TREATMENT AND MANAGEMENT FOR SUICIDE ATTEMPT

Yagatheeswaran Ketheeswaran

Udayana University, School of Medicine, Denpasar

ABSTRACT

Suicidal behavior is a leading cause of injury and death worldwide. Suicide attempt is more prevalent among men, whereas nonfatal suicidal behaviours are more prevalent among women and persons who are young, are unmarried, or have a psychiatric disorder. Despite an increase in the treatment of suicidal persons over the past decade, incidence rates of suicidal behavior have remained largely unchanged.

Key words: psychiatric, suicide attempt

INTRODUCTION

Suicide attempt is something which happens every year. The definition of suicide attempt is a potentially self injurious behaviour with a nonfatal outcome for which there is evidence, either explicit or implicit, that the individual intended to kill himself or herself.[1] The attempter survives in the end as the attempt is unsuccessful. Completed suicide is a self destructive act in which the individual kills himself or herself. Suicide ideation is the thinking or planning of self destruction but no action is taken. Suicide is the forth main cause of death for adults age between 18 to 65 in 2002.[1] Complete suicide rate is more than four times higher in men compared to women.[2] But the suicide attempt rate is four times higher in women comparatively than men.[3] This is because, for women attempting suicide is actually a seeking-help act. Their primary motive is for a change.[3] They are expecting to be discovered and get some help in solving their problems. So, their method of suicide attempt is classified as low lethality such as drinking pesticides. But men are determine to die when he attempt.

Men plan their method discreetly as their unambiguous wish to die is frequent and intense. This makes rescue unlikely.[3]

There are few factors that can trigger suicide ideation or suicide attempt. Mental health disorder plays a major role in which 60% of the suicides are associated mainly with major depressive disorders, schizophrenia, mood disorders and bipolar disorders.[4] Other than that, availability of lethal means such as pesticides, alcohol and drug abuse, access to psychiatric treatment, attitudes to suicide, help-seeking behaviour, physical illness, marital status, age, and sex can be the predisposing factors for attempted suicide.[4] This behaviour disorder can be treated with pharmacotherapy as well as non-pharmacotherapy to erase the suicidal ideation and also to prevent re-attempt for suicide. Selective serotonin reuptake inhibitors (SSRI) is proved to have decreased the number of suicide attempt generally.[4] Cognitive-behavioural therapy is effective along with pharmacotherapy.[1]

SUICIDE ASSESSMENT

The suicide risk assessment includes a number of components that allow the psychiatrist to form a clinical judgment of a patient's risk for suicide and to develop a treatment plan concordant with that risk and with the goal of reducing that risk. These components include an appreciation of the multiple factors that contribute to suicidal behaviours, a thorough psychiatric evaluation, a specific suicide inquiry, determination of level of risk, development of a treatment plan, and relevant documentations.[5]

The psychiatric evaluation serves as the foundation of the suicide assessment. During the evaluation, the psychiatrist must be aware of, appreciate, and seek to identify relevant suicide risk and protective factors. Areas to be evaluated during the assessment include the patient's current and past psychiatric diagnoses, with attention to any comorbidity. Family and personal history of suicide, attempts, and mental illness, as well as individual strengths and

vulnerabilities, should also be evaluated, as should acute and chronic life stressors, possible protective factors, and current complaints, symptoms, and mental state. In particular, the presence or absence of any hopelessness, anxiety, and substance use should be assessed. It is useful to evaluate suicidal thoughts, plans, and behaviours through direct questions about current and past suicidal thoughts and actions.[3] If the patient is not forthcoming it may be necessary to seek history from collateral sources.

A complete psychiatric history and evaluation is crucial to the assessment process because the presence of a psychiatric disorder is probably the most significant risk factor for suicide as more than 90% of persons who die from suicide satisfy the criteria for one or more psychiatric disorders.[5] Affective disorders, primarily major depressive disorder or mixed episodes, cluster B personality disorders, schizophrenia, and substance use disorders, carry the highest risk of suicide. Comorbid psychiatric diagnoses, especially those mentioned above, increase suicide risk.

