I was seeing a new patient—a young woman presenting with symptoms of a urinary tract infection. I thought the visit would be fairly routine. But on entering the examination room, I noticed that the patient seemed almost overly alert. As I moved closer, I saw small reddened areas on her arm as though she had been scratched or cut. Her boyfriend sat silently next to her as, in response to my questions, she gave me a list of medications she was taking, both for her chronic back pain and her depression and anxiety.

The patient also detailed a long psychiatric history, as well as multiple hospitalizations for back pain. She could not remember the names of any of her previous doctors or her psychiatrist. Almost as an afterthought, she confided that she had tried to stab herself with a knife earlier in the day. Somehow her boyfriend had gotten the knife away from her. Her boyfriend calmly confirmed her story.

I thought that this situation was beyond my expertise. I suggested that it might be a good idea to call a mental health clinic for an evaluation. The patient immediately became agitated and started loudly accusing me of calling her "crazy."

I didn't know what to do. I felt as though my suggestion had made things worse. I excused myself from the room to allow her to calm down and to consider my best course of action. Although I didn't have a complete picture of the patient, I thought that she might have some type of personality disorder. I found a chance to talk to the patient's boyfriend in private. He assured me that he had been through similar episodes with her and would not, under any circumstances, leave her alone that night. I gave him the number of the local suicide crisis line and the number of the closest mental health clinic. But I lost sleep that night, wondering if I had made a decision based on what was best for the patient or what was best for me.

The Role of Primary Care Physicians in Preventing Suicide

Since physical illness itself is a risk factor for suicide (Maris, Berman, & Silverman, 2000), primary care physicians and other health care providers are highly likely to see patients who are depressed and may be at risk of suicide. Most people who complete

This effort has been funded in part with Federal funds from the National Institute of Mental Health, National Institutes of Health, under Contract No. N44MH22044.

Version 05/24/2005

National Institute of Mental Health

suicide signal their intention to do so before ending their lives, and they often display these distress signals to their doctors. A substantial number of elderly people who die by suicide contact their primary care physicians within a month before their death (National Institute of Mental Health, 2003).

Successful intervention will depend on your ability to recognize the warning signs of suicide and to make sure that your patient receives immediate and appropriate care for what, after all, is a life-threatening condition.

Recognizing the Warning Signs

People who are in danger of harming themselves may try to reach out to their primary care physicians—sometimes directly, sometimes indirectly. Rarely will patients immediately volunteer the information that they are thinking of harming themselves. Instead, they often describe their concerns in terms of physical symptoms.

As a physician, you should be alert for imminent warning signs that a patient may be at risk of suicide, for example:

- Talking about suicide or death
- Giving direct verbal cues, such as "I wish I were dead" and "I'm going to end it all"
- Giving less direct verbal cues, such as "What's the point of living?", "Soon you won't have to worry about me," and "Who cares if I'm dead, anyway?"
- Isolating him- or herself from friends and family
- Expressing the belief that life is meaningless or hopeless
- Giving away cherished possessions
- Exhibiting a sudden and unexplained improvement in mood after being depressed or withdrawn
- Neglecting his or her appearance and hygiene

These signs are especially critical if the patient has a history or current diagnosis of a psychiatric disorder, such as depression, alcohol or drug abuse, bipolar disorder, or schizophrenia.

People of different ages are at different levels of risk and display different types of warning signs.

Older patients are at an increased risk of dying by suicide. Research indicates that many older adults who visited a primary care physician within a month of dying by suicide had an undiagnosed mental illness associated with suicide, such as depression (National Institute of Mental Health, 2003), or had a common medical condition associated with an increased risk of suicide, such as congestive heart failure, chronic obstructive lung disease, urinary incontinence, anxiety disorders, and moderate or severe pain (Juurlink, Herrmann, Szalai, Kopp, & Redelmeier, 2004). Physicians should pay careful attention to elderly patients who are physically ill and who exhibit any of the following warning signs of suicide (Holkup, 2002):

- Stockpiling medications
- Buying a gun
- Giving away money or cherished personal possessions
- Taking a sudden interest, or losing their interest, in religion
- Failing to care for themselves in terms of the routine activities of daily living
- Withdrawing from relationships
- Experiencing a failure to thrive, even after appropriate medical treatment
- Scheduling a medical appointment for vague symptoms

Adolescents are also at an increased risk of dying by suicide, though their warning signs are different. Be alert for the following:

- Volatile mood swings or sudden changes in their personality
- Indications that they are in unhealthy, destructive, or abusive relationships, such as unexplained bruises, a swollen face, or other injuries, particularly those they refuse to explain
- A sudden deterioration in their personal appearance
- Self-mutilation
- A fixation with death or violence
- Eating disorders, especially combined with dramatic shifts in weight (other than those associated with a diet under medical supervision)
- Gender identity issues
- Depression

Recognizing the warning signs is the first step in preventing suicide.

