

Suicide Risk Assessment and Treatment Introduction

An Epidemic

The most conservative, and certainly inaccurately low, estimation of suicides around the globe is one million annually. This equates to an annual worldwide suicide rate of 14.5 per 100,000, with attempts of at least 260 per 100,000. In the United States, suicide is the eighth leading cause of death overall, amounting to 30,000 deaths annually. It is the third leading cause of death for young persons aged 15-24. (Tondo and Baldessarini, 2001) On average, six or seven people are directly and profoundly affected by each suicide. Roughly half of suicides are by firearm. Suicide is one of the greatest causes of malpractice liability among psychiatrists.

Historical Context

Early historical accounts indicate that suicide was understood as a response to intolerable circumstances, but has long been viewed as a crime against God and society, and punished with damnation as well as legal actions. Records from ancient Rome and early Europe show the confiscation of the estate of a person who suicided as repayment for the loss of a citizen. There were laws preventing a dignified burial and sometimes the law called for more extreme reactions.

In the Middle Ages, a punishment for suicide might include disfigurement of the corpse. Insanity was sometimes recognized as a cause of suicide. In 1670, Louis XIV required that the body be drawn, face down, through the streets, and finally thrown on a garbage heap. The decedent's property was confiscated. (Durkheim, 1897) In early Europe, the lower class had a much higher recorded rate of suicide, but the noble class used dueling as a surrogate for suicide.

The disrespect for corpses of suicide victims may stem from attempts to prevent copycat (imitative) suicides. There are historical accounts of waves of imitative suicides that were stopped when it was decided to create some form of indignity for the victims. In Myths of ancient Greece, Plutarch wrote of a wave of suicides by young women. It ceased when it was decreed that their bodies would be carried to burial through the marketplace. The virgins were to be carried naked. In ancient Rome in the fifth century BCE, soldiers forced to work in the sewers were committing suicide. In response, Tarquin the Proud had their bodies publicly nailed to crosses. This stopped the epidemic.

The word suicide came into use during the mid-seventeenth century. (Minois, 1999) During the seventeenth and eighteenth centuries philosophers began equating it with the emotional state of the individual, using the term "melancholy." (Burton, 1989)

The eighteenth century saw the dawning of a medicalized view of suicide; it came to be seen as a result of mental illness. (Juanatey-Dorado, 1994) Despite opposition from the military and clergy, this resulted in a process of decriminalization that began with elimination of punishment. (Ibid) Nonetheless, it was not until the 20th century that laws against suicide began to be abolished. Suicide was illegal in England until 1961, and Ireland until 1993. (Ibid) With this medical view, people began to study suicide in sociological or psychiatric terms, and to analyze statistics pertaining to suicide.

Nonetheless, the early Christian, Islamic, and Jewish views of suicide as a sin against the will of God. However, even as early as 533 CE, the Roman Catholic Council decreed that suicide was either the Devil's work or caused by insanity. Even by 1995, Pope John Paul II stated that suicide and euthanasia were crimes comparable to homicide and genocide. (Tonda, 2000) Islam similarly condemned suicide, while Judaism had a somewhat softer attitude. As nontheistic religions, Hinduism and Buddhism were not so judgmental, but Buddhism holds that suicide merely postpones suffering that in sum exists as karma that extends through reincarnation.

Clinical Overview

Suicide is a familiar subject to the mental health professional. Tondo and Baldessarini (2001) offer the following statistics: It comprises roughly 10% of psychiatric patient deaths. Life-threatening attempts exceed completed (fatal) suicides. Suicide is the third greatest cause of death for juveniles and young adults, and ranks as the eighth greatest cause across the life span. Suicide has an extraordinary impact on survivors; including family members, friends, co-workers, and even witnesses who do not know the person. It certainly has an impact on clinicians. Even the specter of liability that suicide risk holds over practitioners can affect judgment and professional satisfaction.

Although a good deal is known about key issues such as risk factors and rates of suicide, there is inadequate information upon which to base clinical judgment, particularly where high risk is involved. Treatment and prevention of suicide and development of public policies concerning suicide are areas that are seriously lacking information. (Tondo

& Baldessarini, 2001)

Suicide is notoriously difficult to predict, yet many suicides are predicted but are not prevented despite concerted effort. The majority of suicides result from mental illness and the majority of these are due to mood, psychosis, or alcohol dependence. (Frances, Franklin, & Flavin, 1987) Only a very low percentage of suicides occur among psychologically healthy individuals as a result of stressful life events. However, suicide risk tends to peak over a limited period for nearly all people who experience such risk. This contributes to our understanding of prevention, as limited as it is.

Most cultures confer great shame on suicide, seeing it as a personal or family failure. Unfortunately, moralistic cultural patterns can compound the stress that contributes to suicide, and confound efforts at prevention and treatment. It also suppresses the reporting of suicide statistics, particularly in certain countries. This is an obstacle to the development of social policies and infrastructure that could prevent suicide.

