SUICIDE:
HOW TO CALL A PERSON BACK TO LIFE?

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Abstract: Suicide remains one of the most challenging concerns that face the practicing psychiatrist. It is the leading cause of death in patients with psychiatric disorders. Fifty to seventy-five percent of people who commit suicide do not tell anyone about their suicidal thoughts or plan. The aim of this paper is to present the most important issues in assessment and treatment for the acute and long term risk of suicide. We suggest the use of a mnemonic sad persons escape to help identify the risk factors for suicide. A new dimension of the psychological approach to suicide is the field of personology that emphasizes the uniqueness of each individual and that every person is at risk of suicide when a vital need is thwarted. Addressing the risk factors and acknowledging and validating the meaning of the patient’s psychological pain is helpful in organizing crisis interventions and planning short and long term management. It is very important for every patient to be assessed on a continuous basis to identify all potential risk factors that are amenable to intervention. Together these suggestions and knowledge provides the psychiatrist with an understanding of how to reach out to suicidal patients to bring them back to life.

Key words: suicide, risk factors, personology, crisis intervention
**Introduction**

Suicide is one of the most devastating experiences for families, friends and staff involved in the care of a person who commits suicide. For both authors as academic clinicians and teachers suicide has been a focus of study. Working in New Zealand over the last decade has magnified this concern. Amongst all ages New Zealand has the fourth highest rate of suicide for females and the sixth highest rate of suicide for males in the world [1, p. 2]. The first author as a clinical leader had 8 years experience conducting psychological investigations of completed suicides occurring amongst over 3000 patients. This led to the development and implementation of risk assessment procedures and later to participation in developing national Evidence-Based Best Practice Guidelines on the Assessment and Management of People at Risk of Suicide conducted by the Ministry of Health in collaboration with the New Zealand Guidelines group and the Royal Australian and New Zealand College of Psychiatry [1]. The academic work of the second author produced on-going teaching among mental health staff, Grand Rounds amongst consultant psychiatric colleagues and publication of an article in Transcultural Psychiatry analysing the high frequency of suicide in New Zealand as a new and challenging professional dilemma [2]. The authors identified two major areas of concern:

1. A lack of knowledge about risk factors in suicide and
2. A lack of understanding of the need for an in-depth psychological understanding and relationship with patients at risk of suicide.

Suicide is infrequent and unpredictable and it does not fit easily into a paradigm based on an evidence-based treatment approach. The main body of knowledge we have about suicide comes from population-based data that identifies risk factors and the study of suicide notes and after-the-fact psychological investigations. Unfortunately, risk factors do not predict who will take their life because every human being is absolutely unique. In addition, 50 [3] to 73% [4] of people who commit suicide do not tell anyone they are suicidal. So, in most situations we don’t even know that a patient is suicidal. Edwin Shneidman introduced the field of Personology based on the fact that every person is unique and potentially at risk of suicide if their essential vital needs are blocked and unsatisfied [5]. Shneidman’s psychological approach offers a significant contribution to therapy and crisis intervention for the suicidal patient. It is our task as psychiatrists to learn all that we can about the nature of suicide and to understand each person’s suffering as completely as possible. In this way, we can best prepare ourselves to be present, aware and able to offer our skills and compassion to call a suicidal person back to life.

**Definition**

“Suicide is the anchor point on a continuum of suicidal thoughts and behaviors. This continuum ranges from risk taking behaviors at one end, extends through different degrees and types of suicidal thinking, and ends with
suicide attempts and suicide” [6]. The World Health Organization (WHO) defines suicide as a suicidal act with a fatal outcome where a suicidal act is defined as “self-injury with varying degrees of lethal intent”. Suicide is a drama in the mind in which a person says, “enough” to psychological pain or “psychache”, the negative emotions of shame, guilt, loneliness, abandonment, ennui [5].

Prevalence of suicidal ideation and suicide
In a study of 700 people in Connecticut 10% of non-patients said that they had the experience of feeling that life was not worth living and one person out of 20 had considered suicide [7]. People are often ambivalent. Part of them wants to live and part of them wants to die. Most people deny or minimize their suicidal thoughts or behaviour after the crisis is over. Some people make suicidal threats to elicit responses from others or to exact revenge for suffering or rejection.