Responding to the Warning Signs

There are no hard and fast guidelines for determining a patient's risk of suicide. However, if there's a chance that your patient may be at risk, you can ask the sometimes difficult questions that will provide you with more evidence about his or her state of mind and intentions, for example:

- Do you ever wish you could go to sleep and never wake up?
- Sometimes when people feel sad, they have thoughts of harming or killing themselves. Have you had such thoughts?
- Are you thinking about killing yourself?

You should act immediately if you have any reason to believe that the patient is in imminent danger or poses a grave danger to him- or herself. Immediate action should also be taken when warning signs are combined with any of the following risk factors:

- Past incidents of suicidal behavior or self-harm
- A family history of suicide
- A history of psychiatric disorders or the abuse of alcohol and other drugs
- The patient's admission that he or she has considered suicide
- The patient's expressed wish to die

- Any evidence of a current psychiatric disorder

You can help protect a patient by doing the following:
- Referring the patient to a mental health professional who is better able to evaluate the patient's risk and recommend next steps
- Helping the patient's family, friends, and caregivers develop a plan so that someone is with the patient at all times
- Helping the patient's family, friends, and caregivers make sure that lethal means, especially firearms and medications, are not available to the patient
- Hospitalizing the patient, if necessary

Responding to a potential crisis is never easy. At the very least, it can disrupt your office schedule. You may have to make arrangements for someone to remain at the side of the at-risk patient until family, friends, or a mental health professional arrives. It also takes extra effort not to violate the confidentiality of the at-risk patient or unduly alarm your staff and other patients. Every primary care office should have a crisis intervention plan and should train its staff for crisis intervention.

If you have any suspicions that a patient is seriously considering harming him- or herself, let your patient know that you care, that he or she is not alone and that you are there to help. You may have to work with the patient's family to ensure that he or she will be adequately supported until a mental health professional can provide an assessment. In some cases, you may have to accompany your patient to the emergency room at an area hospital or crisis center. If the person is uncooperative, combative, or otherwise unwilling to seek help, and if you sense that the person is in acute danger, call 911 or (800) 273-TALK (8255). Tell the dispatcher that you are concerned that the person with you "is a danger to [him- or herself]" or "cannot take care of [him- or herself]." These key phrases will alert the dispatcher to locate immediate care for this person with the help of police. Do not hesitate to make such a call if you suspect that someone may be a danger to him- or herself. It could save that person's life.

The use of medications (especially antidepressants) should always be considered when developing a comprehensive treatment plan for patients with a major depressive disorder, or patients who express suicidal ideation, intent, or plans. Antidepressants are effective in reducing the symptoms of depression, as well as other problems, including obsessive-compulsive disorders and panic disorders. The Food and Drug Administration has determined that there is some evidence for an association between the class of antidepressants known as "selective serotonin reuptake inhibitors" and the emergence of suicidal behaviors, particularly in children and adolescents. Although this is a relatively rare occurrence, mental health professionals should carefully monitor the signs and symptoms of depression during the first few months of treatment with any antidepressant medication. Careful monitoring might include frequently contacting the client (in person or by telephone), teaching the client's family and support network to monitor the emergence of suicidal ideation and behaviors, and providing emergency contact information.

You may determine that a patient needs an inpatient assessment or treatment. It is always preferable for patients be active participants in the decision to be hospitalized—to voluntarily agree to be hospitalized and to "sign in" on their own, taking full responsibility for their decision and acknowledging the purpose of the hospitalization. If a patient is incapable of signing in voluntarily or refuses to do so, it will be necessary for you, ideally in collaboration with the patient's family, to initiate an involuntary commitment process. All states have policies and procedures for initiating and completing such a process. You should familiarize yourself with your state's policies about both voluntary and involuntary admission procedures.

