MedicineToday PEER REVIEWED ARTICLE CPD 1 POINT

Meeting the challenge of suicide prevention

All GPs should possess the clinical skills to make a general assessment and management plan for a person who is suicidal, although they should not feel obliged to continue the management. Standard treatments for psychiatric conditions that often involve suicidal behaviour are effective at preventing such behaviour.

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Between years 1997 and 2003 (the latest year for which figures are available) there was a reduction of about 20% in the number of suicides in Australia (Table 1).[1] This has probably been largely attributable to better recognition and management of mental disorders by GPs, who provide most services for those afflicted with these disorders. While this improvement is gratifying, continuing vigilance and the application of standard treatments for psychiatric conditions that involve suicidal behaviour should ensure further reduction of suicide in the future.

Causes of suicide

There are many theories about the causes of suicidal behaviour. The stress–predisposition model probably has most validity, with long standing issues increasing the vulnerability to suicidal behaviour and more immediate stressors acting as precipitants.

Predisposing factors include genetic and biochemical tendencies, personality traits and the presence or absence of interpersonal support systems. Stressors or triggers include mental disorders, physical illness and alcohol and/or other substance abuse. Almost always there is also a final interpersonal loss or rejection.

Understanding the interaction of possible contributing factors can be a major challenge, as is illustrated by considering various hypotheses to account for the four to one preponderance of males to females committing suicide, and the fact that the highest suicide rates are now in males aged 25 to 44 years, rather than the elderly (Table 1).

Suicide in younger males

The high rates of suicide in younger men may be related to:

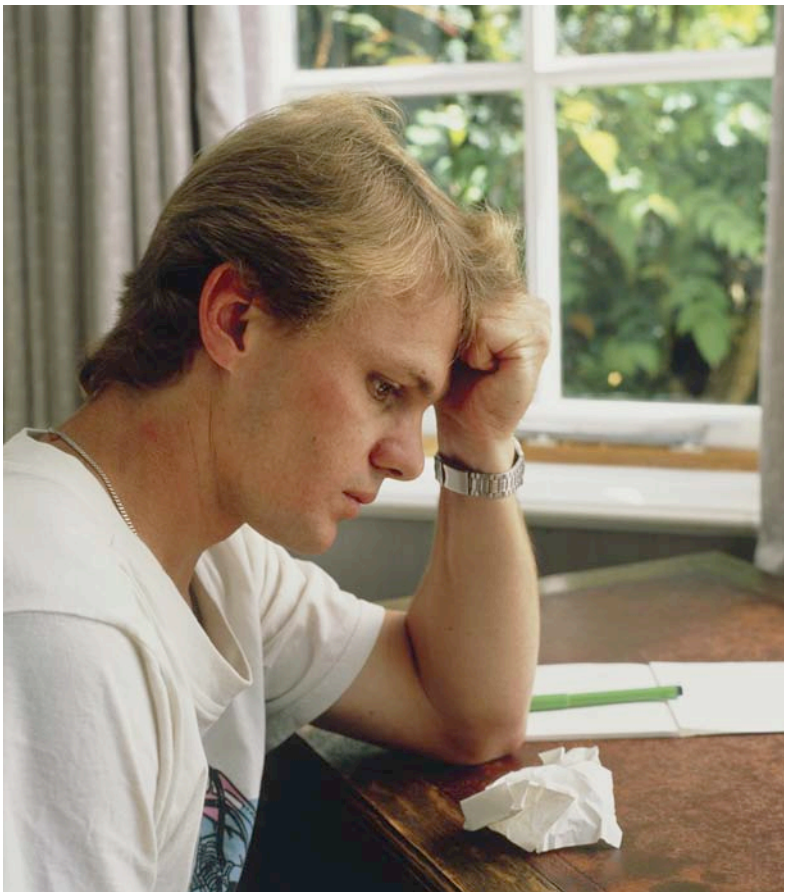
- social changes that provide reduced role

