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Special Populations At Risk for Suicide: Young Adults and Physicians

ASSESSMENT OF SUICIDE RISKS

You are listening to ReachMD XM 157, the Channel for Medical Professionals.

Only accidents and homicides claim more adolescents and IN young adult lives in US than suicide, and researchers, who are interested in suicide prevention have found that college students or a population of young adult easily studied and write for creative new approaches to intervention.

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:

Thank you. It is a pleasure to be here.

DR. MARGOLIN:

Dr. Garlow, you recently published an article in the journal of American College Health about an interactive web-based method of outreached college students at risk for suicide with some very interesting findings about this new approach to outreach, but first, what is the rate of suicide among college students.

DR. GARLOW:

That is a great question. It has been very difficult to get a good accurate read on the rate for a number of reasons. One, I think colleges are reluctant to report this type of information. It is probably the main one. Two, they are dispersed, that is they happened in different places. In general, for this age group, for the 18-24-year-old age group, you think about, this is the third leading cause of or second

leading cause. It is probably something like 7:100,000 students per year, somewhere in that range, 5-7.

DR. MARGOLIN:

Young adults are often an underserved population medically, perhaps due to poor insurance coverage as well as to that gap between being taken care of by their parents and then taking responsibility for their own health. Do you think that this might contribute to the poor detection of the risks in these people.

DR. GARLOW

I think that is an excellent point. I think that one of the key one is young adult person just out of the house, who is not thinking about things like health care is not thinking about things like going to the doctor. They may feel bad at some point, they may have depression, but they do not necessarily understand it or recognize it as a disease state or something that they should be getting treated for. So, I think that idea of being involved or invested in own health care and knowing and be thinking about, oh I need to go to the doctor, hereiswhere the student health center is, those were the things I think would be critical in terms of helping young people get better awareness and better treatment.

DR. MARGOLIN:

And what are the most significant risks factors for suicide among young adults.

DR. GARLOW:

Among young adults it is depression, the diagnosis of depression, substance used, in particular alcohol use. Young adults who are intoxicated can be very impulsive, when persons intoxicated that there is a disinhibition, having had some kind of a failure or setback, having had some kind of a crisis either at school or home in the family can be risk factors, a break up of a relationship can be a provocation. So, these are the mains where things we need to be looking for.

DR. MARGOLIN:

And what are the most common methods for young people, who attempt suicide.

DR. GARLOW:

It differs by gender. Women, predominantly take overdoses and men take a lot of overdoses as well, but in terms of attempts in both groups, nonlethal attempts are mostly overdoses. Lethal outcomes are use of a firearm and use of a firearm for males, for young males with access to a firearm that can be particularly volatile mixture, and for women it is mostly going to be overdoses on pharmaceutical products or medications.

DR. MARGOLIN:

What inspired you to look at how students who attempt and die from suicide use campus based clinical services.

DR. GARLOW:

I have had an interest in understanding and predicting who is and who isn't at risk for suicide in the context of just in the course of my practice as a psychiatrist is this is one of the key problems in medical practice and psychiatric practices is identifying and recognizing that person who really is at risk and trying to make some interventions. So, I have just had an interest in identifying and determining, who that person is throughout my career as a psychiatrist and participate in this particular project. This is the American Foundation for Suicide Prevention called as screening project that you are mentioning. With the unique opportunity to have a unique intervention or an unique outreach method to a kind of a closed population and then to be able to study their responses into study the types of experiences they were having provided a very nice contained package, contained message to make this kind of investigation.

DR. MARGOLIN:

In the article you mentioned that there are increasing numbers of students entering college with psychological problems. Can you talk about that?

DR. GARLOW:

Yeah. It turns out that for many students coming in the college who end up having depression they have already had their first episode of treatment in high school, and so one of the main risks for them having a depression in college is that they had a depression in high school, and so for many of these students, they already have a track record of background in having a mental illness and receiving treatment. Really surprising in our study, about 16% of the people, who had responded to this E-mail solicitation had a history of having made a suicide attempt. To me, that was a probably one of the most remarkable findings with the rate that people had depression at the rate that people had previous episodes of self harm and suicide attempts.

DR. MARGOLIN:

Were those the same students who had received treatment.

DR. GARLOW:

Previously, most of those, I am assuming had been treated currently in the current state when they responded to our study, they were not in treatment. People in our study who were the most severely depressed, who were having suicidal ideations were the ones, who were not currently receiving treatment. There is a real disconnect between the amount of distress and the amount of suffering that students were having versus the amount of treatment that they were getting.

DR. MARGOLIN:

And what are the factors that you believe prevent college students from getting health for mental health problems.

DR. GARLOW:

I think probably first and foremost is stigma or the idea that going and getting help for a mental illness is somehow a sign of weakness or inferiority that she will be discriminated against and some may make fun of in some way. In our study there was a lot of concern about confidentiality and how it might impact their performance in school, how it might impact their work potential, their employment potential, how it might be communicated back to family, and so confidentiality, which to me is certainly the other side of stigma and the people do not want, people may know about this because of the consequences that it might have in their life independent of their mental illness of their depression.

