UNIVERSITY OF SOUTH FLORIDA

Suicide Assessment

Francisco Fernandez, M.D.

Professor and Chair

Department of Psychiatry and Behavioral Neurosciences

ffernand@health.usf.edu

Scope of the Problem

- Chronic hepatitis C (CHC) is a significant world health problem.
  - Leading cause of liver transplantation in the United States.
- An estimated 170 million people worldwide are infected with HCV.
- In the United States, the prevalence of HCV is 2%
  - IDU accounts for the majority of new infections.
- The treatment of choice for CHC is IFNα and ribavirin for either 24 or 48 weeks depending on genotype.

Scope of the Problem

- Although IFNα and ribavirin are viable treatment options for patients with CHC, IFNα is associated with side effects including depression, anxiety, irritable hypomania, psychosis and impaired cognition.
- IFNα-induced depression (IFNα-D) is the most common psychiatric side effect.
  - Prevalence → 10% to 40%
  - Severe episodes of IFNα-D resulting in psychosis or suicide have been published in the literature.

Suicide in HCV Infection

- Individuals infected with HCV suffer significant psychosocial burden, which can be associated with increased suicide rates.
  - A study of 1010 HCV-positive patients showed a standardized mortality ratio of 6.72 for suicide among patients with HCV infection when compared to the general population.
    - Higher mortality rates observed in patients with pre-existing depression who are under the age of 45 years.
    - Co-infection with human immunodeficiency virus (HIV) and HCV is a potential confounder as patients with HIV infection have demonstrated higher rates of suicide.

Suicide During HCV Treatment

- Suicide and suicide attempts during IFNα therapy remains a rare phenomenon.
  - In a sample of patients who terminated pegylated IFNα early, 6.9% discontinued HCV treatment because of suicidal ideation.
  - Fatal adverse effects of IFNα → a 0.02% rate of suicide attempts in a sample of 11,241 patients with CHC.
  - The Virahep-C study excluded patients with current severe psychiatric disorders, suicide attempts or psychiatric hospitalizations within the last 5 years
    - Incidence of depression = 26%
    - Incidence of suicidal ideation on IFNα treatment = 3.5%
    - No patients attempted suicide during the 24-week study period.

Defining Suicide

- Attempted suicide is a potentially self-injurious act committed with at least some intent to die as a result of the act.
- Suicide is an attempt to solve a problem of intense emotional pain with impaired problem-solving skills.
- Individuals of all races, creeds, incomes, and educational levels die by suicide. There is no typical suicide victim.[3]

1. Kalafat, J. & Underwood, M. *Making Educators Partners in Suicide Prevention.* Lifelines: A School-Based Youth Suicide Prevention Initiative. Society for the Prevention of Teen Suicide. http://spts.pldm.com/
2. Kalafat, J. & Underwood, M. *Making Educators Partners in Suicide Prevention.* Lifelines: A School-Based Youth Suicide Prevention Initiative. Society for the Prevention of Teen Suicide. http://spts.pldm.com/
3. Clayton, J. *Suicide Prevention: Saving Lives One Community at a Time.* American Foundation for Suicide Prevention. http://www.afsp.org/files/Misc_//standardizedpresentation.ppt

Characteristics of Suicide

- Alternative to problem perceived as unsolvable by any other means.
  - Viewing suicide from this perspective has several important implications:
    - For one, just as someone may get a temporary high from a drug, he or she may obtain temporary attention, support, or even popularity after a suicide attempt.
    - A second implication of viewing suicide as an alternative is that suicide can then be understood as less than a wish to die than a wish to escape the intense emotional pain generate from what appears to be an inescapable solution.
- Crisis thinking impedes problem solving:
  - When we think of a crisis as any situation in which we feel that our skills do not meet the demands of the environment, we realize that crises can be frequent visitors in most of our lives.

Kalafat, J. & Underwood, M. *Making Educators Partners in Suicide Prevention.* Lifelines: A School-Based Youth Suicide Prevention Initiative. Society for the Prevention of Teen Suicide. http://spts.pldm.com/

Characteristics of Suicide

- Person is often ambivalent.
  - What this means is that the person is feeling two things at the same time:
    - There is a part of that person that wants to die
    - There is a part that wants to live
    - Both parts must be acknowledged.
  - While we ally with and unequivocally support the side that wants to live, this can't be done by ignoring or dismissing that side that wants to die.

