

WHO/MNH/MBD/00.1

Original: English

Distr.: General

PREVENTING SUICIDE

A RESOURCE FOR GENERAL PHYSICIANS

This document is one of a series of resources addressed to specific social and professional groups particularly relevant to the prevention of suicide.

It has been prepared as part of SUPRE, the WHO worldwide initiative for the prevention of suicide.

Keywords: suicide / prevention / resources / general physicians / training / primary health care.

Mental and Behavioural Disorders
Department of Mental Health
World Health Organization
Geneva
2000

© World Health Organization, 2000

This document is not a formal publication of the World Health Organization (WHO), and all rights are reserved by the Organization. The document may, however, be freely reviewed, abstracted, reproduced or translated, in part or in whole, but not for sale in conjunction with commercial purposes.

The views expressed in documents by named authors are solely the responsibility of those authors.

CONTENTS

Foreword.....	4
The burden of suicide.....	5
Suicide and mental disorders.....	5
Suicide and physical disorders.....	8
Suicide and sociodemographic factors.....	9
How to identify patients at high risk of suicidal behaviour.....	10
Management of suicidal patients.....	12
Referral to specialist care.....	13
Summary of steps in suicide prevention.....	13
References.....	15

FOREWORD

Suicide is a complex phenomenon that has attracted the attention of philosophers, theologians, physicians, sociologists and artists over the centuries; according to the French philosopher Albert Camus, in *The Myth of Sisyphus*, it is the only serious philosophical problem.

As a serious public health problem it demands our attention, but its prevention and control, unfortunately, are no easy task. State-of-the-art research indicates that the prevention of suicide, while feasible, involves a whole series of activities, ranging from the provision of the best possible conditions for bringing up our children and youth, through the effective treatment of mental disorders, to the environmental control of risk factors. Appropriate dissemination of information and awareness-raising are essential elements in the success of suicide prevention programmes.

In 1999 WHO launched SUPRE, its worldwide initiative for the prevention of suicide. This booklet is one of a series of resources prepared as part of SUPRE and addressed to specific social and professional groups that are particularly relevant to the prevention of suicide. It represents a link in a long and diversified chain involving a wide range of people and groups, including health professionals, educators, social agencies, governments, legislators, social communicators, law enforcers, families and communities.

We are particularly indebted to Dr Jean-Pierre Soubrier, Groupe Hospitalier Cochin, Paris, France, who produced an earlier version of this booklet. The text was subsequently reviewed by the following members of the WHO International Network for Suicide Prevention, to whom we are grateful:

Dr Sergio Pérez Barrero, Hospital de Bayamo, Granma, Cuba

Dr Annette Beautrais, Christchurch School of Medicine, Christchurch, New Zealand

Professor Diego de Leo, Griffith University, Brisbane, Australia

Dr Ahmed Okasha, Ain Shams University, Cairo, Egypt

Professor Lourens Schlebusch, University of Natal, Durban, South Africa

Dr Airi Värnik, Tartu University, Tallinn, Estonia

Professor Danuta Wasserman, National Centre for Suicide Research and Control, Stockholm, Sweden

Dr Shutao Zhai, Nanjing Medical University Brain Hospital, Nanjing, China.

Our gratitude also goes to Dr Lakshmi Vijayakumar, SNEHA, Chennai, India, for her assistance in the technical editing of earlier versions of these resources.

The resources are now being widely disseminated, in the hope that they will be translated and adapted to local conditions - a prerequisite for their effectiveness. Comments and requests for permission to translate and adapt them will be welcome.

Dr J. M. Bertolote
Coordinator, Mental and Behavioural Disorders
Department of Mental Health
World Health Organization

PREVENTING SUICIDE

A RESOURCE FOR GENERAL PHYSICIANS

One of the worst things a physician has to face is the suicide of a patient. The common reactions experienced by physicians who have gone through such an event are disbelief, loss of confidence, anger and shame. The suicide of a patient can trigger feelings of professional inadequacy, doubts about one's competence and fear for one's reputation. In addition, physicians confront the enormous difficulty of dealing with the family and friends of the deceased.

These resources are intended primarily for general physicians. Their objective is to outline the main disorders and other factors associated with suicide, and to provide information on the identification and management of suicidal patients.

THE BURDEN OF SUICIDE

According to WHO estimates approximately one million people are likely to commit suicide in the year 2000. Suicide is among the top 10 causes of death in every country, and one of the three leading causes of death in the 15 to 35-year age group.

The psychological and social impact of suicide on the family and society is immeasurable. On average, single suicide intimately affects at least six other people. If a suicide occurs in a school or workplace it has an impact on hundreds of people.

