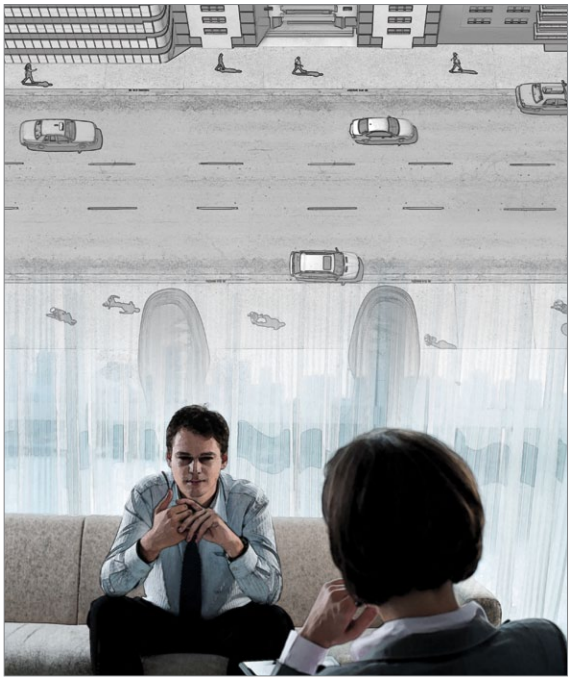
Current PSYCHIATRY

FIRST OF 2 PARTS

How do you score on this self-assessment of suicide risk management?



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Answer these 15 case-based questions to evaluate your skills

The assessment and management of suicide risk are complex and difficult tasks that raise clinical issues without clear-cut, easy answers. This case-based, multiple-choice self-assessment with accompanying commentaries is a teaching instrument that I designed to enhance a clinician's ability to provide care for patients at risk for suicide. Part 1 of this article poses 8 of the 15 questions; the balance of questions will appear in Part 2, in the November 2014 issue of CURRENT PSYCHIATRY.

The questions and commentaries in this self-assessment originate in the referenced work of others and my clinical experience. Therefore, I use the preferred "best response" option—not the customary and more restrictive "correct answer" format.

How do you score?

Question 1

Mr. J, age 34, is a professional basketball player complaining of weight loss, early morning waking, and a dysphoric mood lasting for 1 month. His performance on the basketball court has declined and his wife is seeking a separation. He describes "fleeting" suicidal thoughts. He has no history of suicide attempts or depression. The patient does not abuse alcohol or drugs.

The initial assessment approach is to:

a) obtain a suicide prevention contract
b) assess suicide risk and protective factors
c) determine the cause of Mr. J's depression
d) have Mr. J complete a suicide risk self-assessment form
e) contact his wife for additional history

Disclosure

Dr. Simon reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

Adapted with permission from: Simon RI. Preventing patient suicide: clinical assessment and management, Arlington VA: American Psychiatric Publishing; 2011.

The best response option is B

Suicide prevention contracts do not prevent suicide.[1] Contacting the patient's wife may be an option at a later stage of evaluation or treatment, if Mr. J grants permission. Determining the cause of his depression likely will require ongoing work up. Assessing suicide risk factors without also looking at protective factors is a common error. A comprehensive suicide risk assessment evaluation requires evaluating both risk and protective factors.[2,3] Suicide risk assessment forms often omit questions about protective factors.[4] Do not rely on self-assessment suicide risk forms because they are dependent on the patient's truthfulness. Patients who are determined to commit suicide might regard the psychiatrist and other mental health professionals as the enemy.[5]

Question 2

Ms. P, a 56-year-old, single schoolteacher, is admitted to a psychiatric unit for severe depression and suicidal ideation without a plan. She is devoutly religious, stating, "I won't kill myself, because I don't want to go to hell." Ms. P attends religious services regularly. She has a history of chronic recurrent depression with suicidal ideation and no history of suicide attempts. You suspect a diagnosis of bipolar II disorder.