Causes and Risk Factors

A Biopsychosocial Perspective: Suicidal behavior stems from numerous factors that include personality, health, and circumstances. Biological, psychological, and sociological views each contribute to our understanding. Risk factors in these domains are discovered through analysis of clinical and epidemiological factors. Suicide is recognized as a public health issue that requires societal resources for a variety of interventions for prevention and treatment. While the presence of psychiatric illness is an ongoing risk, suicide is usually triggered by one or more stressful life events. The highest risk events are loss, separations, and situations that negatively impact self-esteem and confidence.

Psychiatric Disorders

There is substantial incidence of mental disorders in suicidal individuals. Estimates that use the most reliable data are in the range of 22%. Higher estimates (as high as 98%) have been criticized as being too biased in interpreting historical data after suicide was completed.

Highest risk: The most common disorders implicated in suicide are mood disorder and substance abuse. (Clark, & Goebel-Fabbi, 1998) The extreme mood swings of bipolar disorder can cause impulsive suicides. Alternatively, mania or psychotic depression may lead to delusions that contribute to suicidal behavior. While mania does not elevate suicidal risk in mood disorders, there is a much higher risk when there is a combination of dysphoria, excitement, and agitation. (Tondo, Baldessarini, Hennen, Floris, Silvetti, & Tohen, 1998) Depression elevates risk, with major depression posing the most severe risk. More severe forms of mood disorders can double or quadruple the risk of suicide overall. (Bostwick & Pankratz, 2000)

Comorbidity: The larger the number of comorbidities, and the more severe the illnesses, the greater the risk of suicide, particularly in conjunction with situational factors. The greatest risk of suicide occurs when there is affective or psychotic disorder with substance abuse. (Roy, 1989)

Eating disorders:

Suicide is a major cause of death in eating disordered (ED) individuals (Berkman et al, 2007; Bulik et al, 2008; Foulon et al, 2007; Pompili et al, 2006). It is the primary cause of death among persons with ED who die from non-natural causes. (Møller-Madsen et al, 1996) According to Harris and Barraclough (1997), the suicide rate among persons with anorexia and bulimia is 23 times greater than the general population. This places the suicide rate among persons with ED among the highest of psychiatric disorders, and there is widespread agreement on this assessment. (Holm-Denoma et al, 2008; Kaye, 2008; Keel et al., 2003) This coincides with very high levels of suicide attempts. (Franko et al, 2006; Milos et al, 2004; Herzog et al, 2000; Keel et al., 2003; Pompili et al, 2006; Favaro et al., 1997; Bulik et al., 2008; Vervaet et al., 2008) Overall, anxiety nervosa appears to be at especially high risk.

Comorbidity increases suicide risk among all subtypes of eating disorders, particularly substance abuse, cluster B personality disorders (dramatic, emotional or erratic, including borderline personality disorder), state and trait anxiety, and post traumatic stress disorder.

Risk for suicide increases with the severity of the ED, as does the likelihood of a comorbid psychiatric disorder, and a sense of hopelessness. (Miotto et al, 2003)

Character and temperament traits can elevate suicide risk, particularly, impulsivity, perfectionism, being less responsible or resourceful, and even a sense of "spiritual acceptance." (Bulik et al., 1999). According to Favaro et al.

(2004) risk is greater among Persons with ED that have high cholesterol levels. Impaired decision-making skills that may be indicative of cognitive impairment are a risk factor. (Cavedini, et al., 2004)

Risk varies with ED subtypes. Among anorexics, the binge eating and purging subtype has a higher risk than the restrictive subtype. (Pryor, et al., 1996). Other studies have made this link for both AN and BN. (Bulik et al, 2008; Foulon et al, 2007; Milos et al, 200; Pryor et al, 1996). It appears that a switch from the restrictive subtype to bingeing and purging is an especially high risk factor. (Foulon, et al., 2007; Milos et al., 2004)

Among persons with AN, risk for suicide attempt was elevated in those whose behaviors included vomiting more than twice per week, using laxatives more than twice per week, a drug use history, self harm history, and compulsive buying history. (Vervaet, et al., 2008)

BN has received less attention from researchers. However, it appears to have a much lower risk for suicide than AN. (Miotto, et al., 2003) For BN, a history of childhood physical or sexual abuse, depression, and borderline personality disorder correlated with suicide risk. (Nickel, et al., 2006) In addition, cluster B personality disorders and poor self-directedness are risk factors. (Favaro, et al., 2008)

Self injury is commonly associated with disordered eating. A self-perception of being over- or under-weight and other forms of body dissatisfaction are risks for suicide attempts. (Miotto et al., 2003) Extreme efforts at weight control such as fasting were shown to be a risk factor in adolescents. (Crow, et al, 2007)

Stereotypes of white women with eating disorders are contradicted by research showing, for example, that black girls are at 50% greater risk for eating disorders than white girls. (National Eating Disorders Association, 2006) Eating disorders occur in all races. Cultural factors may mitigate the pressures that contribute to eating disorders. For example, Cuban women who strongly identified with Cuban culture were less likely to report eating disorders. (Ibid)

Substance use disorders occur in approximately 25% of suicides. These disorders may exist alone or with comorbidities as is common in the case of mood disorders. Lifetime risk for suicide among substance abusers is close to that of persons with depression. (Clark & Goebel-Fabbri, 1998)

Anxiety disorders, even viewed independently with comorbid depression and substance abuse exist in roughly 15% to 20% of suicides.

