Management of Suicidal Attempt

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Suicide is a significant public health problem worldwide. Based on available data, globally suicide is believed to account for an average of 10-15 deaths for every 100,000 persons each year.[1] Approximately 0.9 percent of all deaths are the result of suicide, and each day worldwide about 1,000 persons are estimated to commit suicide.[2]

Risk factors

Clinicians indicated some factors to predict suicidal risk such as race, religion, marital status, occupation, mental disorder etc., as shown in Table 1.[3] Unfortunately, clinicians cannot predict who will or who will not commit suicide by these factors, they only help the clinicians to identify those who are more or less likely to have a committed suicide in the near future.

However, some risk factors, such as depression, history of previous suicide attempt, have a positive relation with high risk suicide. Studies show that about 40 percent of depressed patients and up to 50 percent of those who die by suicide have made at least one previous suicide attempt.[4,5]

Suicide attempts are 10-20 times more prevalent than suicide; attempted suicide rates vary between 100-300 per 100,000. Factors that relate to attempted suicide are female in all countries; under 30 years of age (about 50 percent of attempters), divorced persons, lower social classes, and a diagnosis of depression (between 35 to 79 percent of cases). Females aged 15 to 19 years and males aged 25 to 29 have the highest rate of suicide attempts.[7] A past suicide attempt is perhaps the best indicator that a patient is at increased risk of suicide in the near future.

Significance of the problem in emergency setting

Self-destructive or suicidal behaviors are seen among people of every age, sex, race, religion, and economic and social class. Attempted suicide patients are typically brought to the emergency room by others under conditions of acute and volitional threat to life, some with medical and surgical conditions. Clinicians have to manage emergency medical and surgical conditions and prepare for the immediate tasks of assessing possible repeated self-harm behavior while concurrently protecting against that possibility. To make the situation more complicated, suicidal people tend to defy the health professional's expectation that fostering and maintaining life is a shared goal of patient and doctor.[8] These quali-

TABLE 1. Variables enhancing risk of suicide among vulnerable groups.

Variables enhancing risk of suicide among vulnerable groups
Adolescence and late life
Bisexual or homosexual gender identity
Criminal behavior
Cultural sanctions for suicide
Delusions
Disposition of personal property
Divorced, separated, or single marital status
Early loss or separation from parents
Family history of suicide
Hallucinations
Homicide
Hopelessness
Hypochondriasis
Impulsivity
Increasing agitation
Increasing stress
Insomnia
Lack of future plans
Lack of sleep
Lethality of previous attempt
Living alone
Low self-esteem
Male sex
Physical illness or impairment
Previous attempts that could have resulted in death
Protestant or nonreligious status
Recent childbirth
Recent loss
Repression as a defense
Secondary gain
Severe family pathology
Severe psychiatric illness
Sexual abuse
Signals of intent to die
Suicide epidemics
Unemployment
White race

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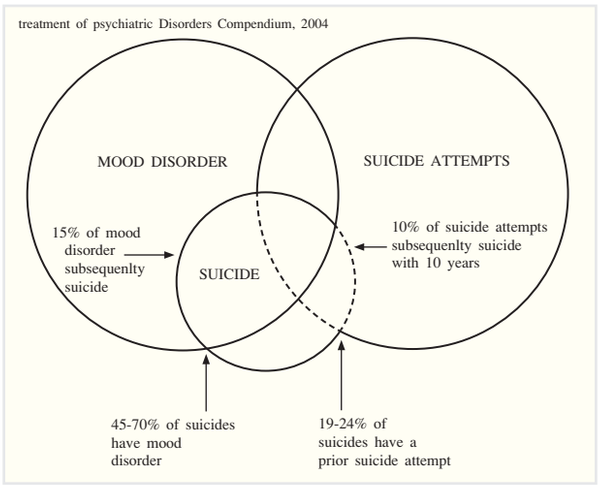