In assessing religious affiliation as a protective factor against suicide, you should consider:

a) the nature of the patient's religious conviction
b) the religion's stated position on suicide
c) severity of the patient's illness
d) presence of delusional religious beliefs
e) all of the above

The best response option is E

Dervic et al[6] evaluated 371 depressed inpatients according to their religious or nonreligious affiliation. Patients with no religious affiliation made significantly more suicide attempts, had more first-degree relatives who committed suicide, were younger, were less likely to be married or have children, and had fewer contacts with family members.

In general, religious affiliation is a protective factor against suicide but may not be a protective factor in an individual patient. Religious affiliation, similar to other presumed general protective factors, requires further scrutiny. Avoid making assumptions. For example, a depressed, devoutly religious patient may curse God for abandonment. A patient with bipolar disorder may believe that God would forgive her for committing suicide. A presumed protective factor may not be protective or might even be a risk factor, such as psychotic patients with religious delusions.

Abrahamic religions—ie, Judaism, Christianity, and Islam—prohibit suicide. Severe mental illness, however, can overcome the strongest religious prohibitions against suicide, including the fear of eternal damnation. For many psychiatric patients, religious affiliations and beliefs are protective factors against suicide, but only relatively. No protective factor against suicide, however strong, provides absolute protection against suicide. Moreover, other risk and protective factors also must be assessed comprehensively.

Question 3

Mr. W, age 18, is admitted to an inpatient psychiatric unit with severe agitation, thought disorder, disorganization, and auditory hallucinations. He is threatening to jump from a nearby building. He has no history of substance abuse.

The psychiatrist conducts a comprehensive suicide risk assessment that includes the patient's psychiatric diagnosis as a risk factor.

Which psychiatric disorder has the highest associated suicide mortality rate?

a) schizophrenia
b) eating disorders
c) bipolar disorder
d) major depressive disorder
e) borderline personality disorder

The best response option is B

Harris and Barraclough (***Table, page 28***)[7] calculated the standardized mortality ratio (SMR) for suicide among psychiatric disorders. SMR is calculated by dividing observed mortality by suicide by the expected mortality by suicide in the general population. Every psychiatric disorder in their study, except for mental retardation,

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Clinical Point

Do not rely on patient self-assessment forms because they are dependent on the patient's truthfulness

Suicide risk assessment

Clinical Point

HIPAA permits health care professionals to communicate about a patient's medical treatment without obtaining patient permission

Table

Mental and physical disorders and mortality from suicide

Disorder	Standardized mortality ratio[a]
Eating disorders	23.14
Major depressive disorder	20.35
Sedative abuse	20.34
Mixed drug abuse	19.23
Bipolar disorder	15.05
Opioid abuse	14.00
Dysthymia	12.12
Obsessive-compulsive disorder	11.54
Panic disorder	10.00
Schizophrenia	8.45
Personality disorders	7.08
AIDS	6.58
Alcohol abuse	5.86
Epilepsy	5.11
Child and adolescent disorders	4.73
Cannabis abuse	3.85
Spinal cord injury	3.82
Neuroses	3.72
Brain injury	3.50
Huntington's chorea	2.90
Multiple sclerosis	2.36
Malignant neoplasm	1.80
Mental retardation	0.88

[a]Standardized mortality ratio is calculated by dividing observed mortality by expected mortality in the general population

Source: Reference 7

was associated with a varying degree of suicide risk. Eating disorders had the highest SMR. The patient's psychiatric diagnosis is a risk factor that informs the clinician's suicide risk assessment.

Question 4

Mr. Z, a 64-year-old, recently divorced lawyer, is admitted to the psychiatric unit from the emergency room. His colleagues brought Mr. Z to the emergency room because of his suicide threats.

On the unit, Mr. Z denies suicidal ideation, plan, or intent. Agitation and suspiciousness are prominent. He refuses to authorize staff to contact his colleagues, his ex-wife, and other family members. Mr. Z demands immediate discharge and forbids contact with his outpatient psychotherapist. He is placed on 72-hour hold as a conditional voluntary admission.