IN SUMMARY

- **Between 2000 and 2500 people die by suicide each year in Australia.**
- **Over 90% of suicides are associated with mental disorders.**
- **There is now persuasive evidence for the effectiveness of both nonpharmacological and pharmacological treatments in reducing suicidal behaviours.**
- **There was a reduction of about 20% in the number of suicides in Australia between the years 1997 and 2003, probably due to better recognition and treatment of mental disorders by GPs.**
- **Continuing vigilance in the detection and management of mental disorders should reduce the number of suicides further.**
- **More males than females commit suicide, and the highest suicide rates are now in males aged 25 to 44 years, rather than in elderly males.**

opportunities, not merely reduced employment options
- alcohol and other substance abuse being particularly prevalent in younger men
- the tendency of younger men to choose the more lethal methods of suicide (such as hanging and carbon monoxide poisoning from car exhaust fumes)
- the Australian macho image, which makes younger men reluctant to acknowledge emotional distress and seek help
- deinstitutionalisation being perceived as the community not wishing to provide asylum and care for people who are emotionally distressed
- media influences resulting in suicide being regarded more readily as an option
- increases in family breakdown.

However, it is not clear why some of these issues would impact more on younger men than on younger women.



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Suicide in the elderly

The decrease in the rates of suicide in the older age groups since 1997 may be related to:
- better social security benefits
- more ready acknowledgement of mental disorders, particularly depression, among

Table 1. Suicide numbers and rates in Australia, by age and sex[1]

Age (years)	Number of suicides (age-specific rate, per 100,000)					
	Male			Female		
	1990	1997	2003*	1990	1997	2003*
15 to 24	379 (27.0)	416 (30.6)	251 (18.0)	60 (4.4)	93 (7.1)	49 (3.7)
25 to 34	412 (29.1)	540 (37.5)	407 (28.3)	98 (7.0)	115 (8.0)	111 (7.7)
35 to 44	330 (25.4)	431 (30.2)	381 (25.6)	75 (5.9)	122 (8.5)	102 (6.8)
45 to 54	198 (21.4)	294 (24.4)	299 (22.1)	60 (6.8)	96 (8.2)	93 (6.8)
55 to 64	182 (24.8)	177 (22.6)	154 (15.0)	45 (6.2)	66 (7.2)	59 (5.9)
65 to 74	139 (26.1)	146 (23.6)	128 (19.4)	49 (7.9)	47 (6.9)	33 (4.7)
75+	89 (32.1)	131 (36.2)	109 (22.9)	39 (8.4)	41 (7.0)	23 (3.2)
Total	1735 (20.7)	2146 (23.5)	1736 (17.7)	426 (4.9)	577 (6.1)	477 (4.7)

* Latest figures available.

Table 2. Suicide risk factors

- Depression, particularly with psychotic features
- Previous suicide attempts
- Alcohol and/or other substance dependence
- Schizophrenia
- Hopelessness, despair, guilt, self-absorption
- Malignant alienation
- Chronic physical illness
- Family history of suicide
- Male sex
- Living alone
- Indigenous group
- Custody or prison
- Sexual identity issues

older age groups
- provision of better psychiatric services, including specialised psychogeriatric units
- better treatment of physical illnesses associated with suicide
- improved palliative care
- the possibility that more doctors are now tacitly in favour of euthanasia or death with dignity, so that fewer older people feel the need to take their own lives.

Suicide risk indicators

Although there is no simple cause of suicide, this should not be daunting in the clinical setting. There are clear options for the clinician who is confronted with a suicidal person.

Risk factors for suicide

Broad sociological issues impose their own risks of suicide, but from the clinician's point of view the primary risk factor for all suicidal behaviour is mental illness. Several psychological autopsy studies involving detailed retrospective inquiry have revealed that over 90% of people in the studies who had died by suicide had a potentially recognisable and treatable psychiatric illness.

Depression is the most important clinical syndrome in people who are suicidal, being present in 50 to 70% of all those who suicide (including adolescents, in whom its significance has sometimes been minimised). Schizophrenia and substance dependence are also associated with suicide, as are other factors (Table 2).

The suicidal mind

Suicidal behaviour is a personal phenomenon. Each suicidal person has his or her own view of the world, which frequently becomes constricted so that alternatives to suicide appear remote. The final act is often precipitated by loss of an interpersonal relationship, and fantasies of retribution or retaliation may be present. These feelings sometimes seem to be turned in on the self, so much so that suicide has been referred to as a murder in the 180th degree.

Coupled with feelings of retaliation and retribution on the suicidal person's part, there is often a sense of omnipotence that suicide is not only the solution to his or her problems but also the ultimate method of making others feel sorry for actual or imagined acts against him or her. Other fantasies may be of reunion with significant others who have died, particularly if their death was by suicide.

