

Psychiatrist

Edwin S. Shneidman wrote, "*Instead of looking for a variety of answers for their problems, suicidal individuals think of only two alternatives: a total solution or a total cessation. All other options have been driven out by desperation and pain.*"

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Introduction

Experts agree that we simply do not know enough about suicide to accurately predict a suicide or to absolutely prevent a suicide (Reference 1). Diagnosing and treating suicidal behavior is complex and challenging even for an experience psychiatrist.

1. Biological perspectives
2. Psychological theories
3. Sociological positions

Psychiatrists are physicians who have been schooled in biopsychosocial perspectives of mental illness and are often sought for consultation with high risk, suicidal individuals.



What to look for as a Psychiatrist

“Causes” of suicidality

The varying perspectives on the causes of suicidality can help psychiatrists to have a comprehensive, biopsychosocial assessment of their patients who may be at risk for suicide or in a suicide crisis.

1. Biological Perspectives

A common perspective among psychiatrists is to view the etiology of suicidality as biochemical in nature. This approach is grounded in the perspective that suicidal individuals manifest various chemical imbalances that must be treated with medications.

Asberg and colleagues initially demonstrated in 1976 that patients with low levels of 5-hydroxyindolacetic acid (5-HIAA), a breakdown product of serotonin, were more likely to die by suicide, and to use more violent means (Reference 2).

2. Psychological Theories

Modern psychological theories of suicide are influenced by Freud's work in the early twentieth century. Edwin Shneidman, considered by many to be the father of modern suicidology, has described several common characteristics of suicide, including a sense of unbearable psychological pain, a sense of isolation from others, and the perception that death is the only solution when the individual is temporarily not able to think clearly due to being blinded by overwhelming pain.

3. Sociological Positions

Social theories such as those posed by French sociologist Emile Durkheim also influence notions about suicidality. Durkheim's beliefs are linked to the notion that there are associated societal factors that can influence suicide rates. Durkheim found that suicide was more likely when a person was not engaged in social relationships or had relationships disrupted through a sudden change in status, such as death or divorce. Durkheim's work has led to the importance of considering the significance of social bonds such as marriage and family and other societal relationships when examining the potential for suicide in an individual.

While educated like other physicians in the biophysical tradition, psychiatrists have also been schooled to consider each of these viewpoints and are often sought for consultation with extreme or particularly high-risk suicidal individuals.



Clinical guidance

More detailed clinical guides such as those provided by Shneidman, a leading authority on suicide, can be of use to the psychiatrist. Shneidman's list describing ten characteristics that are commonly associated with completed suicide is as follows (Reference 3):

1. **The common purpose of suicide is to seek a solution.**
Suicide serves a specific function. Persons who are considering ending their own lives think of suicide as the sole solution to a problem or a way out. People who are intent on dying view suicide as preferable to the emotional pain that they are facing. Suicide is a more appealing option to those individuals who have a family history of suicide or who had a close relationship with someone who died by suicide.
2. **The common goal of suicide is cessation of consciousness.** People who end their lives at their own hands do not want to experience living, as their existence is consumed with painful and overwhelming thoughts and feelings.
3. **The common stimulus (or information input) in suicide is intolerable psychological pain.** People who die by suicide are plagued by feelings of shame, guilt, anger, fear, and sadness. There can be varied reasons for these feelings.
4. **One known common stressor in suicide is frustrated psychological needs.** Individuals with high goals or self-expectations may be at particular risk for suicide if their progress is thwarted. Feelings of worthlessness and hopelessness may prevail. Among teens and young adults family turmoil or other interpersonal relationship difficulties can increase the likelihood of a completed suicide.
5. **The common emotion in suicide is hopelessness-helplessness.** There is an overwhelming pervasive feeling of hopelessness with the suicidal person, being sure that nothing can be done to improve his or her situation and that suicide is the only option.
6. **The common internal attitude in suicide is ambivalence.** It has been noted by survivors that even during the act of attempting suicide, there are feelings of ambivalence. While there is a sincere wish to end their pain and see suicide as the only option for this, there is also a longing for an alternative to suicide
7. **The common cognitive state in suicide is constriction.** There is an inability on the part of the suicidal person to actively problem solve, thus they have no ability to see alternatives to suicide.
8. **The common action in suicide is escape.** While an extreme measure, suicide is viewed as a viable way to escape pain and intolerable circumstances.
9. **The common interpersonal act in suicide is communication of intention.** Most suicidal persons have told others about their plans in some way. Shneidman noted that in as many as 80% of completed suicides, people provide verbal or behavioral messages or clues that suggest their will to die by suicide.