The burden of suicide can be estimated in terms of DALYs (disability-adjusted life years). According to this indicator, in 1998 suicide was responsible for 1.8% of the total burden of disease worldwide, varying between 2.3% in high-income countries and 1.7% in low-income countries. This is equal to the burden due to wars and homicide, roughly twice the burden of diabetes, and equal to the burden of birth asphyxia and trauma.

SUICIDE AND MENTAL DISORDERS

Suicide is now understood as a multidimensional disorder, which results from a complex interaction of biological, genetic, psychological, sociological and environmental factors. Research has shown that between 40% and 60% of people who commit suicide had seen a physician in the month prior to suicide; of these, many more had seen a general physician rather than a psychiatrist. In countries where the mental health services are not well developed, the proportion of people in suicidal crisis consulting a general physician is likely to be higher.

To identify, assess and manage suicidal patients is an important task of the physician, who has a crucial role in suicide prevention.

Suicide is in itself not a disease,
nor necessarily the manifestation of a disease,
but mental disorders are a major factor
associated with suicide.

Studies from both developing and developed countries reveal an overall prevalence of mental disorders of 80-100% in cases of completed suicide. It is estimated that the lifetime risk of suicide in people with mood disorders (chiefly depression) is 6-15%; with alcoholism, 7-15%; and with schizophrenia, 4-10%.

However, a substantial proportion of people who commit suicide die without having seen a mental health professional. Hence improved detection, referral and management of psychiatric disorders in primary care is an important step in suicide prevention.

A common finding in those who commit suicide is the presence of more than one disorder. The common disorders occurring together are alcoholism and mood disorder (i.e. depression), and personality disorder and other psychiatric disorders.

Collaborating with the psychiatrist and ensuring that adequate and appropriate treatment is given is a crucial function of the physician.

Mood disorders

All types of mood disorders have been associated with suicide. These include bipolar affective disorder, depressive episode, recurrent depressive disorder and persistent mood disorders (e.g. cyclothymia and dysthymia), which form categories F31-F34 in ICD-10 (1). Suicide is therefore a significant risk in unrecognized and untreated depression. Depression has a high prevalence in the general population and is not recognized by many as a disease. It is estimated that 30% of patients seen by a physician are suffering from depression. Roughly 60% of those who do seek treatment initially contact a general practitioner. It is a special challenge for the physician to work with both physical disease and psychological disorders simultaneously. In many instances, depression is masked and patients present only with somatic complaints.

In typical depressive episodes, the individual usually suffers from:

- depressed mood (sadness)
- loss of interest and enjoyment
- reduced energy (fatiguability and diminished activity)

Common presenting symptoms of depression are:

- Tiredness
- Sadness
- Lack of concentration
- Anxiety
- Irritability
- Sleep disturbances
- Pain in different parts of the body.

These symptoms should alert the physician to the presence of depression and lead to an assessment of the suicide risk. Specific clinical features associated with increased risk of suicide in depression are (2):

- Persistent insomnia
- Self-neglect
- Severe illness (particularly psychotic depression)

- Impaired memory
- Agitation
- Panic attacks.

The following factors increase the risk of suicide in people with depression (3):

- Age below 25 years in men
- Early phase of the illness
- Abuse of alcohol
- Depressed phase of a bipolar disorder
- Mixed (manic-depressive) state
- Psychotic mania.

Depression is an important factor in suicide among both adolescents and the elderly but those with late onset of depression are at a higher risk.

Recent advances in the treatment of depression are very relevant for suicide prevention in primary care. Education of the general practitioner in identifying and treating depression was found to reduce suicide in Sweden (4). Epidemiological data suggest that antidepressants reduce suicide risk among the depressed. The full therapeutic dose of medication should be continued for several months. In the elderly it may be necessary to continue treatment for two years after recovery. Patients on regular lithium maintenance therapy have been found to have lower suicide risk (5).

Alcoholism

Alcoholism (both alcohol abuse and dependence on alcohol) is a frequent diagnosis in those who have committed suicide, particularly in young people. There are biological, psychological and social explanations for the correlation between suicide and alcoholism. Specific factors associated with increased suicide risk among alcoholics are :

- Early onset of alcoholism
- Long history of drinking
- High level of dependence
- Depressed mood
- Poor physical health
- Poor work performance
- Family history of alcoholism
- Recent disruption or loss of a major interpersonal relationship.

Schizophrenia

Suicide is the largest single cause of premature death among schizophrenics. Specific risk factors for suicide are (6):

- Young unemployed male
- Recurrent relapses
- Fear of deterioration, especially in those of high intellectual ability
- Positive symptoms of suspiciousness and delusions

- Depressive symptoms.

