Suicide

Myths, Realities, and What We Can Do to Help

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Overview

• Over 41,000 suicides in US in 2014 - only leading cause of death trending up in past decade

• 2nd leading cause of death for ages 15-35, 10th for all ages

• More die by suicide than by motor vehicle accident or by homicide (2:1)

• More have recently seen PCP than mental health professional
“Experiential” aspect of suicide

- Wish to escape from unbearable anguish, desperation
- Can feel intolerable and interminable – no beginning, middle, or end
- Risk of suicide as “solution” if feel there is no other way out
- Sometimes a “small” thing can tip the balance
“Suicide can be predicted with a thorough evaluation”

• FALSE
  – Clinicians can do a “suicide risk assessment”
  – *Not* a check list or equation
  – *Is* a cognitive assessment weighing multiple static and dynamic factors to make a reasonable, thoughtful assessment of patient’s immediate and longer term risks and needs
  – *Not* prediction: some at “low risk” complete suicide, many at “high risk” do not
Suicide Risk Assessment

• Risk Factors
• Mitigating ("protective") factors
• Communication of suicidality – direct, indirect
• Preparations/rehearsal
• Available means
• Current clinical condition
Risk Factors - Psychiatric Illness

- All major psychiatric disorders increase risk
- Especially depression (unipolar, bipolar, mixed states)
- Depression with psychotic features is highest risk
- Concurrent ETOH/drug abuse (3)
- Personality disorders – BPD, antisocial personality d/o
Risk Factors - SUDs

- Heavy alcohol consumers at 5x risk of suicide c/w social drinkers
- Heroin use disorder – suicide 5-10% of deaths
- Chronic pain and opioid use – increased risk, especially if misuse of opioids
- Suicide rates are likely underestimated in overdose deaths

Connery and Rockett, Addiction, Overdose and suicide, PCSS-O Training webinar, 2016
Risk Factors

• Gender: Male > female
  – Women more attempts, men 3-4x more completions
  – Men are more likely to use lethal means (firearms, hanging)

• Race: Native American, Alaskan Native > White > non-Hispanic blacks, Asian, Hispanic

• FH of completed suicide or suicide attempts
Risk Factors

• Adverse events – *experienced* as devastating
• Physical illness, chronic pain
• Decrease in social support/connectedness
  – Marital status – widowed, divorced, single
  – Work status: unemployed, retired
  – Living situation: alone, social isolation
Exposure and Suicide Clusters

• Exposure especially important for adolescents/young adults

• Social modeling, making it more acceptable solution

• Up to 20% of adolescents have a friend who made a suicide attempt

• Friends of suicide attempters may already be vulnerable

• How suicide/attempts are discussed can make big difference
Bullying and Cyberbullying

• 20-30% of school children report frequent involvement as victims or bullies, similar for cyberbullying (2010)

• Both victims *and* perpetrators at increased risk for suicidality, and “bully-victims” may be at highest risk
Risk Factors - Firearms

• More than 50% of all suicides in US, more than all other methods combined
  – Less frequent in MA (24% male/11% female)
• Suicide rate by state tracks with rate of gun ownership, independent of other variables
• Having gun in home increases risk for everyone, including children
• Safe storage mitigates risk to some degree
Risk Factors - Firearms

- Near lethal attempts often impulsive
  - 24% < 5 minutes
  - 48% < 20 minutes
  - 70% < 1 hour

- Firearms – quick and deadly (85%)
Clinical Risk Factors - Symptoms

- Depression + psychotic features
- SUDs – especially ETOH, opioids, opioid misuse + chronic pain
- Hopelessness
- Anxiety/agitation
- Sleep disturbance – severe insomnia, frequent nightmares
Mitigating ("Protective") Factors

- Positive relationships, including therapeutic
- Belief in capacity to cope
- Concern for family/children, others
- Sense of "belongingness"
- Active religious involvement
- Moral/spiritual beliefs
- Suicide as "unacceptable" option
“If you stop someone from killing themselves one way, they’ll probably find another”

FALSE

• Many suicidal acts are *impulsive*
• Availability of lethal means makes suicide completion more likely
• “Means restriction” works - most do *not* find other methods
“Asking a depressed person about suicide may put the idea in their heads”

• FALSE
  – Does *not* suggest suicide, or make it more likely
  – Open discussion more likely relief than intrusion
  – Risk is in *not* asking when appropriate
  – “Last straw” phenomenon
“There’s no point in asking about suicidal thoughts…if someone is going to do it they won’t tell you”

