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Suicide
M2 Psychiatry Sequence

Michael Jibson
Fall 2008

“The moment one inquires about the sense of value of life, one is sick.”

Sigmund Freud

Epidemiology

US Suicide Data (2004)

- Annual rate is 11.1 suicides per 100,000
- >32,000 deaths annually
- 15th leading cause of death overall
- 3rd leading cause of death at ages 10-24

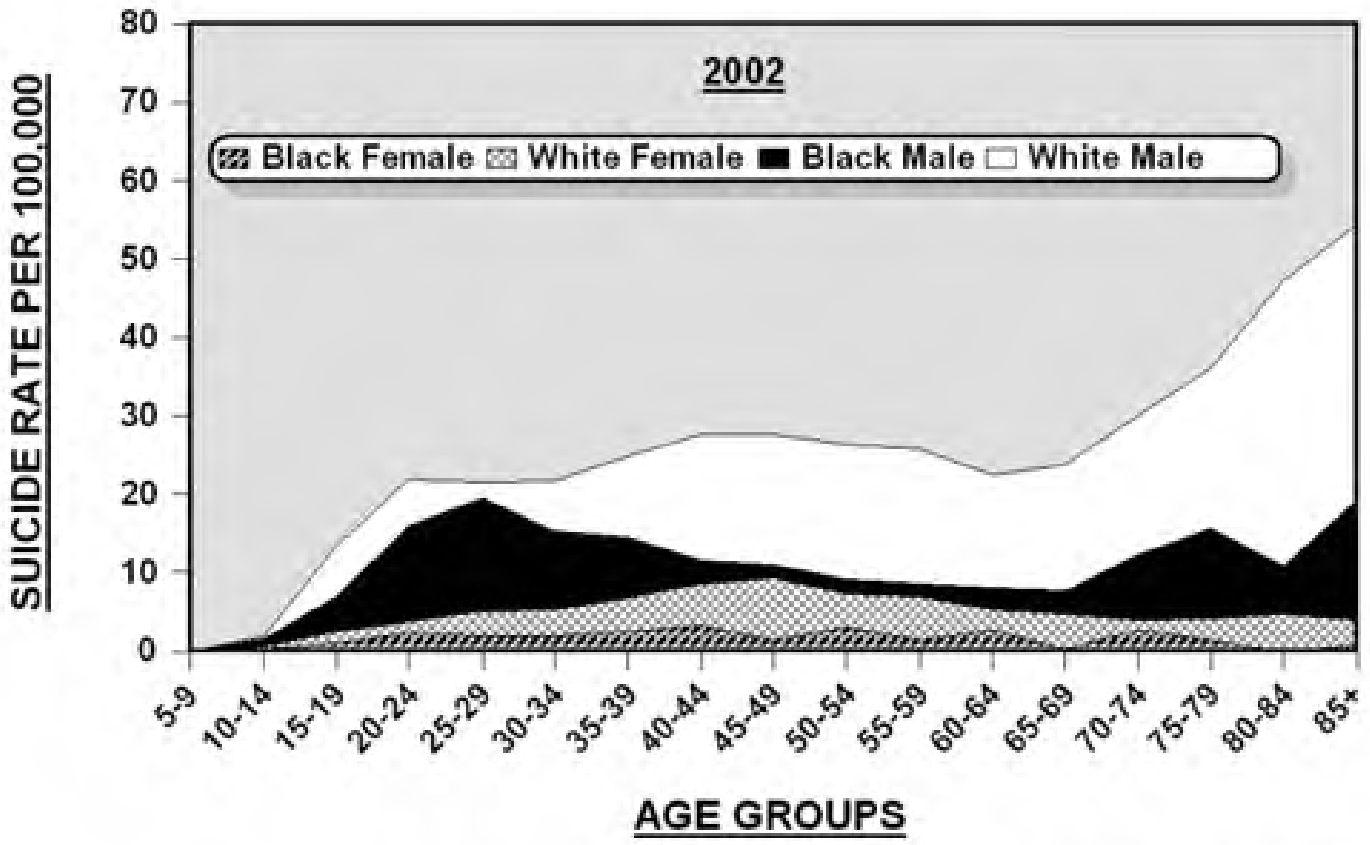
US Suicide Statistics (2004)

Group	Number	Rate (per 100,000)	% of Deaths
US Population	32,439	11.1	1.4
Male	25,566	17.7	2.2
Female	6,873	4.6	0.6
White	29,251	12.3	1.4
Black	2,019	5.2	0.7
Nonwhite	3,188	5.8	0.9
Elderly (>65 yrs)	5,198	14.3	0.3
Young (15-24 yrs)	4,316	10.4	12.9