The rate of suicide is about 1 per 10,000 population per year. Even among those in high risk groups, suicide is uncommon [8].

Risk factors
There is a diagnosis of mental disorder in 90% of people with completed suicides and the remaining 10% probably suffer mental disorders that have not been detected [8]. Thus, a comprehensive psychiatric assessment is indicated in any person with a mental disorder.

Researchers have identified population based factors associated with an increased lifetime risk of suicide. The risk of suicide increases with increasing numbers of risk factors [3]. It is important to understand, however, that one cannot predict who will commit suicide by identifying risk factors. A study by Pokorny using 21 known risk factors with 4800 consecutive clients at a Veterans Administration centre identified a sub-sample of 803 people with an increased risk of suicide. 30 of these people (3.74%) committed suicide over the next 5 years, but a further 37 people committed suicide who were not identified by examining risk factors [3].

Thus, risk factors should be understood as markers of potential risk and as variables that may be amenable to intervention to reduce the overall risk. Some authors divide risk factors into predisposing, precipitating and perpetuating categories. In this paper discussion these distinctions are not emphasized. It is never possible to know exactly what leads a person to take their life.

Risk factors are often expressed in odds ratios (OR). In determining OR, a subgroup is compared to the general population. The general population is given a rating of 1. The frequency of suicide in the subgroup related to the general population is expressed as ratios, for example, X: 1 where X represents the frequency in that particular subgroup and 1 represents the risk
Sad persons escape: A mnemonic to assist in recalling risk factors

Sad persons is an acronym created to help remember the risk factors for suicide [9]. Since it was developed, other factors have been identified and we added the word “escape” to include this additional knowledge.

Sex: Males account for 75% of completed suicides although females attempt three times as often [10].

Age: The highest risk age groups are 15-24 years [11] and people over the age of 60 years [5]. The rate of completed suicides is highest among elderly. The ratio of attempts to completion is 1:10 to 1:200 in youth and 1:4 in the elderly [12]. The elderly account for 39% suicides and after 60 years the suicide rate continues to rise with age [10].

Depression: Depression is present in as many as 70% of completed suicides and there is greater risk with severe anhedonia and greater severity of depression [5]. The risk of completed suicide with depression in youth has an OR of 12 [11]. Fifteen percent of people with affective disorder die by suicide [10]. Depression is the most common diagnosis in older adults attempting suicide [3]. The OR for suicide in mood disorders is 33.4 [14]. Thus, depression increases the risk of suicide by more than thirty times the normal rate and it is the factor associated with the most significant increase of suicide.

Previous attempt: Ten to twenty percent of people who have previously attempted suicide eventually die by suicide according to some authors [10] but others put this figure between eighteen and thirty-eight percent [3]. The rate of suicide among previous attempters is 5-6 times greater [3]. However, the majority or sixty percent of people who commit suicide have not made a previous attempt [3].

Ethanol and drug abuse: Drug abusers have 20 times the risk of suicide, and alcohol is associated with 25-50% of suicides [10]. Substance abuse in youth has a median OR of 5.5 [11]. Among attempters of all ages substance abuse is the highest predictor of completed suicide [10]. The OR for substance abuse in general is 2.7 [14].

Rational thinking impaired: Ten [3] to fifteen percent [10] of people with schizophrenia die by suicide. Suicide accounts for the majority of premature deaths in people with schizophrenia [3]. The risk of suicide in depression is five times greater when the patient is psychotic and twenty percent of people who complete suicides are psychotic [3]. There is a greater risk amongst patients with paranoid schizophrenia as compared to other subtypes and the presence of positive symptoms is associated with a threefold greater risk than negative symptoms [3]. Evaluation of a person’s competence (or rational thinking) means assessing the degree to which their judgment and self-control are impaired by their illness [3].
Support System: Disruption or lack of a support system increases the risk of suicide. In youth disruption of the family of origin is a risk [11]. A family history of suicide has an OR of 4.6 [11].

Organized plan: Having an organized plan for suicide increases the risk [3].

