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Assessing Suicide Risk in Young Adults

THE ASSESSMENT OF SUICIDE RISK

You are listening to ReachMD XM 157, the channel for medical professionals. Knowing the risk factors for suicide, recognizing warning signs and taking appropriate actions are the best ways to prevent suicide. Depression is one of the greatest risk factors for suicide and studies have found that physicians do not recognize or treat 40% to 60% of patients with depression. How and when should clinician include a risk assessment for suicide in their practice and how can medical professionals enlist others to be on the lookout for warning signs that someone might be contemplating suicide? Welcome to the clinician's roundtable. I am Dr. Kathleen Margolin and joining me from Atlanta, Georgia is psychiatrist, Steven Garlow of the Department of Psychiatry and Behavioral Sciences at Emory University School of Medicine.

DR. MARGOLIN:

Welcome Dr. Garlow.

DR. GARLOW:

Thanks, it is a pleasure to be here.

DR. MARGOLIN:

Dr. Garlow, can we begin our discussion of suicide prevention by going over some of the basics?

DR. GARLOW:

Sure.

DR. MARGOLIN:

How prevalent is suicide and how prevalent are suicide attempts?

DR. GARLOW:

Those are excellent questions and they have two different answers really. Suicide is overall the 11th leading cause of deaths in the United States, approximately 1 person in the United States kills himself every 16 minutes, more or less depending on the age, but that risk is not universal across all ages. For young people, for adolescent young adults, it is either the third or second leading cause of death and for old people as well, it rises to one of the higher leading causes of death. The risk is highest on a capitated basis in elderly males.

DR. MARGOLIN:

And how are we defining elderly at what age?

DR. GARLOW:

It depends either 65 and above or 85 and above in the old-old, and in particular, white males are at extremely high risk.

DR. MARGOLIN:

Let us talk about the warning signs of suicide.

DR. GARLOW:

The risks for suicide for completed suicide are there are we refer to as modifiable risks factors or modifiable warning signs and some that are not, so certain things you cannot really change like being male increases risk, being older increases risk, being white increases risk. None of those are really changeable, but things that you should be looking for in a person as a physician as a clinician should be high degree of distress what is referred to sometime as psychic pain or psychic tension, high degree of anxiety, high degree of restlessness, affective instability that is person's emotions, they burst out in tears easily. They are just no gating, no control on their emotional state, or the herald state that really puts the person at risk. That is a very high-risk state regardless of whether the person is sane or feeling suicidal, are certainly the presence of suicidal ideation is a risk factor we shall be speaking for and as clinician, as medical practitioners, we should never by shy about asking about it. If we do not ask, our patients will never tell.

DR. MARGOLIN:

You are describing the symptoms of clinical depression here.

DR. GARLOW:

More than just depression, really looking for somebody who is really stirred up, who is feeling that there is no way out, there is no escape, there is no solution, overwhelmed, feelings of tremendous distress, coupled with feelings of depression or depression in itself increases risk, so people who are sad and feeling forlorn and feeling helpless and having sleep disturbance, all of the classic symptoms of depression that we think about or part of the problem, are part of what we are looking for, but on top of that looking for person who is anxious and agitated and restless and cannot sit still and their emotions cannot sit still either, that is a person who is at very high risk.

DR. MARGOLIN:

Hmm-hmm, so even among those who are depressed, we can further distinguish even beyond suicidal ideation and look at the quality of their affect.

DR. GARLOW:

Right. Unfortunately suicidal ideation does not have a great deal of specificity in terms of identifying people who ultimately commit suicide. It is a fairly common occurrence in people and it is part of the definition of major depression in people who have depression will have thoughts of death and suicidal ideation, ultimately everybody who kill themselves at some point have to have thought, "I am going

to kill myself", but most everybody who thinks that does not go on to end up dying by suicide.

DR. MARGOLIN:

And you mentioned that state of extreme agitation can almost also be the flip side where someone is so lethargic and hopeless and!

