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The suicidal patient in the emergency department – recommendations for clinicians

Konrad Michel, M.D.

University of Bern, Switzerland

konrad.michel@unibe.ch

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ABSTRACT

Health professionals in the emergency departments are often faced with suicidal patients. This article discusses the challenges of suicide risk assessment and the problems of communication between suicidal patients and clinicians. In contrast to somatic disorders, where the natural course of an illness can usually be predicted, a prediction of a patient's suicide risk is basically an impossible task. Mental disorders are suicide risk factors, which may indicate an increased long-term risk, but they do not help to assess short-term suicide risk. Because suicide and suicidal behaviours are inherently psychological, suicide risk assessment must be patient centred. Therapists and patients should collaboratively find an understanding of the patient's suicidality, in particular of the triggers of suicidal behaviour. Studies show that narrative interviewing fosters a therapeutic alliance, and is related to a reduction of suicidal thoughts. Suicide risk should be explored collaboratively, with the suicidal person included as an active participant. This approach leads to a shared understanding of the patient's suicidality and the adequate measures to be taken to ensure the patient's safety.

Introduction

Patients who attempt suicide are frequently admitted to an emergency department (ED), with overdosing being the most frequent method used. Clinicians are then faced with the task of assessing suicide risk. However, studies investigating the effectiveness of suicide risk assessment have concluded that reliable suicide risk assessment is basically impossible. When the issue is addressed directly, patients often deny suicidal thoughts or plans. Suicide risk scales are not reliable for short-term suicide risk prediction. Suicide risk assessment is related to the fear that a patient might die by suicide after discharge. Often, for clinicians to be on the safe side, the usual procedure is to admit the patient to a psychiatric hospital. However, research shows that inpatient care does not protect patients from suicide. Ideally, suicide risk assessment requires a collaborative approach, which includes the suicidal patient as an active participant. In this approach, clinician and patient may come to the conclusion that the suicide risk decreased after the suicide attempt, and that the patient can safely be referred to outpatient follow-up care.

Obstacles in clinical practice

THE DOCTOR'S FEARS

The task of clinicians in EDs to decide on suicide risk after attempted suicide is challenging, because of the fear of a wrong judgment, and the fear of future litigation should the patient die by suicide after discharge. The experienced clinician knows that patients often won't tell the truth about their suicidal thoughts and plans[1]. To be on the safe side, clinicians tend to admit patients to a psychiatric hospital. In cases of involuntary hospitalization, this may mean involving the police, who will take the handcuffed patient to the psychiatric institution. Yet, psychiatric hospitals are far from being safe places[2,3]. A particularly dangerous time is after discharge from inpatient care. A meta-analysis of 183 patient samples found that the post-discharge suicide rate was approximately 100 times the average suicide rate during the first 3 months after discharge[4].

THE PATIENT'S FEARS

Patients on the other hand are often holding back with talking about their own suicidality because of the fear that the physician may not understand what brought them to the point of wanting to die. This is not surprising, considering that patients are often full of shame, with a low self-esteem. In addition, there is the fear of being "locked up" in a psychiatric institution, treated against their will, "filled up with drugs", the fear that they might lose their job and be stigmatized for the rest of their life. In short, the fear that the clinician will decide on the clinical management without consulting them.

PROBLEMS OF COMMUNICATION

In the interaction between clinicians and suicidal patients there is a tendency for clinicians to avoid addressing the issue directly. In video-recorded exchanges between clinicians and outpatients McCabe et al.[5] found that 75 percent of questions were negatively phrased, for example: "Not feeling low?" or "No thoughts of harming yourself?". Questions were typically close-ended and designed to elicit a yes/no answer. The outcome, then, is likely to be a kind of tacit collusion between patient and clinician that suicide cannot openly be discussed in a clinical interview. This form of avoidant communication has aptly been described as "dancing without touching," meaning that there is a mutual agreement between the suicidal patient and the clinician that it is absolutely o.k. to avoid the difficult questions[6]. A Finnish study found that even with patients who were under long-term medical or psychiatric care, at the last visit before suicide the issue of suicide had been addressed in only 22 percent of the cases[7].