No spouse: There is a greater risk of suicide for people who are living alone, divorced, widowed, separated or bereaved [10].

Sickness: Debilitating medical illnesses are present in 25-70% suicides but suicide is rare without psychiatric disease [10]. Specific illnesses include epilepsy with 4 times the risk, temporal lobe epilepsy with 25 times the risk, cancer with several times the risk, Huntington’s Disease with 6 times the risk, renal dialysis with 10-100 times the risk, AIDS with 36 times the risk, and there is an increased risk associated with spinal cord injury, multiple sclerosis, Cushing’s Disease, thyroid and hyperparathyroid disorders [10]. There are many other physical disorders that impair function and cause pain and debilitation that must be considered risks.

Experiences of adversity and the risk of suicide:
1. Humiliation is frequently a factor in suicides [3].
2. Social and educational disadvantage: low Socio-economic Status (SES) doubles the risk, dropping out of school has an OR of 5.1, and not attending college has an OR of 7.8 [11].
3. Disrupted families: a non-intact family of origin has an OR of 1.9; greater than three changes in parental figures has an OR of 2.6 [11].
4. Exposure to parental pathology: depression in family has an OR of 11; substance abuse in family has an OR of 10.4, and parental antisocial behaviour is a clearly identified risk factor [11].
5. A family history of suicide has an OR of 4.6 [11].
6. Physical abuse has a median OR of 5.7 (not in isolation) [11].
7. An impaired parent-child relationship has a median OR of 2.6 [11].
8. Gay, lesbian and bisexual youth are at increased risk of suicide attempts with an OR of 6.2 [15], and an OR of 6.5 for gay men [16].
9. Being in jail increases the risk of suicide by nine times, especially preceding a hearing and when people are kept in a cell alone [17].

Sexual abuse: The median OR for sexual abuse is 4.8. The more severe the abuse, the greater the risk is for suicide. Sexual abuse that includes forced intercourse increases the risk by twelve times [11].

Co-existing disorders: People with two or more psychiatric disorders have an OR of 89.7 times those with no psychiatric disorder [14]. Co-existing disorders are present in 43-70% of suicides with a median of 45%
and the risk increases with increasing numbers of disorders [11]. Risk for the following specific co-existing disorders or symptoms and disorders has been identified.

Substance abuse and hopelessness has 14.3% risk of suicide [18].
1. Substance abuse and depression: 75% of people with alcoholism who commit suicide have depression [3,10].
2. Substance abuse and schizophrenia greatly increases the risk of suicide [3].
3. Depression and substance abuse increase the risk of suicide especially in the elderly [19].
4. Depression and antisocial personality increase the risk of suicide [10].
5. Depression with aggression and impulsivity are associated with an increase risk of suicide [10].
6. Suicide in schizophrenia and bipolar disorder is more likely to occur with the supervention of depression and hopelessness than during florid psychotic episodes [3].
7. Risk associated with co-existing personality disorders, major mental disorders and substance use disorders is discussed under the section on personality factors.

Anxiety: Anxiety is a well recognized co-existing factor [3, 19]. Depression alone is associated with an 8% risk of suicide. Depression with co-occurring anxiety is associated with a 20% risk of suicide. Panic disorder alone has a 7% risk of suicide. Panic disorder with co-occurring depression has triple that risk or 24% risk of suicide [20].

Personality factors: One third of suicide victims meet criteria for a personality disorder. The incidence associated with borderline personality is an example of the increase in risk with the increase in co-occurring disorders. Borderline personality alone has a 3% risk of suicide. Associated with substance abuse the risk is 6%. Borderline personality associated with depression has a risk of suicide of 16%, and associated with depression and substance abuse the risk is 45% [10].

Antisocial personality including conduct disorder and oppositional defiant disorder increase the risk of suicide. Antisocial personality is associated with a 5% risk of suicide but most suicide victims with antisocial personality also met criteria for borderline personality. So, the true incidence in antisocial personality alone is not clear. Antisocial behavior in youth has an OR of 5.4 [11]. The OR for ASP and conduct disorder is 3.7 [14]. Aggression, impulsivity and depression are recognized as factors that increase the risk of suicide [10].