DR. GARLOW:

Hopeless is the word. Not so much lethargic, but hopeless. Person who has developed hopelessness and then comes to this as a solution to this hopelessness that would be another common state. That is a very hard one to pick up for clinicians because that is the person who is probably not going to come to our attention; they are probably not going to end up in our office or any other consultation. Because of that they are not going to come in front of us, we need to be extensive to what we are looking for it. Person comes to the physician's office to be looking for that kind of mood state, that kind of emotional state, but very often that is a person who is going to do something in a kind of an organized fashion to kill themselves and never have told anybody about it.

DR. MARGOLIN:

And that leads to me think of this other phenomena that happens is kind of tricky and it is that switch in affect that can occur in a patient right before the suicide attempt.

DR. GARLOW:

Right. That has been recognized for many years, especially people treated for depression that when they start getting better for some reason, maybe they have more energy, they have more motivation, they are feeling better, then suffers some minor setback, but early on in their course of recovery, a window of risk open that they can respond and end up killing themselves on upswing when they are getting better as opposed to when they are down at the very bottom.

DR. MARGOLIN:

Clinicians often have such brief contact with patients and sometimes feels the risk for suicide, hesitate to disclose all of these symptoms that we have been discussing and it is just not as easily detectable as an obvious physical condition would be. What do you think the clinician's responsibility is when it comes to assessment and education?

DR. GARLOW:

Well, I am a psychiatrist, so every patient I see is subject to a suicide risk assessment that is essential to psychiatric practice, essential to mental status examination that I would conduct on patients for somebody who is not in a mental health setting, being aware of it, being like I said earlier not shy about asking about it, and being explicit. We cannot speak in euphemism. We have to speak very directly, "are you thinking of killing yourself?" questions like that or around that type of, "how is your mood, how is your sleeping, are you feeling anxious, are you feeling desperate", and one of the thing that happens in lot of practices is because we do not have so much time, we do not want to open that door. Suddenly a patient unstable they are having strong affective response and that is going to take up more time. We have to get onto the next patient that can be difficult. That is one on the tensions that we all face in practice nowadays.

DR. MARGOLIN:

Right, but it is just too important not to.

DR. GARLOW:

Yeah.

DR. MARGOLIN:

Do you also feel that physician, psychiatrist, and other types of physicians have any kind of responsibility to educate the population in general, not just those we think might be thinking about this, but just whoever comes across your path so that more eyes are looking out for the signs and symptoms?

DR. GARLOW:

However, actually, we think this is something that we as physicians and we as psychiatrists, I think, have to do a better job of educating a larger medical community about the signs of depression, the risk factors for suicide, to encourage people to be frank in their discussions, to not be afraid to talk about it or to be embarrassed to talk about it, to be forthright, as well I think we have an obligation to have outreach in education to the community as well, to the lay community, to the patient community. I feel for me, one of my obligation is to be available to do speaking, to go to organizations and various types of entities and talk about suicide, suicide risk, and not professional entities, lay organizations of various types to talk about getting their involvement in prevention efforts and those sort of things.

If you just joined us, you are listening to Reach MD XM 157, the channel for medical professionals. I am Dr. Kathleen Margolin and my guest is psychiatrist, Steven Garlow, and we discussing the assessment of suicide risk.

DR. MARGOLIN:

Dr. Garlow you just mentioned educating the lay community and if physicians are going to hesitate at times to talk about the subjects, it is very understandable that others would be as well. Can you talk about the second important part of suicide prevention and that is taking appropriate action? What is the recommended advice for clinicians and then for lay people?

DR. GARLOW:

Appropriate action can be defined along a wide spectrum. It can be as much as hospitalizing the person, making a strong intervention if the patient is eminently at risk. It can be recommending the person get into treatment, encouraging the person to get into treatment, making some definitive step towards treatment. One thing to keep in mind is depression is a very treatable condition. Most suicidal crises are transient, and if we can help safe harbor that person through that crisis, that is a life saved. One of the things that we as physicians need to talk about again in terms of with our patients looking at suicide risk assessment, we always have to ask about things like weapons in the home and unsecured medication in the home, both to patient directly as well as to

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