10. **The common consistency in suicide is with life-long coping patterns.** During the time immediately leading to a completed suicide, individuals use the same coping skills that they have used throughout their lives. For example, people who feel helpless to change a situation persist in that pattern and are therefore incapable of seeing that they can do something different and therefore have increasing feelings of hopelessness.

Case Study

The following clinical example illustrates how a Psychiatrist might encounter a veiled threat and the subtle signs and symptoms associated with a suicidal client.

Tom was a 15-year-old adolescent who was brought to the Emergency Department of the local community hospital after attempting suicide. Following a messy break up with his girlfriend, he had locked himself in his parents' car and started the engine in an enclosed garage. Although he became unconscious, Tom was rescued after his parents smelled the exhaust from the engine and broke a car window to get him out.

Tom was treated and stabilized in the Emergency Department and sent to a medical unit on the 5th floor of the hospital to recover. A psychiatric consult was called and Tom was placed on a "suicide watch" with a private nurse aide seated at his bedside at all times.

The psychiatrist came to the hospital the next morning. He had very little information about Tom. Tom apparently had no history of mental illness, but was described by his parents as moody with few friends. He received average grades, but had been in trouble for skipping school. He told his parents that the kids there had an attitude. When asked about his suicide attempt, Tom said that he was really upset by the breakup with his girlfriend and that he hadn't been thinking clearly. He told the psychiatrist that he would not try to harm himself again and was anxious to return to school.

The psychiatrist was not convinced of Tom's safety and recommended that he be transferred to an inpatient mental health facility for further evaluation. Tom's parents consented to the transfer and along with the psychiatrist discussed the treatment plan with him. While visibly disappointed, Tom agreed to the transfer and after the others left the room prepared to make arrangements for the transfer and transport.

As Tom began gathering the belongings in the small hospital room, he suddenly turned and pushed the nurse's aide aside. He ran down the hall and dove head first out of the 5th floor window. He died immediately.

There were many questions left unanswered by the tragedy of Tom's suicide. "What was missed?" ... "What could have been done differently" ... "Did Tom really want to die, or was he overwhelmed at the prospect of going on".

This case describes a severely distraught adolescent who, following a suicide attempt, was not immediately transferred to a secure mental health facility. No one appeared to be aware of the imminent danger that he presented regarding suicide. The psychiatrist who



consulted on the case suspected that the patient would not be safe if he were released, but did not have an indication of the severity of Tom's pain nor his intent to end his life by suicide. Tom had no previous psychiatric history, so there was no history to consider. While it is difficult to know what cues and clues Tom may have given to the unit personnel during his time on the medical unit, their lack of training in suicide prevention most likely compounded the problem.

Once a diagnosis of suicide risk has been made, the psychiatrist should order the necessary precautions, such as a suicide watch, to prevent further action by the individual who is at risk. Suicide may be difficult to predict, but once an assessment of suicide risk has been made, then the doctor should order the necessary safety precautions.

Additionally hospitals that treat or assess suicidal individuals should ensure a safe environment, such as a ground floor interviewing room, or glass that would not shatter when challenged by a suicidal individual.

This scenario may not represent an exact situation for you as a psychiatrist, but it offers insight as to the ways in which you might encounter a patient at high risk for suicide and the safety factors that have to be considered to determine the best plan of action.



