

Approaching the Suicidal Patient

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The suicide of a patient can be devastating to the family and to the family physician. The patient's death may shake the physician's confidence, undermine any willingness to work with patients with a mental illness, and provoke professional and legal review. In an attempt to help the family physician prevent suicide, this article reviews known risk factors and offers a strategy for assessing these factors in individual patients. The authors outline interventions that fit the existing level of risk and provide suggestions for the physician in the event of a completed suicide. (Am Fam Physician 2003;68:1814-8. Copyright©2003 American Academy of Family Physicians.)

Family physicians frequently encounter patients with suicidal ideation. Ranked as the eighth leading cause of death in the United States and the third leading cause of death in persons between 10 and 24 years of age, suicide kills more than 30,000 Americans each year.¹ A person is nearly twice as likely to die by suicide than by homicide in the United States.² However, family physicians often have opportunities for intervention. One half of the persons who commit suicide saw a physician in the preceding month, and one third were being treated for a mental illness at the time of their suicide.³⁻⁵ The following case illustrates a presentation commonly encountered by family physicians and highlights several of the diagnostic and treatment dilemmas posed by a suicidal patient.

Illustrative Case

A 34-year-old man presents to the physician's office complaining of difficulty falling asleep. During the interview, he says that something is wrong—he has no energy, is crying almost every day, has lost his usual healthy appetite, and has increased his marijuana use in an attempt to fall asleep. He admits that he sees the world as hopeless and has considered driving his motorcycle into a bridge abutment. He says that he would not kill himself, however, because suicide is a sin, and his mother would be saddened and shamed by such a death. Until his girlfriend left him two months earlier, he had never had these symptoms. He wants help in sleeping but fears the

impact of treatment on his ability to continue his job as a police officer, which includes carrying a handgun.

Epidemiology

The presence of a mental illness is the primary predictor of suicide. More than 90 percent of persons who commit suicide have a psychiatric disorder. More than 50 percent of completed suicides are associated with a major depressive episode, 25 percent with a substance abuse disorder, and 10 percent with a psychotic disorder such as schizophrenia.^{1,3,6} Mortality rates with each of these disorders are elevated and reflect the high rates of death by suicide associated with them.⁷ However, most persons with a mental illness do not commit suicide, and other factors play important roles in precipitating a suicide attempt.⁸

Suicide rates increase with age, are higher among men than women (women attempt suicide more often but by less-lethal means than men), and increase with social isolation and in persons who are not married. Cultural and religious factors also can play a role, with increased suicide rates in whites, immigrants, and persons without religious involvement or affiliation.^{1,8} It is important to realize that in certain populations, such as young Asian women, suicide rates are particularly elevated.⁹ Increased suicide rates occur in patients with significant medical illnesses such as cancer, human immunodeficiency virus infection, seizure disorders, and chronic pain, as well as persons with access to a firearm or who are victims of domestic violence.³

See page 1692 for definitions of strength-of-evidence levels.

A previous suicide attempt significantly increases the likelihood that the patient will die by suicide in a subsequent attempt. Twenty percent of those who attempt suicide die as a result of suicide, with the greatest risk of a completed suicide being within two years following an attempt.³ Suicide is a behavior associated with many different illnesses and requires an assessment that fits within the context of the patient's overall health status.

Clinical Evaluation

Discussing ideas about or plans for suicide may relieve patients of the anxiety and guilt they may have and help establish a safe environment for full assessment and treatment.^{3,10,11} Evaluating a patient for suicide risk does not predict its happening; rather, it is a judgment of the current likelihood of a suicide attempt. Directly assessing the suicide risk of a patient allows for appropriate interventions that may be lifesaving. The family physician should not hesitate to directly ask an at-risk patient about suicidal thoughts. Because there are no known, reliable assessment tools or rating scales, the evaluation depends on subjective assessment and clinical judgment.