Kalafat, J. & Underwood, M. *Making Educators Partners in Suicide Prevention.* Lifelines: A School-Based Youth Suicide Prevention Initiative. Society for the Prevention of Teen Suicide. http://spts.pldm.com/

Characteristics of Suicide

- Suicide as a "solution" has an irrational component:
  - People who are suicidal are often unaware of the consequences of suicide that are obvious to the rest of the word.
    - They are usually not thinking about the impact of their death on others.
    - They hold a perception they will be reincarnated or somehow still present to see how others react to their deaths.
  - This irrationality affects how trapped and helpless the person feels.

Kalafat, J. & Underwood, M. *Making Educators Partners in Suicide Prevention.* Lifelines: A School-Based Youth Suicide Prevention Initiative. Society for the Prevention of Teen Suicide. http://spts.pldm.com/

Characteristics of Suicide

- Suicide is a form of communication
  - For people who are suicidal, normal communication has usually broken down and the suicide attempt may be the person's way of sending a message or reacting to the isolation they feel because their communication skills are ineffective.

Kalafat, J. & Underwood, M. *Making Educators Partners in Suicide Prevention.* Lifelines: A School-Based Youth Suicide Prevention Initiative. Society for the Prevention of Teen Suicide. http://spts.pldm.com/

Death by Suicide and Psychiatric Diagnosis

- Psychological autopsy studies done in various countries from over almost 50 years report the same outcomes.
  - 90% of people who die by suicide are suffering from one or more psychiatric disorders:
    - Major Depressive Disorder
    - Bipolar Disorder, Depressive Phase
    - Alcohol or Substance Abuse
    - Schizophrenia
    - Personality Disorders such as Borderline Personality Disorder

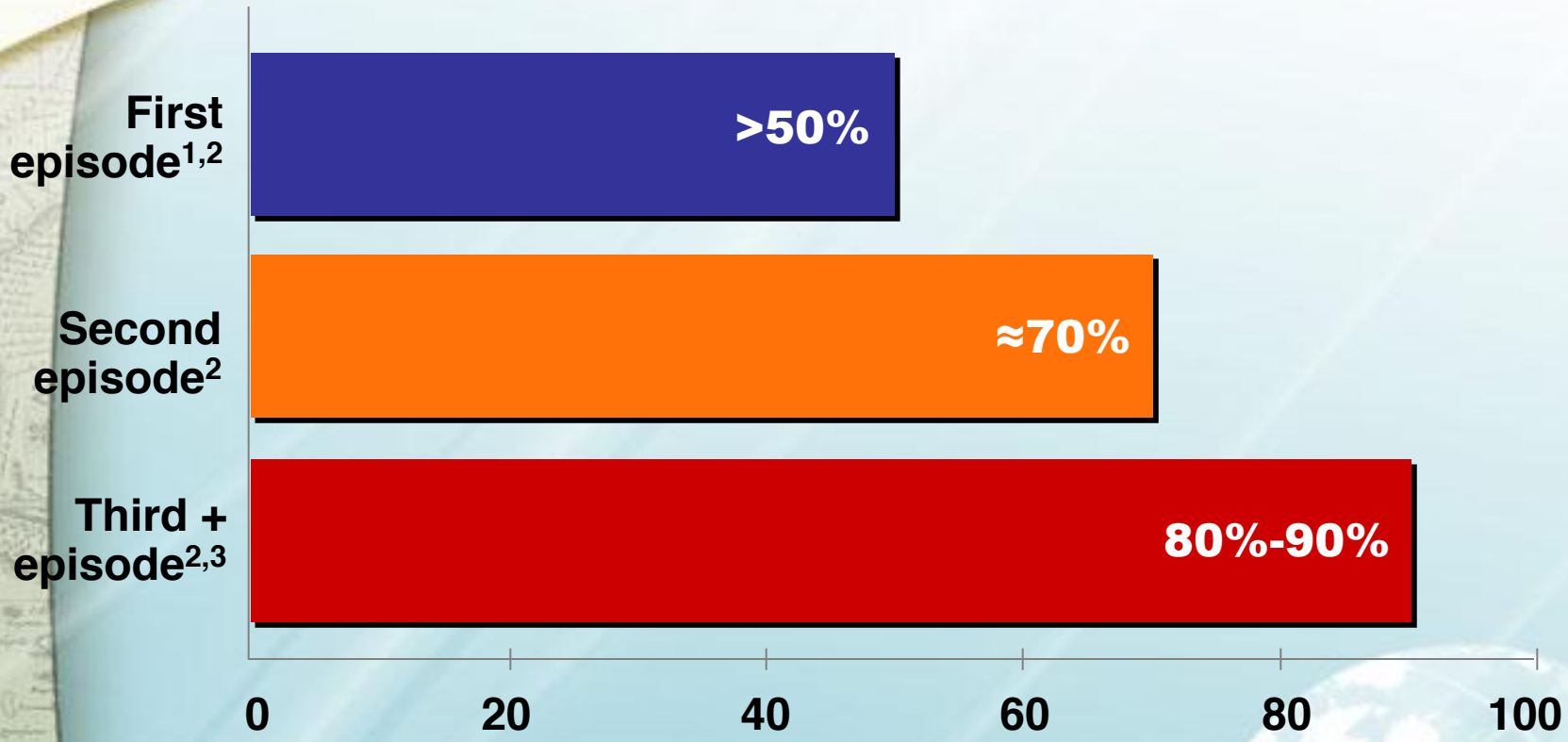
Clayton, J. *Suicide Prevention: Saving Lives One Community at a Time.* American Foundation for Suicide Prevention. http://www.afsp.org/files/Misc_//standardizedpresentation.ppt