What to look for as a Psychiatrist: Resources

1. Maris, R. W., Berman, A., & Silverman, M. M. (2000). *Comprehensive textbook of suicidology*. Guilford Press: New York, NY.
2. Shneidman, E. S. (2001). *Comprehending suicide: landmarks in 20th-century suicidology*. American Psychological Association: Washington, DC.
3. Preuss, U. W., Schuckit, M. A., Smith, T. L., Danko, G. P., Bucholz, K. K., Hesselbrock, M. N., Hesselbrock, V., & Kramer, J. R. (2003). Predictors and correlates of suicide attempts over 5 years in 1,237 alcohol-dependent men and women. *American Journal of Psychiatry*, 160(1), 56-63.
4. **Survivors of Suicide (SOS) Web site**

The SOS Web site is an independently owned and operated web site and is in no way associated with any specific group, organization or religious affiliation. The purpose of the Survivors of Suicide Web site is to help those who have lost a loved one to suicide resolve their grief and pain in their own personal way.

Edwin Shneidman's Common Characteristics of Completed Suicide is available on the SOS Web site and reference credit is given to Thomas Oltmanns and Robert Emery from the University of Virginia.

The SOS Web page detailing Shneidman's Common Characteristics of Completed Suicide is available at the following Web address:

<http://www.survivorsofsuicide.com/understanding.shtml>



What to do to help as a Psychiatrist

Helping guidance

The following general guides may help psychiatrists balance the personal and professional issues associated with treating suicidal patients:

1. Clinicians should set **reasonable treatment terms and boundaries** by working with the patient to diffuse the tension and create a safe environment in which therapy can proceed
2. Both patient and psychiatrist need to **evaluate the efficacy and safety of the environment** before therapy proceeds
3. Clinicians should perform an **adequate suicide risk assessment** and determine the details of the risks for suicide. Axis I disorders such as major depressive disorder, bipolar disorder, and dysthymic disorder should be actively considered. Additionally, past history and current life information such as noted in Axis IV is important for a comprehensive suicide risk assessment
4. A **suicide prevention contract** is usually not a useful clinical tool. There are no studies that demonstrate that a no-suicide contract is effective in preventing suicide. Patients can deviate from a suicide contract at any time
5. Some patients can evoke reactions of frustration or conversely over-involvement from therapists. Clinicians should have **self-awareness and may require adequate supervision** to remain effective
6. Some situations are so volatile that clinicians may seek legal options such as **involuntary hospitalization** for appropriate treatment of suicidal patients
7. It is **impossible to predict with accuracy** which patients will die by suicide. Suicide risk factors are excellent guides for identifying at-risk patients, but are not specific enough because suicide is a multifaceted phenomenon. The best that clinicians can hope to do is conduct **systematic suicide risk assessments**
8. While some **risk factors such as anxiety can be modified other factors such as access to weapons, especially firearms must be prevented**

The above principles have been adapted from a case study published on the Agency for Health Care Research and Quality (AHRQ) Web site (Reference 4).



What to do to help as a Psychiatrist: Resources

1. Kessler, R. C., Borges, G., & Walters, E. E. (1999). Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. *Archives of General Psychiatry*, 56(7), 617-26.
2. Stanford, E. J., Goetz, R. R., & Bloom, J. D. (1994). The No Harm Contract in the emergency assessment of suicidal risk. *Journal of Clinical Psychiatry*, 55, 344-8.
3. **Agency for Health Care Research and Quality (AHRQ)**

The AHRQ is a federally funded agency and the Morbidity and Mortality Rounds on the Web (Web M& M) is the Nation's first Web-based patient safety resource and journal. The AHRQ Web M&M is an online journal and forum on patient safety and health care quality. This site features expert analysis of medical errors reported anonymously by readers, interactive learning modules on patient safety, and forums for online discussion. Continuing Medical Education (CME) credit is available.

AHRQ presents a case study involving a supervising psychiatrist, psychiatry resident and a suicidal person known to have a firearm available at the following Web address:

<http://www.webmm.ahrq.gov/cases.aspx?ic=15>



What other resources are available for Psychiatrists

As an expert clinician, you have encountered severely depressed and acutely suicidal patients on several occasions. In a national study conducted in 1987 nearly half of the US psychiatrists surveyed had had a patient who died by suicide (Reference 5). Other international studies indicate that as many as 68% of psychiatrist consultants have had a patient who died by suicide (Reference 6). Both studies reported that completed suicides had an impact on both the personal and professional lives of psychiatrists. The following information concerns the ramifications of a completed suicide upon a psychiatrist and further resources are recommended.