US Suicide Statistics

Group	Number	Rate (per 100,000)
White Male	23,081	19.6
White Female	6,170	5.1
Black Male	1,655	9.0
Black Female	364	1.8
Nonwhite Male	2,485	9.3
Nonwhite Female	703	2.4

U.S. SUICIDE RATES BY AGE, GENDER, AND RACIAL GROUP



Source: National Institute of Mental Health
Data: Centers for Disease Control And Prevention, National Center For Health Statistics

Prevalence Rates for Subpopulations

- Age: Highest rates among elderly
- Gender: Men complete suicide 3-4x more often than women; however, women attempt suicide 3x more often than men
- Race: Whites have highest rate; African Americans the lowest
- Region: Highest rates in Mountain States (inc Alaska)

Prevalence Rates for Subpopulations

Profession

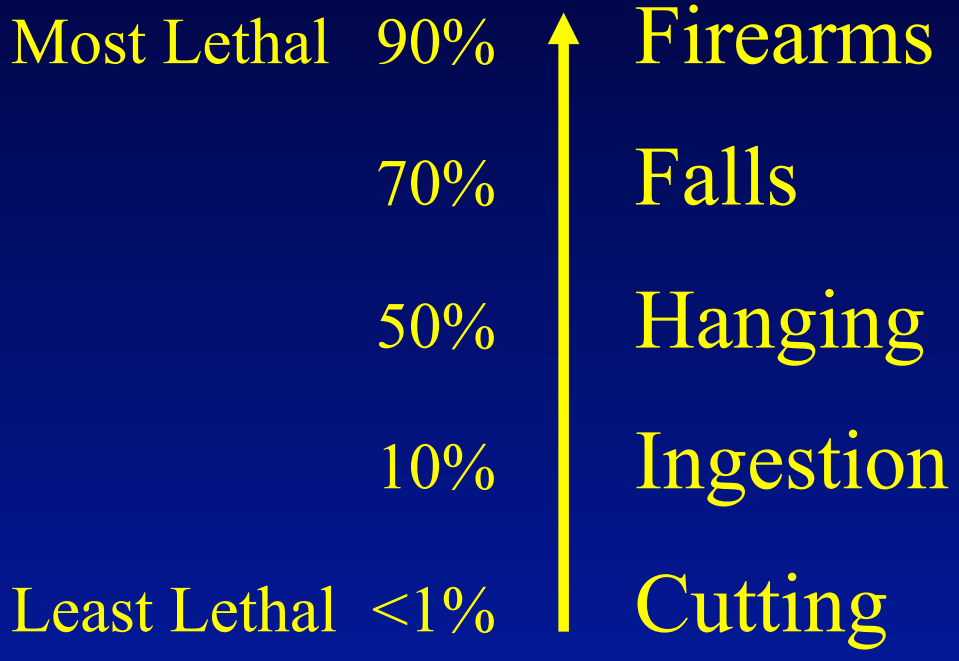
- Highest rates for professions that deal with death and violence, and that have access to lethal means
  - Physicians (men & women: 38/100,000)
  - Police officers
  - Military personnel

Methods for Subpopulations

Completed Suicides

- Firearms most common method for men and women in the U.S. (57%)
- Hanging second most common for men
- Toxic ingestion (poison, drug overdose) second most common for women

Lethality of Means



Recent Trends and their Public Health Implications

- Increases among young and women
- Increases in suicide by firearms

Suicide Rates for Various Nations

- U.S. has a moderate suicide rate relative to other nations
- Hungary has the highest rate; Finland, Denmark, Austria, Switzerland, France, Japan, Norway, among others, also have higher rates than the U.S.
- Italy, Ireland, England, Portugal, Spain, Israel, Greece, Venezuela, among others, have lower rates than the U.S.

Previous Attempt and Help Seeking Histories

- 30-40% of completers have attempted suicide before
- Nearly two-thirds of suicide completers communicated their suicidal intentions to others (including to health-care providers)
- Most suicide attempters are able to experience a reduction in suicidality and a return to full function

Clinical Risk Factors

Mental/Psychiatric Disorders

- Depression
- Alcohol/Drug Abuse
- Schizophrenia
- Other Psychiatric Disorder

Depression

- >50% clinically depressed at time of suicide
- Nearly 15% of persons with significant mood disorders will commit suicide
- Depression is genetically predisposed, and there is a strong link between depression and suicide
- Suicide can occur in all phases of depressive episode
- Risk may be highest during early recovery phase

