



Suicidality



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Content

1. Introduction and Caveat
2. Definitions
3. Epidemiology
4. Suicide Vulnerability
5. The Crisis
6. Assessment
7. Treatment
8. Impact on Clinicians

Caveat

“Ah, what a dusty answer gets the soul when hot for certainty in this our life.”*

*George Meredith



CAVEAT #2

Every slide today could be, and has been, the topic of a separate lecture and/or a separate journal article.



Definitions

- The killing of oneself
 - Self-inflicted
 - Self-intentioned
 - Non-coerced
- Character structure's reaction to stress.

The “Way” of Suicide

- A way of “getting out” of life
 - Episodic
 - Unremitting
- A way of “getting on” in life
 - Characterological



The Suicide Continuum

- Ideation
- Parasuicide (suicidal gesture)
 - 25 times more frequent than completed suicide
- Failed suicides (serious attempts that do not succeed)
- Completed suicide

Epidemiology

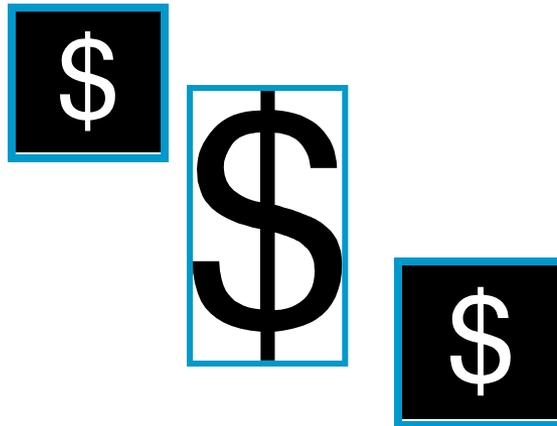
- Methodologic challenges in the study of suicide
 - No control group validity
 - **90% of attempters do not complete**
 - Gross under-reporting
 - **Shame**
 - **Cultural, religious, and social taboos**

Suicide Completers

- >90% have or could have a psychiatric Dx
- >8% had expressed suicidal ideation.
- >40% had made a previous suicide attempt.
- 30% were in current psychiatric treatment.
- 4% are in the hospital (Perhaps)
- 50% never had any psychiatric contact.
- 75% saw a physician in the 6 months prior to suicide. (*Only 1 in 6 physicians had prior knowledge of the suicide preoccupation.*)

Malpractice

26% of psychiatric related claims, and more than 50% of the dollar losses from psychiatry are related to suicide.*



*Risk Management Foundation of the Harvard Medical Institution

PHYSICIAN SUICIDE

- Male Physicians: 70+% higher risk
- Female Physicians: 250—400%+% higher risk

“JAMA”, June, 18, 2003

Predicting Suicide

Picking a group is much, much easier than picking an individual within that group.

“An ‘n’ of one is highly significant when you’re the one.”

*

Therefore, if we cannot know “who”, maybe knowing “why” could be very helpful.

*Darcy Wentworth Thomas

Suicide Assessment Scales

- Hamilton Rating Scale for Depression (Suicide item)
- Beck Depression Inventory BDI-II (Suicide, Hopelessness items)
- Scale for Suicide Ideation (and SSI-Worst)
- Beck Hopelessness Scale
- Acute Suicidal Ideation Questionnaire
- Columbia Univ. Protocol

CAVEAT: Low base rate means high false positives.

Therefore, comprehensive evaluation is needed.



Suicidal Vulnerability

Final common pathway is **despair** (not depression)

Two Parts:

- Intolerable affective state
- Recognition of that state and subsequent giving up oneself.

Suicidal Vulnerability

Affective State

- Aloneness (not loneliness)—Represents existential dread.
- Worthlessness—Implies irrevocable abandonment. The person is beyond love and care. There is murderous self-contempt due to an implacable superego.
- Rage—When threatened with abandonment, there is murderous rage and hate and the wish to escape.

