MASSACHUSETTS GENERAL HOSPITAL
PSYCHIATRY ACADEMY

Suicide

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Disclosures

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General Facts About Suicide

- Ninth leading cause of death in the USA
- Results in more than 30,000 deaths/year
- Accounts for 1.3% of all deaths
- One of every 8-10 attempts are successful
- Average rate is 12.7/100,000
  - when > 65 years old, rate is 19.2/100,000
- Rate increases will social unrest

Problems of Prediction

- Predicting the future is problematic
- Most suicidal patients do not commit suicide
- Assessment of suicide risk can be complicated by the physician's emotional reactions
- Awareness of risk factors does not make prediction infallible
- Some individuals effectively hide their true feelings and plans

Risk Factors: Major Depression

- Accounts for 50% of completed suicides
  - 15% of those with affective illness suicide
- Risk of suicide increases when psychosis co-exists
- Screening for neurovegetative symptoms is essential
  - Remember the SIG E: CAPS mnemonic

Risk Factors: Alcoholism and Drug Dependence

- Accounts for 25% of completed suicides
- Use and/or intoxication may disinhibit depressed patients and facilitate an attempt
- Substance abuse may co-exist with affective illness

Risk Factors: Schizophrenia

- Accounts for 10% of completed suicides
  - 10% of those with schizophrenia suicide
- Results in a deadly combination with depression
- Risk increased with delusions, paranoia, or command hallucinations urging self-destruction

Risk Factors: Character Disorders

- Accounts for 5% of completed suicides
  - and the majority of patients we evaluate for suicide risk
- Dysphoric patients frequently attempt suicide
- Impulsivity predisposes to suicide attempts and to suicide

Additional Risk Factors

- History of suicide attempts or threats
  - Nearly 50% have made prior attempts
- Male sex
  - Men attempt 3-4 times less often
  - Men succeed 2-3 times more often
  - Men tend to use more violent means
- Advancing age
  - Rates rise steadily with age, alienation, & debilitation

Additional Risk Factors

- Marital status
  - Never married > widowed > separated > divorced > married
- Being unemployed and unskilled
- Having chronic illness, pain, or a terminal illness
- Panic disorder
- Caucasian race

Additional Risk Factors

- Family history of suicide
- Organic brain syndrome
- Biological markers
  - Decreased CSF levels of 5-HT and 5-HIAA
- Recent hospital discharge
- Firearms in the household

Rates of Suicide by Psychiatric Disorder

• Affective illness	50%
• Drug or alcohol abuse	25%
• Schizophrenia	10%
• Character disorders	5%
• Secondary depression	5%
• Organic brain syndromes	2%
• None apparent	2%

Who Needs Evaluation?

- Survivors of a suicide attempt
- Patients who complain of suicidal thoughts
- Patients with other complaints who admit to being suicidal
- Patients who deny being suicidal, but whose actions demonstrate suicidal potential

Why Do People Suicide?

- Murder in the 180th degree (Freud)
- Transition to a better life (Hara-kiri)
- Release, as from pain and suffering
- Response to hallucinations and delusions
- Anger, impulse, or to spite others
- Recent loss
- Feeling helpless or trapped
- “Rational” suicide

How Do People Suicide?

- Violent means
  - e.g., Shooting, stabbing, hanging, jumping
- Non-violent means
  - Drug overdose
    - e.g., acetaminophen, alcohol, aspirin, barbiturates, benzodiazepines, tricyclic antidepressants

Suicide Assessment

- Take all potentially fatal threats, gestures, and attempts seriously
- Consider the possibility
  - If you don't, you won't make the diagnosis
- Be empathic
  - Try to establish rapport before honing in on the issue of suicide
- Perform a mental status examination

Suicide Assessment

- Ask about suicidal thoughts and intent
- Ask about plans for suicide
  - Is there a detailed plan?
  - Are the means available?
- Determine if there are plans for the future
- Determine, “Why now?”
  - Is there a precipitant?

Suicide Assessment

- Obtain information from friends or family
  - Remember, the suicide assessment is often an emergency evaluation
- Review for the presence of risk factors

Suicide Assessment After an Attempt

- What was the risk?
- What were the chances for rescue?
- Did the person believe the method would work?
  - Was he disappointed he survived?
- Was the attempt impulsive?
- What is different now?

