

Practical management of the suicidal patient

David Horgan

BACKGROUND Suicide is nearly always due to untreated depression, causes widespread distress, and is a waste of life years. Eighty percent of suicides are male, mainly in the age range of 25-44 years. Nearly every person who commits suicide has talked about it before the event.

OBJECTIVE This article focusses on teaching some 'tricks of the trade' used by the author in treating suicidal patients.

DISCUSSION General practitioners should ask the patient to indicate on a scale of 0-10, the stresses, emotional suffering and suicidal intensity they are feeling. They should offer understanding, very frequent contact, antidepressants, discussion, guarantees of improvement, and benzodiazepines for relief from pain during the process.

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It could never happen to me

Those fortunate enough never to have suffered morale destroying depressive illness, or never experienced pressures beyond their ability to cope, often cannot understand the need to escape embodied in suicide attempts, successful or otherwise. Past President of the United Kingdom Royal College of General Practitioners, Dr John Horden, described the pain of depression as far worse than the pain he suffered with renal colic and myocardial infarction.¹ Professor Lewis Wolpert, Professor of Biology at University College in London, only accepted intensive treatment of his own depressive illness after his wife agreed she would assist in his suicide if treatment failed.² No one is immune from depressive illness and the subsequent temptation to escape pain by suicide.

GPs are the front line

We all warn young people to drive safely. Suicide is as common as car accidents as a cause of death, representing just under 2% of all deaths in the population. General practitioners are best placed to reduce this needless waste of life by being given adequate training in managing the suicidal patient,

especially diagnosing and treating the almost inevitable underlying depression. With experience, this can be achieved within the time constraints of general practice schedules.

Over 75% percent of completed suicides occur in males, due to their propensity to use violent means and their reluctance to raise issues of emotional distress. For every completed suicide, it is estimated there are 30 nonfatal episodes of deliberate self harm, mainly in women, half of which result in hospitalisation.

Prevalence of suicidal thoughts and actions

Thoughts of suicide are a normal human experience, with surveys suggesting at least 3% of the population in Australia have considered suicide in the previous 12 months,³ and 5-7% of the USA population having similar thoughts.⁴

Comparing suicidal thoughts to actual suicide rates, it can be calculated that approximately one in 80 males, and one in 400 females with suicidal thoughts will commit suicide in the next 12 months; so predicting and treating individuals at the most risk is a needle in a haystack exercise from a public health perspective, even if all seems

Table 1. Asking about suicide

- Are things so bad you sometimes wish you did not wake up in the morning?
- Do you actually wish you were dead?
- Have you thought of harming yourself?
- Have you considered various ways?
- Have you made plans?
- Have you made any preparations?
- Have you been close to doing something?
- Have you done something?

NB: If a patient admits to suicidal thoughts, it is very important there and then to acknowledge their revelations, to express empathy for their suffering, and to reassure them intensely that they have a known and treatable illness which can be cured.

obvious in retrospect in individual cases. While suicide rates in Australia have remained in the range of 10-14 per 100 000 since the 1920s,³ shifts have occurred in the distribution of groups most at risk.

In the past 30 years, suicide rates have tripled in males aged 15-24, and rural young male suicides have changed from being half to being double the rate of their city peers. On a more optimistic note, despite our rising population, there has been an

- > Ask about suicide, especially males
- > Assure recovery will occur

annual progressive fall in the overall number of suicides in Australia in recent years; from 2723 suicides in 1997 to 2363 suicides in 2000; a fall from 14.7 to 12.2 per 100 000.⁵ Males aged 25-44 years are a current focus of concern,⁶ as their suicide rate currently exceeds those of younger males.

Detecting suicidal thoughts

The lay person's belief that those who talk about suicide will never actually do it, is wrong.

- Patients recently discharged from psychiatric units are statistically at extreme risk of suicide, especially in the first few weeks.
- Those who have attempted suicide in the past 12 months, especially those middle aged or older, are also at extreme risk, with the risk escalating almost exponentially relative to the age of the attempter. Determination to die is the issue to assess. Up to 50% of people will

repeat a suicide attempt.

- Consider depression - useful screening questions are: does the patient have the ability to concentrate as usual (needs to reread newspapers and magazines?), and does the patient have their normal level of energy?
- Be aware of high risk groups; especially patients with alcohol or drug abuse problems and elderly males living alone, (especially those who have had psychiatric illness, have recently been widowed, or have recently had financial setbacks or a serious health problem).

Ask questions: it saves lives

An anecdotally useful means of obtaining a quick global view is by asking the patient to rate the following subjective complaints on a scale of 0-10:

- current stresses
- depression
- anxiety and fear
- hopelessness about their situation
- suicidal thoughts.

There is an understandable embarrassment on both sides to discuss suicidal thoughts, but doctors are the last hope of such a discussion for many suicidal patients. It is quite appropriate to lead from discussion of emotional distress to ask progressively more specific questions about suicidal thoughts, plans, preparations and indeed attempts (Table 1). Doctors seem particularly reluctant to ask males about such thoughts, although 80% of suicides occur in males.

