Crisis Intervention and Suicidal Patients

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Suicide

• “self-murder”

• >30,000 persons commit suicide each year in the US

• >600,000 suicide attempts

• Nevada has the highest rates of suicide for men and women

• suicide is impossible to predict precisely

• almost always the result of a mental illness
Prediction

- High-risk characteristics include more than 45 years of age, male gender, alcohol dependence, Violent behavior, previous suicidal behavior, previous psychiatric hospitalization

- Asking depressed patients whether or not they have had thoughts of wanting to kill themselves does not plant the seed of suicide

- Also rare, some patients lie to the psychiatrist about their suicidal intent

- Most suicides among psychiatric patients are preventable because evidence indicates that inadequate assessment or treatment is often associated with suicide
• However:
  • The statistical rarity of suicide makes it impossible to predict on the basis of risk factors either alone or in combination
  • Knowledge of risk factors will not permit the psychiatrist to predict when or if a specific patient will die by suicide
  • This does not mean that the psychiatrist should ignore risk factors or view suicidal patients as untreatable
  • Primary and ongoing goal is to reduce suicide risk
Characteristics Evaluated in the Psychiatric Assessment of Patients With Suicidal Behavior
Current Presentation of Suicidality

- Suicidal or self-harming thoughts, plans, behaviors, and intent

- Specific methods considered for suicide, including their lethality and the patient’s expectation about lethality, as well as whether firearms are accessible

- Evidence of hopelessness, impulsiveness, anhedonia, panic attacks, or anxiety

- Reasons for living and plans for the future

- Alcohol or other substance use associated with the current presentation

- Thoughts, plans, or intentions of violence toward others
Psychiatric Illnesses

• Current signs and symptoms of psychiatric disorders with particular attention to mood disorders (primarily major depressive disorder or mixed episodes), schizophrenia, substance use disorders, anxiety disorders, and personality disorders (primarily borderline and antisocial personality disorders)

• Previous psychiatric diagnoses and treatments, including illness onset and course and psychiatric hospitalizations, as well as treatment for substance use disorders
History

- Previous suicide attempts, aborted suicide attempts, or other self-harming behaviors

- Previous or current medical diagnoses and treatments, including surgeries or hospitalizations

- Family history of suicide or suicide attempts or a family history of mental illness, including substance abuse
Psychosocial Situation

- Acute psychosocial crises and chronic psychosocial stressors, which may include actual or perceived interpersonal losses, financial difficulties or changes in socioeconomic status, family discord, domestic violence, and past or current sexual or physical abuse or neglect

- Employment status, living situation (including whether or not there are infants or children in the home), and presence or absence of external supports

- Family constellation and quality of family relationships

- Cultural or religious beliefs about death or suicide
Individual Strengths and Vulnerabilities

- Coping skills
- Personality traits
- Past responses to stress
- Capacity for reality testing
- Ability to tolerate psychological pain and satisfy psychological needs
Once factors are identified, the psychiatrist can determine if they are modifiable.

Past history, family history, and demographic characteristics are examples of nonmodifiable factors.

Financial difficulties or unemployment can also be difficult to modify, at least in the short term.

To decrease a patient’s suicide risk, the treatment should attempt to mitigate or strengthen those risk and protective factors that can be modified.
Treatment

- Whether to hospitalize patients with suicidal ideation is the most important clinical decision to be made

- Not all such patients require hospitalization

- Indications for hospitalization
  - Absence of a strong social support system, history of impulsive behavior, a suicidal plan of action

- Hospitalization, by itself, is not a treatment
• In treating suicidal patients, particularly those with severe or recurring suicidality or self-injurious behavior, the psychiatrist should be aware of his or her own emotions and reactions that may interfere with the patient’s care

• For difficult-to-treat patients, consultation or supervision from a colleague may help
• Suicide prevention contract, or “no-harm contract,” is commonly used in clinical practice but should not be considered as a substitute for a careful clinical assessment

• A patient’s willingness (or reluctance) to enter into an oral or a written suicide prevention contract should not be viewed as an absolute indicator of suitability for discharge (or hospitalization)
Somatic Interventions