Suicidal Vulnerability

Having a Dx, by itself, is Not Helpful >> Vulnerability to suicide appears at all levels of descriptive psychopathology and normalcy. The most useful way to assess someone for suicidality is the old-fashioned way—

- history
- mental status examination
- psychodynamic formulation
- ?scales



The Suicide Crisis

- Illness—Loss of valued abilities
- Object Loss
 - Real, threat, or fantasy of abandonment
- Loss of sources of relief
 - Clearing of a paranoid psychosis
 - Cessation of drugs and/or alcohol
- Change—Undesirable or very desirable
- Occupational/school difficulties and humiliation

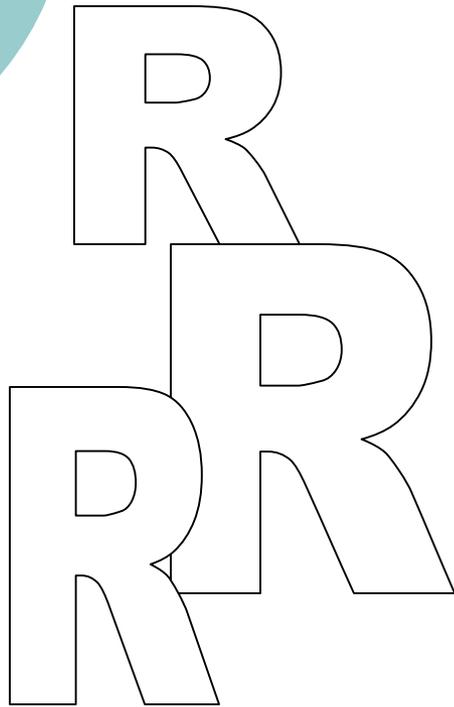


The Suicide Crisis

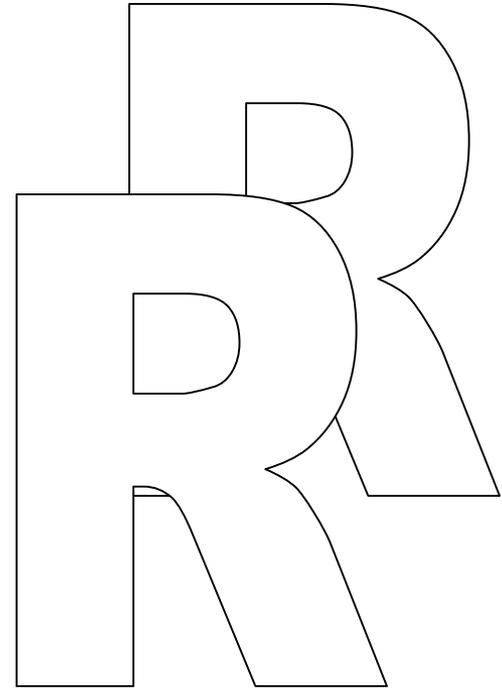
- Family strife and psychopathology of parents
- Parental emotional abuse
- Physical and sexual assault
- Changes in physical and/or sexual activity
- The extent to which the patient precipitated the event

“Fantasy” of Suicide

The Five “R”s



- **R**eunion
- **R**ebirth
- **R**iddance
- **R**evenge
- **R**est



“Fantasy” of Suicide

R

- **R**eunion with a beloved or going on a journey
- **R**ebirth—a transformation to a new, higher/different level of being
- **R**iddance—escape from intolerable affect or feeling

“Fantasy” of Suicide

- **R**evenge—Against the hostile others
 - Guilt and sorrow around the coffin
 - Attacking something dearly cherished by another
 - Child’s suicide

Medea vs. Jason—Euripides

- **R**est—Nothingness—What does it mean?
 - State of feeling of sleeping, satiated infant, insentient, unconscious, incorporeal, timeless



Assessment of Suicide

“The diagnosis of despair can be as difficult and elusive as the most difficult diagnostic problems that general medicine presents.”*

* Leston Havens



Psychodynamic Formulation

- Who is suffering from what?
- How is it experienced?
- How was it experienced in the past?
- What in his personality structure led to this problem in the past?
- What is his characteristic response likely to be?
- What defenses are likely to be used?

Psychodynamic Formulation

- Major defenses:
 - Denial
 - Projection
 - Acting Out
 - Splitting
- Defenses prevent:
 - Experiencing
 - Identifying
 - Remembering
 - Articulating





Assessment for Suicide

- Exploration of mood, affect, behavior
- Exploration of why and how he cannot bear his life
- **Manifest content is not sufficient to rule in or out suicidality. Manifest denial is not sufficient to rule it out.**
- Age, sex, sexual orientation, marital status, living arrangements, physical health, and drug and alcohol uses-past and present.