The suicide risk is highest at the following times:

- Early stages of the illness
- Early relapse
- Early recovery.

Suicide risk decreases with increasing duration of the illness.

Personality disorders

Recent studies on young people who committed suicide have shown a high prevalence (20-50%) of personality disorder. The personality disorders that are more frequently associated with suicide are borderline personality and antisocial personality disorders (7).

Histrionic and narcissistic personality disorders and certain psychological traits such as impulsivity and aggression, have also been associated with suicide.

Anxiety disorders

Among anxiety disorders, panic disorder has been most frequently associated with suicide, followed by obsessive-compulsive disorder (OCD). Somatoform disorder and eating disorders (anorexia nervosa and bulimia) are also related to suicidal behaviour.

SUICIDE AND PHYSICAL DISORDERS

Suicide risk is increased in chronic physical illness (8). In addition, there is generally an increased rate of psychiatric disorder, especially depression, in people with physical illness. Chronicity, disability and negative prognosis are correlated with suicide.

Neurological diseases

Epilepsy has been associated with increased suicide. The increase has been attributed to the increased impulsivity, aggressivity and chronic disability associated with epilepsy.

Spinal and brain injuries also increase the risk of suicide. Recent studies have shown that after a stroke - particularly in the presence of posterior lesions, which cause greater disability and physical impairment - 19% of patients are depressed and suicidal.

Neoplasms

The risk of suicide is highest at the time of diagnosis and in the first two years of the terminal illness with an increase in risk in cases of progressive malignancy. Pain is a significant contributing factor to suicide.

HIV/AIDS

HIV infection and AIDS represent an increased risk of suicide in the young, with high suicide rates. The risk is greater at the time of confirmation of the diagnosis and in the early stages of the illness. Intravenous drug users are at still higher risk.

Other conditions

Other chronic medical conditions such as chronic renal disease, liver disease, bone and joint disorders, cardiovascular disease and gastrointestinal disorders are implicated in suicide. Disabilities of locomotion, blindness and deafness can also precipitate a suicide.

In recent years euthanasia and assisted suicide have become issues that may confront the physician. Active euthanasia is illegal in almost all jurisdictions, and assisted suicide is enmeshed in moral, ethical and philosophical controversy.

SUICIDE AND SOCIODEMOGRAPHIC FACTORS

Suicide is an individual act; however, it occurs in the context of a given society, and certain sociodemographic factors are associated with it.

Sex

In the majority of countries, more males commit suicide than females; the male/female ratio varies from country to country. China is the only country in which female suicides outnumber male suicides in rural areas and are approximately equal to male suicides in urban areas.

Age

The elderly (above 65 years) and the younger (15-30 years) age groups are at increased risk of suicide. Recent data suggest an increase in suicide rates in middle-aged men.

Marital status

Divorced, widowed and single people are at increased risk of suicide. Marriage appears to be protective for males in terms of suicide risk but not significantly so for females. Marital separation and living alone increase the risk of suicide.

Occupation

Certain occupational groups such as veterinary surgeons, pharmacists, dentists, farmers and medical practitioners have a higher risk of suicide. There is no obvious explanation for this finding, though access to lethal means, work pressure, social isolation and financial difficulties might be the reasons.

Unemployment

There are fairly strong associations between unemployment rates and suicide rates, but the nature of these associations is complex. The effects of unemployment are probably mediated by factors such as poverty, social deprivation, domestic difficulties and hopelessness. On the other hand, people with mental disorders are more likely to be unemployed than people in good mental health. At any rate, due consideration should be given to the difference in the significance of recent loss of employment and long-term unemployment: greater risk is associated with the former.

Rural/urban residence

In some countries suicides are more frequent in urban areas, whereas in others they occur more frequently in rural areas.

Migration

Migration - with its attendant problems of poverty, poor housing, lack of social support and unmet expectations - increases the risk of suicide.

Other

Certain social factors, such as the ready availability of the means of committing suicide and stressful life events play a significant role in increasing the risk of suicide.

HOW TO IDENTIFY PATIENTS AT HIGH RISK OF SUICIDAL BEHAVIOUR

A number of clinically useful individual and sociodemographic factors are associated with suicide (9). They include:

- Psychiatric disorders (generally depression, alcoholism and personality disorders);
- Physical illness (terminal, painful or debilitating illness, AIDS);
- Previous suicide attempts;
- Family history of suicide, alcoholism and/or other psychiatric disorders;
- Divorced, widowed or single status;
- Living alone (socially isolated);
- Unemployed or retired;
- Bereavement in childhood.