Depression

- Depression is a medical disease – not a malady, an illness, state of mind or existential state
- Depression is caused by an interaction of genetic, biological, psychological, and environmental factors.
- Depression impacts people across age, gender, racial, cultural, and socioeconomic boundaries.
- ***Unlike other medical diseases:***
  - ***It robs you of your "fighting spirit"***
  - ***It extinguishes one's survival instinct → suicide***

Zenere, F. *Youth Suicidal Behavior: Prevention and Intervention.* Miami-Dade County Public Schools. http://www.helppromotehope.com/documents/Zenere_for_parents.pdf

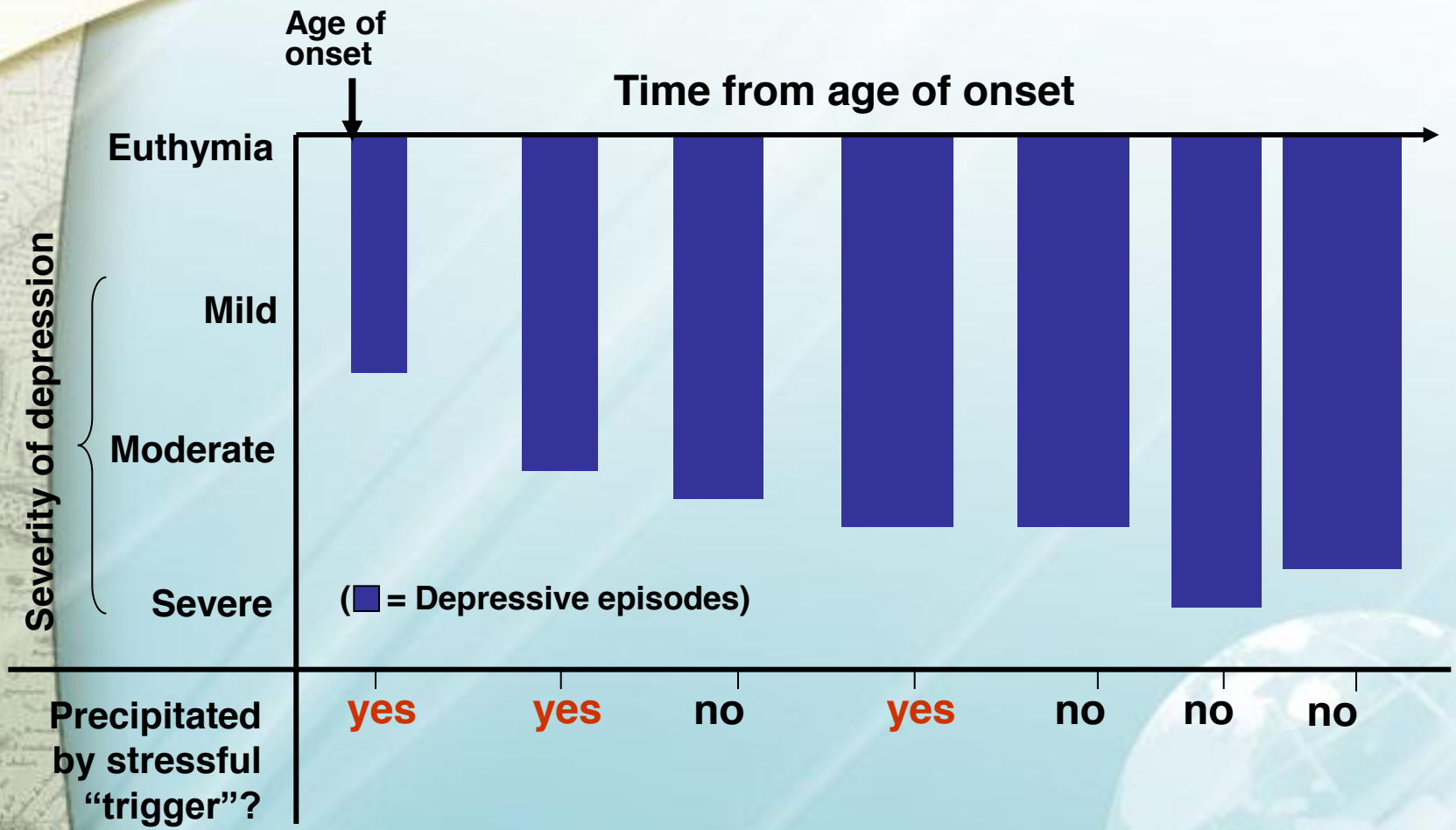
Recurrence Becomes More Likely With Each Episode of Depression