Thus, a suicide risk assessment includes a multi-axial differential diagnosis and an estimation of suicide risk as low, moderate, or high. Estimating the degree of the patient's suicide risk guides decisions about immediate safety measures and the most appropriate treatment setting. Awareness of specific high-risk diagnoses and modifiable risk factors helps identify treatment targets and clarifies treatment planning in both the short and long term.[5]

The amount of information that can be gathered in a psychiatric evaluation varies with treatment setting and the ability or willingness of the patient and other sources to provide accurate information. In some situations, the psychiatrist's initial focus may need to be on the areas judged most relevant, leaving further evaluation to be done at subsequent contacts. However, the psychiatrist is advised to obtain sufficient information to determine suicide risk. The extent of information needed will be based upon the psychiatrist's judgment.[5]

Depending on the clinical situation, information can come from collateral sources such as family, friends, and other healthcare providers. An added benefit of contacting members of the patient's support system is that it provides the psychiatrist an opportunity to assess that network. Often this can be accomplished simply by listening to the collateral sources, without revealing private or confidential information about the patient.[5] However, when information needs to be shared to maintain the safety of the patient or others, the psychiatrist may have to, and should, breach confidentiality.[5] Documentation of the assessment, including risk level and treatment plan, is essential for risk-management purposes and for conveying important information about the patient's status and changes in status over time.

IMMEDIATE TREATMENT

There are several things that go into treatment for suicidal. Initially, after a suicide attempt has been made, crisis intervention is very important where physical examination and evaluation is necessary. Emergency measures may be necessary after a person has attempted suicide. First aid, CPR, or mouth-to-mouth resuscitation may be required. Physical treatment is a necessary part of suicide treatment because he or she is in danger of harming him or her self until stability is achieved. Hospitalization is often needed to treat the recent actions and to prevent future attempts. Psychiatric intervention is one of the most important aspects of treatment. The mental health portion of treatment for suicidal includes an evaluation of the person's life leading up to the suicide attempt, as well as an evaluation of the family and home situation. These factors are important parts of determining the person's individual needs, as well as figuring out which treatment options would work best with the person's situation.[5]

There are several options that can be incorporated into the treatment when one needs treatment for suicidal thoughts or suicidal attempts. Individual therapy is to help the involved

person to get through suicidal thoughts or feeling.[6] Family therapy is to provide a supporting environment for the person, especially when the involved person is a teenager and also for the family to help them cope with the problem together. Sometimes, hospitalization is necessary to provide, secure, safe and constantly supervised environment especially in the extreme cases.[6]

PSYCHIATRIC MANAGEMENT OF SUICIDAL PATIENTS

Because suicidal thoughts and behaviours may present across the entire spectrum of diagnostic categories, a large variety of therapeutic interventions are included under the broad umbrella of psychiatric management of suicidal patients. Psychiatric management is defines as including the determination of a setting for treatment and supervision and attendance to patient safety.[5] In addition, management includes working to establish a cooperative and collaborative physician patient relationship.

Psychiatric management is more extensive for patients in ongoing treatment. Management for these patients includes establishing and maintaining a therapeutic alliance, coordinating treatment provided by multiple clinicians, monitoring the patient's progress and response to the treatment plan, and conducting ongoing assessments of the patient's safety, psychiatric status, and level of functioning.[5] In addition, encouraging treatment adherence and providing education to the patient and, when indicated, family members may also be included.

In general, treatment should be provided in the least restrictive environment that still provides safe and effective treatment for the patient. The choice of treatment setting will be based on the estimate of suicide risk determined through the psychiatric evaluation and the suicide assessment. In addition, the benefits of intensive interventions such as hospitalization must be weighed against their possible negative effects offers specific guidelines for selecting a treatment setting.[5]

Although widely used, the no-harm or suicide prevention contract must not take the place of a thorough suicide risk assessment.[5] Contracts have not been demonstrated to reduce suicide, and reliance on contracts may reduce staff vigilance about a patient without reducing the patient's suicide risk. Patient discharge or hospitalization should not be based on the patient's willingness or reluctance to enter into a suicide prevention contract.[6] No-harm contracts may be useful in opening up conversation on the availability of clinicians and staff for support, especially in inpatient settings. However, the no-harm contract specifically is not recommended for use with new patients, in emergency room settings or with psychotic or impulsive patients.[5]

Both pharmacotherapy and psychosocial interventions, including psychotherapy are considered when developing a treatment plan for a patient with suicidal thoughts and behaviours.[3] The psychiatrist should address the modifiable risk factors previously identified and continue to assess the patient during the course of treatment. Pharmacotherapy is often focused on acute symptom relief, whereas psychotherapies tend to have broader and longer-term goals related to the patient's psychosocial functioning.[2]