Borderline, narcissistic and antisocial personality disorders are all recognized as potentially associated with an increased risk of suicide [3].

Event: In young people an identifiable stressful event precedes suicide 70-97% of the time with a median of 90.5% [11]. The presence of an
identifiable stressor was associated with an OR of 4, [11] especially interpersonal loss/conflicts, disciplinary/legal action. With substance abusers, the event frequently involved rejection, interpersonal loss, or the onset of medical illness [11].

Homicide: Ninety-one percent of people committing homicide have a history of attempted suicide [21].

Acute and chronic risks

The acute risk of suicide happens as a result of sudden overpowering distress especially in people who have limited personality resources. Mental disorders alone and in combination with personality disorders and substance use disorders make people vulnerable to impaired coping. The risk factors associated with acute risk for suicide include severe psychic anxiety, anxious ruminations or impaired concentration, global insomnia, psychosis with delusions of poverty or doom, recent alcohol abuse and severe anhedonia [22, 23].

One group of patients at acute high risk are those people recently discharged from a mental inpatient ward. Forty-two percent of completed suicides were within six months of discharge. The risk is greatest during the week after hospital admission, the month immediately after discharge and during the early stages of recovery from a mental illness [22].

Nearly two-thirds of patients with schizophrenia committed suicide when they developed a co-existing depression. People with psychotic depression with delusions of guilt and loss as prominent features are at risk. Bipolar patients who have stopped taking their lithium have 13 times increased risk of suicide [22].

Chronic or long term risk is characteristic of personality disorders, particularly borderline personality. Other long term risks are: family history of suicide, fall in a social or economic status, rejection by spouse or lover, anniversary of important losses and high impulsivity [23].

Protective factors [24]

Factors that protect against suicide include: being married or having a significant relationship, being employed, having a support system (family, friends, social, church), having children younger than 18 years of age, having constructive use of leisure time and social life, having a general purpose or meaning for life, having effective problem solving skills, having a sense of belonging to one’s own religion, culture and ethnicity [24].

Assessment of level of perturbation and lethality

From his lifelong study of sociology Shneidman concludes that it is the presence of both perturbation and lethality that are the most accurate markers of suicidal risk.
Perturbation refers to being mentally upset and disturbed. It exists in everyone and can be rated from 1-9. It is a continuum with 1 being serene, contented and well-adjusted to 9 being out of this world and possibly dangerous to oneself or others [5].

Lethality refers to the probability that a specific individual will be dead by suicide within the next several days, that the individual will “do” something about his perturbation. There is no high lethality without heightened perturbation, but there is plenty of elevated perturbation without elevated lethality [5].

Perturbation can be assessed during a normal interview but it is also important to ask the family and friends who are with the patient outside the interview. Lethality is explored by asking about previous suicide attempts, what means were used and how lethal they were, whether or not the attempt was premeditated and if so, whether or not the person took precautions not to be discovered [5]. The availability of guns or other weapons significantly increases the risk of fatal suicides [3].

Assessment of the suicidal patient

The goal of assessment is not to predict suicide but to place the person along a putative risk continuum, to appreciate the basis for suicidality and to allow more informed interventions [3].

The most meaningful assessment of a person who is suicidal is a comprehensive and ongoing psychiatric assessment including collateral information from family and friends and significant others [25]. Patients who completed suicide share their suicidal thoughts with their mental health clinician or doctor 18% of the time, with their relatives 50% of the time and with their spouse 60% of the time [22].

The assessment examination has multiple purposes. One is to determine whether or not there is evidence of a psychiatric disorder that requires treatment. The second is to determine what factors precipitated the suicidal thinking and whether or not any of these factors might be amenable to intervention. The third is to assess the nature and the degree of perturbation and lethality of the suicidal thinking and whether or not the person has formulated a plan or has already made an attempt. It is important to determine when the person began thinking about suicide, what specific thoughts they have about suicide and what they believe suicide will resolve or accomplish. Some people have no idea how to resolve their problems, and see suicide as a solution. The fourth purpose of assessment is to inform interventions and treatment.

