and when the next follow-up visit is scheduled within several days. With minimal suicidal ideation, however, involvement of relatives in contracts is less necessary. To illustrate the use of contractual agreements and other management techniques as a deterrent to suicide, the following clinical vignettes are presented.

CASE ILLUSTRATIONS

Case 1. A 60-year-old widowed man with a history of alcohol abuse and diabetes mellitus complained of depression, impaired appetite, and insomnia and expressed a wish to die. He reported that his wife had died during the previous month. He now lived alone, stating that "it hurts a lot." The mental status examination revealed an alert, oriented man without psychosis or cognitive deficits. In spite of expressing the wish to die, further questioning revealed that he still wanted to live. He categorically denied any overt suicidal intention.

The above case presents some long-term risk factors for suicide: alcoholism, older age, male sex, loss of spouse, depression, lack of a support group, and suicidal thoughts. The most essential point, however, is that the man clearly stated that he would not kill himself. He was regarded as reliable.

A recommended treatment strategy for cases such as this case, without active suicidal intent, consists of frequent counseling sessions, telephone contacts, or possible home visits. Simply allowing the bereaved individual to express negative feelings is therapeutic.[27] Enlistment of additional support from church groups or Alcoholics Anonymous would be helpful. Treatment of diabetes and consideration of antidepressant therapy would be warranted if sadness and dysfunction were protracted beyond a usual bereavement. Disulfiram might be indicated if alcohol abuse persisted. The patient need not be immediately hospitalized or referred to a psychiatrist. For more concrete suicidal urges, however, patient care should be more rigidly structured.

Case 2. A 52-year-old widowed woman came to the hospital complaining of shortness of breath. She acknowledged being on multiple medications and home oxygen for severe chronic obstructive pulmonary disease. During history taking it was learned that her friend with similar lung disease had recently jumped to her death. The patient described living alone and not going out much because of smoke sensitivity, lack of energy, and the recent necessity for oxygen administration even at home. She stated that "she wanted to die and may as well jump off a bridge." She had had no previous psychiatric treatment, was not psychotic, and was cognitively intact.

The long-term risk factors included severe disabling chronic illness, social isolation, and widowhood. The recent loss by suicide of her friend constituted a situational crisis. A psychiatric referral was indicated because of her disclosed suicidal ideas, especially as a specific means was described. Subsequent psychological testing and repeat mental status examinations did not reveal a persistent depressive disorder or suicidal intentions. Several days of hospitalization with observation for suicidal behavior improved the patient's condition sufficiently to allow for

outpatient follow-up. Closer management of the lung disease was beneficial at improving her attitude. Suicidal statements were taken seriously and recovery followed. The next case illustrates another result.

Case 3. A 44-year-old single woman, well known to the hospital because of multiple suicidal gestures, entered the emergency room with a superficial forearm laceration. During repair of the injury a physician commented on her attention-seeking behavior and doubted the seriousness of her intent to die. Upon discharge from the emergency room, the woman walked directly from the hospital to a nearby river and drowned herself. The body was in the hospital morgue only hours later.

This case is a tragic example of mismanagement of suicidal behavior. A physician should not suggest that a patient is insincere in seeking help. Suicidal behavior, at the least, represents an emotional disorder and calls for serious medical concern. A mental status evaluation is mandated including questions about suicidal intent and social supports. Often suicide precautions on a closed psychiatric ward are necessary following an overt attempt. A negotiated contract against suicide with outpatient follow-up can then occur according to the clinical progress.

When a person considered overtly suicidal refuses hospitalization, emergency hospital detention must be ordered. Although legal procedures differ in each state, a petition for judicial determination of dangerousness, mental illness, and need for hospital care should be solicited.

CONCLUSIONS AND RECOMMENDATIONS

A composite of an individual at high suicide risk would be an elderly, physically ill, disabled, unemployed, alcoholic man, recently divorced and living alone without friends or relatives. He would feel severely depressed and hopeless about the future and would be preoccupied with thoughts of violent self-harm, with a specific means in mind for ending his life. He might write a suicide note indicating his imminent death. Voices might instruct him to end his misery.

In the evaluation and management of patients at risk for suicide the following points are emphasized:

1. Direct questions about suicide are necessary to discern vulnerability.

2. Psychiatric consultation is indicated for patients recently attempting suicide or expressing suicidal intent. Similarly, psychosis, substance abuse, or past suicidal behavior complicating suicidal ideation warrants consultation.

3. Hospitalization is mandated when suicidal ideation complicates self-injurious behavior or substance intoxication.

4. Hopelessness is reduced by widening available patient options and by contacting significant others to aid in crisis resolution.

5. Depressed patients who are potentially suicidal should be given antidepressant prescriptions in sublethal quantities, less than a total of 1.5 g.

6. Family involvement provides information about previous suicidal communication as well as observation, support, and verification for a no-suicide agreement. Outpatient contracts against suicide require reliability and the absence of psychosis or drug abuse.

7. Physicians should not express doubt about the sincerity of patients seeking help, especially those who have gestured toward suicide.

8. Involuntary hospital admission procedures are mandated for overtly suicidal patients refusing treatment.

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