Guarantees and benzodiazepines are invaluable

Suicidal patients are killed by hopelessness, anxiety and panic, and by insomnia, nearly always resulting from depressive illness. Intensive targeting of these symptoms will save many lives. Try to persuade patients not to use alcohol when feeling suicidal, as this increases disinhibition, and increases the risk of acting on suicidal thoughts.

Hopelessness

Professor Kay Redfield Jamison (Professor of Psychiatry at Johns Hopkins University) in her book about her own depressive illness and suicide attempt, describes progressively extreme pain accompanied by such a sense of futility and hopelessness that suicide becomes a logical solution.⁷ Telling suicidal patients that others, including high

profile public figures, have experienced the same despair, and have fully recovered, helps to lessen the sense of isolation and hopelessness which leads

- > Assume suicidal thoughts are due to depression, and use antidepressants
- > Abolish anxiety and insomnia with antidepressants

to suicide. It is illogical but extremely useful to unconditionally guarantee suicidal patients that you (with or without specialist assistance) will be able to change things, if they give you enough time.

Anxiety, panic and insomnia

All doctors appreciate the value of analgesia in extreme physical suffering. It is my personal view that in life threatening psychic pain, basic medical principles equally apply. A particularly dangerous scenario is the experience of suffering intensely, and being unable to sleep. Control of insomnia to reduce suicide risk is emphasised especially by Professors Goodwin and Jamison.⁴ Although not standard teaching in Australia, many doctors subscribe to the usefulness of giving patients access to benzodiazepines to relieve fear, anxiety and insomnia. Addiction is not an issue with one or two benzodiazepine prescriptions. Access to nonfatal oblivion gives suicidal people a safe option when overwhelmed by emotional pain. Evidence based review has shown that the combination of an antidepressant and a benzodiazepine gives a better outcome than an antidepressant used alone.⁸ An overdose of benzodiazepines is preferable to many other options available to the desperate! (Do not enlighten patients as to the lethality of various options!).

Is it depressive illness?

It is safe to assume any patient with significant suicidal ideas has depressive illness, and doctors need to act accordingly, backing both horses in a two horse race, namely antidepressants and therapy. All antidepressants are equally effective. Once an antidepressant is prescribed the dose needs to be escalated as quickly as can be tolerated by the patient. If there is not a marked improvement in three weeks (as reflected by their 0-10 self rating), then change antidepressants. The risk of a washout

period allowing the partially eradicated depression to return with renewed suicidal ideas, versus the slight risk of antidepressant interactions should be discussed. Modern antidepressants are far safer in overdose than tricyclics!

Can the patient walk out the door?

This difficult judgment is the responsibility of the treating doctor, based on how suicidal the patient is, and on whether or not the patient can solemnly promise not to harm themselves before their next appointment; an illogical but emotionally pressurising technique. You must decide if you can trust the promise.

Predicting suicide is like predicting the weather; long gaps lead to errors. Arrange to see the patient every 1-2 days if they have active suicidal ideas, and be available for emergency contact in the interim if the patient feels they cannot hang on. A GP recently told me of an effective technique of accompanying the patient to the desk to arrange the next appointment.

'Therapeutic blackmail' can often sway the patient who is reluctant to promise no self harm until the next visit. A ruthless summary of the increased risk of psychiatric illness and increased suicide risk for their siblings and children, of the risk of surviving with central nervous system damage, and you being exposed to official investigation, all combine to persuade patients to hang on until the antidepressants work.

Preventing access to the means the patient has considered in attempting suicide may be feasible with family cooperation and ensuring the patient is

- > Ask for promise of safety until next visit
- > Attend very often
- > Ask patient to avoid alcohol

not left alone at any time lessen the risks. Avoiding alcohol completely is very important, as alcohol allows raw emotions more sway.

If you have to involve other services, in the case of very ill patients, or unconvincing promises, or if your clinical intuition rings alarm bells, emphasise to the patient you will still be involved in their care and you are not giving up on them. If the patient's illness has irrevocably convinced them there is no

hope, compulsory steps should be invoked. It is often effective in such cases to explain to the patient that the easy thing for you is to let them do as the illness demands; the difficult thing for you is to enforce treatment.

Conclusion

Depression will return in the majority of cases. In my opinion, patients become desensitised to suicide in subsequent episodes, causing suicidal ideas to appear earlier, and with less automatic resistance from the healthy part of the mind. You cannot win every battle, but you can make a difference to many families.

Conflict of interest

The author lectures for multiple manufacturers of antidepressants. The author owns and operates a range of voluntary and commercial internet psychiatry websites.

SUMMARY OF IMPORTANT POINTS

- The GP is often the only person with whom a patient can discuss suicidal ideas, if you ask.
- It is vital to combat hopelessness, the killer in depressive illness, by emphasising recovery will occur if you are given time to treat the symptoms.
- Use antidepressants liberally.
- Benzodiazepines are invaluable as emotional analgesics and as safety escape valves in desperation.
- The more suicidal a patient is, the more often they need to be seen, even daily if necessary.

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