Assessment for Suicide

- Exploration of history of actual self-harm and lethality of the attempt(s)
 - Serious attempt vs. gamble vs. histrionic
- Evaluate the intent and nature of what was done, social content, etc.
- Exploration of communication of intent
 - Telegraphing
 - Anticipated response from others



Assessment for Suicide

- Evaluation of loss
 - Real or imagined
 - Neurotic or psychotic
 - Temporary or permanent
 - Already happened or anticipated
 - Available substitutes



Assessment for Suicide

Suggestions from others to suicide—

- Manifest

- “Why don’t you kill yourself?”
- “Dear, you’re not thinking of killing yourself, again, are you?”

- Latent

- The most deadly—the silent withdrawal or indifference and frigidity

Treatment of Suicide

- Pharmacotherapy

- Direct pharmacotherapy toward the underlying disorder

- Antidepressants
- Mood stabilizers
- Antipsychotics
- Benzodiazapines
- Sedative-Hypnotics



- ECT

Treatment of Suicide

- Psychotherapy—The role of the therapist is to help the patient
 - Recognize what's going on
 - Accept responsibility for it
 - Change patterns of feeling, thinking, and actingAlso to...
 - Decrease morbid fantasies, fantasies of loss, rejection, and punishment
 - **NOTE:** CBT—Good evidence for effectiveness, but one can *still* envisage all of this talk at a meta-level of understanding

Treatment of Suicide

What the therapist must *also* do:

- Convey interest and respect
- Show the patient that his sensitivity and vulnerability results from internalized beliefs in his own worthlessness (rather than “mere reality”).
- Help patient see suicidality as a pattern, a logical misperception, a series of steps, which can be changed. (Negative and automatic thinking in CBT language)
- Understand his countertransference
- “Sincerity is the sine qua non which guarantees nothing.”



Chronic Suicidality

- Secondary gain from chronic suicidality
- Family education—“psychological cancer”
- Chronic discussion of suicidal behavior
- Countertransference and heroism



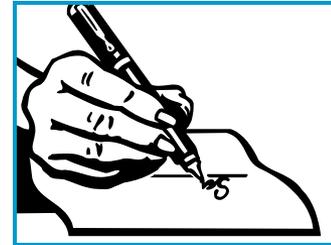
Chronic Suicidality

- Empathize with, but don't get trapped by:
 - Suicidal temptation
 - Longing for peace
 - Excitement of self-directed aggression
 - Pleasure in taking revenge against others
 - Exhilarating sense of power

Special Words & Situations

- Contracts

- Do they prevent suicide?
- Are they a consequence for misbehavior or a set of expectations?



vs.

- Alliance

- Focus on ability to participate in treatment and develop an alliance, rather than on a promise.



Special Words & Situations

- Limit Setting
 - An attempt to stop maladaptive behavior
 - Must be balanced against abdication of responsibility
- Confrontation
 - Focus inner experience onto outer reality
- Empathy
 - “Vicarious introspection”



Special Situations

- Legal Issues
 - Patient's safety takes precedence
- Manifest Mood—is not sufficient without a context
 - Despair vs. Depression
- Intuition
 - Dangerous without context



Special Situations

- Sustaining Resources
 - Are they immediately adequate?
- Diurnal Change in Mood & Mental Status
 - Alters the way one deals with suicidality



Common Errors

- Countertransference difficulties
- Excessive reliance on clinical intuition
- False beliefs
- Failure to take into account the sources and reliability of emotional support
- The belief that suicide may be prevented by impersonal means



Difficulties & Warnings for Clinicians

- Avoid reassuring self by reassuring patient
- Avoid being too self-revelatory
- Counterpoint of malice and aversion is wish to save.
- Avoid feeling overwhelmed
- Develop set of protective professional stances.



Protective Factors

- Easy access to effective care
- Restricted access to highly lethal means of committing suicide
- Strong family, community ties
- Cultural and religious beliefs that discourage suicide
- Skills in problem solving, conflict resolution, and non-violent handling of disputes



How Therapists Treat themselves

- Develop outside interests
- Take vacations
- Communicate and collaborate with peers
- Modify duties and responsibilities
- Restrict the number of difficult patients
- Give a talk like this one