Psychotic disorders such as schizophrenia comprise 10% to 15% of suicides. (Roy, 1989)

Personality disorders, especially borderline and antisocial, multiply suicide risk by roughly six times. A comorbid mood disorder or substance abuse problem greatly increases suicide risk for personality disorders. (Foster, Gillespie, McClelland & Patterson, 1999) The chronic nature of these latter profiles is a key reason for the high rates because of the prolonged times of being at risk. The boil of interpersonal problems, conflict, and rejection that can surround the individual with a personality disorder may add a substantial level of stress. As many of these individuals age and begin to put life into perspective, an accumulation of regrets and loss, and the emergence of recognition of one's own role in it all may be particularly difficult to tolerate, especially while facing increasing vulnerabilities of aging and poor prospects for interpersonal support.

Schizophrenia: The lifetime rate of suicide attempts for schizophrenia is estimated to be 25% to 50%, with completed suicide being 9% to 13%. Suicide attempts are the primary reason for psychiatric admission in persons with schizophrenia and are the leading cause of mortality in patients under age 35. Treatment with antipsychotic medication decreases the rate a great deal, but must be weighed against complications such as hematologic mortality from a leading antipsychotic, clozapine.

The genetic risk factors for specific mental disorders and groupings of disorders are becoming known through various means. A number of twin studies have shown a genetic relationship. Suicide is much more likely in first-degree biological relatives than adoptive relatives. (Wender, Kety, Rosenthal, Schulsinger, Ortmann, & Lunde, 1986)

Serotonin: Autopsies appear to show that low serotonin levels contribute to suicide. More specifically, disinhibition of impulsive and aggressive behavior appear to stem from the ventral prefrontal cerebral cortex having low serotonergic functioning. (Mann, et al., 2000) This is in keeping with clinical studies suggesting that individuals with previous suicide attempts are more likely to engage in aggressive acts.

It is known that factors such as stress, loss, substance abuse, and even a low cholesterol level can dampen serotonin levels. Thus, a genetic propensity to depression or impulsiveness may combine with trauma history, high chronic stress, or other situational risk factors to create more serious spikes in suicide risk.

This alteration may help explain why a seemingly bizarre act such as killing the children so that they do not become orphans (and other forms of murder-suicide) might seem rational to some suicidal individuals who are not necessarily delusional.

There is substantial research indicating that many accidental deaths are suicides intended to secure life insurance payouts. This appears to be more common to males who measure their worth by their capacity to produce income, and who perceive themselves as having run out of options. The individual's depression may be generated or compounded by severe financial strain and related situational factors. In a depressed state, this motivation for suicide may seem all the more rational.

Cognitive impairment may result from numerous medical, violent, and accidental sources affecting the brain. Even with cognitive impairments that can greatly improve, such improvement can require a long duration that outlasts the resources of the individual, and that are often un- or under-diagnosed and treated. There is also increased risk of emotional destabilization and impulsiveness, as well as disorganization and memory problems. This is a major factor in homelessness, victimization, and other vulnerabilities. It is an intersection of numerous factors that elevate suicide risk.

Post traumatic stress disorder (PTSD) is a significant suicide risk factor for reasons similar to brain damage, particularly in the case of complex PTSD, which tends to be more chronic, and results from sustained traumatic experience, even in adulthood. It can lead to emotional destabilization, impulsiveness, poor judgment, and cognitive impairment. Many veterans have returned from service with a combination of concussive blast brain injury as well as complex PTSD. Complex PTSD is proving to bear a strong likeness to borderline personality disorder, but developmental issues will be different depending on factors such as age of onset.

Epilepsy: Vulnerability to mental disorders is partly genetic, and this takes place as clustered risk factors. A large study has shown that depression increases risk for developing epilepsy by 70%. Epilepsy is a health problem that may cause cognitive impairment or other problems that increase risk of suicide. In a large study, epilepsy conferred a 300% increase in attempted suicide risk. Individuals recently diagnosed with epilepsy that also had a psychiatric illness were 29 times more likely to commit suicide. The risk was higher for younger individuals and females. Suicide attempts, independent of depression, increase risk of subsequent epilepsy.

Table: Pooled Standard Mortality Ratios (SMR) for Suicide in Psychiatric and Neurological Illnesses

About the Table:

The conditions are listed by descending magnitude of risk.

The third column, **SMR, is the mean ratio of suicide risk compared to the population at large.** Thus, "Prior Suicide Attempt" is a risk factor 34 to 43.1 times above the risk for the general population.

The fourth column is the range of ratios from the studies included in the analysis.

These ratios are for a broad sampling of individuals, without screening for comorbidities or stress level.

The second column, Studies, is the number of studies from which statistics were drawn.