Fig 1. Venn diagram summarizing suicide data and its relation to mood disorder and suicideattempts.[6]

(From Sadock BJ, Sadock VA. Kaplan & Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry, 10th ed. Lippincott, Williams & Wilkins, 2007.)

ties bring tension and instability to (and potentially impede) the necessary working alliance with the health-care team.[9]

In-patient versus out-patient setting

After stabilizing the attempter's medical condition, clinicians have to evaluate and assess an individual patient's risk to re-attempt suicide on the basis of a clinical examination. Whether to hospitalize patients with suicidal intention is the most important clinical decision to be made. Not all such patients require hospitalization; some can be treated on an outpatient basis. However, in the absence of a strong social support system, a history of impulsive behavior, and a suicidal plan of action are indications for hospitalization. Suicide is grouped into high-risk-related and low-risk-related factors so that the clinicians can decide the disposition of the patients and work with them in the appropriate setting.

The American Psychiatric Association suggested recommendations for selecting a treatment setting for suicidal patients. The clinician can use it as a guideline. However, it depends on his clinical judgment which setting is safe and appropriate for management.

How to work with suicidal patients

The typical context of suicide risk assessment is replete with strong emotional reactions on the part of both the client and the clinician, is time limited and highly structured by the clinician, and is focused on a more narrow range of topics viewed by the clinician as relevant to assessing risk and providing interventions.

TABLE 2. Evaluation of suicidal risk[10]

Evaluation of suicide risk		
Variables	**High risk**	**Low risk**
Age	Over 45 years	Below 45 years
Sex	Male	Female
Marital status	Divorced or widowed	Married
Employment	Unemployed	Employed
Interpersonal relationship	Conflictual	Stable
Family background	Chaotic or conflictual	Stable
Health		
Physical	Chronic illness	Good health
	Hypochondriac	Feels healthy
	Excessive substance intake	Low substance use
Mental	Severe depression	Mild depression
	Psychosis	Neurosis
	Severe personality disorder	Normal personality
	Substance abuse	Social drinker
	Hopelessness	Optimism
Suicidal activity		
Suicidal ideation	Frequent, intense, prolonged	Infrequent, low intensity, transient
Suicide attempt	Multiple attempts	First attempt
	Planned	Impulsive
	Rescue unlikely	Rescue inevitable
	Unambiguous wish to die	Primary wish for change
	Communication internalized (self-blame)	Communication externalized (anger)
	Method lethal and available	Method of low lethality or not readily available
Resources		
Personal	Poor achievement	Good achievement
Social	Poor insight	Insightful
	Affect unavailable or poorly controlled	Affect available and appropriately controlled
	Poor rapport	Good rapport
	Socially isolated	Socially integrated
	Unresponsive family	Concerned family

(From Adam K. Attempted suicide. Psychiatr Clin North Am 1985;8:183.)

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This is a scenario not particularly conducive to effective and open communication. Michel et al[12] and Shea[13,14] have presented arguments related to the tendency of clinicians working with suicidal clients to minimize attention to the therapeutic relationship. They have suggested that a strong therapeutic relationship is a prerequisite for communication about suicidal intent, while the primary obstacle to collecting reliable and valid information via the clinical interview is low engagement on the part of the client in the interview process. Therefore, the recommendations made by them to improve the quality of the information gathered through the clinical interview are also relevant to enhancing the reliability and validity of data collected through suicide assessment measures.

Conceptualizing suicide

To work with patients effectively, clinicians need to understand the characteristics of suicide.[15] These understandings can provide the structure for the essential interventions.

1. Suicide is viewed as an *alternative*, a solution to a problem or a feeling of intense emotional pain that the client feels is not resolvable by any other means.

2. A person who is thinking about suicide is in *crisis*. The crisis state is characterized by cognitive constriction or tunnel thinking.

3. The thinking of most suicidal clients is characterized by *ambivalence*, and many clients have the awareness that two feelings exist simultaneously: the wish to live versus the wish to die or escape.