It is important to thoroughly explore both individual and social dynamics because patients who present with suicidal ideation are often isolated and may have suffered chronic problems with attachment. In these individuals, the importance of establishing a meaningful and deep therapeutic alliance is crucial. If a clinician is finding this alliance difficult to establish, the clini-
cian needs to seek supervision and/or consult with the wider clinical team to determine whether another approach is possible, or whether some other change in the management plan is necessary.

A thorough assessment of risk for suicide must be explored with every new patient and needs to be a part of the on-going assessment of every patient with a psychiatric disorder. With any patient who has acknowledged suicidal ideation, it needs to be continued at every crisis interview. In multidisciplinary teams clinicians frequently dismiss suicide as a risk when the patient denies suicidal ideation. This approach is fraught with error and the involvement and assessment of the psychiatrist is often essential in helping to identify patients at risk who are not expressing the degree of their distress.

There is no screening test, clinical technique or biological marker for suicide sufficiently sensitive and specific to support an accurate short-term plan. There is no substitute for a comprehensive psychiatric assessment. Clinicians do, however, often overlook key information in their documentation and this can be improved when clinicians use structured assessments [25,26]. In addition, training in suicide assessments [27] and structured assessments [28] can improve the performance of all staff in assessing, documenting and making appropriate referrals for people with suicidal ideation.

The sad persons escape is offered here as a tool for education as well as a guide to review during assessment. If each letter or factor is given a value of 1, then a score of 6-7 indicates moderate risk and higher scores are cause for further caution and/or intervention. This tool has not been studied in random, controlled double-blind studies. It is rather a means to gather together clinical knowledge about suicide to assure that these areas are carefully understood and addressed in the assessment.

Understanding Each Individual

The psychological approach to suicide relies on the clinician having a deep understanding of the psychological suffering and dynamics that have lead the patient to intense psychological pain coupled with the idea that death is the best solution to the unremitting and intolerable psychological pain. The psychodynamic formulation represents that the psychological pain is a result of frustrated, blocked or thwarted psychological needs. The patient should be asked “Where do you hurt?” and “How can I help you?” [5].

The psychiatrist needs to explore and understand what the essential issue is that is driving the suicidal thoughts. For practical purposes the psychological causes for most suicides fall into the following five clusters of unmet needs:

1. Thwarted love, acceptance and belonging related to frustrated needs for succorance and affiliation.
2. Fractured control, predictability and arrangement related to frustrated needs for achievement, autonomy, order and understanding.
3. Assaulted self-image and avoidance of shame, defeat, humiliation and disgrace related to frustrated needs for affiliation and shame-avoidance.

4. Ruptured key relationships and attendant grief related to frustrated needs for affiliation and nurturance.

5. Excessive anger, rage and hostility related to frustrated needs for dominance, aggression and counteraction [5].

Therapeutic alliance and relationship

It is generally believed that an ongoing meaningful relationship will protect against suicide. Many studies conclude that social support is protective against depression. A therapeutic alliance is defined as the conscious talk-oriented collaboration between a clinician and patient for the purpose of mutual exploration of the patient’s problems. The presence of a therapeutic alliance is felt to be an important nonverbal statement indicating the patient is willing to seek help and has a desire to live. Clinicians should assess the presence, strength and reliability of the therapeutic alliance. Inherent in the concept of an alliance is the implication of two-way communication. The better the patient and clinician understand each other, the more protection that understanding offers. Fostering a therapeutic alliance may be crucial in people who have a difficulty in reaching out to anyone, and in counteracting a sense of hopelessness that may lead people to believe there is no one who can relieve their pain [3].

Crisis intervention

For the purpose of this paper therapeutic intervention is organized into three phases: assessment, setting of treatment goals, and implementation of interventions. We have already discussed assessment.

Treatment is first of all determined by the specific diagnosis and the social and psychological problems identified. It may include medication, establishing a therapeutic alliance, providing psycho-education of the patient and family about mental and substance use disorders, organizing patient and family support and psychotherapy. Any potential risk factors that are able to be modified need to be addressed. Several examples follow. Isolation needs to be addressed by working through engaging the person in a variety of social activities and groups. Specific major mental disorders need immediate and aggressive treatment. Substance abuse needs to be addressed and the patient and family need to be told that all substance use must cease because it impairs judgment and disinhibits people. If this is not possible, then it may be essential to pursue detoxification either as an inpatient or outpatient and residential substance abuse treatment or treatment facilities that treat both substance use and mental disorders concurrently.

