SUICIDAL PATIENTS

Jan Prasko^{a,b,c,d*}, Tomas Diveky^{a,b}, Ales Grambal^{a,b}, Klara Latalova^{a,b}

^a Department of Psychiatry, University Hospital Olomouc, I. P. Pavlova 6, 775 20 Olomouc, Czech Republic

^b Psychiatry Clinic, Faculty of Medicine and Dentistry, Palacky University Olomouc, I. P. Pavlova 6, 775 20 Olomouc

^c Prague Psychiatric Centre, Ustavni 91, 181 03 Prague 8

^d Centre of Neuropsychiatric Studies, Ustavni 91, 181 03 Prague 8

E-mail: prasko@fnol.cz

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Background. Suicide is the eighth leading cause of death in adults and the second leading cause of death in the 15- to 24-year-old age group. Suicidal impulses and suicidal behavior result from emotionally unbearable feeling of mental suffering and cognitive narrowing that prevent resolution to experienced stress, that is, in a situation when personal coping mechanisms have failed. Suicide attempts are a frequent cause of hospital admissions, in particular to anesthesiology and resuscitation departments.

Risk factors. Women attempt suicide three times more often than men. Four times more men than women complete suicide. More than 90% of people who complete suicide are diagnosed with severe mental illness and 50% suffer from depression at the time of suicide.

Assessment. Physicians should be aware of possible suicidal behavior in any patient with mental illness, especially if accompanied by depressive symptoms. The physician should approach the topic of suicide carefully and discreetly, only after a therapeutic relationship with the patient has been established.

Management. Patient protection, usually in the setting of a closed psychiatric ward, is necessary if he or she has a clear plan and means to commit suicide. After the patient's safety is secured, treatment may be initiated. If the patient is treated on an outpatient basis, his/her condition must be carefully monitored.

INTRODUCTION

Suicidal impulses and suicidal behavior result from emotionally unbearable feelings of mental suffering and cognitive narrowing that prevent resolution to experienced stress¹. That is, in a situation when personal coping mechanisms have failed. An increased risk of suicidal behavior is particularly associated with feelings of helplessness and hopelessness². One of the few situations a psychiatrist feels as uncertain in as in the case of a patient threatening suicide. A patient stating that he or she does not want to live anymore or will harm himself or herself always means an emergency situation that has to be dealt with immediately. Besides its psychological aspects and relation to stress³, suicidal behavior is a manifestation of genetic preconditions. It is also more frequent though in adopted children of parents who have attempted suicide⁴. Neurobiologically, it is associated especially with serotonergic dysfunction⁵.

Generally, the incidence of suicide increases with age. One peak is in young persons between 15 and 24 years of age but most affected are people over the age of 75. The ratio of attempted to completed suicides is 10:1. In the elderly, there are fewer suicide attempts but more completed suicides. Suicide attempts are a frequent cause of hospital admissions, in particular to anesthesiology and resuscitation departments. For example, 1–2% of all admissions to intensive care departments and 1–5% to anesthesiology and resuscitation departments were due

to drug overdose⁶. Women attempt suicide three times more often than men. Four times more men than women complete suicide⁷. Men choose more violent means of suicide. Women more often attempt suicide to express their hurt or to “call for help”. Men, on the other hand, may postpone suicide until helplessness and despair become unbearable. Persons attempting suicides may not always suffer from a mental disorder. However, mental disorders, in particular depression, significantly increase the suicidal risk. Suicide is more common in divorced persons than in single persons and more common in single persons than in those who are married. Most suicides occur in urban agglomerations.

RISK FACTORS

Numerous studies have tried to determine the predictive factors (Tables 1 and 2) justifying the use of measures to prevent suicide in vulnerable patients. Unfortunately, even though the risk factors are known, there is no reliable way to anticipate the long-term suicide potential in a given patient.

PHYSICAL ILLNESS AND SUICIDE RISK

Relatively frequent suicidal thoughts and attempts were found in physically ill persons in both primary care

Table 1. Risk factors (adapted from Johnson⁸).