If the patient is under psychiatric treatment, the risk is higher in:

- Those who have recently been discharged from hospital;
- Those who have made previous suicide attempts.

In addition, recent life stressors associated with increased risk of suicide include:

- Marital separation;
- Bereavement;
- Family disturbances;
- Change in occupational or financial status;
- Rejection by a significant person;
- Shame and threat of being found guilty.

There are various scales to assess suicide risk in surveys, but they are less useful than a good clinical interview in identifying the individual who is at immediate risk of committing suicide.

The physician may be confronted with a variety of conditions and situations associated with suicidal behaviour. An elderly male, recently widowed, treated for depression, living alone, with a history of attempted suicide, and a young lady with a few scratches on the forearm whose boyfriend has left her are two contrasting examples. In reality, most patients fall between those two extremes and they may fluctuate from one category to the other.

When physicians have a reasonable indication that the patient could be suicidal, they face the dilemma of how to proceed. Some physicians are uncomfortable with suicidal patients. It is important for them to be aware of that feeling and to seek help from colleagues, and possibly

mental health professionals, when confronted with such patients. It is essential not to ignore or deny the risk.

If the physician decides to proceed, the first and most immediate step is mentally to allocate adequate time to the patient, even though many others may be waiting outside the room. By showing a willingness to understand, the physician starts to establish a positive rapport with the patient. Closed-ended and direct questions at the beginning of the interview are not very helpful. Remarks like "You look very upset; tell me more about it" are useful. Listening with empathy is in itself a major step in reducing the level of suicidal despair.

Myths	Reality
Patients who talk about suicide rarely commit suicide.	Patients who commit suicide have usually given some clue or warning beforehand. Threats must also be taken seriously.
Asking about suicide in a patient may provoke suicidal acts.	Asking about suicide will often reduce the anxiety surrounding the feeling; the patient may feel relieved and better understood.

How to ask?

It is not easy to ask patients about their suicidal ideas. It is helpful to lead into the topic gradually. A sequence of useful questions is:

1. Do you feel unhappy and helpless?
2. Do you feel desperate?
3. Do you feel unable to face each day?
4. Do you feel life is a burden?
5. Do you feel life is not worth living?
6. Do you feel like committing suicide?

When to ask?

It is important to ask these questions:

- After a rapport has been established;
- When the patient feels comfortable about expressing his or her feelings;
- When the patient is in the process of expressing negative feelings.

Further questions

The process does not end with confirmation of the presence of suicidal ideas. It continues with further questions aimed at assessing the frequency and severity of the idea and the possibility of suicide. It is important to know whether the patient has made any plans and has the means to commit suicide. If a patient mentions that the method planned is shooting, but has no access to a gun, the risk is lower. However, if a patient has planned a method and is in possession of the means (e.g. pills), or if the proposed means are easily accessible, the suicide

risk is higher. It is crucial for questions not to be demanding or coercive, but to be asked in a warm way showing the physician's empathy with the patient. Such questions might include:

- Have you made any plans for ending your life?
- How are you planning to do it?
- Do you have in your possession [pills / guns / other means]?
- Have you considered when to do it?

Caution

- *Misleading or false improvement.* When an agitated patient suddenly appears calm, he or she may have made the decision to commit suicide and hence feel calm after making the decision.
- *Denial.* Patients who have very serious intentions of killing themselves may deliberately deny such ideas.

MANAGEMENT OF SUICIDAL PATIENTS

If a patient is emotionally disturbed, with vague suicidal thoughts, the opportunity of ventilating thoughts and feelings to a physician who shows concern may be sufficient. Nevertheless, an opportunity for further follow-up should be left open, particularly if the patient has inadequate social support. Whatever the problem, the feelings of the suicidal person are usually a triad of helplessness, hopelessness and despair. The three most common states are:

1. *Ambivalence.* The majority of suicidal patients are ambivalent till the very end. There is a see-saw battle between the wish to live and the wish to die. If the ambivalence is used by the physician to increase the wish to live, the suicide risk may be reduced.
2. *Impulsivity.* Suicide is an impulsive phenomenon and impulse by its very nature is transient. If support is provided at the moment of impulse, the crisis may be defused.
3. *Rigidity.* Suicidal people are constricted in their thinking, mood and action and their reasoning is dichotomized in terms of either/or. By exploring several possible alternatives to death with the suicidal patient, the physician gently makes the patient realize that there are other options, even if they are not ideal.