Shock Waves

An attempted or completed suicide is a disturbing and shocking experience for all people involved. Different reactions and emotions can arise, and psychiatrists need to be prepared to respond to the reactions of others as well as attend to their own feelings.

The Counseling Department at Humboldt State University offers the following as a list of common reactions following an attempted or completed suicide (Reference 7):

- Feeling of abandonment
- Disbelief
- Confusion
- Anger - both at the person and at self
- Resentment
- Anxiety
- Bewilderment
- Fear
- Respect
- Aggrieved loss
- Current stressors that suddenly seem overwhelming
- Idealization of the person
- Failure -- "What didn't I do?"
- Blame -- "I should have been able to..."
- Guilt -- "It's my fault for not...."
- Humiliation
- Your own emotional reactions



Studies indicate that expert clinicians, such as psychiatrists are likely to have acute emotional reactions that follow a completed suicide that can last up to a month. This is the time during which support is most needed. Redneck (Reference 8) ascribed three stages that clinicians must move through in coming to terms with the suicide of a patient.

1. **Psychological resuscitation:** the survivor's emotional revival with support from a trusted colleague
2. **Psychological rehabilitation:** the processing of the loss
3. **Psychological renewal:** the movement beyond grief and the establishment of new contacts and relationships

The survivor literature notes that at the very least, psychiatrists should seek the counsel of a trusted peer and that consultation with colleagues should occur as quickly as possible following the completed suicide of a patient. Postvention, a term used to describe the process of working through the shock of a completed suicide, is something the expert clinician must seek out as soon as possible.



1. Alexander, D. A., Klein, S., Gray, N. M., Dewar, I. G., & Eagles, J. M. (2000). Suicide by patients: Questionnaire study of its effect on consultant psychiatrists. *British Medical Journal*, 320 (7249), 1571-4.

The full text of this article is available online at the following Web address:

<http://bmj.bmjournals.com/cgi/content/full/320/7249/1571>

2. Campbell, C. & Fahy, T. (2002). The role of the doctor when a patient commits suicide. *Psychiatric Bulletin*, 26(2), 44-49.

The full text of this article is available online at the following Web address:

<http://pb.rcpsych.org/cgi/content/full/26/2/44>

3. Hendin, H., Lipschitz, A., Maltzberger, J. T., Haas, A. P., & Wyncoop, S. (2000). Therapists' reactions to patients' suicides. *American Journal of Psychiatry*, 157(12), 2022-2027.

4. Hodelet, N. & Hughson, M. (2001). What to do when a patient commits suicide. *Psychiatric Bulletin*, 25, 43-45.

The full text of this article is available online at the following Web address:

<http://pb.rcpsych.org/cgi/content/full/25/2/43>

5. New Therapist

The New Therapist is an independent, subscription-based magazine for mental health therapists, produced by journalists and therapists on five continents. New Therapist is not affiliated to any organizations, associations or particular school of therapeutic thought.

The New Therapist Web site provides the article, *When Clients Kill Themselves: How Therapists Cope with Suicide*, by John Soderhund available online at the following Web address:

<http://www.newtherapist.com/suicide.html>



References for Psychiatrist

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- (3) Oltmanns, T. F. & Emery, R. E. (2003). *Understanding suicide: Common elements*. Retrieved on February 27, 2004 from <http://www.survivorsofsuicide.com/understanding.shtml>
- (4) Simon, R. I. (2003). *Suicidal patient known to have firearm in his home*. Retrieved on February 27, 2004 from <http://www.webmm.ahrq.gov/cases.aspx?ic=15>
- (5) Chemtob, C. M., Hamada, R. S., Bauer, G., Kinney, B. & Torigoe, R. Y. (1988). Patients' suicides: Frequency and impact on psychiatrists. *American Journal of Psychiatry*, 145(2), 224-228.
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- (7) Rickgran, R. (2003). *Adapted from THE ISSUE IS SUICIDE by the Counseling Services Department Humboldt State College*. Retrieved on February 27, 2004 from <http://www.humboldt.edu/~hsucaps/suicide.shtml>
- (8) Soderlund, J. (2003). *When clients kill themselves: How therapists cope with suicide*. Retrieved on February 27, 2004 from <http://www.newtherapist.com/suicide.html>

