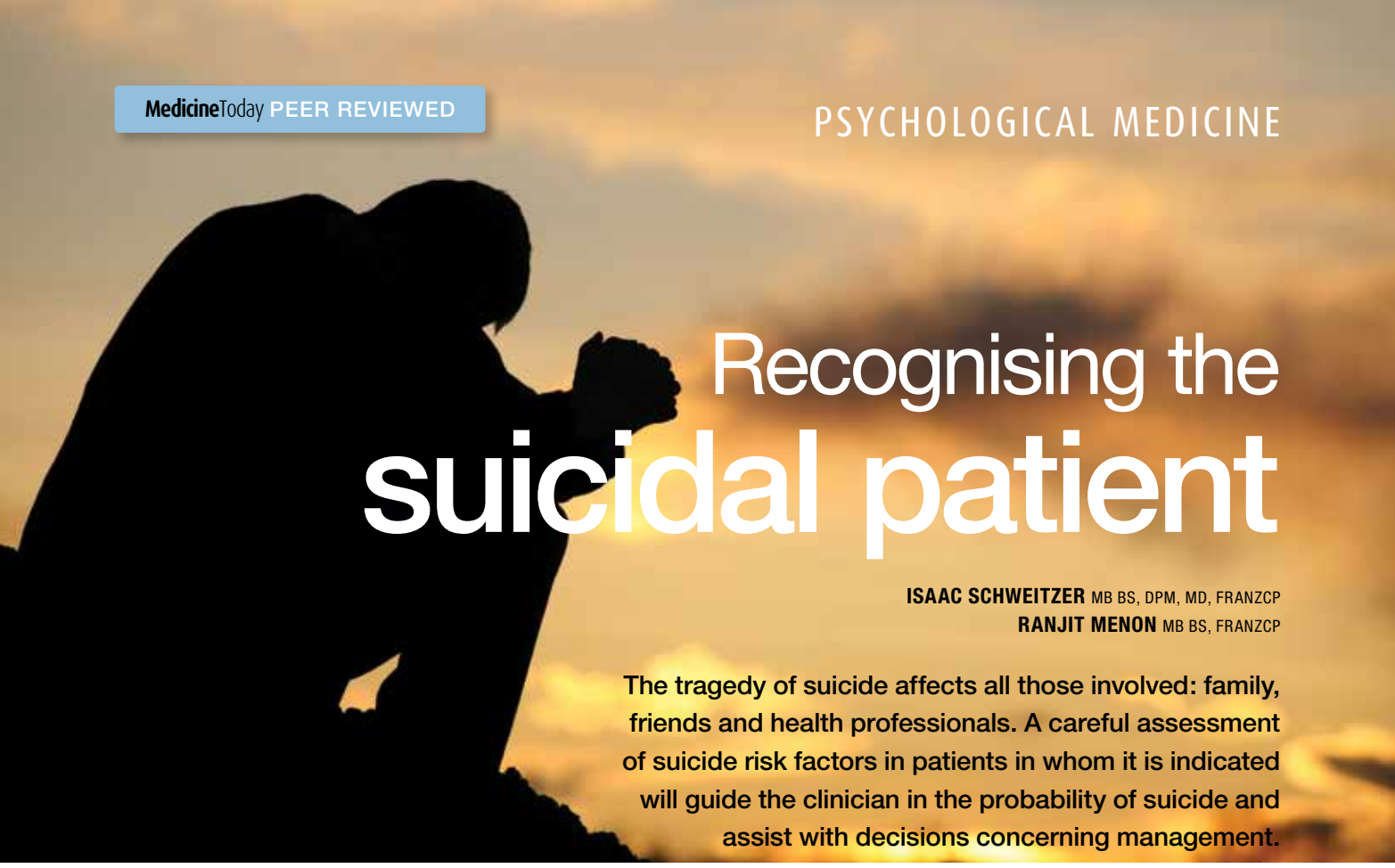

Recognising the suicidal patient

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The tragedy of suicide affects all those involved: family, friends and health professionals. A careful assessment of suicide risk factors in patients in whom it is indicated will guide the clinician in the probability of suicide and assist with decisions concerning management.

From this world-wearied flesh. Eyes, look your last!
Arms, take your last embrace! and, lips, O you
The doors of breath, seal with a righteous kiss
A dateless bargain to engrossing death!
…
Here's to my love!
O true apothecary!
Thy drugs are quick. Thus with a kiss I die.