These ratios may be overly high because suicide in the general population may be under-reported by 33% to 50% for various reasons.

Condition	Studies	SMR	95% CI
Prior Suicide Attempt	9	38.4	34.0-43.1
Eating Disorders	15	23.1	15.3-33.4
Major Depression	23	20.4	18.3-22.6
Sedative abuse	3	20.3	14.2-28.2
Mixed drug abuse	4	19.2	16.1-22.8
Bipolar disorder	15	15.0	12.2-18.4
Opioid abuse	10	14.0	10.8-17.9
Dysthymia	9	12.1	11.5-12.8
Obsessive-compulsive	3	11.5	2.38-33.7

Panic disorder	3	10.0	4.57-19.0
Schizophrenia	38	8.45	7.98-8.95
Personality disorders	5	7.08	4.77-10.1
AIDS	1	6.58	5.77-7.63
Alcohol abuse	35	5.86	5.41-6.33
Epilepsy	12	5.11	3.90-6.58
Pediatric psychiatric	11	4.73	3.97-5.60
Cannabis abuse	1	3.85	1.84-7.07
Spinal cord injury	1	3.82	3.29-4.42
Neuroses	8	3.72	2.97-4.60
Brain Injury	5	3.50	1.14-8.18
Huntington's chorea	4	2.90	2.24-3.68
Cancer	1	1.80	1.71-1.89
Mental retardation	5	0.88	0.18-2.58

(Harris, & Barraclough, 1997)

Suicide in Extreme Contexts

Suicides in which mental disorders may not play a role include suicide in response to extreme disability or pain, or to avoid living through extreme social disapproval, a trial, or imprisonment. Rarer forms of suicide, such as for the purpose of political protest or as an element of a terrorist attack, must be viewed in their cultural context if they are to be understood.

Despite the elevated risk of suicide in mental disorders, it is not common for persons with psychiatric disorders to kill themselves. Situational factors that may lead to suicide, even in the absence of a mental disorder can include occupational or interpersonal problems, particularly when they involve separations or losses. Elderly persons are at increased risk due to medical illness, retirement, isolation, loss, and poor support services. Physical illness is associated with approximately 25% of suicides in the elderly, and malignancies pose the highest risk. The elderly often experience undiagnosed depression or substance abuse.

Cult suicides appear to stem from the use of various psychological techniques by cult leaders. Charismatic leadership and the reinterpretation of induced psychological phenomena can result in intense faith in a belief system that can result in suicide. Also, loyalty to such a leader, when that leader is mentally imbalanced, may result in inducement to suicide. Analysis of cult psychology and specific incidences of cult suicide such as that of Jonestown and Heaven's Gate helps us understand and prevent such phenomena.

Physician-assisted suicide is nearly universally prohibited. Where it is allowed, strict criteria that include psychosocial and medical factors must be met.

Medication Increasing Suicidality

SSRI antidepressants have been shown to increase risk of suicide in adolescents by as much as 200%. They decrease suicide in the elderly. However, the elderly have an elevated risk of suicide when using sedatives and hypnotics, according to a large study.

Various other medications may alter the client's state and have an influence on suicidality.

Clinicians should ensure that there is adequate supervision of individuals who are initiating medication that may create or increase suicidality. In some cases, previous concerns regarding mental health and suicidality were not present prior to suicide that has been associated with a medication.

Imitation

There is controversy regarding the number of suicides inspired by media accounts and literature that expose people to suicide. Because of concerns raised by some researchers, the media have limited their reporting and portrayal of suicide, particularly by people with whom many people may identify, and they have limited reporting on the details of the means of suicide. Research has produced contradictory results. This may be due to changes in attitudes regarding suicide and the media that took place in the late 1970s.

A sociologist, David Phillips, coined the term "Werther Effect" for copycat suicide, because of a wave of copycat suicides following the publication of the Van Goethe novel, *The Sorrows of Young Werther*, published in 1774. The suicidal response to the book was so notorious that some countries banned it. Phillips fathered the study of copycat suicide when he reported a large increase in suicides following the overdose suicide of Marilyn Monroe in 1962. According to Peters, her death resulted in the greatest rise in suicide rate of any celebrity suicide that he studied.

However, the early studies were, "plagued with methodological problems as well as some inconclusive findings." (Maris, Berman, & Silverman, 2000) Some subsequent research showed actual reductions in suicides after popular press reporting of suicides. It does, however, appear that celebrity suicides have the strongest effect in elevating suicide rates. Also, it may be that changes in media handling of suicide stories and changing social awareness and attitudes may have created changes the population responds to suicide and whether the stories are conducive to inspiring suicide, and how much, if at all, the suicide is covered.

An aspect that Peters speculated about was accidents that may not have been accidents at all. He argued that accidents have also been shown to increase after reports of suicides. He speculated that many of these accidents are the result of suicides disguised to appear accidental. Analysis of the accidents themselves, he said, showed that many of the fatal accidents occurring during these spikes did not conform to normal accidents. For example, there tended to be a higher number of casualties and faster death of the person responsible for the accident. This suggested to Peters that there was intention. This perspective, he said, was supported by the lack of any attempt to prevent or reduce the impact and seriousness of the crash. Also, the demographics of the individuals at cause tended to resemble those of the suicide victim portrayed in the news.

