Tidsskriftet Tidsskrift for Den norske legeforening

Assessment of acute suicide risk in life crises

OPINIONS

ARNE VAALER

arne.e.vaaler@ntnu.no
Arne Vaaler, senior consultant at the Department of Acute Psychiatry, St. Olav's Hospital, Trondheim University Hospital.
The author has completed the ICMJE form and declares the following conflict of interests: He is head of a clinical academic research group studying the prediction and treatment of acute suicide risk. The group is funded by Central Norway Regional Health Authority.

In cases of acute suicide risk during severe life crises, intensive psychotherapeutic and pharmacological treatment must be initiated immediately.

Despite national prevention campaigns and guidelines, data from various countries show that the incidence of suicide is increasing (1). The problem is very common. In Norway, suicide risk is the primary factor or a contributing factor for admission to an acute psychiatric department in more than 70 % of cases (1). When faced with a person in crisis, clinicians must try to distinguish between two main groups: one consisting of patients prone to repeated episodes of self-harm without clear signs of a genuine desire to die, and another where the patient has exhibited explicit or implicit suicidal behaviour, including signs of a genuine wish to die (2). This article focuses on the latter group.

> *«Traditional risk factors offer little guidance for clinicians in direct interactions with patients»*

Risk factors versus warning signs

Until the start of the new millennium, the knowledge base primarily consisted of retrospective psychological autopsy studies, in which individuals who knew the suicide victim were interviewed after the event. These studies identified numerous risk factors, mostly categorical variables, that may indicate a statistically increased risk of suicide, particularly in a long-term perspective. Examples of these risk factors include sex, severe somatic illness, old age, mental illness, previous suicide attempts and substance use.

Traditional risk factors offer little guidance for clinicians in direct interactions with patients. Their clinical predictive value is limited because they do not provide insight into the acute psychological processes that lead to suicide or a state of immediate suicide risk (3). Neither do they differentiate high-risk patients from others with an acute mental illness. Upon admission to a psychiatric ward, more than 70 % of patients will be under the influence of at least one medication or substance. Previous suicide attempts carry a statistically higher long-term risk, but more than 60 % of suicide victims die on their first attempt.

Do you need to talk to someone after reading this article?
If there is an immediate risk of suicide, contact emergency services. You can find more information and local resources at: findahelpline.com.

What should the clinician look out for?

Prospective clinical studies can measure different parameters from retrospective studies (4). Warning signs for suicide are dynamic, state-related, cognitive, emotional and behavioural symptoms that indicate an immediate or imminent danger. The clinician is therefore able to diagnose a 'suicidal crisis' (5, 6).

The important warning signs that the clinician should look out for are 'mental pain', agitation, desperation, panic, severe sleep problems, hopelessness, shame, increased substance use in the last few days, acute relational problems and the feeling of being trapped or locked in the mental state of pain (2, 3, 6, 7). These warning signs give an indication of which patients need urgent, intensive treatment (3, 4). In contrast to risk factors, warning signs can be addressed immediately through therapeutic interventions, including medication (4).

«Many clinicians believe that serious suicidal behaviour only occurs after prolonged contemplation. This is a misunderstanding»

What should be given less emphasis?

There is no evidence to suggest that an open dialogue on the topic can in any way worsen the situation for patients. What could mislead the clinician is the extent to which the patient's responses influence their subsequent treatment. Some patients give reliable answers, but various studies show that 75 % of suicide victims denied any suicidal intent in their last conversation with a healthcare provider (3, 4). The key point is that the clinician should not view the patient's statements about suicidal thoughts merely as a 'screening' tool for further assessment, but should place greater emphasis on symptoms and behaviours that indicate a high or acute risk (3). The main message is that a patient's denial of suicidal intent is neither sufficient nor determinative for how the therapist should assess individuals in severe life crises.