William Shakespeare
Romeo and Juliet, Act V, Scene 3

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Literature's most famous portrayal of suicide is depicted in William Shakespeare's play *Romeo and Juliet*, in which the suicide of two young lovers is both romanticised and ennobled. The risk is that such behaviour may be viewed by those who are vulnerable as an appealing option when faced with seemingly insurmountable obstacles. In 2010, suicide was the 15th leading cause of death in Australia, accounting for 1.7% of all deaths.[1] Suicide occurs in all age groups, but among the young it is the second most common cause of death, following road trauma.[2]

THE TRAGEDY OF SUICIDE

When suicide occurs, it is invariably a tragedy that affects all those who are close to the victim. Clinicians may endure a variety of emotions, including grief, self-recrimination, guilt, anger and remorse. They may ask themselves: What else could have been done and should have been done? Did I miss something?

CAN SUICIDE BE PREVENTED?

Psychological autopsies (studies involving in-depth analysis of the antecedents of suicide) have found that in about 90% of cases there is an underlying mental health problem.[3] About 50% of individuals have seen a medical practitioner in the four weeks prior to their suicide. Not all suicides can be prevented, but there is strong evidence that accurately diagnosing and appropriately treating underlying psychiatric pathology may reduce the likelihood of suicide.[4] Careful screening and supportive assessment are crucial.

Predicting which individual will commit suicide is often an unreliable exercise, perhaps as accurate as predicting the weather or the economy. On occasion there may be clear and obvious signals, such as when an individual admits to a definite plan and has the means to carry it out. Clinicians need to evaluate their patients and their current psychosocial circumstances and make an assessment concerning the probability of suicide. This is always at best a skilled judgement, subject to all the constraints of human error, but one that is best made when it is informed as well as possible. There are situations that even the most astute clinician could not foresee. Some determined individuals are so secretive that there are no evident signs or clues. Some suicides occur suddenly without warning, such as when individuals under circumstances of acute stress and drug or alcohol intoxication impulsively end their lives. Nonetheless, all practitioners need to be able to complete a reasonably thorough risk assessment of their patients when indicated; such a practice alerts the practitioner to potential risk and the need for further treatment and possible referral.

If the assessment reveals clinically relevant psychiatric or psychological issues, management strategies should include provision of explanation and reassurance to the patient and family and, if appropriate, psychological or pharmacological treatment of underlying pathology. The intervention may involve scheduling further appointments or organising a referral to a psychiatrist or psychologist, or having the patient either referred to an emergency psychiatric service or admitted into a psychiatric unit. If a patient is identified as being a likely future risk but there is no imminent danger then review and referral to an appropriate mental health service is usually the best strategy.

WARNING SIGNS OF ACUTE SUICIDE RISK: 'IS PATH WARM?'*

- **I Ideation** – threatened or communicated
- **S Substance abuse** – excessive or increased
- **P Purposelessness** – no reasons for living
- **A Anxiety** – agitation/insomnia
- **T Trapped** – feeling there is no way out
- **H Hopelessness** – negativity about future
- **W Withdrawal** – from friends, family, society
- **A Anger** – rage, uncontrolled anger, seeking revenge
- **R Recklessness** – risky acts, impulsive
- **M Mood changes** – dramatic and rapid

* The 'IS PATH WARM?' mnemonic for warning signs of acute suicide risk was developed by a working group convened by the American Association of Suicidology in 2003.

PREDICTORS OF SUICIDE

Past behaviour is usually the best predictor of future acts and it is of crucial importance to critically evaluate previous history. It is essential to distinguish past actual suicide attempts from episodes of self-harm behaviour. In the former there may be a wish to die, even if it is only brief, whereas in the latter this is less common and usually an impulsive attempt to relieve tension, to draw blood or to experience pain. Some suicidal behaviour has been viewed as attention-seeking and referred to as 'para-suicidal'. It is important for all actual attempts at suicide to be evaluated for seriousness and risk; the lethality of attempts has a tendency to increase as the number of attempts increases.[5] A corroborative history (if it can be obtained) can be most informative.