Suicide Attempts and Ideation

Also known as parasuicide, attempts occur much more than completed suicides. The ratio is estimated to be 18:1 worldwide. Suicide attempts indicate a greatly elevated risk for a completed suicide. 30% to 60% of suicides are preceded by one or more attempts. Persons with mood disorders have a much lower ratio of attempts to completions, indicating the greater seriousness of the attempts by this population.

It is difficult to estimate suicidal ideation and it varies among groupings, but it is estimated to be roughly 6% to 14% in the general population over the course of a year.

Demographics

The World Health Organization (2009) indicates that in the United States, the annual suicide rate per 100,000 people is 4.5 for women and 17.7 for men. However, suicide in the general population may be under-reported by a factor of 33% to 50%. Demographic groups and geographic regions vary a great deal in their rates of suicide. The World Health Organization maintains tables of this data. Female gender poses a mild elevation of risk for suicide attempt, while male gender is associated with a substantially higher suicide rate because of the high ratio of completed to attempted suicides. This is because men are more likely to use more violent means such as guns. Women are more likely to use less effective means, such as overdosing.

Married persons, particularly those with dependent children, have a lower risk. This is most likely do to a higher percentage of persons with better mental health and functioning, and because of the sense of responsibility. In terms of gender and marital status, elderly, widowed men have the greatest risk.

Demographic risk factors include age. Youth suicide has increased a great deal since 1950. However, overall, suicide risk increases with age, while the ratio of attempts to completed suicide decreases.

For adolescents 15 to 19 years of age, suicide is the third-leading cause of mortality. The 203 Youth Risk Behavior Survey of 9th through 12th graders, 28.6% reported that they had felt sad or hopeless nearly every day for at least two weeks in a row during the twelve months prior to the survey. 16.5% had actually planned a suicide attempt. 8.5% had attempted to commit suicide. 2.9% had required medical attention for a suicide attempt.

Because of the high prevalence, routine history taking should involve questions about mood disorders, thoughts of suicide, sexual orientation, and any other risk factors. Physicians have the opportunity to incorporate this into their assessments. Clinicians need to collaborate closely with family members, physicians, and service providers for treatment and follow-up of at risk adolescents. Clinicians should familiarize themselves with local and national resources for suicide prevention and psychopathology treatment and support for adolescents.

Clinicians can help family members put medication into perspective, showing the relative risks and benefits. Additional training in intervention and prevention is advised, as clinicians vary widely in their level of training and

expertise in this area. For adolescents, firearms in the home are a great risk factor. Clinicians should be strong advocates for authorization from insurance plans for adequate preventive care of adolescents, particularly when there are red flags.

People who live in areas where there are crises such as war, even those in concentration camps, have lower suicide rates, and these rates increase appreciably after the crisis or release from the camp. However, economic expansion and recession has shown mixed results that are confounded by factors such as regional alcohol consumption. Likewise, unemployment varies in its impact on suicide rates, and is, in part, contingent upon the culture and how widespread unemployment is in the region. Recent studies are supporting that unemployment elevates rates, particularly in the young. As with marriage and parenting, this analysis is confounded by the selection bias resulting from the impact on mental health and overall functioning on employment of each individual. Regarding elevated rates in some professional groups, including physicians and dentists, the various popular theories remain unproven.

Despite the bad reputation of urban living for alienation and artificiality, urban living is not associated with higher suicide risk. Some studies are showing increased risk in rural areas, and this is probably because of less access to mental health services, and less access of diverse persons to the support of similar people, for example, lesbian and gay social groups.

Race and ethnicity have diverse rates of suicide that are even similar between immigrants and their countries of origin. White men and women have rates double that of nonwhites. Among Europeans, Finno-Ugric peoples have double the rate over the general European population. Mediterranean countries show one third the rates of the rest of Europe.

Homosexual and bisexual orientation carries a higher suicide risk for young people, presumably because of stigma and related factors. This risk has held up even in more recent, better controlled studies.

Religious groups show different rates of suicide. Catholic regions have shown lower rates than Protestant. However, improvements in reporting appear to be eliminating this difference. Participation in religious activities such as church attendance has been associated with lower rates.

Rapid, major changes in socioeconomic status, even when they are improvements, raise suicide risk. Higher and lower education and socioeconomic levels bear lower risk. Spring brings an elevation in suicides, and this has been recorded since the Middle Ages. Despite perennial workshops and articles on Holiday Depression, December brings the lowest suicide rate. However, after the holidays, rates jump in many areas.

Assessing and Managing Suicide Risk

Assessment

Clinicians are generally unable to predict suicide, but are able to assess and manage risk factors in order to reduce the number of suicides that occur. Assessment for suicide risk factors should be indicated in the clinical record for client safety and liability protection. Suicidal potential should determine the degree of suicidal ideation and intention and how specific and extensive any attempt planning has become. During periods of acute risk, clinicians should institute clinical control throughout the period of acute risk, and should maintain ongoing assistance in cases involving long-term suicidality. It is essential that the clinician directly inquire about the client's self-perceived level of suicidality as well as factors associated with risk of suicide and other danger factors.