It is important to understand that it may not be possible to do a comprehensive assessment from patients who are mute, refuse to talk or are heav-
ily disorganized or incapacitated. A patient who is unable to co-operate with outpatient treatment planning or with an initial assessment requires hospital treatment. Patients who are co-operating and who want treatment may be able to help staff make a decision as to whether or not they need hospital treatment. The presence and strength of support of family or friends may be critical in determining whether or not outpatient treatment is an option. The availability of intensive outpatient support teams also influence whether or not a patient requires hospital treatment. If a patient clearly at high risk of suicide refuses to cooperate and refuses treatment, they require immediate assessment for admission under some form of medical/legal commitment. Patients with severe disorders who are actively suicidal require hospital treatment. When the psychiatrist is in doubt, it is better to be safe than sorry. It is much better to admit someone for observation and treatment when the history or rapport is insufficient or there is no support system available. If the patient is treated in the community it must be with intensive crisis team involvement, weekly or biweekly assessment by the psychiatrist and involvement of the family or friends.

Assessment is an on-going process and the psychiatrist and crisis team must be prepared to change their mind at any point and admit someone who has been receiving outpatient care if their situation suddenly changes.

A thorough medical examination, laboratory screening and other investigations as indicated by a medical doctor need to be done as soon as possible to rule out a medical cause for the patient’s symptoms.

Most community mental health services have found that separate crisis teams allow for optimum functioning of the entire service. In this way the majority of professionals can carry their work without being interrupted continuously for crises. In addition, each crisis deserves time for a sufficient assessment. Ideally crisis team members should be nurses and several should take turns acting in a triage role. The triage nurse takes phone calls from general practitioners, other psychiatric services, family members, friends, employers, or patients in crisis. The triage nurse does phone assessments to determine whether or not the person requires mental health assistance. If the person is not suicidal or at risk to themselves or others and there is nothing to suggest that the person is suffering from an acute psychiatric disorder that needs urgent attention, the clinician/family or patient are given information and referred to other community services.

When a patient is suicidal it is essential that a comprehensive psychiatric assessment is done by a psychiatrist who works with the crisis team. Working with the team assists all members involved and helps the team over time to improve their quality of care and interpersonal communication. It is helpful if a nurse of the crisis team is present during each crisis assessment. This facilitates the transmission of information amongst the crisis team members and makes it possible for the staff to determine when there are changes to the patient’s condition. Crisis nurses need to maintain very close
monitoring of suicidal patients that remain in the community and visit them daily until they can negotiate with the patient to alternate visits with phone calls.

Treatment planning

Once assessment of the patient at risk for suicide has been made, an individual treatment plan is needed. The plan is developed in co-operation with the patient and caregivers and it must include the understanding that the plan may need to change at any time if there is some change in communication, co-operation, availability of caregivers or change in the patient’s mental or physical state. The plan may need to include both short term and long term goals. If it is at all possible planning should involve the family or caregivers if not at the first visit, then at subsequent visits. Consult with other existing clinicians if this is feasible. Suicide contracts that state that over a given period the patient agrees not to harm him or herself are not reliable and may give staff a false sense of security. It is better to rely on an assessment of the patient’s ability to understand and participate in treatment planning and the patient’s capacity to form a therapeutic alliance.

An inpatient unit provides safety, support, and hope and relies on a progression through a hierarchy of observation levels, supervision levels, privileges and therapeutic passes. With clinical improvement suicidality may persist. Although the goal is toward a less restrictive environment, the clinician’s decision must be based on on-going psychiatric assessment and risk assessment. Levels of observation include continuous observation of one staff member who remains in sight of the patient at a certain distance, restricting the patient to an area where he or she can be seen at all times, restricting the patient to public areas and not allowing them in their room alone, checks at intervals of 5, 15 or 30 minutes. The staff may need to supervise when the patient using potentially dangerous objects and in all activities including use of the bathroom.