Helping Yourself and Your Colleagues

Along with recognizing warning signs in your patients, it is equally important to recognize warning signs among your colleagues and in yourself, and to take protective measures when necessary. Physicians are not immune to suicide. The culture among physicians often prohibits any complaints about the exhaustion and stress associated with long hours of work and minimal sleep. Grueling schedules coupled with the knowledge that a missed "cue" or clinical finding could lead to the illness, injury or death of a patient places a great deal of stress on physicians. An American Foundation for Suicide Prevention consensus statement on depression and suicide among physicians (Center et al., 2003) cited a lack of attention in this area, and urged physicians, medical institutions, and health organizations to pay more attention to the treatment of depression and prevention of suicide among physicians. The statement recommends a shift in professional attitudes and institutional policies—one that encourages physicians to seek help and obtain treatment for mental illness, if needed.

References

Center, C., Davis, M., Detre, T., Ford, D. E., Hansbrough, W., Hendin, H., et al. (2003). Confronting depression and suicide in physicians: A consensus statement. *Journal of the American Medical Association, 289*(23), 3161–3166.

Hamilton, N. G. (2000). Suicide prevention in primary care. Careful questioning, prompt treatment can save lives. *Postgraduate Medicine, 108*(6), 81–84, 87. Retrieved March 23, 2005, from http://www.postgradmed.com/issues/2000/11_00/hamilton.htm

Holkup, P. (2002). *Evidence-based protocol—Elderly suicide: Secondary prevention.* Iowa City, IA: University of Iowa Gerontological Nursing Interventions Research Center. Retrieved March 23, 2005, from http://www.guideline.gov/summary/summary.aspx?doc_id=3308&nbr=2534&string=Elderly+AND+suicide

Juurlink, D. N., Herrmann, N., Szalai, J. P., Kopp, A., & Redelmeier, D. A. (2004).

Medical illness and the risk of suicide in the elderly. *Archives of Internal Medicine, 164*(11), 1179–1184.

Maris, R. W., Berman, A., & Silverman M. M. (Eds.). (2000). *Comprehensive textbook of suicidology*. New York: Guilford Press.

National Institute of Mental Health. (2003). *Older adults: Depression and suicide facts.* Rockville, MD: National Institutes of Health. (NIH Publication No. 03-4593, revised May 2003.) Retrieved March 23, 2005, from http://www.nimh.nih.gov/publicat/elderlydepsuicide.cfm

Resources

Resources for Primary Care Physicians

Online Resources

American College of Emergency Physicians. (1997, reaffirmed 2001). *Civil commitment: ACEP policy statement.* Retrieved March 23, 2005, from http://www.acep.org/webportal/PracticeResources/PolicyStatementsByCategory/MentalHealth/default.htm

Bronheim, H. E., Fulop, G., Kunkel, E. J., Muskin, P. R., Schindler B. A., Yates W. R., et al. (1998). The Academy of Psychosomatic Medicine practice guidelines for psychiatric consultation in the general medical setting. *Psychosomatics*, *39*(4), S8–S30. Retrieved March 23, 2005, from http://www.apm.org/prac-gui/psy39-s8.shtml

Frierson R. L., Melikian M., & Wadman, P. C. (2002). Principles of suicide risk assessment. How to interview depressed patients and tailor treatment. *Postgraduate Medicine, 112*(3), 65–66, 69–71. Retrieved March 23, 2005, from http://www.postgradmed.com/issues/2002/09_02/frierson4.htm

Gliatto, M. F., & Rai, A. K. (1999). Evaluation and treatment of patients with suicidal ideation. *The American Family Physician*, *59*(6), 1500–1506. Retrieved March 23, 2005, from http://www.aafp.org/afp/990315ap/1500.html

Office of Quality and Performance, Veterans Health Administration. (2000). *Major Depressive Disorder (MOD) clinical practice guidelines: Module A. Primary Care.* Retrieved March 23, 2005, from http://www.oqp.med.va.gov/cpg/MDD/MDD_Base.htm
These guidelines were developed for clinicians by the Department of Veterans Affairs and the Department of Defense. They draw heavily from the American Psychiatric Association and Agency for Health Care Policy and Research Clinical Practice Guideline No. 5: Depression in Primary Care. The guidelines include information on assessment and treatment of potentially suicidal patients, patient handouts on depression, and

guidelines for treatment of depression. The guidelines, supporting documents, and tools are available online at the URL listed above.