Acute Risk Factors: the American Association of Suicidology convened a committee of highly regarded researchers to create a list of empirically-validated signs of risk for suicide. This was based on empirical data derived from the 12-month period prior to completed suicides. Clinicians can use the mnemonic IS PATH WARM.

I - Ideation (suicidal)

S - Substance Abuse (especially current or increase in use)

P - Purposelessness (sense of, no reason for living)

A - Anxiety (state or trait, or trauma symptom)

T - Trapped (feeling of being)

H - Hopelessness (sense of)

W - Withdrawal (behavior, isolation from friends or family)

A - Anger (especially rage, impulsive anger, desire for revenge)

R - Recklessness (impulsive and dangerous behavior)

M - Mood Changes (recent or recurring, possibly due to bipolar disorder or change in life circumstances, or a decision to commit suicide)

The committee provided the following recommendations: (Rudd, et al, 2006)

- Conduct a comprehensive psychiatric evaluation for comorbidity among all Persons with ED
- Routinely assess Persons with ED, especially those with comorbid disorders, for suicide ideation.
- Even when ideation is denied, routinely assess for the presence of other acute risk factors for suicide.

Tondo and Baldessarini, (2001) point out that, "risk factors may or may not be identical for suicides and those attempting suicide." In discussing specific factors, they point out that,

Notable risk factors include social isolation and threats to emotional security and self-esteem, including psychiatric or medical illness. Particularly important predisposing factors seem to be a depressive disorder, hopelessness, previous suicide attempts, and substance or alcohol abuse. Alcohol abuse is a major factor that has been found in the history of at least one fourth of all suicides examined, and identified as an acute factor in at least half. Risk tends to be very high in older men who live in rural or other socially isolated location. Additional factors specific to youth include early marriage, unwanted pregnancy, and absence of parental support, a history of abuse, school problems, lack of social acceptance, and availability of firearms. ...Suicidal risk may paradoxically increase after antidepressant treatment is initiated." (Ibid) On the other hand, "Protective factors may include religious faith and the presence of young children." (Ibid)

They provide the following list of risk and protective factors:

Demographic or social factors

- Young and elderly men
- Native American or Caucasian
- Being single (widowed > divorced > separated > single)
- Social isolation, including new or worsening estrangement, and rural location
- Economic or occupational stress, losses, or humiliation
- New incarceration
- History of gambling
- Easy access to a firearm

Clinical factors

- Past and current major psychiatric illness (especially depressive)
- Personality disorder (borderline, narcissistic, antisocial)
- Impulsive or violent traits by history
- Current medical illness
- Family history of suicide
- Previous suicide attempts or other self-injurious or impulsive acts
- Current anger, agitation, or constricted preoccupation
- Current abuse of alcohol or drugs or heavy smoking
- Easy access to lethal toxins (including prescribed medicines)
- Formulated plan, preparations for death, or suicide note
- Low ambivalence about dying vs. living

Factors specific to youth

- All of the above, less racial difference
- Recent marriage, unwanted pregnancy
- Lack of family support
- History of abuse
- School problems
- Social ostracism, humiliation
- Conduct disorder
- Homosexual orientation

Precipitants

- Recent stressors (especially losses of emotional, social, physical, or financial security) (ibid)

Protective factors

- Intact social supports, marriage
- Active religious affiliation or faith
- Presence of dependent young children
- Ongoing supportive relationship with a caregiver
- Absence of depression or substance abuse
- Living close to medical and mental health resources
- Awareness that suicide is a product of illness
- Proven problem-solving and coping skills

Treatment and Prevention

Research on the effectiveness of typical suicide intervention is limited and inconclusive (Tondo & Baldessarini, 2001). Guidelines can be drawn from clinical experience and existing research. Generally, interventions are relevant to the risk factors that are currently active. Cognitive behavior therapy, with its emphasis on rapid development of rapport, treatment objectives, motivational factors, and relevant change, is a strong candidate therapy for suicidality reduction and has fared well in early research. However, there is risk of overestimating the impact of a given therapy because of the natural course of suicidality. There is a period of high risk, followed by high, but lessened risk, and then steady reduction. According to a study, this was true regardless of whether there is treatment by medication, by psychotherapy, or no treatment. (Gregory, Simon, & Savarino, 2007)

The value of a good therapeutic alliance cannot be understated where danger is concerned. Clients who are ambivalent about life and death may be accessible to rapport because of their fear of tipping toward self harm. Intensive contact with the client is indicated during periods of elevated suicide risk. Intensive psychotherapy and mood-stabilizing medication has been shown to decrease suicide rates as much as 17-fold in persons with bipolar disorder. (Rutz, 2001) Even in patients who, after hospitalization for suicidal risk, received follow up letters showed a decrease in suicide risk over two years. (Motto & Bostrom, 2000)

Social support is implicated in suicide reduction according to various studies. Interventions that support social connections include programs that link elderly persons to each other for phone support. Internet discussion forums may prove to have a significant impact, especially with increasing use in older persons, and the increasing availability of multimedia communication and other creative implementations.