The clinician should:

a) contact Mr. Z's family, as an emergency exception to confidentiality
b) e-mail his family members with questions
c) contact the patient's psychotherapist as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
d) try to develop a therapeutic alliance with Mr. Z
e) none of the above

The best response option is C

HIPAA permits psychiatrists and other health care providers who are treating the same patient to communicate with each other about medical treatment without obtaining permission from the patient.[8] However, mental health professionals cannot share psychotherapy notes without a patient's consent, except when legally required, such as reporting abuse or duty to warn. This is the most expeditious and productive way of obtaining essential clinical information. E-mail merely changes the mode of unauthorized communication with significant others.

Mr. Z is agitated and suspicious, and developing a therapeutic alliance would require time. It is necessary to gather information about his psychiatric condition as soon as possible. An emergency exception to maintaining confidentiality is another option.[9] The definition of emergency varies among jurisdictions. Consulting with a knowledgeable attorney may be necessary, but it usually takes time. Ethically, it is permissible to breach confidentiality to protect the suicidal patient.[10]

Question 5

Mr. G, a 42-year-old engineer, is re-hospitalized after a failed hanging attempt. Initially, he is profoundly depressed but improves sud-

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continued from page 28

Suicide risk assessment

denly and requests discharge. The psychiatrist and clinical staff are perplexed. Is the sudden improvement real or feigned?

The treatment team should consider all of the following options except:

a) obtain records of earlier hospitalizations
b) check collateral sources of information
c) assess Mr. G's compliance with treatment
d) obtain psychological testing to evaluate Mr. G's honesty
e) determine whether behavioral signs of depression are present

The best response option is D

Short length of hospital stay makes it difficult to assess sudden patient improvement.[11] Real improvement in a high-risk suicidal patient is a process, even when it occurs quickly. Feigned improvement is an event. Obtaining patient information from collateral sources is crucial. Sudden improvement might be caused by the patient's resolve to complete suicide. Identifying behavioral risk factors associated with psychiatric disorders informs the clinician's systematic suicide risk assessment of a guarded or dissimulative patient. Psychological testing will take critical time and is not a substitute for careful clinical assessment.

Clinical Point

The process of a comprehensive suicide risk assessment encompasses identification, analysis, and synthesis of risk and protective factors

Question 6

In mid-winter, Ms. M, a 42-year-old homeless woman, is seen in the emergency room of a general hospital. She complains of depression and auditory hallucinations commanding her to commit suicide. Ms. M has 5 earlier admissions to the psychiatry unit for similar complaints.

The psychiatrist conducts a comprehensive suicide risk assessment. Acute and chronic risk factors for suicide are identified. Protective factors also are assessed. The psychiatrist weighs and synthesizes risk and protective factors into an overall assessment of Ms. M's suicide risk.

The main purpose of suicide risk assessment is to:

a) predict the likelihood of suicide
b) determine imminence of suicide
c) inform patient treatment and safety management
d) identify malingered suicidal ideation
e) provide a legal defense against a malpractice claim

The best response option is C

Suicide cannot be predicted.[12] The term *imminent suicide* is a veiled attempt to predict when a patient will attempt suicide.[13] The process of a comprehensive or systematic suicide risk assessment encompasses identification, analysis, and synthesis of risk and protective factors that inform the treatment and safety management of the patient.[3] The overall suicide assessment is a clinical judgment call that determines risk along a continuum of low to high. In Ms. M's case, comprehensive suicide risk assessment will assist the clinician in determining the patient's overall suicide risk and make an appropriate disposition. Without a systematic suicide risk assessment methodology, the clinician is at the mercy of the pejoratively labeled "frequent flyer" who is looking for sustenance and lodging. The frustrated clinician is left with little choice but to admit the patient.