A) Decision and history
1. Recent/previous attempts or attitudes
2. Direct or indirect communication about the intention
3. Specificity of the plan
4. Lethality of the means
5. Availability of the means
6. A family history of suicidal behavior
B) Demographic characteristics
1. Age (teenagers, middle-aged person and the elderly have the highest risk)
2. Sex (males use more lethal means and more frequently complete suicide; women attempt suicide more often)
3. Homosexuality (as another stressor or factor limiting the social support)
4. Race (Caucasian)
5. Marital status (separated, widowed, divorced)
6. Social support (a lack of support, loneliness)
7. Occupation (unemployment, a change in the status or position)
C) Emotional functioning
1. Diagnosis (depressive episode, recent remission of depression, schizophrenia, alcoholism, bipolar disorder, borderline personality disorder)
2. Auditory hallucinations commanding suicide (bizarre methods may also indicate psychosis)
3. A recent loss or anniversary of a loss
4. Fantasies about reunion with a dead loved one
5. Stress (chronic or related to recent changes)
6. Poor coping abilities
7. The degree of hopelessness or despair
D) Behavioral patterns
1. Isolation
2. Impulsiveness
3. Rigidity
E) Physical health and condition
1. Chronic insomnia
2. Chronic pain
3. Progressing disease
4. Recent birth

and hospitals⁹⁻¹¹. The risk is particularly high at the time when the physical illness is diagnosed. The risk increases with the patient's concerns about the prognosis, level of pain, unpleasant therapeutic procedures and adverse effects of medication. Another factor increasing the risk of suicide in hospitalized patients is a lack of social support. The risk is significantly higher in chronic disease that lead to demoralization, depression, fear of death, as well as physical and mental handicaps. Similarly, there is a higher risk in the terminal stage of disease¹²⁻¹⁴. In addition to worries or sadness stemming from their own impaired functioning, patients may be concerned about burdening their relatives. Sometimes they do not want others to see their weakness, fear being dependent on their family etc. The risk also depends on the level of pain they experience

Table 2. Protective factors against suicide.

children in the family, feeling of responsibility towards the family, pregnancy, faith, life satisfaction, ability of adequate testing of the reality, positive coping abilities, support from the environment, positive therapeutic partnership

and their ability to stand it. It is also necessary to explore their fear of death and its character. Patients who fear suffering before death may opt to escape from life much earlier. Further, the risk of suicide is increased by panic symptoms since fear associated with vegetative symptoms of anxiety makes the patients feel as if they were dying right now. Suicide then may be an escape from repeated attacks of "dying" they experience. Symptoms of post-traumatic stress disorder (PTSD) should not be overlooked as well. Patients who have undergone extensive therapeutic procedures may develop both acute stress reaction and later post-traumatic stress disorder. They may choose suicide to avoid further therapeutic interventions that they are extremely afraid of.

The presence of physical illness increases the chance of suicide attempts 2- to 100-fold, depending on the type of physical disease¹⁵. The highest risk was reported in patients with AIDS, lung diseases including severe asthma, chronic bronchitis and tuberculosis, ulcer diseases, diabetes mellitus¹⁶, rheumatoid arthritis¹⁷, systemic lupus erythematosus¹⁸, epilepsy (especially temporal lobe epilepsy, with about 12% suicide rate)¹⁹, migraine²⁰ and psoriasis²¹. In the older population, the risk is higher in those with angina pectoris, chronic obstructive pulmonary disease, epilepsy, urinary incontinence²², cancer and prostate disease²³. In one study, about 5% of completed suicides were committed by patients with terminal stage disease²⁴. According to the author, however, the actual percentage is even higher than that since certain physicians do not report suicide as the cause of death to help the relatives to avoid its psychosocial and economic consequences.

MENTAL ILLNESS AND SUICIDE RISK

About 90% of persons who commit suicide suffer from mental illness²⁵ (Table 3). The risk of another attempt is highest within one year²⁶. The risk is particularly high in depression, psychosis, agitation, severe anxiety disorder, post-traumatic stress disorder, hypochondriasis and borderline personality disorder. In classical studies, about 15% of individuals suffering from mood disorders²⁷ and about 10% of those with psychosis²⁸ ended their lives by suicide. The risk is even higher if depressive disorders are combined with anxiety disorders, in particular with PTSD or panic disorder. A history of suicide attempts is an important predictor of increased suicide risk. In this case, the risk may be as much as 100 times higher than that in the normal population²⁹.

In bipolar disorder, about 15% of patients are reported to die from suicide, with approximately 80% of them at the time of a depressive episode. Particularly dangerous

Table 3. Standardized index of mortality for psychopathological risk factors for suicide (adapted from Harris and Barraclough³⁰).