DR. MARGOLIN:

I found it interesting in your article that you actually had quotes from some of the treatment and also you were saying that students were so concerned about confidentiality; how did that come about?

DR. GARLOW:

How the system work is that with all the undergraduates received an E-mail essentially inviting them to come out and fill out this, to come to a website, a secure website where they set up their own password and they had filled out this questionnaire form based on the PHQ-9, which measures the symptoms of depression, where we also asked about current suicidal ideation, past suicide attempts. We asked questions about that they feel out of control and desperate and overwhelmed, strong emotional questions like that. Those results would go to a counselor or therapist, who would then review each individuals responses and then send a message back to them essentially giving a report on the results of the evaluation, and then there is a dialogue feature where the students could then essentially E-mail or text message back and forth to the therapist in a completely anonymous fashion prior to being encouraged to come in to the goal, which was to get them to come in to treatment, come in to face-to-face treatment. By having a live person on the other end, a live person giving a real evaluation personalized to that individual student and available to sort of dialogue with them is a very powerful outreach method, and as you can see in some of those quotes, the students concerns with things like confidentiality, with things like how they be perceived by their friends or their family, how it would impact their understanding at the school, how it would impact their grades, how it would impact their employment status, and they seems very willing to engage in these anonymous dialogues with the therapist.

DR. MARGOLIN:

And willing you to allow you to publish their thoughts.

DR. GARLOW:

Sure.

DR. MARGOLIN:

That's great. If you just joined us, you are listening to ReachMD XM 157, the Channel for Medical Professionals. I am Dr. Kathleen Margolin and my guest is psychiatrist, Steven Garlow and we are discussing the assessment of suicide risks.

College students aren't the only ones who hesitate to seek mental health care. Physicians are often remised in attending to depression and suicide in their patients and in themselves. Let's talk about the suicide rate among physicians, because surely that plays a factor and how well they are able to find and address the warning signs of suicide in others.

DR. GARLOW:

That is a great question. Physicians, we are a strong-minded, strong-willed stoic group, who are trained for many, many years to put the needs of the patient ahead of ours to focus on what we have to do in terms of our clinical responsibilities or obligations to our patients. It becomes very easy then to sort of not pay attention to our own needs, to our own emotional state, to discount feeling, burned out feeling, exhausted feeling, anxious feeling, stressed, and overwhelmed. All of those things contribute to risk in physicians. The expectations from the very beginning of our training is that we are going to take care of it, we will solve the problem. The simplicity in the training of a physician is that we are trained to be <____> make the difficult decision, and in that training it is very, very easy than to not pay attention to our own needs, not pay attention to just discount our own emotional state, our own distress, our own suffering because our obligation is elsewhere.

DR. MARGOLIN:

Do you think it interferes with the ability to recognize those things and others.

DR. GARLOW:

Because it would then cause us some self-recognition, certainly I think contributes to our difficulties some times in assessing substance use disorders or own utilization of things like alcohol can sometimes complicate our recognition and assessment in our patients. I think our talking to our patients about suicide risk is another one of those areas where that will also force us to focus on our own self, our own thoughts, own ideas, and then as we are able to do through our training, we can block ourselves out of our own thoughts and not deal with our own thoughts.

DR. MARGOLIN:

And in addition to those personality qualities that you described that physicians share, if those physician does recognize that they are suffering and need some help, are there other issues that might stand in the way of they getting help, things about confidentiality in career.

DR. GARLOW:

Absolutely. Confidentiality, career, report to the licensing board, the medical board, everybody has concerns about the integrity of their medical license, what their peers will think about them, how they will be perceived, that they will be perceived not as competent, or not as capable, the impacts on malpractice, impacts on practice opportunity and employment opportunity, I think those are all critical to a physicians just lack of engagement of mental health resources.

DR. MARGOLIN:

Let's talk a little about the statistics involved here as like how physicians compare to their general population and then there is just a really interesting sex difference among physicians as compared to the general population with regard to risk.

DR. GARLOW:

In the general population, males typically commit suicide about 4:1 to females. That ratio equalizes amongst physicians. That has been subject to some conversation of discussion as to why that may be, what is it about a physician experience about a female physician that makes them appear at least in terms of suicide risks or more demographically like a male, as that is a completely open question at this point. Some would say it has some to do with the stress, has something to do with a higher acuity nature of medicine into the medical profession. This expectation that we solve our own problems and that we do not ask for help, women in general have more depression than men. So, in some ways should have greater suicide risk, and if you would then couple that to not wanting to ask for help or a professional expectation of not seeking that kind of help, that is getting at increased risk.

DR. MARGOLIN:

Thank you for listening to the Clinician's Roundtable on ReachMD XM 157, the Channel for Medical Professionals. I am Dr. Kathleen Margolin and my guest has been psychiatrist, Dr. Steven Garlow of the Department of Psychiatry and Behavioral Sciences at Emory University School of Medicine. Thank you for joining me, Dr. Garlow.

DR. GARLOW:

Thank you. It was a pleasure.

This is Dr. Randy Hogerman, professor of pediatric at the UC Davis Mind Institute. You are listening to ReachMD XM 157, the Channel for Medical Professionals.