The medical model of suicide does not help the health professionals, nor does it help the suicidal individuals to understand the dynamics of their suicidal development. Mental health problems are risk factors, *not* the cause of suicide. It is not the depression that kills but the person who acts according to a personal logic. In Bern we have developed a model of understanding the suicidal mind based on the paradigm that suicide is an action for which people have their personal reasons. The theory of goal-directed actions implies that we explain and understand actions through stories[8]. A narrative approach is related to a better therapeutic relationship and reduced suicidal ideation[9-12]. In hundreds of video-recorded narrative interviews with patients who had attempted suicide, we learned that each suicide-related story is very individual.

The art of connecting: The narrative approach

When trying to understand the suicidal person we need to distinguish between external and internal attributions. External attributions are based on theories and models we create in order to explain the behaviours of others. This is typical for the medical model, which is basically "a third-person science". Buss[13] argued that there is a fundamental difference between explanations by an outsider and explanations by the acting person. Outside observers tend to use causal ("why?") explanations, for example "H.B. attempted suicide because his girlfriend had left him." The individuals themselves – in our context people who attempt suicide - explain their actions with their personal reasons, e.g. "At that moment I saw suicide as the only possible way to put an end to that unbearable experience of mental pain".

The royal road to build a collaborative working relationship is the narrative interview[14]. This approach requires the clinicians to switch roles in that in the narrative interview they are not in their usual role of being the expert of a disorder, but in the "not knowing" position. When we approach suicidal patients as human beings who have their inner reasons to consider suicide as a goal, we find that these patients generally have a good narrative competence, that is, they can give us a coherent story of the suicidal development, often going back to adverse childhood experiences.

Imagine the following two scenarios: (1) The clinician in a busy emergency room faced with an eighteen-year-old girl who took an overdose of painkillers will probably assume from the intake notes that this girl took the overdose because her boyfriend left her. Most probably she wanted to threaten or punish him or make him feel guilty. Or gain attention. Whatever the circumstances, it is obvious that it was manipulative behaviour. After adequate medical treatment, she will be discharged, ideally with a follow-up appointment for psychological assessment (which she will probably not attend).

Imagine another scenario: (2) The clinician sits down with this teenage girl (alone, no parent or boyfriend in the room) for fifteen or twenty minutes, perceives her as a deeply hurt human being, and asks her: "Let me try to understand, I would like you to tell me what got you to the point of harming yourself. I have time, I left my beeper with the nurse outside." Let's assume that the approach is successful and that in fifteen to twenty minutes the clinician and the patient come to a shared understanding. And both feel calm. The girl talked about her inner pain, which had been unbearable for her, which she can connect to earlier experiences, not only a previous relationship breakup with an earlier suicidal crisis, but also the time her parents split up, when she was seven—and where she felt it was her fault. The narrative approach establishes a first working relationship and includes the patient as an active participant in the assessment of suicide risk and the therapeutic procedure. Experience shows that with shared decision-making involuntary admissions to psychiatric inpatient care are rare.

Each suicidal development is very personal. A health professional who is a nonjudgmental and attentive listener creates trust and becomes an ally of the patient, supporting the patient in gaining insight into one's own suicidal dynamics, the drivers and the actual trigger of the suicidal crisis. The assessment of medical suicide risk factors (where the health professional is the expert, asking specific questions) should always follow the narrative interview. The result will be a joint understanding of the psychosocial situation, possible health issues and further steps to be taken for the patient to be based on of shared decision-making[15]. If patient and clinician decide on outpatient follow-up care, an appointment with a therapist should ideally be made before the patient is discharged from the ED.

Suicide risk assessment

Suicide prediction is basically impossible[16,17]. Suicide risk scales are unreliable and should be avoided[18]. They may provide a false reassurance for clinicians and prevent them from real engagement with suicidal patients. It is central to include the suicidal person as an active participant in risk assessment. Risk assessment should be carried out as a collaborative process in which the therapist recognizes that he cannot be the expert of a patient's suicide risk[19]. The goal must be to reach a shared decision making about the indicated procedure. What does the patient need in order to be safe for the next few hours and days? In some

cases, the clinician's "gut feeling" may be a warning that the patient is not fully participating. This may be an indication for psychiatric inpatient care[20].

It is useful to distinguish between long-term and short-term risk. *Long-term risk* assessment is based on risk factors such as a history of suicide attempts; psychiatric disorders such as depression, bipolar disorder, substance use, personality disorders, etc., and a family history of suicidal behaviour. David Rudd's Fluid Vulnerability Theory[21] posits that a long-term baseline risk varies from individual to individual (and for instance, is higher for individuals with a history of two or more suicide attempts), while the *short-term risk* is highly determined by aggravating factors and suicide triggers for limited periods of time (hours, days, weeks) and which will then return to the baseline level.

