

# Assessing Lethality-Suicide

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# Guidelines for Identification, and Assessment of Suicidality

Taken, in part, from Suicide Risk  
Advisory Committee of the Risk  
Management Foundation of the  
Harvard Medical Institutions - 1  
1996

# SUICIDE FACTS

- Over 30,000 people in the U.S kill themselves every year.
- 8th leading cause of death in the U.S.
- A person commits suicide every 18 minutes
- An attempt is made once a minute.
- Every day app. 86 Americans take their lives and 1500 attempt.

# SUICIDE FACTS

- Suicide is the 6th leading cause of death among 5-14 year olds.
- Suicide is the 3rd leading cause of death among 15-24 year olds
- Death by firearms is the fastest growing method of suicide
- Firearms are now used in more suicides than homicides

• Rates based on 1998 US statistics CDC, m Nat'l Center for Health Statistics

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# SETTING THE STAGE

- Room preparation
- Interview process
  - Transitions / Gates
    - Referred Gate
    - Natural Gate
    - Phantom Gate
- Use the words

# Assessing Lethality Data

- Begins with comprehensive psychiatric evaluation
- Includes
  - relevant complaints
  - history
  - limited MSE
  - relevant physical and lab examinations

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# • Psychiatric Diagnosis

- Identify if patient suffers from a psychiatric illness associated with higher suicide risk
  - Mood disorders
  - Schizophrenia
  - Substance abuse
  - Anxiety disorders
  - Borderline, or other, personality disorders
  - Patients with co-morbid illness

- Disorders correlated with Suicidal Behavior

- More than 90% of completed suicides carry a Dx of alcoholism, depression, schizophrenia or some combination of these.

# • MOOD DISORDERS

- **15% lifetime risk of suicide**
- Absence of psychosis does not imply safety
- Concern is warranted especially when the patient appears emotionally removed, shows constricted affect or is known to have given away belongings.

# MOOD DISORDERS

- The likelihood of suicide within one year is increased when the patient exhibits:
  - Panic attacks
  - Psychic anxiety
  - Anhedonia
  - Alcohol abuse

# MOOD DISORDERS

- The likelihood of suicide during the ensuing 1-5 years is increased when the patient exhibits:
  - Increased hopelessness
  - Suicidal ideation
  - History of suicide attempts

# PANIC DISORDER

- **7-15% LIFETIME RISK OF SUICIDE**
- Suicide rate may be similar to mood disorders
- greater likelihood is correlated with more severe illness or comorbidity
- Suicide does not necessarily occur during a panic attack.

# PANIC DISORDER

- Demoralization or significant loss increases the likelihood of suicide
- Agitation may increase the likelihood of translating impulses into action.

# SCHIZOPHRENIA

- **10% lifetime risk of suicide**
- Suicide is relatively uncommon during psychotic episodes
- Relationship between command auditory hallucinations and actual suicide is not clearly causal
- Suicidal ideation occurs in 60-80% of patients

# SCHIZOPHRENIA

- Suicide attempts occur in 30-55% of patients
- Suicide potential is increased by:
  - Good pre-morbid functioning
  - Early phase of illness
  - Hopelessness or depression
  - Recognition of deterioration, eg., during a post-psychotic depressed phase

# ALCOHOLISM

- **3% Lifetime risk of suicide**
- Abusers of alcohol/drugs comprise 15-25% of suicides
- Alcohol is associated with nearly 50% of all suicides

# ALCOHOLISM

- Increased suicide potential in an alcoholic patient correlates with:
  - Active substance abuse
  - Adolescence
  - Second or third decades of illness
  - Co-morbid psychiatric illness
  - Recent or anticipated interpersonal loss
  - Substance abuse can represent self medication

# BORDERLINE PERSONALITY DISORDER

- **7% Risk of suicide**
- Higher risk associated with comorbidity, especially with mood disorder and substance abuse

# BORDERLINE PERSONALITY DISORDER

- Psychopathology associated with increased risk:
  - Impulsivity, hopelessness/despair
  - Antisocial features (with dishonesty)
  - Interpersonal aloofness (malignant narcissism)
  - Self-mutilating tendencies
  - Psychosis with bizarre attempts