PHARMACOTHERAPY

Suicidal rates decreased with the higher prescription rates of antidepressant.[4] Antidepressants are a mainstay in the treatment of suicidal patients with acute, recurrent, or chronic depressive illness. They also may be effective in treatment of anxiety disorders. Surprisingly, there is limited evidence that antidepressants reduce suicide risk.[5] Because depression is one of the most significant risk factors for suicide, however, antidepressants may be essential in the treatment of suicidal patients for depressive-symptom reduction. Selective serotonin reuptake inhibitor (SSRI) such as fluoxetine is an effective antidepressant which will improve psychomotor withdrawal in patient and permitting them to act on

preexisting suicidal impulses.[3] Prescriptions for suicidal patients should be conservative quantities of antidepressants with low lethality in overdose. Sedating antidepressants may be used to treat prominent insomnia. Psychiatrists should monitor patients closely during the early weeks of antidepressant treatment. Suicidally depressed inpatients especially, must be treated in a locked room where the windows are shatterproof and nearing nursing station for close observations.[3] Patients should be informed that symptom relief may not occur for a period of days or weeks and be advised that recovery is sometimes uneven and setbacks are possible even when medication is being administered.[5] Geographic regions or demographic groups with the highest SSRI prescription rates have the lowest suicide rates as its efficacy is established for major depression which contributes mainly for suicidal.[4]

Severe insomnia, agitation, panic attacks, and psychic anxiety are associated with an increased risk of suicide. Benzodiazepines can address these symptoms and may be indicated for short-term symptom reduction. The longer-acting agents are preferred over short-acting agents. The benefits of benzodiazepine treatment should be examined carefully. Their occasional tendency to produce disinhibition and their potential for interactions with other sedatives, including alcohol, must be considered. Agents with sedating effects such as trazodone, some second-generation antipsychotics, and some anticonvulsants may also be used to treat highly anxious and agitated patients. If benzodiazepines are being discontinued after prolonged use, their doses should be reduced gradually and the patient monitored for increasing symptoms of anxiety, agitation, depression or suicidal.[5]

Recent studies have shown major reductions in the risk of both suicide and suicide attempts associated with long-term maintenance treatment of bipolar disorder with lithium salts. There is moderate evidence for a similar anti-suicide effect of lithium on patients with major depressive disorder. Although certain anti-convulsants have demonstrated effectiveness in treating mania, there is no evidence to date of any associated protection against suicide. The

risk–benefit analysis regarding prescription of mood stabilizers must include the anti-suicide effect of lithium but also its potential toxicity in overdose.[5]

Electroconvulsive therapy (ECT) has established efficacy in patients with severe depressive illness with or without psychotic features. Electroconvulsive therapy is associated with a rapid and robust antidepressant response as well as a rapid reduction of suicidal thoughts. Electroconvulsive therapy is the treatment of choice for patients with catatonic features, regardless of diagnosis. Electroconvulsive therapy may also be indicated for suicidal patients for whom medication is not appropriate because of pregnancy or prior treatment failure. Maintenance medication or electroconvulsive therapy is necessary for long-term reduction of suicide risk.[5]

Antipsychotic medications are an essential treatment for patients with psychotic symptoms and disorders. For highly agitated patients, antipsychotics may reduce suidice risk. One recent study has addressed this issue, where this mirror image study assessed suicidality in a prospective follow-up of 88 neuroleptic-resistant schizophrenics who were treated with clozapine.[6] They found that suicide attempts were dramatically and significantly reduced following initiation of this drug. Anti-suicide benefits need to be weighed against risk of serious side effects, including agranulocytosis and myocarditis, associated with clozapine treatment. Second-generation antipsychotic agents are generally preferred over first-generation agents.[5]

Hopelessness may be an especially important marker for the need to treat a depressive syndrome aggressively. Although negative symptomatology and the deficit syndrome may be associated with reduced suicide risk in schizophrenic patients, the presence of these conditions should not reduce a clinician's vigilance, because they too may mask a clinically significant depressive syndrome.[7]

Twenty percent of inpatients and 40% to 70% of outpatients with schizophrenia are estimated to be medication-noncompliant, the most common cause of relapse. No study of which we are aware has yet examined the association between medication noncompliance and suicide risk. However, because each of these may reflect the demoralization and frustration of having a chronic and deteriorating illness, such investigation is warranted.

BEHAVIOURAL AND PSYCHOSOCIAL TREATMENT

According to several studies, intensive follow-up treatment or intensive case management, interpersonal psychotherapy or cognitive behaviour therapy as well as cognitive behaviour therapy or problem-solving therapy are effective for reducing suicide behaviour.[1] Cognitive behavioural therapy proved to have halved the reattempt rates. Other therapies improved treatment adherence and decreased suicide attempt rates compared to standard therapy.[4]

Clinical consensus suggests, however, that psychosocial interventions and specific psychotherapeutic approaches are beneficial in reducing risk of suicide. Regardless of the theoretical basis or type, the key element in psychotherapy is a positive and sustaining therapeutic relationship. Psychotherapy is especially important in the early stages of a patient's illness to target issues such as denial of symptoms and lack of insight. It is also recommended to help manage hopelessness, anxiety, and other symptoms. Intuitively, the better the therapeutic alliance, the more likely the patient is to be treatment compliant.