The profile of the higher-risk patient is quite general and encompasses a huge number of individuals who visit the busy general practice. Therefore, in the first place, decisions will need to be made regarding which patients warrant a more comprehensive assessment. It is the sum of the parts, rather than each characteristic, that is most informative. As an initial approach, it may be useful for clinicians to think about risk in terms of internal risk factors (such as mental or physical illness, personality difficulties, substance abuse) and to then consider external risk issues for that individual (such as relationship break-up, financial hardship). The Tool for Assessment of Suicide Risk (TASR) is a useful checklist of key suicide risk factors and is available online (http://onlinelibrary.wiley.com/doi/10.1002/9781119953128.app1/pdf).[6] The 'IS PATH WARM?' mnemonic, a clinical tool used by the American Association of Suicidology for assessing risk, can also be useful (see the box on this page).

Men are more likely to suicide than women and, according to current statistics, young and elderly men are most at risk. In Australia, there is a particular risk of suicide in young rural men and young Indigenous men. Suicide risk is increased by the presence of a psychiatric disorder, such as major depression, bipolar disorder, schizophrenia, post-traumatic stress disorder, borderline personality disorder and substance abuse. A history of childhood abuse (physical or sexual), the presence of serious medical comorbidity and social isolation have been identified as contributing to overall risk. The presence of recent stressful life events, such as loss of employment, loss of accommodation, serious unexpected financial hardship and the breakdown of relationships may lead to an increase in suicidality. Severe or extreme emotional states, such as humiliation, despair, guilt and shame, may be followed by desperate behaviour.

Consideration should also be given to the presence of factors that tend to lessen the risk of suicide. Protective factors include good support from family and friends, certain religious beliefs, a sense of purpose in living (such as family responsibility), good coping and problem-solving skills, and a good therapeutic working alliance with a health professional.

It is important to be aware that although clinical risk assessment tools can be useful to identify some patients at risk they are not precise and have well-established deficiencies in accuracy, generating poor specificity and sensitivity in large samples.[7] They should be used judiciously and seen as another useful tool in the overall suite of approaches.

ASKING ABOUT SUICIDE

Many clinicians feel anxious when asking patients about suicide; they worry that their enquiry might precipitate suicidal behaviour. There is no evidence to support such concerns and in fact the opposite is true – discovering the presence of suicide risk provides an opportunity to institute an effective strategy. Assessment of suicide risk should be considered for any depressed patient who is presenting for the first time and when a patient reports a worsening of depressive symptoms or a failure to improve. It should also be considered for a patient who has recently experienced a major psychosocial stressor or a patient who is in an acute psychological crisis (such as following the breakdown of a relationship).

Asking about suicide can only be accomplished effectively after good rapport has been established; empathy and a nonjudgemental stance are key. It is helpful to begin with supportive statements and open-ended questions that are at first general and to then move sensitively toward specific areas.

Enquiries initially should refer to suicidal ideation. For example:

- Have you been thinking that life is not worth living?
- Do you feel as if you would be better off not here?
- Are there more reasons for living than there are for dying?
- Do you feel you would be better off dead?
- Are you thinking of dying much of the time?

The questions above demonstrate the progression of suicidal ideation from passive thoughts to more active ideation, which is considered an escalation of risk. The intensity and frequency of these thoughts should be assessed to inform the clinician about suicide risk. For example: Are these ideas intense? Are you able to control them? Are they overwhelming?

If suicidal ideation is present then it is important to ask specifically about suicide intent and plans:

- Have you been thinking of ways how you might take your own life?
- Do you have a plan? Can you tell me what you might do? Have you more or less put the plan in place? Have you considered when and where you would proceed?
- Do you have access to the means to end your life (firearms, medications or poison)?
- Have you done anything to prepare for your death (changed will or written a suicide note)?

The presence of intent and specific plans also show progression from stages of early planning to more advanced planning. The feasibility of these plans and their imminence should also be assessed carefully.

CONCLUSION

Although suicide may be viewed as potentially a preventable act, the sad truth is that not all suicides can be prevented. When a suicide has been averted, the clinician may not be made aware of the success of his or her interventions. Nonetheless, there is now a strong body of empirical evidence that appropriate and effective management of underlying psychiatric pathology, where it exists, reduces suicide risk. To prevent suicide, the clinician must be aware of the potential for it to occur, and this requires a careful risk assessment when suspicion of suicide risk arises. Despite the difficulties involved in this task, an empathic approach to patients who are distressed and enquiry about risk, where appropriate, have been acknowledged as useful strategies in identifying and managing risk. MT

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COMPETING INTERESTS: None.

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