Quinnett, P. (2000) *Counseling suicidal people: A therapy of hope.* Spokane, WA: QPR Institute. Retrieved March 23, 2005, from http://www.qprinstitute.com/
This book was written for therapists, mental health workers, physicians, nurses, and others who are not clinical suicide counselors, but who might find themselves counseling people at risk of suicide. It provides tools and strategies for risk assessment and intervention.

Sharp, L. K., & Lipsky, M. S. (2002). Screening for depression across the lifespan: A review of measures for use in primary care settings. *American Family Physician, 66*(6), 1001–1008. Retrieved March 23, 2005, from http://www.aafp.org/afp/20020915/1001.html

Stovall, J., & Domino, F. J. (2003). Approaching the suicidal patient. *American Family Physician, 68*(9), 1814–1818. Retrieved March 23, 2005, from http://www.aafp.org/afp/20031101/1814.html

Books

Hawton, K., & Wan Heeringen, K. (Eds.). (2000). *International handbook of suicide and attempted suicide.* Chichester, UK: John Wiley and Sons.

Jacobs, D. (Ed.). (1999). *The Harvard Medical School guide to suicide assessment and intervention.* San Francisco: Jossey-Bass.

Rutz, W. (2001). The role of primary physicians in preventing suicide: Possibilities, short-comings, and the challenges in reaching male suicides. In D. Lester (Ed.), *Suicide prevention: Resources for the millennium* (pp. 173–188). Philadelphia: Brunner-Routledge.

Videos

American Foundation for Suicide Prevention [Writer] & Kingsley Communications [Producer]. (1999). *The suicidal patient: Assessment and care* [Motion picture]. Available from the American Foundation for Suicide Prevention at http://www.afsp.org/survivor/doctor.htm.

General Resources on Suicide and Suicide Prevention

Suicide Prevention Resource Center (http://www.sprc.org/). The Suicide Prevention Resource Center (SPRC) provides prevention support, training, and materials to strengthen suicide prevention efforts. Among the resources found on its website is the SPRC Library Catalog (http://library.sprc.org/), a searchable database containing a wealth of information on suicide and suicide prevention, including publications, peer-reviewed

research studies, curricula, and web-based resources. Many of these items are available online.

American Association of Suicidology (http://www.suicidology.org/). The American Association of Suicidology is a nonprofit organization dedicated to the understanding and prevention of suicide. It promotes research, public awareness programs, public education, and training for professionals and volunteers and serves as a national clearinghouse for information on suicide.

American Foundation for Suicide Prevention (http://www.afsp.org). The American Foundation for Suicide Prevention (AFSP) is dedicated to advancing our knowledge of suicide and our ability to prevent it. AFSP's activities include supporting research projects; providing information and education about depression and suicide; promoting professional education for the recognition and treatment of depressed and suicidal individuals; publicizing the magnitude of the problems of depression and suicide and the need for research, prevention, and treatment; and supporting programs for suicide survivor treatment, research, and education.

National Center for Injury Prevention and Control (http://www.cdc.gov/ncipc/). The National Center for Injury Prevention and Control (NCIPC), located at the Centers for Disease Control and Prevention, is a valuable source of information and statistics about suicide, suicide risk, and suicide prevention. To locate information on suicide and suicide prevention, scroll down the left-hand navigation bar on the NCIPC website and click on "Suicide" under the "Violence" heading.

National Suicide Prevention Lifeline (http://www.suicidepreventionlifeline.org/). The National Suicide Prevention Lifeline provides immediate assistance to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider through a toll-free telephone number: (800) 273-TALK (8255). Technical assistance, training, and other resources are available to the crisis centers and mental health service providers that participate in the network of services linked to the National Suicide Prevention Lifeline.

Suicide Prevention Action Network USA (http://www.spanusa.org). Suicide Prevention Action Network USA (SPAN USA) is the nation's only suicide prevention organization dedicated to leveraging grassroots support among suicide survivors (those who have lost a loved one to suicide) and others to advance public policies that help prevent suicide.