Clinical warning signs

There are several clinical features that should alert the clinician to the possibility of suicide. The expression of suicidal intent, with depression, agitation, guilt, hopelessness and a constriction of interest or self-absorption, are particularly ominous. So too is malignant alienation, a syndrome seen in those who have exhausted the patience and resources of friends and relatives and also of the helping professions. The person may have been subjected to disparaging comments from others, including clinicians.

Although these factors are associated with suicide risk, the dilemma is that they lack specificity and are of limited value in individual cases. GPs will frequently see patients with these risk factors but suicide is relatively infrequent, although dramatic when it does occur. On average, a GP probably has first hand experience of only one suicide every five years.

Initial management

The fundamentals of managing a suicidal patient are summarised in Table 3.

First contact

The initial contact with a suicidal person is particularly important, but it often occurs in less than ideal circumstances, such as in the home or in a busy emergency room. There may be concerns about the physical condition of the patient and he or she may be antagonistic towards others, including clinicians, as almost invariably the suicidal behaviour will have been precipitated by perceived rejection by someone significant.

Considerable expertise and patience may be required to establish rapport. This may be achieved by emphasising that you want to try to understand what has happened and that a certain amount of time has been set aside to discuss this. It is best to avoid challenging, closed questions such as 'Do/did you really want to die?'. Open-ended enquiry such as 'What are/were your feelings about living and dying?' is far more likely to elicit useful information.

The patient should be given the opportunity to express his or her thoughts and feelings and encouraged and permitted to discharge pent-up and repressed feelings. This catharsis should put the person's suicidal intentions at least temporarily on hold.

It is important to provide the patient with privacy. It is unrealistic to expect someone to divulge sensitive personal

information unless confidentially is assured.

Suicidal intent

It is crucial to consider the degree of suicidal intent, both from the patient's subjective experience and from the clinician's objective assessment. This can be estimated by exploring the following:

- degree of planning
- knowledge of lethality of method
- degree of premeditation
- isolation
- timing
- precautions against discovery
- awareness of chance of rescue
- communication of suicidal ideation
- purpose of attempt
- ambivalence regarding life or death
- presence and content of suicide note
- acts in anticipation of death.

Firearms and other weapons

It is important to ask about the availability of methods for suicide. This may result in the need to invoke local laws about the possession of firearms because the law in most States and Territories mandates that if doctors have reasonable grounds for concern, notification to firearms regulatory authorities is required. Tact is required, and the clinician should emphasis the concern for safety rather than punitive action.

Hospitalisation

Hospitalisation may be necessary for profoundly suicidal people who have a psychiatric illness. Compulsory admission may be required to reduce the risk to the patient or others. In these circumstances it is important to emphasise to the suicidal person and his or her relatives and friends that this is to protect the person, not to punish him or her.

Hospitalisation, or at least specialist psychiatric referral, is advisable if:

- there are specific suicide plans, particularly with associated impulsivity
- an active psychotic illness is present
- there is profound hopelessness and nihilism.

The degree of social support a patient has may also influence the decision to hospitalise.

Subsequent management

The opportunity to express their thoughts and feelings, with resultant catharsis, may be sufficient for some suicidal patients. If there is no psychiatric illness and the suicidal thoughts and actions have resulted in positive changes in personal relationships, further contact may not be necessary. However, the opportunity for follow up should be left open, particularly if there are inadequate social supports.

Psychotherapy

Few people require the support of a therapist for longer than two to three months. This may involve three to six therapy sessions, each of sufficient duration to allow the patient to address their interpersonal difficulties. Cognitive behavioural therapy (CBT) has been demonstrated to be the most effective form of intervention.

Cognitive behavioural therapy

CBT focuses on the here-and-now issues in a problem solving manner. It is based on the fact that most suicidal patients see themselves as inadequate and unworthy, viewing the future with negative expectancies, and anticipating that any initiatives are doomed from the start.

CBT is designed to counteract errors of cognition by asking patients to define specific thoughts that seem plausible to them. The patient's statement is examined objectively in a nonjudgmental manner, and the therapist helps the patient to appreciate that his or her thinking is idiosyncratic and self-defeating. The patient is then invited to generate alternative hypotheses that fit the situation. This important part of the therapy provides the patient with alternative modes of thinking that are less self-defeating and less likely to lead to suicidal behaviour. Indeed, it is useful to insist that the patient clearly describes his or her options, other than suicidal behaviour, should he or she find himself or herself in a similar crisis in the future.