• FALSE
  – *Ambivalence* is characteristic
  – Contradictory statements/behavior not uncommon
  – Many *will* tell clinician when asked – often a relief
  – Many give some hints/warnings to friends or family, even if don’t tell clinician
“Most suicides are out of the blue, without warning”

FALSE

• Most *do* communicate - direct/indirect
• Important to take any communication seriously, and inquire
“The people who talk about suicide are not the ones who do it”

FALSE

• Most who are suicidal are ambivalent – talking about it so that someone might help
• While some complete suicide without any prior communication, generally “the talkers are the doers.”
Warning Signs

- Suicidal or self-harming behavior
- Feeling/appearing hopeless
- Talking about wanting to die
- Indirect communication (e.g., texts)
- Appearing to “give up”
- Withdrawal from family, friends
- Increasing use of drugs/ETOH
“If someone kills himself, he must have had a major mental illness”

FALSE

• Most with severe mental illness do not kill themselves
• Psychological autopsy studies: >10% of completions in absence of diagnosable mental illness
• Some may be vulnerable to suicidal states, but only under certain stressors (e.g., person whose self-esteem is based on success suffers sudden bankruptcy)
“Suicide is really an older white male problem”

• FALSE
  – In past decade, suicide in “middle aged” (35-64) has increased greatly, almost 50% for ages 50-59
  – This is now highest risk age group
  – Older white males still highest rates (esp > 85)
  – Rate for women much lower than men, but rates for middle aged women have risen faster (60-65)
He would never kill himself, because...

- He has so much to live for
- He has young children at home
- He has such a loving family
- He just paid for his upcoming vacation
- He loves his dog
- He has so many friends
He would never kill himself, because...

FALSE (may be true)

– These are all mitigating (“protective”) factors, but they can be overwhelmed by suicidal despair

– Thinking gets very constricted, often not rational

– People often feel that they are a burden
“She has tried so many times, she doesn’t really mean it”

• FALSE
  – Even low lethality self-harm increases suicide risk
  – “Gestures” vs. “non-suicidal self injury” or “deliberate self harm”
  – Greater number of past attempts → increased risk of eventual suicide
“Suicide risk is low in the absence of a prior attempt”

FALSE

• A previous suicide attempt is one of the strongest risk factors

• However, is estimated that about two thirds of suicides occur on the first attempt
“A person who wants to commit suicide is probably going to do it eventually”

• FALSE
  – >90% of those who make serious suicide attempts do not go on to kill themselves
  – Includes even most serious attempts, such as attempt to jump off Golden Gate Bridge
  – Most chronically suicidal patients do not go on to kill themselves
  – *If we can help person through suicidal crisis, this may be life saving*
“A lot of people have suicidal thoughts at some point in their lives”

TRUE

• Range of suicidal thoughts:
  – Passive suicidal ideation (e.g., “I wish I were dead, would disappear”, etc.)
  – Specific thoughts but no intent
  – Specific thoughts with some intent
  – Suicidal plan/intent/means
“A lot people have suicidal thoughts at some point in their lives”

TRUE

– “Passive” suicidal thoughts are a common human experience

– College students:
  • > 50% had thought about suicide at some point in life
  • 15% had seriously considered attempting it
  • > 5% had made an attempt
“My friend just lost a family member to suicide, but I don’t feel like I shouldn’t intrude by saying anything”

FALSE

• “Survivors” of suicide experience catastrophic grief

• Avoidance by others deprives everyone of human healing connection
“Suicide can be prevented”

TRUE…

• Much we can do to prevent suicide
  – Careful risk assessment
  – Treatment of depression and modifiable risk factors
  – Taking steps to intervene when needed, including hospitalization
“Suicide can be prevented”

But also **FALSE**

- Can’t predict, so can’t *always* prevent
- Some are able to conceal, others act impulsively
- 5% of suicides happen *in the hospital*
- Every suicide is *not* someone else’s failure – family, friends, clinicians
“We all have a role in suicide prevention”

TRUE

• Doctors, teachers, friends, family
• Taking depression, life crises seriously
• Not dismissing warning signs, statements
• Willingness to ask, even if uncomfortable
• Suggesting, facilitating professional help, and trying to ensure it when necessary
Resources


- AFSP website: [https://afsp.org/](https://afsp.org/)