

Passive suicidal ideation: Still a high-risk clinical scenario

Robert I. Simon, MD

Thorough risk assessment may reveal active suicide ideation

The commonly held belief that passive suicidal ideation poses less risk for suicide than active suicidal ideation is steeped in the lore of psychiatric practice. “Passive suicidal ideation” appears countless times in psychiatric records, articles, texts, guidelines, and clinical discourse. When a patient reports passive suicide ideation, the clinician may seize upon it as an indicator of low risk of suicide. The clinician may feel relieved and not perform a thorough suicide risk assessment.

Whether suicide ideation is active or passive, the goal is the same—terminating one’s life. Suicidal ideation, such as the wish to die during sleep, to be killed in an accident, or to develop terminal cancer, may seem relatively innocuous, but it can be just as ominous as thoughts of hanging oneself. Although passive suicidal ideation may allow time for interventions, passive ideation can suddenly turn active.

CASE

“I love my family too much to hurt myself”

Mr. F, a 52-year-old business executive, is brought to the hospital emergency room by his wife. His business is heading to bankruptcy and he is unable to go to the office and face his employ-

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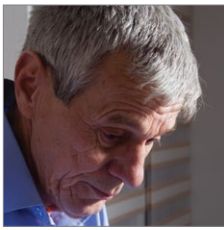
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Passive suicidal ideation

Clinical Point

When a patient reports passive suicidal ideation, active suicidal ideation invariably is present

ees. Mr. F cannot sleep or eat, spending most of the day on the couch crying. His wife has threatened her husband with separation if he does not seek psychiatric treatment.

Mr. F tells the emergency room psychiatrist, "I am stressed but have no intention of hurting myself. I love my wife and kids too much to put them through that." He admits to having wishes to die during sleep, but reports, "I can't sleep anyway." His wife finds a loaded gun in the glove compartment of his car, but he says the "gun is for my protection." He angrily denies any suicidal ideation and protests, "I do not need to be here." His wife insists that he be treated, stating, "I will not take my husband home in his condition."

Mr. F refuses psychiatric hospitalization but changes his mind when confronted with the alternative of involuntary hospitalization. He admits that, unknown to his wife, he recently purchased a \$2 million life insurance policy and made funeral arrangements. He planned to kill himself with his revolver. A thorough suicide risk assessment reveals a number of evidence-based risk factors that place the patient at acute, high risk for suicide.

Passive ideation is active

When a patient reports passive suicidal ideation, active suicidal ideation invariably is present. No bright line separates them. Suicidal ideation, active or passive, contains a dynamic mix of ambivalent thoughts and feelings along a continuum of severity. It reflects ongoing change in the patient's psychiatric disorder.¹

Reynolds et al² assessed the clinical correlates of active suicidal ideation vs passive death wishes in geriatric patients with recurrent major depression. Their data challenged the utility of distinguishing active and passive suicidal ideation. The authors also noted that the patient's ideation can change from passive to active during an episode of illness. They recommended that clinicians be no less vigilant with patients expressing passive suicidal ideation.

Suicidal ideation that expresses active or passive methods of suicide usually reflects psychodynamic, cultural, religious, and moral issues as well as evasiveness, guardedness, denial, and other factors. Assessing passive suicidal ideation may reveal few protective factors, which may increase the patient's suicide risk.

Patients often find it easier to talk about protective factors than suicidal thoughts. Patients whose culture or religion strongly condemns suicide may feel less conflicted reporting suicide ideation in the passive mode, if at all. For the patient who is determined to commit suicide, passive expression of suicide intent may indicate minimizing risk or deception, as seen in the case described here.³

"Fleeting" suicidal ideation, a frequent companion of "passive" suicidal ideation, also requires careful evaluation. In a study of 100 patients who made severe suicide attempts, Hall et al⁴ found that 69 reported only fleeting or no suicidal ideation before their attempt. "Fleeting" thoughts of sui-



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Suicide rehearsals: A high-risk psychiatric emergency

Author Robert I. Simon, MD, reports that:

"A suicide rehearsal is presumptive evidence that the patient is at acute, high risk for suicide and immediate clinical intervention is necessary."

Find it in the July 2012 issue of CURRENT PSYCHIATRY
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cide must not be accepted at face value but require thorough assessment.

Structured assessments instruments for evaluating suicide ideation are available. The Chronological Assessment of Suicidal Events (case approach) is designed to uncover detailed information related to the patient's suicidal ideation.⁵ The Scale for Suicide Ideation, and the later version, Beck Scale for Suicide Ideation,⁶ rates passive suicidal ideation on a 3-point Likert-type scale as:

- 0 "would take precautions to save life"
- 1 "would leave life/death to chance (eg, carelessly crossing a busy street)"
- 2 "would avoid steps necessary to save or maintain life (eg, diabetic ceasing to take insulin)."

Although the Beck scales have psychometric properties (reliability and validity), no scale can substitute for thorough clinical assessment of suicidal ideation. If used, ratings scales or checklists of suicidal ideation can alert clinicians to thoroughly assess this crucial symptom of suicide risk.

When treating a suicidal patient, clinicians often experience complex, distressing feelings. Maltzberger and Buie⁷ describe anger, frustration, despair, and even hate toward the suicidal patient. In addition to the devastating loss of one's patient, fears of a lawsuits and damage to one's professional competence and reputation may arise if the patient attempts or completes suicide. These can all lead a clinician to prematurely accept a patient's statement regarding passive suicidal ideation rather than conduct a thorough suicide risk assessment. Consultation should be considered.

Related Resources

- Simon RI. Suicide rehearsals: A high risk psychiatric emergency. *Current Psychiatry*. 2012;11(7):28-32.
- Baca-Garcia E, Perez-Rodriguez MM, Oquendo MA, et al. Estimating risk for suicide attempt: are we asking the right questions? Passive suicidal ideation as a marker for suicidal behavior. *J Affect Disord*. 2011;134(1-3):327-332.

The necessity of action

Suicidal ideation must be carefully assessed—not labeled. Passive suicidal ideation should not deter a clinician from performing a thorough suicide risk assessment. A patient's report of passive suicidal ideation is not an end but a beginning of thorough suicide risk assessment.⁸

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Clinical Point

Passive suicidal ideation should not deter a clinician from performing a thorough suicide risk assessment

Bottom Line

Passive suicidal ideation, such as a wish to die during sleep or being killed in an accident, does not indicate that a patient is at a low risk of suicide. A thorough suicide risk assessment may reveal active suicidal ideation that informs treatment and management interventions.