Regarding *long-term risk factors*, a history of past suicide attempts is the strongest indicator of an increased long-term risk. After attempted suicide, the suicide risk is increased fortyfold or more, it is higher when the suicide attempt was medically serious, and it increases with further suicide attempts[22,23]. The main other long-term risk factors are psychiatric diagnoses: Affective disorders (depression, bipolar disorder), substance abuse, and personality disorders. This is an information clinicians can normally get from a clinical interview. Even sophisticated suicide risk scales cannot add much to the usual clinical assessment[18]. However, algorithms in electronic medical records can help to alert clinicians that there may be a long-term suicide risk. For instance, the "High Risk for Suicide List" in the U.S. Veterans Health Administration ensures that a "flag" is placed on the veteran's medical chart to notify all VHA staff to explore suicide risk factors and prevention measures at each clinical contact[24].

The effect of no-suicide contracts is controversial. A no-suicide contract is an agreement between the patient and clinician, in which patients agree not to harm themselves and/or to seek help when in a suicidal crisis and when they feel they are unable to honour the commitment. A joint agreement should include details about the duration (for instance until the next appointment with the long-term therapist), and a contingency plan in case of increased risk (calling a crisis line, the therapist or GP, or present at the ED. Rudd et al[25] recommend a "commitment to treatment" agreement. This might, for example be useful when a suicidal patient has a follow-appointment with a therapist. The authors recommend that the agreement must be individualized collaboratively by the clinician and the patient. It should always include a crisis response plan, that is, the specific steps the patient should take to avoid self-harm.

Safety planning is a brief intervention to help patients develop strategies to recognize suicidal thoughts and manage them safely[26,27]. Action steps may include calming activities, identifying supportive people to talk to and providing contact information for crisis lines or chat services (https://suicidesafetyplan.com/). Ideally, patients admitted to emergency rooms can be engaged into follow-up care as early as possible. This requires an established procedure to refer suicidal patients either to an existing therapist, or to a specific therapy program targeting suicidal thoughts and behaviours. Examples are the ED-SAFE Study, an effective combination of brief interventions administered both during and after an emergency department visit[28]. A brief follow-up therapy programme is ASSIP, a highly structured treatment protocol, which is ideally initiated as early as possible after attempted suicide[29]. In an RCT with 120 patients it was found that ASSIP reduced the risk of suicide reattempts over a follow-up of two years by 80%[30]. Other established follow-up therapy programs are the Brief Cognitive Behavioral Therapy BCBT[31] and the Collaborative Assessment and Management of Suicidality CAMS[32]. Attendance rates for a follow-up treatment are higher, when the therapist contacts patients in the ED, informs them about the therapy, gives them written information about the therapy program and goals, and makes a first follow-up appointment. An early therapeutic relationship established while in the hospital will increase patient treatment adherence and reduce nonattendance in follow-up.

Generally, in suicide prevention, the power of a long-term therapeutic relationship with a trusted clinician cannot be underestimated. A long-term therapeutic contact can provide a sense of security to people, which has been aptly expressed in this patient's statement: *"He [the general practitioner] was like a rock. He really was, he was genuinely concerned for me and I could tell he was. He was really worried and in a way he made me feel better*

to know that someone cared and he, you know, he would see me every, maybe every month every two months just to see how everything was and till he retired really so he was a great help"[33].

Conclusion

Clinicians in emergency departments often have to deal with patients admitted after a suicide attempt. After medical interventions to physically stabilise the patient, a major challenge is the assessment of suicide risk and the further management of the patient. Because suicidality is inherently psychological, short-term risk assessment is impossible without the suicidal patient's collaboration. The recommended approach is a brief narrative interview, based on the model of suicide as a goal-directed action. This model posits that patients have a narrative competence to explain their suicidal development to an attentive listener. A typical narrative interview in this context can be conducted in 20-30 minutes. Listening to the suicidal person with a genuine interest creates trust in the patient and a working relationship which allows to collaboratively discuss the question of personal suicide risk factors and what the patient needs to be safe in terms of clinical management. This includes discussing the question of admission to psychiatric inpatient care, or, ideally, to an outpatient follow-up appointment that, if possible, should be established before the patient is discharged from the ED.

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