High acute risk calls for family involvement if appropriate, or hospitalization that will guarantee ongoing monitoring until the high risk subsides. If the client is with family, the family members must understand the gravity of risk, and have a specific plan for responding to what may arise. This includes contacting emergency support from the police or psychiatric emergency team if the client becomes too agitated, psychotic, or uncooperative. In some cases, it may be appropriate and necessary for the family to transport a cooperative but immanently suicidal family member to the hospital. The family should be instructed to alert the hospital that they are coming, and to contact the therapist as soon as possible. The therapist must ensure that the client and family have a hospital selected. This may involve coordinating with any managed care company involved.

The value of a no-suicide contract has not been proven, but is a common practice, and may strengthen client commitment, particularly where a therapeutic alliance is strong.

Antidepressant medication has not been proven conclusively to lessen suicide risk. Despite increasingly widespread use, the suicide rate in the United States has been stable or increased somewhat, with the exception of a moderate reduction in the elderly and a possible slight decrease in women. (Ibid) However, the implication of depression in suicide has caused the administration of antidepressants to be considered a standard of care for such cases. (Ibid) There is an alternative theory that rising rates of depression would have increased suicide rates to a greater degree were it not for the use of antidepressants. (Ibid) Studies are showing resolution of suicidal ideation associated with the implementation of antidepressant and mood stabilizing medication in depression and bipolar disorder.

Electroconvulsive Therapy (ECT) has not been proven effective with suicide, but clinical experience is strong, and it is recommended as a first line treatment by the National Institute of Mental Health. Antipsychotics and anti-anxiety medications are also in use for suicide, but have yet to be adequately studied. (Ibid)

An exceptional area is bipolar disorder, for which lithium maintenance therapy is shown to substantially reduce suicide. Although there are some criticisms of the studies, they show a nine-fold reduction in suicide rates. Discontinuation results in suicide rates that appear to parallel levels expected without treatment, but rapid reduction of lithium treatment may result in a greater increase of risk. (Ibid)

Metastudies of children and adolescents has confirmed an elevation of treatment-emergent suicidal ideation and behavior. Two metastudies producing similar results led to the conclusion that cautious, well-monitored use is supported by the data. SSRI use elevated risk of suicidal ideation or behavior from 2% to 4% in the FDA metastudy, and less in a subsequent one. None of the studies involved fatalities. (Bridge, et al., 2007)

Postvention

Responding from a public health perspective after a suicide is intended to help secure the mental health and functioning of those affected by the suicide, and to prevent additional suicides, including imitative suicides. Known as postvention, it is recommended by "the Centers for Disease Control and Prevention (CDC), crisis intervention centers, school districts across the country, and the public at large." (Maris, Berman, & Silverman, 2000)

The CDC provides guidelines for a coordinated community response to suicide, as well as guidelines for the media to consult for development of policies regarding reporting on suicides. (Ibid) Therapists must make their clients aware of their policies and availability for crisis calls, including the practical limitations of providing such support.

The appropriate level of care must be determined. This may include individual therapy, structured outpatient, or inpatient treatment. Augmentation with a dialectical behavior therapy (DBT) group may be very valuable. DBT is a highly regarded approach to suicide risk that has produced good research outcomes. It is especially valuable for persons with borderline personality disorder and complex PTSD.

It is very important for clinicians who are used to thinking in psychodynamic terms to focus upon additional factors that can enhance stabilization, including situational factors that pose acute risk, and physiological factors that threaten stability. Sleep loss and inadequate REM sleep, poor nutrition, and other physical factors should be reviewed. Appropriate referrals should be made as needed.

Clients with cognitive difficulties may have little understanding of the course of recovery when it is possible. They should be oriented as to typical durations of recovery, and what support for maintaining independent living and avoiding serious financial and other complications is available.

Legal Issues, Confidentiality, and Related Case Management Issues

Overview

A legal matter: Law pertaining to threat of suicide is primarily at the state level, and is concerned with imminent threat of harm to self or others. It is understood that the clinician can not predict with certainty that there will be harm without intervention. The clinician has detected risk that is too great and requires a higher level of intervention.

When clients are unable to recognize or respond to this need, the therapist must take action according to the laws of the state. The clinician must become familiar with these laws in case quick decision-making is required. In situations in which it is legally required or allowed, the therapist can breach confidentiality in order to inform the authorities of the risk. State laws generally afford a high degree of protection from civil and criminal action against therapists in such cases.

Psychiatric Emergency Response Team: When the call is made, every effort should be made to have specialists available. Many communities have such specialists available. They are referred to by terms such as Psychiatric Emergency Team (PERT). Generally, police have training and experience in such situations, but there is always the possibility that the officers who respond may not be well prepared. This may result in handling of the situation that the client finds too objectionable or, in rare cases, an overly aggressive response.