- Antidepressants
  - Evidence for a lowering of suicide rates with antidepressant treatment is inconclusive
  - However, the documented efficacy of antidepressants in treating acute depressive episodes and anxiety support their use
  - Select an antidepressant with a low risk of lethality on acute overdose, such as a SSRI or other newer antidepressant, and to prescribe conservative quantities
• Lithium

• Associated with major reductions in the risk of both suicide and suicide attempts in bipolar disorder

• Moderate evidence for similar risk reductions in patients with recurrent major depressive disorder

• Potential toxicity of lithium in overdose
• Clozapine
  • Associated with significant decreases in rates of suicide attempts/suicide in schizophrenia and schizoaffective disorder

• ECT
  • No evidence of a long-term reduction of suicide risk
Psychosocial Interventions

- Interpersonal psychotherapy and cognitive behavior therapy
  - Effective in clinical trials for the treatment of depression.

- Psychodynamic therapy and dialectical behavior therapy
  - May be appropriate treatments for suicidal behaviors because modest evidence has shown these therapies to be associated with decreased self-injurious behaviors, including suicide attempts, in borderline personality disorder

- Therefore, psychotherapies may be considered appropriate treatments for suicidal behavior, particularly when it occurs in the context of depression
Chronic Suicidality

- Seen often in context of borderline personality disorder (BPD)
- May be maladaptive interpersonal mode of relating to others or of securing emotional needs
- Requires long term intervention
  - To restructure the interpersonal meaning of such behavior and shift the patient to healthier modes of relating to others
  - To develop improved way to manage overwhelming affects
Indications for Level of Care

- This list is not intended to be exhaustive

- Since indications for level of care are difficult to empirically investigate and studies are lacking, these recommendations are derived primarily from expert clinical opinion.
Indications for partial hospitalization include the following:

- Dangerous, impulsive behavior unable to be managed with outpatient treatment
- Nonadherence with outpatient treatment and a deteriorating clinical picture
- Complex comorbidity that requires more intensive clinical assessment of response to treatment
- Symptoms of sufficient severity to interfere with functioning, work, or family life that are unresponsive to outpatient treatment
Indications for brief inpatient hospitalization include the following:

- Imminent danger to others
- Loss of control of suicidal impulses or serious suicide attempt
- Transient psychotic episodes associated with loss of impulse control or impaired judgment
- Symptoms of sufficient severity to interfere with functioning, work, or family life that are unresponsive to outpatient treatment and partial hospitalization
• Indications for extended inpatient hospitalization include the following:

  • Persistent and severe suicidality, self-destructiveness, or nonadherence to outpatient treatment or partial hospitalization

  • Comorbid refractory axis I disorder (e.g., eating disorder, mood disorder) that presents a potential threat to life

  • Comorbid substance abuse or dependence that is severe and unresponsive to outpatient treatment or partial hospitalization

  • Continued risk of assaultive behavior toward others despite brief hospitalization

  • Symptoms of sufficient severity to interfere with functioning, work, or family life that are unresponsive to outpatient treatment, partial hospitalization, and brief hospitalization
• Little evidence supports hospitalization as an effective treatment for suicidality in BPD

• However, when the patient’s safety is judged to be at serious risk, hospitalization may be indicated

• It has been recommended that hospitalization for BPD patients be crisis oriented and brief to avoid reinforcing suicidal behavior and to promote coping with suicidality in the natural environment
• Evidence shows that BPD patients are at high risk for completed suicide

• Even in the context of appropriate treatment, some patients with BPD will commit suicide

• Take their suicidal ideation and behavior seriously, and target it directly via safety management, psychotherapy, and pharmacotherapy
References

- APA Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors (2010)

- APA Practice Guideline for the Treatment of Patients With Borderline Personality Disorder (2010)


- Chronic suicidality and borderline personality. Sansone, R. Journal of Personality Disorders; 2004 Jun

- Kaplan and Sadock’s Synopsis of Psychiatry