RISK FACTOR	STANDARDIZED INDEX OF MORTALITY (SIM)
Previous suicide attempt	38.4
Depressive disorder	20.4
Sedative abuse	20.3
Eating disorder	20.1
Abuse of multiple addictive substances	19.2
Bipolar disorder	15.0
Dysthymia	12.1
Obsessive-compulsive disorder	11.5
Panic disorder	10.0
Schizophrenia	8.5
Personality disorder	7.1
Alcohol abuse	5.6
SIM is the ratio of observed mortality to expected mortality, estimating the risk of mortality from suicide in the presence of a certain disorder.	

are milder periods after? severe depression when patients have more energy to commit suicide. Patients coming out of severe depression may also commit suicide as they fear its recurrence in the future. The same situation may occur after hospital discharge when the patients suddenly feel that it is more difficult for them to cope with themselves and their problems in the natural environment than under the protection of a psychiatric ward. Moreover, in patients with depression, the situation may be complicated by alcohol abuse³¹.

Suicide may be a reaction to a loss, either real or metaphorical. Fantasizing about eternal peace, return, revenge, reunion with a lost person (especially following the loss of a child) or a decrease in suffering may be a motivation for

suicide attempts³². The anniversary of a loss, Christmas, lost person's birthday, as well as holidays may be the times when the affected persons are occupied by the loss and the risk of suicide increases.

Psychotic states may lead to suicide to escape the unbearable threat. The risk of suicide is also increased by psychotic states of restlessness and agitation. Most significant is agitated depression with patients feeling helpless in dealing with anxiety attacks.

Patients with personality disorders, in particular those suffering from affective lability, impulsivity or mood disorders have a high index of suicide. Frequently, several factors of increased risk are combined in those patients, such as impulsivity, mood disorders, tension, alcohol or substance abuse and/or inadequate social support. The risk of attempted or completed suicide is most prominent in persons suffering from borderline personality disorder³³. Persons who harm themselves have double the risk of suicide than those without self-harm behavior. In borderline personality disorder, suicidal (as well as parasuicidal) behavior is usually viewed as maladaptive behavior when dealing with problems³⁴. Frequently, it is a learned response in order to avoid negative emotions. Patients move in a vicious circle: suicidal behavior produces more emotional dysregulation which in turn leads to more frequent suicidal behavior. The chain of a triggering event and subsequent cognitive, emotional and behavioral processing has to be logically and intelligibly dealt with. Blaming the patient for being "manipulative" is not only useless but it usually results in an increase of symptoms by repeating the pathogenetic experience.

In patients with hypochondriasis, the risk of suicide is often underestimated despite the fact that they experience suicidal moods relatively frequently and may kill themselves to escape from the suffering of their imagined illness.

SUICIDAL DEVELOPMENT

Suicidal behavior frequently develops gradually. Initially, suicidal thoughts have no specific content. The affected person fights them and tries to drive them away. The next stage is characterized by suicidal tendencies.

Table 4. Ringel's presuicidal syndrome.

Constriction of the subjective space – more limited experience and perception; the person is overwhelmed by an extreme situation, feels trapped, does not know which way to turn, keeps away from others or reduces social relations, is lonely; emotions are narrowed to despair, fear, anxiety and helplessness; the affected person loses the ability to control his/her emotions; certain areas of life are no longer interesting; the world of values diminishes; there is helplessness to achieve important goals; the patient considers his/her own existence worthless, his perception of relations is narrowed, they have no benefit for him/her, he/she devalues them;
Inhibited aggression turned toward the self – the affected person is increasingly persuaded that he/she has neither the qualities nor the abilities he/she should have, he/she is to blame for the whole situation which has no solution, he/she devalues himself/herself, feels hatred and anger towards himself/herself;
Urgent suicidal fantasies – a wish to be dead, suicidal ideation, considering the mechanism of suicide, compulsion to suicide; the fantasies bring relief, are increasingly attractive, gradually appear to be the only or the best solution of the situation, escape from pain and suffering.

The person has an ambivalent attitude to them and does not fight them. Later in the development, he or she is identified with the idea of ending one's life and starts considering the best way of doing it. This is followed by the decision to commit suicide which, paradoxically, may result in calmness. At the beginning of suicidal development, a triad named by Vienna professor E. Ringel may be observed (Table 4).