TABLE 3. Guidelines for selecting a treatment setting for patients at risk for suicide or suicidal behaviors.[11]

Guidelines for Selecting a Treatment Setting for Patients at Risk for Suicide or Suicidal Behaviors
Admission generally indicated: high risk of suicide
After a suicide attempt or aborted suicide attempt if:
Patient is psychotic
Attempt was violent, near-lethal, or premediated
Precautions were taken to avoid rescue or discovery
Persistent plan and/or intent is present
Distress is increased or patient regrets surviving
Patient is male, >45 years of age, especially with new onset of psychiatric illness or suicidal thinking
Patient has limited family and/or social support, including lack of stable living situation
Current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident
Patient has change in mental status with a metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting
In the presence of suicidal ideation with:
Specific plan with high lethality
High suicidal intent
Admission may be necessary: moderate risk of suicide
After a suicide attempt or aborted suicide attempt, except in circumstances for which admission is generally indicated in the presence of suicidal ideation with:
Psychosis
Major psychiatric disorder
Past attempts, particularly if medically serious
Possibly contributing medical condition (e.g., acute neurological disorder, cancer, infection)
Lack of response to or inability to cooperate with partial hospital or outpatient treatment
Need for supervised setting for medication trial or electroconvulsive therapy
Need for skilled observation, clinical tests, or diagnostic assessments that require a structured setting
Limited family and/or social support, including lack of stable living situation
Lack of an ongoing clinician-patient relationship or lack of access to timely outpatient follow-up
In the absence of suicide attempts or reported suicidal ideation/plan/intent but evidence from the psychiatric evaluation and or history from others suggests a high level of suicide risk and a recent acute increase in risk
Release from emergency department with follow-up recommendations may be possible: lesser risk
After a suicide attempt or in the presence of suicidal ideation/plan when:
Suicidality is a reaction to precipitating events (e.g., exam failure, relationship difficulties), particularly if the patient's view of situation has changed since coming to emergency department
Plan/method and intent have low lethality
Patient has stable and supportive living situation
Patient is able to cooperate with recommendations for follow-up, with theater contacted, if possible, if patient is currently in treatment
Outpatient treatment may be more beneficial than hospitalization: lesser risk of suicide
Patient has chronic suicidal ideation and/or self-injury without prior medically serious attempts, if a safe and supportive living situation is available and outpatient psychiatric care is ongoing

(From Practice Guidelines for Assessment and Treatment of the Suicidal Patient, 2nd ed. The American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders Compendium, 2004)

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4. There is an *irrational* quality to suicidal thinking. When asked what they think will happen when they die, many suicidal people will relate, with some degree of righteous satisfaction, the details of their funerals or what they expect to happen in their honor after they die.

5. Suicide is an act of *communication.* If we see suicidal behavior as an attempt to *act* on unbearable psychic pain, we can appreciate that the client's ability to *talk about* that pain has vanished.

The suicidal crisis is caused by a unique synergy of intrapersonal, interpersonal, environmental, social, and situational variables. Motto[16] suggested a step-by-step progression to a series of cognitive steps, which allow a person to gradually think of suicide as an acceptable means for dealing with pain. For example, a person must: 1) Be faced with a problem that is perceived as unsolvable, 2) View the problem as continuing despite his or her best efforts to solve it, 3) See suicide as the only solution, 4) Conceptualize suicide as ego-syntonic, 5) Disregard all other problem-solving options, 6) Believe death will bring relief. If the clinician can handle and change their cognition by the crisis intervention and counseling to see the solution and establish a working alliance with them, the suicide crisis can be overcome.

CONCLUSION

In general practice, clinicians must be prepared to face a range of potential suicidal crisis situations. Effective intervention and treatment of suicidal people always begins with a thorough assessment and subsequent interventions based on that assessment. By using crisis model to understand patients' cognition during crisis will help clinician to work with them effectively.

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