RECOGNITION

Familiarity with the risk factors will allow the family physician to recognize at-risk patients and complete a thorough assessment that includes nonverbal and verbal cues as well as the patient's current quality of life.¹²

Nonverbal cues, including downcast eyes, psychomotor retardation of speech or movement, and a decline in attention to appearance, should alert the physician to the possibility of depression and the need for prompt follow-up. Comments such as, "I notice you seem sad today," or "Something else seems to be troubling you today," may help start a conversation. Verbal cues are easily overlooked in the press of time or the discomfort that often follows a

Suicide risk can be minimized by accurately assessing psychiatric illness and initiating proper treatment.

patient's response. Statements such as, "I am under a lot of pressure," or "My nerves are shot," offer the physician the opportunity to address the patient's emotional state. Good eye contact, empathetic responses, and direct invitations such as, "Tell me more," or "Please tell me why you are feeling that way," will often prompt a revealing response from the patient. Connecting the patient's other illnesses and experiences with the current problem may clarify the severity of his or her feelings, and asking about the patient's family life, school, work, and relationships may allow the patient the opportunity to reveal suicidal thoughts.¹²

INTERVIEW

Physicians often feel uncomfortable asking about suicidal thoughts during an interview. Many physicians are unprepared to respond to the patient's answer or fear they will intensify a patient's intention or put the idea of suicide in the patient's head. It is important that the physician approach the patient in a culturally sensitive manner and be aware that in certain religions suicide is considered sinful. In some Asian cultures, suicide is a sign of disrespect to one's parents.⁹ At times, beginning the interview with more general and less confrontational questions and then moving on to a more specific approach may help the physician.¹³ Table 1 outlines this interview strategy.

Asking the patient to talk about his or her plan or thoughts will allow the physician to ascertain whether the patient has the intent and the means to commit suicide. For example, does the patient have a handgun, like the patient in the illustrative case, or has the patient been hoarding pills? During the clinical assessment, additional information about

TABLE 1
Questions for Assessing Suicidality

Other people with similar problems sometimes lose hope; have you?
This must be a hard time for you; what do you think about when you're feeling down?
Do you ever consider running away from your problems?
With this much stress, have you thought of hurting yourself?
Have you ever thought of killing yourself?
How would you do it?
What would happen to your family or significant others if you did that?
What has kept you from acting on these thoughts?

mood, the presence of anxiety or psychotic symptoms, and any indication of substance misuse (e.g., alcohol, cocaine, marijuana, heroin, prescription medications) should be gathered. The psychiatric and social history should include identifying previous suicide attempts or treatment for a psychiatric disorder, and clarification of the patient's current social supports and stressors.

Given the likelihood that suicidal ideation occurs within the context of a mental illness, interventions to reduce the risk of suicide must include treating the underlying illness. The formal examination should include a mental

status assessment that includes current cognition, mood, thought process and content, and the patient's ability to cooperate with and reveal information to the physician. Physical signs of substance use or withdrawal, restlessness, and agitation are important findings in the evaluation of a potentially suicidal patient.

Data supporting clinical interventions to reduce the rate of suicide over time are somewhat limited. Existing data do not indicate that the use of antidepressants reduces suicide rates among individuals with major depression.¹⁴ [Evidence level B, prospective cohort study] Only two medications, lithium^{15,16} and clozapine (Clozaril),¹⁷ have been shown to reduce suicide rates over time. [Reference 15—Evidence level B, observational study of patients treated for bipolar disorder; Reference 16—Evidence level B, meta-analysis of randomized and nonrandomized trials of patients treated for major affective illness; Reference 17—Evidence level B, observational study of patients treated for schizophrenia] Research in this area is hindered by the statistical challenges that arise given the low base rate of the event. However, given the high likelihood that the presence of suicidal ideation is a symptom of a mental illness, the family physician should begin a clinically sound treatment of the underlying illness even if the suicidal ideation subsides.¹⁸

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Management of Suicidal Ideation

At first, management of suicidal ideation should focus on establishing safety, possibly through hospitalization. For patients at high, although not imminent, risk of suicide, aggressive treatment of the underlying psychiatric illness is imperative and should involve a combination of pharmacotherapy and psychotherapy.^{10,11}