ASSESSMENT

Patients considering suicide often feel shy and ashamed. One of the reasons for suicidal tendencies may be the perceived loss of self-esteem. Therefore, when assessing the suicide risk, the patient should always be approached with respect and emphasis on his or her personality and value. Every patient's reference to suicide must be taken seriously and a thorough exploration is needed. Moralizing and contempt should be avoided since we might not learn anything and would not be able to help the patient. We must be calm, caring and careful, deeply interested in what the patient is experiencing. Very often, it is the feeling that there is someone who is interested and understands the patient which increases his or her will to fight the tendencies as early as during the assessment. Besides questions about the suicidal ideation, thoughts or plans, the context of suicidal moods needs to be ascertained (Table 5). What has happened in the patient's life? Have his or her feelings or self-esteem been hurt? Is the patient alone or are there people he or she care about? Questions about suicidal thoughts are relatively direct, using the "vertical arrow" technique: "Do you think that your life is no longer enjoyable or meaningful? Would you rather not live? Do you consider hurting yourself? Do you think of how to do that? Do you have a particular plan?" In addition to these questions gradually determining the severity of the risk, the patient's coping factors and rescue factors need to be assessed. We ask the patient what helped him or her to resist and fight suicidal thoughts, how he or she coped with situations when they were more urgent or when being alone with the thoughts. Has the patient considered some steps to gain control over himself or herself in such situations? Then we ask about persons who helped the patient, maybe even unconsciously, those who were told about the patient's problems and those he or she might potentially approach if needed.

If an acute suicide crisis is suspected, this topic must be directly addressed in the interview and the patient's ability to discuss the issue must be assessed. Acute sui-

Table 6. Severity of suicidal intent.

The severity of suicidal intention is proportional to the number of the following features present:	
Preparation:	<ul style="list-style-type: none"> - a planned act - a suicide note - steps made with the prospects of death, e.g. the last will
Circumstances:	<ul style="list-style-type: none"> - alone during the act - timing that ruled out potential help - measures taken to prevent disclosure
After the act:	<ul style="list-style-type: none"> - does not strive for help - still wishes to die - believes the attempt will be successful - regrets that the attempt failed

cidal patients must be referred and accompanied to a psychiatric ward. Involuntary hospital admission may be necessary if the patient is not aware of his or her disease and the need for treatment.

If suicide has already been attempted, psychiatric assessment should always be accompanied by physical examination to reveal potential health threat resulting from the attempt. When assessing the attempted suicide it must be determined whether the attempt was real and just failed, what the motive was, whether the patient is mentally ill etc.

Some people do not talk about suicide but drop hints. An important step is to refer to suicide. The hints of suicidal intent may be either direct or indirect. The direct hints are expressed by sentences such as "I want to die!" or "I will kill myself!" The indirect ones are less striking: "I cannot stand my life anymore!", "There is no point to life!" or "My life is unbearable!" When the patient suggests that there is no point to life he or she usually expects us to ask directly if he or she is considering not being here. If the answer is positive, we have to ask directly: "Are you thinking of suicide?" For the patient, such a question changes the situation. Very often, something that he or she has kept secret, could not express, has been ashamed of or had ambivalent feelings about is openly identified for the first time. As a result, the patient opens up and the associated conflicting attitudes may be discussed. Whenever it is clear that the patient has suicidal thoughts we should find out whether he or she has already thought about how to do it. If there is no plan and the patient says he or she would prefer to die the danger is usually not imminent and the patient is in the stage of consideration. The most important criterion of severity is the *suicide plan* with four components to assess: lethality of the method, availability of means, elaboration and preparedness for the death. A plan to shoot oneself or jump from a bridge is more lethal than a plan to ingest a drug or cut one's wrist. We ascertain whether the patient wrote a suicide note or the last will, gave away the valuables etc. In the case of attempted

Table 5. Basic questions when assessing a suicidal patient.

1. How serious is the decision?
2. What is the motive?
3. Does the patient suffer from mental illness?
4. What problems does the patient have?
5. Is hospitalization necessary?

Table 7. Sad persons scale (adapted from Patterson et al.³⁵).