Alcoholism/Drug Abuse

- Nearly one-third of suicides occur in persons with chronic alcoholism
- 2-4% of chronic alcoholic patients commit suicide
- Positive blood alcohol levels are found in 30-40% of suicides

Schizophrenia

- 5-10% of schizophrenic patients commit suicide
- In general population studies, schizophrenia accounts for 5% of suicides

Other Disorders

- Other mental disorders increase risk to 5-10%
- Serious physical illness increases risk

Social Isolation/ Interpersonal Loss or Conflict

- Among alcoholics who commit suicide, 50% have a history of interpersonal loss within previous year
- Suicide more common among divorced, widowed, and single/never married than among married

Social Isolation/ Interpersonal Loss or Conflict

- Among adolescents & young adults, interpersonal conflict and disciplinary or legal problems often precipitate suicide
  - Break-up with boyfriend or girlfriend
- Hopelessness regarding a dilemma, especially with the prospect of public humiliation
  - Failing class but don't dare drop out
  - Sexual impropriety about to come to light

Suicidal Indices

Suicidal Ideation

- Passive – no plan or intent
  - I wish I were dead
  - I wish I could just go to sleep and not wake up
- Active –specific plan and intent to act
  - Intrusive and obsessional vs
  - Researched and thought out

Suicide Indices

- History of attempts (esp if highly lethal)
  - Highest predictive value in past 2 months
  - Suicide rehearsals or preparation
    - Counting pills
    - Holding gun
    - Checking out high places

Suicide Indices

- Final arrangements
  - Will
  - Suicide note
  - Giving away possessions

Current Mental Status

- Hopelessness
- Acute agitation
- Intoxication
- Psychosis (especially with command hallucinations or delusions)

Summary of Risk Factors

Demographic	Psychiatric	Mental Status	Other
Older	Depression	Suicidal ideation	Medical Illness
White	Substance abuse	Hopeless	Recent losses
Male	Psychosis	Agitated	Intractable dilemma
Living alone	Other psychiatric disorders	Command hallucinations or delusions	Prospect of public humiliation
Not working			

Availability and Lethality of the Means	Firearms>Falls>Hanging>Ingestion>Cutting

Clinical Assessments/Interventions

General Principles of Intervention

- Recognize the "cry for help" or the expressed suicidal ideation/intent
- Ask questions in an objective, straightforward, nonjudgmental manner
- Assess depression, substance abuse, impulsivity, and psychosis
- Ask specifically about availability of firearms

Clinical Assessments/Interventions

General Principles of Intervention

- Do not alienate the patient with sarcasm, ridicule, or disbelief
- Do not minimize their perceived problems
- Talk calmly and openly about problems
- Convey a sense of hope; counteract hopelessness

Clinical Assessments/Interventions

General Principles of Intervention

- Always seek corroborative information
  - Family and friends
  - Outpatient mental health providers
- Ask the tough questions that need to be asked
  - What will keep this from happening again?
  - What is be different now?

Clinical Assessments/Interventions

Clinical Decision Making

- Gather as much information as possible
- Carefully assess the risk and protective factors
- Discuss the case with another clinician
- Establish limit-setting on self-destructive behavior

Clinical Assessments/Interventions

Clinical Decision Making

- Assess and discuss reasons for living
- Involve family or friends whenever possible
- Convey knowledge that depression (or other treatable condition that is present) is treatable

Clinical Assessments/Interventions

- Hospitalize if:
  - An attempt is clinically serious
  - Risk factors suggest high risk
  - There is no established outpatient care
  - There is a discrepancy between the patient's story and other information

Clinical Assessments/Interventions

- Consider outpatient care if:
  - Risk is relatively low
  - Stressors can be immediately addressed
  - The patient already has a mental health provider
  - Other safeguards can be implemented (eg, family support)
  - Suicide threats or attempts are repeatedly used to communicate distress or manipulate others

Myths

- People who talk about suicide won't commit suicide
- People who want to commit suicide won’t tell you
- Suicide happens without any warning
- All suicidal persons are "insane"
- Suicide stems from a single mental disorder
- Asking about suicide "plants" the idea in the patient's mind

Additional Source Information

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Slide 6: State of Connecticut Department of Mental Health and Addiction Services, http://www.ct.gov/dmhas/lib/dmhas/prevention/cyspi/AAS2004data.pdf
Slide 7: State of Connecticut Department of Mental Health and Addiction Services, http://www.ct.gov/dmhas/lib/dmhas/prevention/cyspi/AAS2004data.pdf
Slide 8: National Institute of Mental Health, http://www.nimh.nih.gov/index.shtml
Slide 12: Michael Jibson
Slide 27: Michael Jibson