Many clinicians believe that serious suicidal behaviour only occurs after prolonged contemplation. This is a misunderstanding; it typically takes less than ten minutes from decision to action (7, 8). Serious suicidal behaviour is often an impulsive act. Our assessments must therefore be based on the psychological processes, behaviours and symptoms that may indicate the presence of a suicidal crisis.

Warning signs are dynamic and state-related. They are also highly variable, meaning that acute risk can change quickly after an assessment. Guidelines suggest that parental responsibility, a supportive spouse and access to treatment can be protective factors, but these can also be misleading for the clinician (3).

Treatment of individuals at acute risk of suicide

When patients exhibit warning signs indicating a suicidal crisis, clinical interventions should aim to maximise safety in the days that follow (5). This involves immediate psychotherapeutic, milieu therapeutic and pharmacological interventions in collaboration with the patient's support network. Patients experiencing a suicidal crisis should be monitored around the clock. Intensive milieu therapy and pharmacological treatment for three to five days will significantly reduce the patient's mental pain, which in turn will reduce the risk of suicide.

All patients in suicidal crises should be subject to continuous observation and interval observation. Observation at 15-minute intervals and various forms of 'agreements not to self-harm during hospitalisation' have no documented effect (4). Observation at 10-minute intervals should be the maximum permitted.

The psychotherapeutic intervention should have a psychoeducational and straightforward profile. Patients experience cognitive impairment, so information needs to be simplified and repeated. Be an optimistic therapist. The mental pain of almost all patients will improve significantly as soon as they receive the appropriate medication. The vast majority recover within three to five weeks.

Psychopharmacology

Many patients in acute suicidal crises will meet the diagnostic criteria for depressive disorders. However, the main focus of primary pharmacological treatment is not depression; the immediate symptoms to address are anxiety, desperation and panic. The patient also needs to sleep (4). The priority, therefore, is to administer medications with sedative and anxiolytic properties that do not lower the seizure threshold. These clinical guidelines have been in place since the 1990s (4).

Patients experiencing a severe suicidal crisis are victims of an unbearable, internal pain (7). They are by no means rationally thinking, acting or autonomous individuals (9).

REFERENCES

1. Prestmo A, Høyen K, Vaaler AE et al. Mortality Among Patients Discharged From an Acute Psychiatric Department: A 5-Year Prospective Study. Front Psychiatry 2020; 11: 816. [PubMed][CrossRef]

2. Rudd MD, Berman AL, Joiner TE et al. Warning signs for suicide: theory, research, and clinical applications. Suicide Life Threat Behav 2006; 36: 255–62. [PubMed][CrossRef]

3. Berman AL. Risk Factors Proximate to Suicide and Suicide Risk Assessment in the Context of Denied Suicide Ideation. Suicide Life Threat Behav 2018; 48: 340–52. [PubMed][CrossRef]

4. Goodwin FK. Preventing inpatient suicide. J Clin Psychiatry 2003; 64: 12–3. [PubMed][CrossRef]

5. Berman AL, Silverman MM. A Suicide-Specific Diagnosis - The Case Against. Crisis 2023; 44: 183–8. [PubMed][CrossRef]

6. Cohen LJ, Imbastaro B, Peterkin D et al. A Suicide-Specific Diagnosis - The Case For. Crisis 2023; 44: 175–82. [PubMed][CrossRef]

7. Fredriksen KJ, Schoeyen HK, Johannessen JO et al. Psychotic Depression and Suicidal Behavior. Psychiatry 2017; 80: 17–29. [PubMed][CrossRef]

8. Deisenhammer EA, Ing CM, Strauss R et al. The duration of the suicidal process: how much time is left for intervention between consideration and

accomplishment of a suicide attempt? J Clin Psychiatry 2009; 70: 19–24. [PubMed][CrossRef]

9. Larsen K. Hva er galt med selvmord? Tidsskr Nor Psykol foren 2014; 51: 227–35.

Publisert: 10 January 2025. Tidsskr Nor Legeforen. DOI: 10.4045/tidsskr.24.0609
Received 18.11.2024, accepted 2.12.2024.