An acronym to remember an assessment tool to determine the risk of an individual for suicide – SAD PERSONS : Scoring: 0–2 = little risk; 3–4 = following patient closely; 5–6 = strongly considering hospitalization; 7–10 = very high risk, hospitalize Each risk factor present equals one point	
Sex	Men have more completed suicides, women have more attempted suicides
Age	Higher risk
Depression	In particular with hopelessness or agitation
Previous attempt	Especially a serious one
Ethanol abuse	Alcohol or other substance abuse or dependence
Rational thinking loss	For excessively catathymic way of dealing with events (personality disorders), impulsivity but also due to cognitive impairment – hallucinations, delusions, organic brain disorder
Social support lacking	The lack may be objective but also the objectively adequate social support may be subjectively viewed as insufficient by the patient
Organized plan	Planning of how to commit suicide
No spouse	In particular after a break-up, divorce, widowing or in lonely patients
Sickness	Especially in chronic and disabling diseases

suicide, other circumstances should be assessed, such as whether the person was alone, whether the timing ruled out potential help or whether he or she ensured concealing the tendency. The severity of suicide risk may also be assessed from the patient's behavior after the act: he or she does not strive for help, still wishes to die, believes the attempt will be successful or regrets that the attempt failed (Table 6).

To assess the suicide risk, information obtained from the patient's relatives and health workers may be of importance. Cultural values and religious beliefs of the patient and the family may play a protective role since suicide may be viewed as a sin³⁶. However, this cannot be relied upon. The patient may also be protected by his or her care for the children and the need to continue helping the family³⁷.

The psychiatrist must also be able to identify the current stressors and the patient's ability to manage them, deal with them or adapt to them. These may involve negative life events such as the death of a loved one, breakdown of a relationship, loss of a job, financial problems, changes in physical appearance, fear of treatment or surgical mutilation etc. (Table 7).

Considering the patient's strengths and sources of support is as important as evaluating the negative aspects of the entire situation. It is necessary to find persons potentially supporting the patient, be it the family, friends or members of a religious group. Reactions of those around the patient must be carefully assessed. Close relatives or friends may both help and harm seriously. If the patient is rejected or reproached or if his suffering is trivialized by them, he or she may feel misunderstood and lonely. Sometimes the people around are helpless, giving the patient the feeling that he or she cannot be helped.

CARING FOR A SUICIDAL PATIENT

If a psychiatrist detects the suicide risk it is his or her task to prevent it or decrease the risk as much as possible. The aim of caring for suicidal patients is to protect them from self-destruction until they are able to take over this responsibility. Persons at high risk of suicide and unable to control themselves have to be controlled from the outside³⁸. Acute suicide risk requires a hospital admission. The affected person must be immediately limited physically, pharmacologically or by both means. Hospitalization is necessary especially if the patient is highly suicidal or impulsive or, at the same time, psychotic, deeply depressed or his physical condition is severely altered (Table 8). A short stay in a psychiatric ward is also needed in persons lacking the external support system (e.g. the family members are gone for a holiday), until the suicidal tension is over or the support systems are restored. The patient has to be informed calmly but firmly about the planned procedures involving physical examinations and hospitalization. Further therapy depends both on the severity of the risk and the presence or absence of mental illness. In the absence of severe mental disease or in adjustment disorders, the main therapeutic procedures are psychosocial intervention with the psychotherapeutic interview. If severe mental disorder is diagnosed, the administration of psychoactive drugs must be carefully considered in addition to psychosocial intervention.

First aid involves crisis intervention, identification of stressors and establishing a contact and therapeutic relationship. A safe therapeutic relationship is crucial for decreasing the suicidal tension. The patient needs to feel that the therapist is caring, understanding, accepting and not judging, regardless of the suicidal thoughts. He/she should be helpful and on the side of the patient. The

Table 8. Decisions about hospitalization.