Psychotherapy has demonstrated efficacy in treating disorders associated with increased suicide risk, such as depression and borderline personality disorder, and may, therefore, be seen as appropriate treatment for suicidal behaviours. Cognitive behavioural therapy may be useful in addressing such risk factors as hopelessness. Another form of therapy, dialectical behavioural therapy, has been studied for effects in a narrow range of potentially suicidal patients, particularly chronically suicidal or self-harming women with personality disorders.[7]

Overall, research and clinical experience indicate a combination of psychosocial interventions and pharmacotherapy offers the best strategy for reducing suicidal behaviours.

Self-injurious behaviours and suicidality are chronic and repetitive for some patients. These behaviours often result in frequent contacts with the healthcare system. It is important to recognize that self-injurious behaviours may or may not be associated with suicidal intent. Although self-injurious behaviours are sometimes characterized as 'gestures' aimed at achieving secondary gains such as receiving attention and avoiding responsibility through hospitalizations, patients' motivations for such behaviours are quite different. Behavioural techniques are particularly useful for patients with chronic behaviour.[5] Chronic suicidal ideation generally is best treated on an outpatient basis, as long as both a supportive living situation and an ongoing doctor–patient relationship are available. For patients with chronic suicidal behaviour who have difficulties with treatment adherence, clinicians should be familiar with local statutes on involuntary outpatient treatment.[3] The psychiatrists are cautious to monitor their own feelings, including counter transference reaction, and advises that consultation with a colleague may be helpful.[5]

Research on behavioural and psychosocial approaches to management of suicide risk in patients with schizophrenia is sparse. Researchers underscored the value of empathic support in diminishing suicide risk. They advise that the clinician acknowledge the patient's despair, address his or her losses, and help establish new, accessible goals and tasks. Families can provide support, prevent social isolation, and maintain a stable, accepting environment as key components of psychosocial treatment.[6] A cognitive approach may be useful in helping the patient recognize suicidal urges and acknowledge them to his or her health care providers. Cognitive-behavioural therapy will be very effective when combined with pharmacotherapy to produce best results.[8]

FOLLOW UP CARES

As noted, discharge is an especially tenuous time through which close patient-therapist alliances must be maintained. Rehabilitative measures and supportive therapeutic contacts must be established. Most mental health disorders are chronic and tend to recurrent[3] and compliance with maintenance medications is poor. Most patients showing symptoms of depression, anxiety, and hopelessness, especially who is just discharged from psychiatric hospitalization should be closely monitored; and when crisis occur, hospital readmission should be considered.[4]

SUMMARY

Fourth leading factor of death in 2002 among people age between 18 and 65 was suicide. Men suicide rate is higher than women but for attempted suicide rate, women recorded higher in numbers than men. The psychiatric evaluation is the essential element of the suicide assessment process. During the assessment a psychiatrist should determine the factors that contribute to suicidal behaviours. Thorough psychiatric evaluation and a specific suicide inquiry will help to determine the level of suicide risk and in the development of treatment plan for the patient as well as to get some other relevant documentation. Psychiatric management is more extensive for patients in ongoing treatment. Management for these patients includes establishing and maintaining a therapeutic alliance, coordinating treatment provided by multiple clinicians, monitoring the patient’s progress and response to the treatment plan, and conducting ongoing assessments of the patient’s safety, psychiatric status, and level of functioning. The treatment setting should be arranged according to the estimated suicide risk of the patient which still provides a safe and effective environment. The no-harm or suicide prevention contract should not be based to discharge a patient from hospitalization as the patient is not reliable at that mental state. It may also increase the recurrent suicide

attempt in future. The main stressor of suicide attempt is psychological disorder and followed by other causes. This stressor can be managed by pharmacological therapy and psychological therapy. Selective serotonin reuptake inhibitor (SSRI) is proved to have reduced the rate of suicide attempt. Fluoxetine is the common SSRI used to control this behaviour disorder. Other than that, clozapine, which is an antipsychotic drug, is proved to be very effective in controlling suicide ideation and attempts for schizophrenic patients. Apart from that, benzodiazepine, lithium salt and electroconvulsive therapy are also said to be effective in reducing the risk of suicide attempt in patients. Meanwhile, psychosocial therapy is also very important in managing suicide attempted patients. Cognitive-behaviour therapy is useful in helping the patients to recognize the suicidal urges and warn the healthcare provider. It also helps in improving the patient's mental health. Cognitive-behaviour therapy works best with antipsychotic drug therapy. Follow up care is very important especially to patients who have just discharged from psychiatric hospital. Most mental disorders are chronic and tend to recurrent if poor monitoring.

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