It is sometimes beneficial to involve significant others, such as the person's parent(s), partner or children, because the presence of a neutral therapist allows the expression of mixed feelings in a controlled manner, and further reality testing of behaviour and its effect on others can be explored.

Supportive therapy

Therapists must be willing to listen to the demands of suicidal patients, but these demands cannot be met unconditionally and the focus must be on the person accepting responsibility for his or her own

Table 3. Fundamentals of management

- Establish rapport
- Assess suicidal intent
- Assess mental state
- Ensure safety
- If no psychiatric illness:
  - catharsis
  - follow up
- If family/interpersonal issues:
  - catharsis
  - CBT/problem solving approach
  - possible referral to social worker or psychologist
- If psychiatric illness:
  - catharsis
  - standard treatment, i.e. CBT/ problem solving approach, with or without psychotropic medication
  - referral to psychiatrist if concerns about diagnosis, illness is severe or no response to initial management

actions. There is a fine line between fostering independence and appearing to reject those who are suicidal. The fostering of independence can be aided by the therapist making it quite clear to the patient that his or her involvement will be time-limited and then, at the end of that time, expressing confidence in the patient's ability to cope in a more adaptive manner when future crises arise, even though the person may not be completely at ease with himself or herself.

While this approach is appropriate for most suicidal patients, some – such as young parents with few family and social supports and patients with borderline personalities and chronic psychiatric illness – will require longer term treatment and continuing support from the GP or social agencies.

Pharmacotherapy

There is always concern about prescribing drugs to patients who are suicidal because they might be used in a suicide attempt. However, antidepressant, antianxiety or antipsychotic medications may be prescribed when the signs and symptoms of psychiatric illness warrant their use.

The most commonly prescribed medications are antidepressants. These are particularly useful for patients with the classic biological features of depression, including agitation, poor concentration, insomnia and weight loss.

There has been concern about reports of suicidal behaviour being precipitated by the newer antidepressants. However, recent comprehensive reviews have indicated that there is no adverse association with suicidal ideation or suicide, although there is a weak association (about one in 700 patients) with nonfatal deliberate self-harm, which needs to be balanced with the potential benefits of treating and also the risks of not treating those who are suicidal. It is also apparent that this association is not specific to the newer antidepressants, with similar effects being found with tricyclic antidepressants. The jury is still out as to whether this is an idiosyncratic response or whether it is related to the natural history of improvement from depression, as it has been observed for almost 200 years that the risk of suicidal behaviour persists during early convalescence.

When antidepressants are used, it is imperative that an adequate dose be prescribed. It is also essential to be aware of the potential risk of suicide and the toxicity of the antidepressant used. Newer antidepressants should be prescribed because they are less toxic in overdose. It is also important that the duration of treatment is adequate. Antidepressants should be used for four to six months in patients with a first episode of major depression, for 18 to 24 months in those with a second episode, and long term on a maintenance basis in those who have had three or more episodes.

If compliance is an issue, consideration should be given to using treatment or Guardianship Board orders appropriate to the local community. By the time such approaches are necessary, community mental health workers are likely to be involved. However, it is still important for each patient to have a GP who co-ordinates overall management, particularly in this era of deinstitutionalisation. The GP is in a good position to provide continuity of care, which seems to be at a premium in some public health systems.

Conclusion

GPs should not feel obliged to continue the management of patients who are suicidal. However, they should all possess the clinical skills to make a general assessment and management plan, albeit with referral to a colleague with a specific interest in psychosocial conditions or to a psychologist or psychiatrist. Whereas in the past there was a sense of pessimism about our capacity to prevent suicidal behaviour, now there is sound evidence for the effectiveness of standard treatments for psychiatric conditions that are antecedents of suicidal behaviour.

There has been a reduction in the total number of suicides in Australia over the years 1997 to 2003 and there is no reason to think that it cannot be reduced further, primarily by improved general practice care. MT

References

1. Australian Bureau of Statistics. Suicides: recent trends, Australia 1993 to 2003. Canberra: Commonwealth Government; 2004

Further reading

Goldney R.D. Suicide prevention: a pragmatic review of recent studies. Crisis 2005; 26: 128-140.

DECLARATION OF INTEREST: Professor Goldney has received research funding and has accepted honoraria for participating in educational programs from several pharmaceutical companies.

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