Decision Pathways

- Determine ongoing risk of suicide
  - If suicidal
    - protect and admit
  - If unsure about risk
    - protect, get consultation, and consider hospitalization
  - If not suicidal
    - decide on a reasonable plan that may not require hospitalization

High-Risk Patients

- Psychotic and suicidal
- Greater than 45 years old
- Survivors of a violent attempt
- Those who took precautions to avoid rescue
- Those who refuse help
- Those without social supports

Prediction of Risk: Results of an MGH Study

- None of 74 patients sent home from the ER after an overdose (OD) was readmitted for an OD or another suicide attempt within 6 weeks
- 1 of 26 patients admitted from the ER to Medicine after an OD was readmitted within 6 weeks
- 5 of 35 patients admitted to Psychiatry after an OD were readmitted within 6 weeks after hospital discharge

Treatment and Decision Options

- If not suicidal
  - Send patient home with follow-up
- If complications from an attempt are present
  - Admit to a general hospital and obtain further consultation
- If suicidal
  - Admit to a psychiatric hospital
    - voluntarily or involuntarily

Management Pointers

- Protect the patient
  - Throughout the evaluation and disposition process
- Document decisions in the medical record

Involuntary Hospitalization

- Know the laws and procedures in your state
- Often involves:
  - One physician, police officer, or judge
  - Simple documentation
  - Guaranteed transport to a facility for evaluation

Treatment of Suicidal Patients: General Principles

- Treat the problem as specifically as possible
- Remember:
  - Even a week's supply of some antidepressants can be lethal

Treatment of Suicidal Patients

- Psychopharmacology
- Psychotherapy
  - Strengthen relationships, be flexible, be active, demonstrate concern, listen for symbolic communication, emphasize options
- Social supports
  - Engage the help of others
- Protection
  - Prevent escape, avoid dangerous objects, consider use of restraints

Unusual Situations

- Rooftop evaluations
  - Be flexible
  - Be mindful of what you are wearing
  - Enlist the help of others

When Is Hospitalization No Longer Required?

- When the precipitant or crisis has resolved
- When supports are strengthened
- When psychosis has resolved
- When depression has abated
- When suicidal thoughts and intent have passed

Suicide in the General Hospital

- More common recently with greater numbers of psychiatric patients in general hospitals
- Jumping from a height is the most common method
- Often precipitated by medical illness
  - HIV infection, renal failure/dialysis, COPD
- Medical staff may focus on medical illness and avoid its psychiatric aspects

Know Your Limits

- Work with suicidal patients is stressful
  - Monitor your reactions
  - Monitor the behaviors of others
  - Determine when consultation and support are necessary

Reactions of Physicians to Suicide

- Anger
- Denial
- Depression
- Intellectualization

Countertransference Reactions to Suicidal Patients

- Hatred
- Restlessness
- Fear
- Helplessness
- Indifference
- Rejection
- Over-involvement

Conclusion

- Be prepared

Selected References

- Maltsberger JT, Buie DH: Countertransference hate in the treatment of suicidal patients. Arch Gen Psychiatry 1974;30: 625-633.
- Stern TA, Mulley AG, Thibault GE: Life-threatening drug overdose: Precipitants and prognosis. JAMA 1984;257: 1983-1985.
- Stern TA, Gross PL, Pollack MH, et al: Drug overdose seen in the Emergency Department: Assessment, disposition, and follow-up. Ann Clin Psychiatry 1991;3: 223-231.
- Weisman AD, Worden JW: Risk-rescue rating in suicide assessment. Arch Gen Psychiatry 1972;26: 553-560.

Selected References

- Lagomasino IT, Stern TA: The suicidal patient. In, Stern TA, Herman JB, Slavin PL, eds., The MGH Guide to Primary Care Psychiatry, 2/e. McGraw-Hill, New York, 2004: 127-135.
- Lafayette JM, Stern TA: The impact of a patient's suicide on psychiatric trainees: a case study and review of the literature. Harv Rev Psychiatry 2004; 12 (1): 49-55.
- Brendel RW, Wei M, Lagomasino IT, Perlis RH, Stern TA: Care of the suicidal patient. In: Stern TA, Freudenreich O, Smith FA, Fricchione GL, Rosenbaum JF, editors. Massachusetts General Hospital Handbook of General Hospital Psychiatry, 7/e. Philadelphia, Pennsylvania. Elsevier. 2018: 541-554.

Selected References

- Brendel RW, Brezing CA, Lagomasino IT, Perlis RH, Stern TA: Suicide. In: Stern TA, Fava M, Wilens TE, Rosenbaum JF, editors. Massachusetts General Hospital Comprehensive Clinical Psychiatry, 2/e. Philadelphia, Pennsylvania. Elsevier. 2016: 589-598.
- Brendel RW, Koh KA, Perlis RH, Stern TA: Suicide. In: Stern TA, Herman JB, Rubin DH, editors. Massachusetts General Hospital Psychiatry Update and Board Preparation, 4/e. Boston, Massachusetts. MGH Psychiatry Academy. 2018: 613-618.

Thank You

- Questions?