HOSPITALIZATION		
ALWAYS	RATHER YES	RATHER NO
After SA, if the patient <ul style="list-style-type: none"> Is psychotic Is severely depressed or melancholic Is agitated Has a suicide plan Has made a violent attempt Has made a SA recently Resisted rescue Regrets being rescued Is older than 45 years and has early mental illness Lives in isolation Has the mental state altered by physical illness (metabolic, toxic, infectious...) With suicidal thoughts <ul style="list-style-type: none"> A specific plan A firm decision to commit suicide 	Suicidal ideation <ul style="list-style-type: none"> With psychosis Another severe mental disorder A history of a SA Severe physical comorbidity (cancer, neurological...) Inability to comply with outpatient treatment A lack of the external support system Impulsive personality Prolonged sleep problems Absence of suicidal ideation <ul style="list-style-type: none"> But they may be assumed 	After SA or with suicidal ideation <ul style="list-style-type: none"> SA as a reaction to an adverse life event (exam failure, break-up with a partner, argument...), especially if the patient has a detached point of view A low-lethal SA method The patient cooperates, has good family and social support Is able to cooperate on an inpatient basis Outpatient treatment more beneficial than hospitalization <ul style="list-style-type: none"> Even though the patient has suicidal thoughts, suicide has never been attempted

SA=suicide attempt

therapeutic relationship is deepened by the knowledge of the patient's life, current situation, personality, strengths and life problems. The therapeutic relationship might be difficult to establish with patients who are paranoid or those suffering from personality disorders. Such patients should be observed more closely to prevent suicide. Initially, three steps are necessary to decrease the suicide risk:

- reducing stress resulting from mental illness including fear from death;
- reducing psychosocial distress resulting from the patient's life situation and inadequate social network;
- reducing stress resulting from physical illness and its treatment.

To reduce stress resulting from the patient's life situation and inadequate social network, it is necessary to discuss his or her life situation, social support and its potential sources, as well as the patient's place in the family and past function and merits. Very often, ambivalent attitudes to relatives should be discussed, or even to ancestors who died long ago. To reduce concerns resulting from physical illness, it is necessary to identify and discuss the patient's fear of physical and mental function impairment, pain, other diagnostic and therapeutic procedures, a shorter life and its decreased quality.

The therapist should try to be empathetic toward the patient's feelings since misunderstanding might push the patient closer to suicide. A prerequisite for effective help is a will to maintain focus on the patient's personality, careful listening to his or her story, problems and ambivalence. We encourage the patient's expression of emotions and right to any feelings, without assessing, criticizing or

moralizing. Empathy and sensitive questions are used to help the patient interconnect with his or her own emotions and hidden ambivalence, realize his or her problems by expressing them verbally. We can confirm the patient's abilities and both inner and outer resources that might help. We stress the limits of the current situation and the fact that it will inevitably be over one day. If a person is considering suicide, he or she needs to talk about these thoughts. Through this, his or her emotions and life problems are approached that are related to the suicidal thoughts. The patient must be helped to express the aggressive and hostile feelings in a constructive manner and towards the outer world, not destructively and towards oneself. The therapist and the patient may discuss alternative solutions to the situation. The patient should be encouraged to talk about the problems not only with us but also with his or her close relatives. The patient's trusted friends or members of a religious group may also be used for that.

People deciding whether or not to live seem to be in a different, slower, time dimension. Therefore, we must not show impatience or interrupt their speech but respect their silence, pauses or hesitation since these are filled with ambivalent thoughts. Patients are sensitive to our involvement. They automatically observe whether we are tuned in to them or not. We express respect to their decisions and sympathy with their suffering. It is important to realize that their irritation or aggression is a reaction to the situation rather than to us. Therefore, we must avoid reacting. Sometimes, at the beginning of discussions about suicide, the patient's ambivalence is manifested and projected into us. He or she might ask: "Do you think

that I do not have the right to do it?" Regardless of our life philosophy, we cannot confirm that since it usually strengthens the patient's feeling of guilt and attitude of failure, or it may produce the patient's resistance and he or she stops talking to us about the thoughts. What absolutely does not work in a suicide crisis is appealing to morals, responsibility towards close relatives or assessment. This only deepens the patient's self-reproach and helplessness. We might say that we think it is not a good decision, avoiding discussions about the right to do it. A different situation is when the patient starts talking about responsibility and relatives. In that case, we have an opportunity to support and appreciate his or her attitudes against suicide. For people who are persuaded that they have never had the freedom to make their own decisions, considering suicide is something they do not want anyone to interfere with. For them, it is important to hear that it is solely their decision. However, it is our obligation to protect them and help them find other solutions. The dialogue should continue by stressing the irreversibility of such a decision and considering potential alternatives or ways of overcoming confusion, hopelessness, fear and helplessness. The act of suicide may be put off to give a chance to alternative solutions (Table 9).