# BORDERLINE PERSONALITY DISORDER

- Psychopathology associated with diminished risk
  - Infantile personality (with hysterical features)
  - Masochistic personality

# OTHER CONDITIONS

- Delirium associated with organic illness
- Other personality disorders/traits
- Psychopathology in family and social milieu including life stress and crisis
- Family history of psychiatric illness and, particularly, suicide
- Presence of firearms in the home (especially for adolescents)

# DETECTION OF SUICIDALITY

- The assessment of suicidality is an active process during which clinicians evaluate:
  - Suicidal intent and lethality
  - Dynamic meanings and motivation for suicide
  - Presence of a plan
  - Presence of overt suicidal/self-destructive behavior

# DETECTION OF SUICIDALITY

- The patient's physiological, cognitive and affective states
- The patient's coping potential
- The patient's risk factors

# RISK FACTOR CONSIDERATIONS

- Is the patient competent to participate in treatment?
- Is the patient able to develop a therapeutic alliance?
- Are suicidal thoughts/feelings present?
- What form does the patient's wish for suicide take?

# RISK FACTOR CONSIDERATIONS

- What does suicide mean to the patient?
- Has the patient lost, or anticipate losing an important relationship?
- Has the patient lost, or anticipate losing, a main reason for living?
- How far has the suicide planning process proceeded?
- Have suicidal behaviors occurred in the past?

# RISK FACTOR CONSIDERATIONS

- Has the patient engaged in self mutilating behaviors?
- Does the patient's mental state increase the potential for suicide?
- Are depression/despair present?
- Does the patient's physiologic state increase the potential for suicide?  
(illness, intoxication, pain, delirium, organic impairment)

# RISK FACTOR CONSIDERATIONS

- Is the patient vulnerable to painful affects such as aloneness, self-contempt, murderous rage, shame or panic?  
Are there recent stresses in the patient's life?
- What are the patient's capacities for self-regulation?

# QUESTIONS - DETAILS

- Suicidal Intent and Lethality
  - Are suicidal thoughts present?

# QUESTIONS - DETAILS

- Dynamic meanings and motivation for suicide

# QUESTIONS - DETAILS

- Presence of a suicidal plan

# QUESTIONS - DETAILS

- History of overt suicidal/self-destructive behavior

# QUESTIONS - DETAILS

- Patient's physiological, cognitive and affective states

# QUESTIONS - DETAILS

- Patient's coping potential

# SAD PERSONS SCALE

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# SUICIDAL RISK FACTORS

- S EX
- A GE
- D EPRESSION
- P REVIOUS ATTEMPTS
- E tOH (alcohol) use
- R ational thinking loss (psychosis)
- S ocial supports (lack of)
- O rganized plan
- N o spouse
- S ickness

# SAFETY CONTRACTING

- Original article: "NO SUICIDE DECISIONS: PATIENT MONITORING OF SUICIDAL RISK"
- Robert Drye, MD, Robert Goulding, MD, Mary Goulding, MSW
- American journal of Psychiatry Feb. 1973 130:2

# SAFETY CONTRACTING

- Enables the evaluator to make the following judgments:
  - 1. "Is suicide a risk at all for this pt?"
  - 2. "If it is a risk, to what degree and for how long can the pt be trusted not to kill himself?"

# SAFETY CONTRACTING

- “NO MATTER WHAT HAPPENS, I WILL NOT KILL MYSELF, ACCIDENTALLY, OR ON PURPOSE AT ANY TIME.”
- Pt also asked to report his internal responses to this statement
- “If the patient reports a feeling of confidence in this statement, with no direct or indirect qualifications and with no incongruous voice tones or body motions, the evaluator may dismiss suicide as a management problem.”

# SAFETY CONTRACTING

- Has been advocated by many
- Can be used as an assessment tool to uncover the nature/severity of a pt's suicidality, identify specific issues and evaluate their competency to to enter into such a contract.
- Affords an opportunity to form a therapeutic alliance.

# SAFETY CONTRACTING

- The contract is NOT legally binding and does not protect against claims of malpractice.
- **BOTTOM LINE:** No empirical evidence supports the effectiveness of no-harm contracts