Therapy

It can be understood that part of person who wants to live and part of them wants to die. The management of this ambivalence is critical. It is very important to make it clear to the patient that no one can stop them from taking their life. All that anyone can do is to help the part of them that wants to live. So, if the person is going to survive this crisis, they must help us understand what they need in order to remain safe. Defining this boundary it critical as unconsciously some people believe that threatening suicide is a kind of game and that mental health staff may have some special skills and perhaps the ability to stop them from taking their lives. This illusion must be addressed and clarified in order for the part of the person who wants help to take responsibility for full engagement in treatment. Other staff and family also need to understand these limitations so they are able to work alongside
the patient to ensure safety. Safety must be given the foremost and ultimate concern in treatment. Ideally the patient will collaborate in developing a treatment plan. People who refuse to cooperate need compulsory treatment and need to remain in the hospital until there is some shift in their insight and judgment.

Following Shneidman’s psychological model of suicide the goal of crisis intervention therapy is to single out the most important problem since people in crisis don’t prioritize well. One must attempt to reduce the perturbation or to reduce the pain of the triggering problem. Accepted that there is a thwarted or unmet need, one must try to fill the frustrated needs and provide a viable answer to the problem and assist in indicating alternatives. In regard to the risk of hopelessness and helplessness, one needs to give transfusions of hope. In regard to the internal ambivalence, one workable strategy is to play for time instead of trying to tackle this problem head on. Increasing cognitive options assists in widening cognitive constrictions. Listening to the cry for help and involving others assists in the communication of the patient’s distress and improves their support. The therapist should be active in attempting to block the aggression from life. Invoking previous patterns of successful coping can assist in combating the loss of hope [29].

Concluding remarks
Every psychiatric assessment must include an assessment of risk and an assessment for depression, anxiety and substance use as these are frequent co-existing risk factors in schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder and personality disorders. All psychiatric disorders need prompt and thorough treatment. Co-existing substance use should be treated concurrently and continue to be addressed in a consistent and persistent way. Severely unwell patients require 24 hour observation either at home or in the hospital. Each individual deserves the time required to develop a therapeutic alliance and a deep understanding of the conditions that precipitated their suicidality. Effective treatment must address these unmet needs and the risk factors identified.

Psychiatrists have an opportunity to offer their validation and support for people who are at serious risk of suicide. They should make it clear that they will never give up trying to find ways to help a patient and that there is every reason in the world to have hope. The psychiatrist must encourage the patient to do his or her part in order for them to regain themselves and their life.
SAMOUBISTVO:
KAKO DOZVATI NEKOGA DA SE VRATI U ŽIVOT?

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Apstrakt: Samoubistvo je i dalje jedan od najvećih izazova sa kojim se psihijatri suočavaju u praksi i vodeći uzrok smrti kod pacijenata sa psihijatrijskim poremećajima. Između pedeset i sedamdesetpet procenata samoubica ne govore nikome da razmišljaju o samoubistvu ili ga planiraju. Cilj ovog članka jeste da predstavi najvažnija pitanja u vezi sa procenom i tretmanom akutnog ili dugoročnog rizika od samoubistva. Radi lakše identifikacije faktora rizika od samoubistva, predlažemo upotrebu mnemoničkog akronima sad persons escape. Novu dimenziju psihološkog pristupa samoubistvu predstavlja oblast personologije, koja naglašava jedinstvenost svakog pojedinca, kao i stav da je svaka osoba u opasnosti da početi samoubistvo ako joj je uskraćena neka vitalna potreba. Posvećivanje pažnje faktorima rizika i prepoznavanje i potvrda značenja psihološkog bola pacijenta pomaže prilikom organizovanja kriznih intervencija i planiranja kratkoročnih i dugoročnih akcija. Kontinuirana procena pacijenata je veoma važna, kako bi se identifikovali svi potencijalni faktori rizika koji su podložni intervenciji. Uz pomoć ovih predloga i saznanja, psihijatar može da nauči na koji način da pristupi suicidnom pacijentu kako bi ga vratio u život.

Ključne reči: suicid, faktori rizika, personologija, krizna intervencija
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