Enlisting support

The physician should assess the available support systems, identify a relative, friend, acquaintance or other person who would be supportive to the patient, and solicit that person's help.

Contracting

Entering into a "no suicide" contract is a useful technique in suicide prevention. Other people close to the patient can be included in negotiating the contract. The negotiation of the contract can promote discussion of various relevant issues. In the majority of instances patients respect the promises they give to a physician. Contracting is appropriate only when patients have control over their actions.

In the absence of severe psychiatric disorder or suicidal intent, the physician can initiate and arrange pharmacological treatment, generally with antidepressants, and psychological (cognitive behaviour) therapy. The majority of people benefit from continuing contacts; these should be structured to meet individual needs.

Except for the treatment of underlying diseases, few persons require support for longer than two or three months and the focus of the support should be providing hope, encouraging independence, and helping the patient to learn different ways of coping with life stressors.

REFERRAL TO SPECIALIST CARE

When to refer a patient

Patients should be referred to a psychiatrist when they have:

- A psychiatric disorder;
- A history of a previous suicide attempt;
- A family history of suicide, alcoholism and psychiatric disorder;
- Physical ill-health;
- No social support.

How to refer

After deciding to refer a patient, the physician should:

- Take the time to explain to the patient the reason for the referral;
- Allay anxiety about stigma and about psychotropic medication;
- Make clear that pharmacological and psychological therapies are effective;
- Emphasize that referral does not mean "abandonment"
- Arrange an appointment with the psychiatrist;
- Allocate a time for the patient after his or her appointment with the psychiatrist;
- Ensure that the relationship with the patient continues.

When to hospitalize a patient

These are some of the indications for immediate hospitalization:

- Recurrent thoughts of suicide;
- High level of intent to die in the immediate future (the next few hours or days);
- Agitation or panic;
- Existence of a plan to use a violent and immediate method.

How to hospitalize the patient

- Do not leave the patient alone;
- Arrange for hospitalization;
- Arrange for transfer to the hospital by ambulance or the police;
- Inform the concerned authorities and family.

SUMMARY OF STEPS IN SUICIDE PREVENTION

The following table summarizes the main steps for the assessment and management of patients when the physician suspects or identifies a suicide risk.

Suicide risk: identification, assessment and plan of action

Suicide risk	Symptom	Assessment	Action
0	No distress	-	-
1	Emotionally disturbed	Enquire about suicidal thoughts	Listen with empathy
2	Vague ideas of death	Enquire about suicidal thoughts	Listen with empathy
3	Vague suicidal thoughts	Assess the intent (plan and method)	Explore possibilities Identify support
4	Suicidal ideas, but no psychiatric disorder	Assess the intent (plan and method)	Explore possibilities Identify support
5	Suicidal ideas and psychiatric disorder or severe life stressors	Assess the intent (plan and method) Make a contract	Refer to psychiatrist
6	Suicidal ideas and psychiatric disorder or severe life stressors or agitation and previous attempt	Stay with the patient (to prevent access to means)	Hospitalize

REFERENCES

1. WHO. International Statistical Classification of Diseases and Related Health Problems, Tenth Revision. Vol. 1. Geneva, World Health Organization, 1992.
2. Angst J, Angst F, Stossen HM. Suicide risk in patients with major depressive disorders. *Journal of clinical psychiatry*, 1999, 60, Suppl. 2: 57-62.
3. Simpson SG, Jamison KR. The risk of suicide in patients with bipolar disorder. *Journal of clinical psychiatry*, 1999, 60, Suppl. 2: 53-56.
4. Rutz W, von Knorring L, Walinder J. Long-term effects of an education programme for general practitioners given by the Swedish Committee for Prevention and Treatment of Depression. *Acta psychiatrica scandinavica*, 1992, 85: 83-88.
5. Schou M. The effect of prophylactic lithium treatment on mortality and suicidal behaviour. *Journal of affective disorders*, 1998, 50: 253-259.
6. Gupta S, et al. Factors associated with suicide attempts among patients with schizophrenia. *Psychiatric services*, 1998, 10: 1353-1355.
7. Isometsa ET, et al. Suicide among subjects with personality disorders. *American journal of psychiatry*, 1996, 153: 667-673.
8. González Seijo JC, et al. Poblaciones específicas de alto riesgo. [Population groups at high risk.] In: Bobes García J et al., eds. *Prevención de las conductas suicidas y parasuicidas*. [Prevention of suicidal and parasuicidal behaviours.] Masson, Barcelona, 1997, 69-77.
9. Gunnell D, Frankel S. Prevention of suicide: aspirations and evidences. *British medical journal*, 1999, 308: 1227-1233.