Management of suicide attempts

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Suicide is ranked as the ninth overall cause of death in the United States. Whether a true suicide or parasuicide attempt, it remains a psychiatric emergency for which each clinician needs an appropriate management strategy.
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Summary
Suicide refers to the act, or absence of a preventative act, that is utilised by a person who has decided to end their own life. The true incidence of suicide and suicide attempts is estimated to be much higher than reported figures. This is due to intentional misclassification in reporting the cause of death, accidents of undetermined cause as well as non-reporting of attempts; most probably because of the ongoing stigma attached to suicidal behaviour.

It is important to differentiate between a true suicide attempt and a parasuicide attempt.

A true suicide attempt originates from an intense desire to end one's life. The individual is unable to foresee a future change in unsatisfactory circumstances, or a change in terms of the hopelessness and unending stress currently being experienced. Death becomes egosyntonic; a welcome outcome.

On the other hand, a parasuicide attempt is associated with a fear of death, and not a desire for death at all. The individual is impulsively attracted to the escape or release the act will bring. Death is egodystonic, but perceived as the only way out.

A number of risk factors have been shown to be associated with successful suicide in adults; these include male gender, age (45 or older), unemployment, prior psychiatric illness, socio-economic loss, substance dependence and living alone. However it is important to realise that the absence of these criteria does not imply that an attempt is less serious and that both true and parasuicide attempts can lead to death.

An appropriate management strategy for failed suicide attempts is vital and the ultimate hope is that the person in crisis will emerge with new insights, skills and improved stress management skills.

Management

All patients who present with suicide attempts deserve a thorough evaluation. Immediate physical care is the first step followed by the rest of the evaluation as soon as possible but preferably within 48 hours (unless the patient's physical condition prohibits this).

This evaluation constitutes a full psychiatric history and a thorough mental state examination with particular attention being paid to the suicide risk assessment.

Important signs, symptoms and elements of history need to be elicited as they point to ongoing suicide risk include:

1. Male, >45, single, unemployed, conflictual interpersonal relationships.
2. Chronic physical illness.
3. Psychiatric diagnosis, e.g. psychosis, severe depression, severe personality disorder.
4. Substance dependence.
5. Availability of means of suicide, ongoing verbalised suicidal ideation, previous attempts, family history of suicide, preparation of a will or "last" letters to loved ones.
6. Unsupportive family, socially isolated.

It is also imperative that the problem (motivation for suicide attempt) is clearly defined – questions that need to be answered are:

1. How did the problem develop?
2. What factors are maintaining it?
3. What attempts have been made to solve it?
4. What is the road ahead (future strategies)?

At the end of this evaluation the clinician should therefore be able to make a full DSM-IV five axis diagnosis (I – Psychiatric diagnosis; II – Personality or Developmental diagnosis; III – Medical conditions; IV Psychosocial stressors; V – Premorbid functioning during the previous year). This is essential because it gives the clinician a clear indication of the patient's current distress, motivation

for suicidal behaviour, ability to cope with stress and which factors are present that maintain or aggravate the ongoing distress.

Once this information has been garnered the clinician is able to make an informed decision regarding the management of the patient. Whether to hospitalise a patient after a suicide attempt could be regarded as the most important immediate clinical decision that needs to be made.

Admission to an appropriate facility is recommended if the patient:

1. Requires ongoing medical attention.
2. Is still incapacitated or temporarily emotionally and cognitively "paralysed".
3. Has a psychiatric illness (e.g. major depressive disorder).
4. Has to be temporarily removed from overwhelming pressure.
5. Is subjected to ongoing crisis and therefore constitutes a suicide risk.
6. Has not yet been fully evaluated.

Discharge with or without follow-up is recommended:

1. When crisis management has been completed and growth has taken place.
2. In the presence of an ongoing crisis but where the patient is emotionally and cognitively able to cope and social support is good, an action plan for the future has been agreed upon and where necessary a suicide contract has been agreed upon. Such a contract must always make provision for a follow-up intervention.

Admission would not be indicated in the case where a patient exhibits willful manipulative behaviour and threats, without acknowledgement of own responsibility. To manipulate the environment on behalf of the patient only reinforces further incorrect dysfunctional behaviour. The patient should rather be helped to mobilise their own resources e.g. referral to social services.

Once a patient is admitted appropriate treatment should be commenced immediately. These include management of ongoing medical problems, psychopharmacotherapy or referral to other services e.g. psychiatry, psychology or social work. Always remember that a patient who poses an ongoing suicide risk (especially in conjunction with psychiatric illness) continues to do so in spite of hospitalisation. Ideally such patients need rooms located near the nursing station in order to maximise observation by nursing staff. Every therapist should be able to do basic crisis intervention and problem solving with the patient.

Where a decision is made to discharge and continue treatment on an outpatient basis, the necessary follow-up arrangements need to be made before discharge. A patient with whom a suicide contract is closed, needs to have 24-hour access to follow-up services in a manner that has been clearly agreed upon with the patient. Possible follow-up arrangements include outpatient appointments with the primary clinician or referral to psychiatry, psychology, social work or community support services.

In an ideal situation primary prevention of suicide, in other words attempting to reduce known population risk factors, e.g. alcoholism, availability of firearms, social isolation, etc. as well as broad interventions early in suicidal pathways, would be the norm. However such prevention often does not truly exist and we have to settle for secondary (treatment of suicidal individuals) and tertiary (management of suicide attempts) prevention. The primary clinician is most often involved in tertiary prevention thus underscoring the importance of having an appropriate, implementable strategy for the management of suicide attempts.

References

1. Kleespies PM and Dettmer EL. An evidence-based approach to evaluating and managing suicidal emergencies. *Journal of Clinical Psychology* 2000 Sep; 56(9): 1109-30.
2. Maris RW. Suicide. *Lancet*, 2002; 360(9329): 319-27.

Note:

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