Cooperation, case management, and information: With a sufficient threat of suicide or violent behavior, the client must be hospitalized in order to gain further assessment and stabilization. The clinician must provide the hospital with all clinical information needed for assessment and treatment.

Whenever possible the clinician should encourage the client to participate and cooperate with assessment and treatment. The clinician should also explain the process, client rights, and how the clinician will support the process and the client's return to the community. The clinician should stress what continued support will be available in the community.

The therapist must be prepared for vigorously managing the return of the client to the community. Many inpatient facilities provide inadequate follow up in these situations. The clinician should maintain regular contact with the facility so as not to be surprised to find that the client has already been released and is falling through the cracks. The client may need immediate linkage to community resources such as a community-based psychiatrist, financial and housing assistance, or other help, not to mention follow up with the primary clinician. Regardless of the fact that the client has been released, the clinician should carefully assess the current level of impairment, danger, and need. This should include checking to see if the client is in possession of any prescribed medication and understands how and when to take it. To mitigate against the potential for poor records management on the part of the referring organization, the clinician should note any medication that the client is on, and any other treatment recommendations. This will ensure that the such information will be managed promptly.

Involuntary Commitment

If the authorities on the scene determine that action is necessary, the client will be transported to a hospital for further assessment. A client unfamiliar with this process will need to know that law limits the time they may be held. The clinician is not generally the individual to decide whether to transport and evaluate the client on the basis of a legal hold. A designated clinician will be responsible for determining whether the individual can be held beyond an initial time limit set by law to preserve client rights. A person must be clearly at imminent risk or clearly unable to care for basic needs in the community in order for the legal criteria of an extended involuntary commitment to be met. The client has limited rights to contest the hold.

Whatever the opinion of the client's primary clinician, family members, or friends, the system may respond based on these criteria, keeping or releasing the client against what others feel is appropriate and necessary. In some cases, the client may remain voluntarily, aware that the risk or need for treatment is too great to attempt to be safe or adequately functional in the community at that time. There is some controversy as to where to draw the line, with a substantial community of clinicians and family members advocating for a lower standard to be met, particularly in cases of grave disability that results in severe neglect of physical health.

When the clinician has determined that there is imminent risk of suicide, they must contact the authorities without delay, regardless of whether the clinician knows where the client is at that time. If the client has called the clinician in crisis, the clinician can ask the police to check on the individual's welfare. The clinician need not be present for this to occur. This may upset some clients, but they generally understand that their therapist had reason to be alarmed. The action may even enhance the relationship because the therapist's actions were consistent with a competent evaluation and response to the situation.

More information on involuntary commitment is generally provided in courses on confidentiality or specialized courses on this topic.

Appendix: American Academy of Pediatrics 2007 Statement Highlights Regarding Adolescent Suicide

Specific suggestions for clinicians in screening or treating adolescents at risk for suicide are as follows:

- Throughout adolescence, routine history taking should include questions about mood disorders, suicidal thoughts, sexual orientation, and other risk factors for suicide. Ideally, this should occur during acute care as well as routine care visits.

- The medical and psychiatric needs of the suicidal adolescent need to be recognized and addressed, preferably by close collaboration with families and healthcare providers involved in the treatment and follow-up of adolescents who are at risk or who have attempted suicide. This collaboration should also extend to emergency departments and colleagues in child and adolescent psychiatry, clinical psychology, and other mental health professions, while coordinating care that may be delivered through different systems. Good communication between providers, continuity of care, and follow-up by the primary care provider are essential.
- Familiarity with local, state, and national resources for treatment of psychopathology and suicide prevention in youth is essential because resources for adolescents and clinicians vary by community. A list of relevant telephone numbers should be readily available in the office, including local hospitals with psychiatric units, mental health agencies, family and children's services, crisis hotlines, and crisis intervention centers.
- Clinicians and their patients should be educated about the risks and benefits of antidepressant medications. Often it is necessary to remind the healthcare providers and reassure the family that antidepressants are relatively safe, whereas depression is relatively dangerous.
- Particularly after starting antidepressant drugs or changing the dose, patients with depression must be carefully monitored.
- General clinicians vary widely in specific training and in their comfort level with evaluating and treating patients with mental health problems, as well as in access to appropriate mental health resources. Especially if practicing in an underserved area, these providers should consider additional training and ongoing education in diagnosing and managing adolescent mood disorders. However, even clinicians without specific psychiatric skills must still play a vital role in screening all patients and referring them to specialists when needed.
- Routine evaluations should include questions about availability of firearms in the home. Parents should be advised of the increased risk for adolescent suicide when firearms are present. Parents of adolescents at risk for suicide should be counseled to remove guns and ammunition from the house and to safeguard potentially lethal medications.
- By knowing the risk factors for adolescent suicide, clinicians can be a valuable resource on this topic for parents, teachers, school staff, clergy, and community youth workers.
- Clinicians should advocate for health insurance plans to cover preventive and therapeutic mental health services for adolescents.

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
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