A significant aspect of intervention involves contacting the patient's family or support network to assist in the elimination of the patient's access to potentially lethal means of suicide.^{1,3,11} The suicide prevention contract, although frequently used, is of unproven clinical and legal

usefulness during times of increased suicide risk and generally should be avoided.¹⁹

If an imminent risk of suicide is present, hospitalization is indicated. The family physician should know how to access emergency psychiatric services and hospitalization, and know the relevant legal guidelines for involuntary hospitalization. If the risk is not imminent, the physician should establish a plan with the patient that targets the underlying psychiatric illness and begin treatment immediately. Access to means of suicide can be limited by involving family and friends of the patient and increasing physician contact with the patient. The general approach to assessment and treatment of a patient with suicidal ideation is summarized in *Table 2*.²⁰

Caring for the Patient with Chronic Thoughts of Suicide

In some patients, suicidal thoughts are a chronic part of an unstable mental status that is associated with a mood or personality disorder, most commonly borderline personality disorder. Substance abuse is often a contributing factor. The patient may present with ongoing thoughts of suicide and a history of suicide attempts. The patient's mental status and an assessment of suicide risk become a part of every clinical encounter. The patient and physician should discuss how a deterioration will be addressed, including hospitalization, a brief stay at a day program, and increased use of social supports. Chronic thoughts of suicide must be considered part of a serious psychiatric illness, and adequate treatment for the illness must be initiated. It is unlikely that treatment by the family physician alone will suffice, and the treatment requires a coordinated plan involving the family physician, a psychiatrist, and a psychotherapist.

Prevention

The U.S. Surgeon General has proposed a national strategy for the prevention of suicide.²¹ The U.S. Preventive Services Task Force

found that screening for depression in primary care settings can improve outcomes, especially when combined with feedback and system changes to ensure treatment and follow-up.^{22,23} [Reference 22—Level of Evidence A, meta-analysis of randomized trial]

Family physicians can minimize the risk of suicide among their patients by thoroughly assessing for the presence of psychiatric illnesses, being aware of clinical and social situations that might precipitate suicide, and initiating treatment with or facilitating access to treatment for patients with psychiatric disorders. Educating patients and their families about mental illness, substance abuse, and the safe storage of medications and firearms also is useful in suicide prevention.

When a Patient Commits Suicide

Unfortunately, patients sometimes successfully commit suicide. This event can be devastating for a physician and can lead to intense feelings of sadness, anger, helplessness, and fear of legal and professional repercussions. In the event of a patient's suicide, the physician should express condolences to the family with-

TABLE 2

Summary of Assessment and Treatment of the Suicidal Patient

- Identify predisposing factors (e.g., psychiatric illness, previous suicide attempts, substance abuse).
- Identify contributing factors (e.g., family history, current life crises, medical illnesses, access to lethal means, demographic factors).
- Conduct a specific suicide inquiry, identifying if a suicide plan or psychiatric symptoms (e.g., depression, anxiety, hopelessness, hallucinations) are present.
- Develop a diagnosis formulation that encompasses the current level of suicide risk.
- Identify available interventions, including family and social supports.
- Begin a thorough and organized treatment that targets the identified psychiatric illness.
- Document the assessment and plan.

Information from Jacobs DG. The Harvard medical school guide to suicide assessment and intervention. Retrieved July 11, 2003, from: <http://www.mentalhealthscreening.org/suicide.htm>.

out accepting or placing blame; review the medical record, taking care not to alter or destroy it; and consult with colleagues, particularly those who have had the same experience.^{11,23} It is important for the treating physician to regain confidence and be able to maintain a professional approach the next time the issue of suicide arises with another patient. If legal action is a possibility, the physician should consult an attorney. The malpractice insurance carrier or institutional risk-management office also may provide advice.

The effect of suicide on the patient's family can be devastating. Grief caused by a suicide differs from grief associated with other causes of death.²⁴ In a family practice setting, where the physician may treat many members of a family, this grief must be addressed. The emotional, social, and financial sequelae among the surviving family members often require attention.

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