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What You Need To Know – Assessment of Suicide Risk

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INTRODUCTION

Suicide refers to fatal deliberate acts of self-harm. It is among the ten leading causes of death in Singapore. Between half and two-thirds of people who commit suicide see a doctor in the last months of their lives. The mainstay of assessing suicidal risk is a thorough clinical evaluation of the individual patient.

HISTORY

The interview should take place in a quiet room where interruption is unlikely and where the patient feels able to talk freely.

1. The demographic factors themselves may alert the interviewer to an elevated suicide risk. An elderly male retiree who is living alone and having health problems, belongs to a group that is at a very high risk for suicide.

2. The interviewer will have to screen for psychiatric disorders such as depression, alcoholism and schizophrenia. Completed suicide in the absence of a psychiatric disorder is rare; psychological autopsy studies of suicides in the United States, United Kingdom, and Australia have found that a major psychiatric disorder is implicated in at least 90% of cases of completed suicide[1]. In a study of suicide in Singapore, it was found that mental and physical illness were the major causes of suicide, followed by financial, work and interpersonal problems[2].

Symptoms of a depressive illness include: severe mood disturbance, with or without diurnal variation, early morning awakening, disturbed appetite, feelings of hopelessness and guilt, impaired concentration, and morbid thoughts of suicide. Depressed patients with agitation, persistent insomnia, self-neglect and profound hopelessness are at an increased risk of suicidal behaviour. Many depressed elderly present to the general practitioner with somatic complaints like headache or chest discomfort, which may mislead the doctor[3]. If depression is diagnosed, it is mandatory for the doctor to elicit any suicidal thoughts. The doctor should also be alerted if the patient requests for a higher dose of hypnotics or comes more regularly for these drugs.

A history of substance use and symptoms of withdrawal suggest substance dependence. For substance abusers, those with depressed mood and serious physical complications are at a higher risk of suicide.

Among schizophrenic patients, those who are younger and have painful insight into their chronic disability are at an elevated risk of suicide.

3. Medically ill patients who may resort to suicide include those with chronic, intractable pain, terminal illness, or loss of mobility.

4. If the patient has attempted suicide, the circumstances of the suicide attempt give an important indication of the suicide intent. The method used to obtain the poison may indicate the degree of premeditation. For example, a patient who collects tablets or who visits several doctors to obtain a large supply may have suicidal plans. True suicidal intent is suggested by preparations made in anticipation of death. These "final acts" may include making out a will or organising insurance. The person may pay off his debts or give instructions to his wife to look after the children. The person has settled his affairs with the intention of taking his life. Those who ingest an overdose when alone, in an isolated place, who time the act so that intervention is unlikely or take precautions against discovery, are also likely to have real suicidal intent. Communication of suicide intent and leaving a suicide note also suggest suicidal intent.

5. Considerable information about a patient's problems will be gathered from detailed inquiry concerning recent events, and it is also useful to check through a list of potential problem areas. These include: relationship problems (spouse, family, children), employment or studies, financial matters, legal problems, social isolation, bereavement, and housing problems[4].

If circumstances fail to change as a result of an overdose, there is an increased risk of repetition in both parasuicidal and genuinely suicidal patients.

Mental state examination

In the formal examination of the patient's mental state, the interviewer should observe the following.

1. Appearance: The interviewer notes if there are signs of self-neglect, recent injury or physical illness.

2. Mood: The patient may be markedly depressed with psychomotor retardation or psychomotor agitation. Incongruous affect may indicate schizophrenia.

3. Thought content

a. Hopelessness

Patients experiencing a profound sense of hopelessness and pessimism about the future often have suicidal ideas.

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b. Suicidal ideation
The sequence of questioning about suicidal ideas should move sensitively and progressively on to what is a distressing topic for the patient. The way to introduce the topic of suicide is to progress from the patient's dysphoric state to symptoms of hopelessness and then to morbid thinking and suicide. A question such as, "Do you ever think life is not worth living?" is a good starting point. If the patient has had thoughts of death, further enquiry is made to determine if these have been limited to passive thoughts of death (eg. "I would be better off dead") or whether the patient has progressed to thoughts of ending his life. The interviewer must determine if the patient has made actual plans regarding a method of suicide as well as their reasons for living.

4. Abnormal phenomena
The interviewer checks for psychotic symptoms such as auditory hallucinations or delusions of persecution. Suicide in schizophrenia can sometimes be in response to command hallucinations instructing the patient to perform specific acts, particularly violent or destructive acts. Some schizophrenic patients kill themselves to escape from frightening imaginary persecutors.

Further information

It is always good practice to interview a close family member as suicidal patients are more likely to communicate their suicidal thoughts to those who are closest to them.

Establishing what further help is required

Outpatient counselling will be indicated for patients who are capable of taking responsibility for themselves and where the risks of suicide or immediate repetition are relatively small[4].

Psychiatric in-patient care will be indicated in patients who fall into three main categories:

1. Those with severe psychiatric disorder;
2. "Failed suicides" (this group overlaps to a large extent with the first category);
3. Those who require a short period of removal from stress, because their coping resources are temporarily exhausted.

CONCLUSION

Clinicians are guided by general principles in the management of the suicidal patient[5]. The most basic principle is that most suicide victims end their lives in the midst of a psychiatric episode and accurate diagnosis and careful management of the acute psychiatric illness could significantly alter the suicide risk. Other general principles include family involvement for support; treatment of any co-morbid medical condition; the provision of hope; and indications for psychiatric hospitalisation.

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Letters to the Editor

Congratulations on a splendid and most worthy 40th anniversary issue – attractive format and high standard of contributions on appropriate and well chosen topics.

Reading some of the articles and seeing some of the old familiar names and faces brought back memories from the distant past.

Dr A H Ang
Newcastle
Australia

I enjoyed the anniversary issue of the SMJ. It's beautifully done, and most of the articles are excellent.

Congratulations!

Prof T C Quah
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