Even during hospital stay, patients need to know that they may talk about their suicidal intentions and tendencies and may expect help from the staff. The patients' daily program should be focused on activities that make them feel useful. The staff must ensure that patients do not have access to anything that they might use to harm or injure themselves, in particular sharp objects. Their luggage must also be searched. Hospitalized suicidal patients must be closely monitored, especially in the bathroom where they might drown or harm themselves with the items there. Patients with serious suicidal intentions may

be suicidally active despite the most stringent preventive measures.

Most patients with less serious suicidal tendencies in anxiety disorders and personality disorders may be treated on an outpatient basis. Provided a trustworthy relationship has been established, their state may be monitored and a support system may be created in the family or friendship relations. However, if depression, psychosis or agitation are present, hospitalization should be preferred.

The long-term goal is to help patients find a more positive view of themselves and the world and to boost their self-esteem as well as the feeling of belongingness. They need to gain self-confidence to see that they are able to solve their own problems and others can help them in many ways. A frequent need is reconsideration of unachieved life goals in young psychotic patients, cured depressive persons or those with early-stage dementia. In people suffering due to the loss (of their loved ones, physical health, life position etc.), their complaints of the loss must be accepted and they should be given the opportunity to talk about the loss and to express their emotions. Their future search should be supported. Empathetic listening, support and encouragement results in a release of emotions, gradual elaboration of the loss and search for options in the future. The patients' families should be invited to participate as soon as possible since they will provide the future support. This is particularly important in patients with chronic physical illness limiting their mobility and social functioning.

PSYCHOPHARMACOTHERAPY

The deeper, more acute and more urgent the suicide risk is, the greater is the need for use of sedatives

Table 9. Steps in a program for suicidal patients or patients after suicide attempts.

- Treat the symptoms and underlying mental disorder
- Ask about suicidal thoughts even though the patient does not mention them. Focus on:
 - The last suicide attempt
 - A history suicidal thoughts and behavior
 - A family history of suicide
 - Important anniversaries, e.g. of a child's or partner's death; a feeling that suicide will lead to a reunion with the loved one
- Elucidate the motives and use them in the therapy
- Ascertain the role of death, suicide and fantasies and its consequences (e.g. what reactions does the patient expect from the others)
- Work with the patient's tendency to "solve" problems radically
- Elucidate the recent losses, including those related to therapy
- Minimize the availability of means potentially used to commit suicide as well as disinhibiting and depressogenic substances
- Try to provide the missing components of the social support
- When prescribing medication, avoid prescribing an extra supply of medication or lethal doses
- Announce your absence from work well in advance and encourage the patient to continue the sessions with the substitute therapist
- Try to understand the significance of a suicide attempt for the patient so that you can try to find an adequate replacement for it

(Table 10). Depressive patients are usually administered antidepressant medication. However, this is effective only after a longer period of time and may increase tension and thus the risk of suicide in the initial stage of administration. Therefore, suicidal patients should be given sedating antipsychotics, sometimes in combination with highly potent anxiolytics³⁸. In this case, electroconvulsive therapy is rapidly effective.

Even after hospital discharge, the suicide risk is real. In mental disease, prophylactic treatment might be important. In schizophrenic disorders, therapy with clozapine was found to decrease the suicide risk³⁹. In bipolar affective disorder, long-term administration of lithium has a prophylactic effect not only on phases of the disorder, but also acts as a prevention of suicide^{40–42}.

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Table 10. Psychoactive drugs according to the types of crisis.

- In psychotic fear, anxiety, restlessness: sedating antipsychotics (levopromazine, sulpiride) augmented with benzodiazepines (lorazepam 2–4 mg, diazepam 20–30 mg, alprazolam 4–5 mg, clonazepam 2–3 mg);
- In depressive disorders: antipsychotics + added antidepressants or benzodiazepines;
- In severe anxiety disorders: temporary treatment with benzodiazepines, followed by antidepressants;
- In personality disorders: temporary treatment with benzodiazepines and low-dose antipsychotics (olanzapine 5 mg, risperidone 1 mg);
- In acute intoxication: detoxification, followed by symptomatic therapy (antidepressants, antipsychotics).
- Independent of mental illness, good night's sleep must be ensured; if necessary, it is recommended to divide the doses so that a higher dose of an antipsychotic or sedating antidepressant is administered late at night and, possibly, a hypnotic is added.

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