Although not the main purpose, systematic suicide risk assessment can help provide a sound legal defense if a suicide malpractice claim is filed against the clinician alleging negligent assessment.[14]

Question 7

A psychiatrist is treating Mr. S, a 36-year-old computer analyst, with once-a-week psychotherapy and medication management for panic and depressive symptoms that emerged abruptly after the break-up of a romantic relationship. Mr. S is using alcohol to sleep. He reports occasional suicidal ideation but no plan. He finds the idea of suicide to be morally repugnant. A therapeutic alliance develops.

The psychiatrist is concerned about Mr. S's suicide risk and the need for hospitalization. The psychiatrist performs a systematic suicide risk assessment that includes identification of individual and evidence-based protective factors. For example, Mr. S continued to pursue his interests and to participate in civil causes. The overall suicide risk

is determined by the assessment of individual and evidence-based protective factors.

All of the following options are evidence-based protective factors except:

a) therapeutic alliance
b) survival and coping beliefs
c) responsibility to family
d) fear of suicide
e) moral objections to suicide

The best response option is A

Clinical consensus holds that the therapeutic alliance is an important protective factor against suicide. However, no evidence-based research supports or refutes this widely held belief among clinicians.

Linehan et al[15] developed the Reasons for Living Inventory, a self-report instrument that identifies 6 subscales:

- survival and coping beliefs
- responsibility to family
- child-related concerns
- fear of suicide
- fear of social disapproval
- moral objections to suicide.

Survival and coping beliefs, responsibility to family, and child-related concerns were useful in differentiating between suicidal and non-suicidal individuals. Malone et al[16] administered the Reasons for Living Inventory to 84 inpatients with major depression; 45 had attempted suicide. Depressed patients who had not attempted suicide demonstrated more sense of responsibility toward family, more fear of social disapproval, more moral objections to suicide, greater survival and coping skills, and greater fear of suicide than patients who attempted suicide. The authors recommended adding the Reasons for Living Inventory to the assessment of patients at risk for suicide.

Related Resources

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- Simon RI. Suicide rehearsals: A high-risk psychiatric emergency. Current Psychiatry. 2012;11(7):28-32.
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Drug Brand Names

Clonazepam • Klonopin
Clozapine • Clozaril
Lithium • Eskalith, Lithobid
Lorazepam • Ativan
Quetiapine • Seroquel

Question 8

A 38-year-old mother of a newborn child is admitted to the psychiatric unit after expressing suicidal thoughts to her husband. She has been hospitalized previously after a hypomanic episode and severe depression; she has no history of suicide attempts. A psychiatrist diagnoses bipolar II disorder (recurrent major episodes with hypomanic episodes). The patient's maternal aunt has bipolar disorder. Her paternal grandfather committed suicide.

The psychiatrist conducts a systematic suicide risk assessment and determines the patient is at high risk of suicide. He considers a suicide-risk reduction drug.

Which one of the following drugs has been shown to reduce suicide and suicide attempts in bipolar II patients?

a) clozapine
b) clonazepam
c) lorazepam
d) lithium
e) quetiapine

The best response option is D

Prospective, randomized and controlled trials consistently have found lower rates of completed suicides and suicide attempts

Clinical Point

Clinical consensus holds that the therapeutic alliance is an important protective factor against suicide

Bottom Line

Suicide risk assessment and management are challenging for even experienced clinicians. Suicide risk assessment guides appropriate treatment and management for patients at risk for suicide. This self-assessment helps mental health professionals identify potential gaps in their knowledge and reinforce best practices.

Suicide risk assessment

during lithium maintenance treatments for patients with bipolar disorder and other major affective disorders.[17]

Editor's note: Part 2 of this self-assessment on suicide assessment and management in the November 2014 issue of CURRENT PSYCHIATRY *poses 7 additional questions.*

Clinical Point

Controlled trials have found lower rates of completed suicides and suicide attempts during lithium maintenance treatment

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