*Patients were followed for 3 to 15 years following recovery of previous episode.

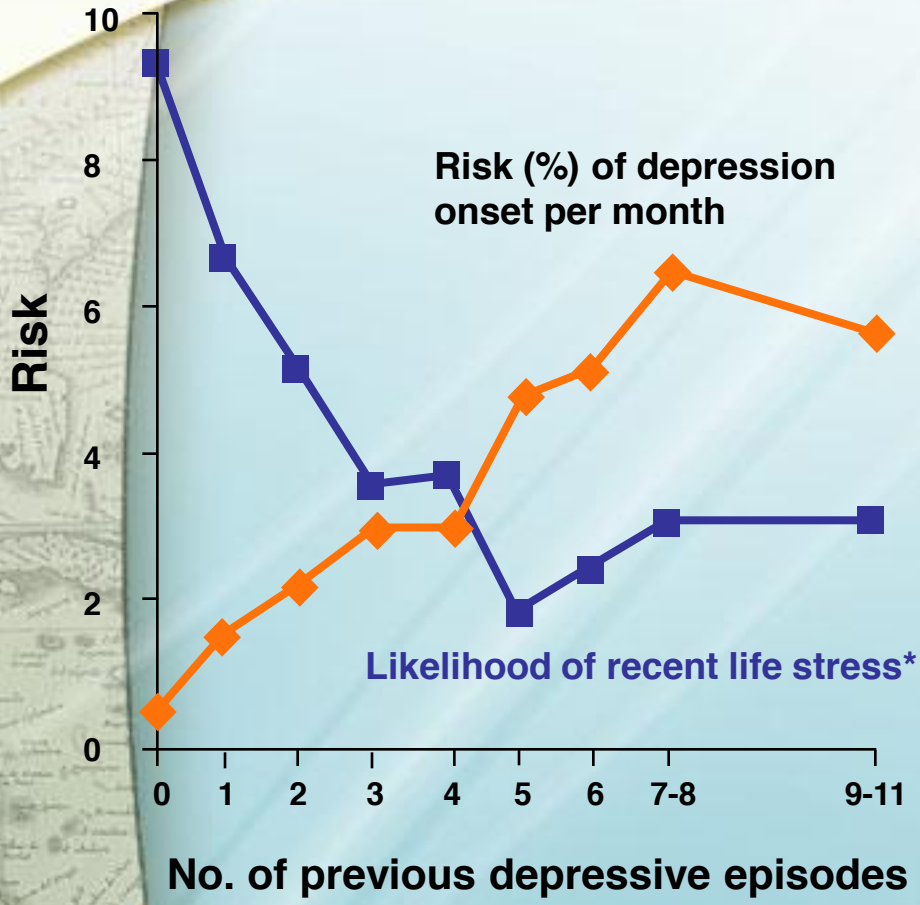
1. Judd LL, et al. *Am J Psychiatry.* 2000; 157:1501-1504.
2. Mueller TI, et al. *Am J Psychiatry.* 1999;156:1000-1006.
3. Frank E, et al. *Arch Gen Psychiatry.* 1990;47:1093-1099.

Lifetime Course of Illness in Patients With Recurrent Depression



Adapted from:
Roy-Byrne P, et al. *Acta Psychiatr Scand Suppl*. 1985;317:1-34.
Post RM. *Am J Psychiatry*. 1992;149:999-1010.
Greden JF. *J Clin Psychiatry*. 2003;64:5-11.

Stressful Life Events as a "Trigger" for Depression Progressively Declines



"Kindling" Phenomenon

With increasing depressive episodes:

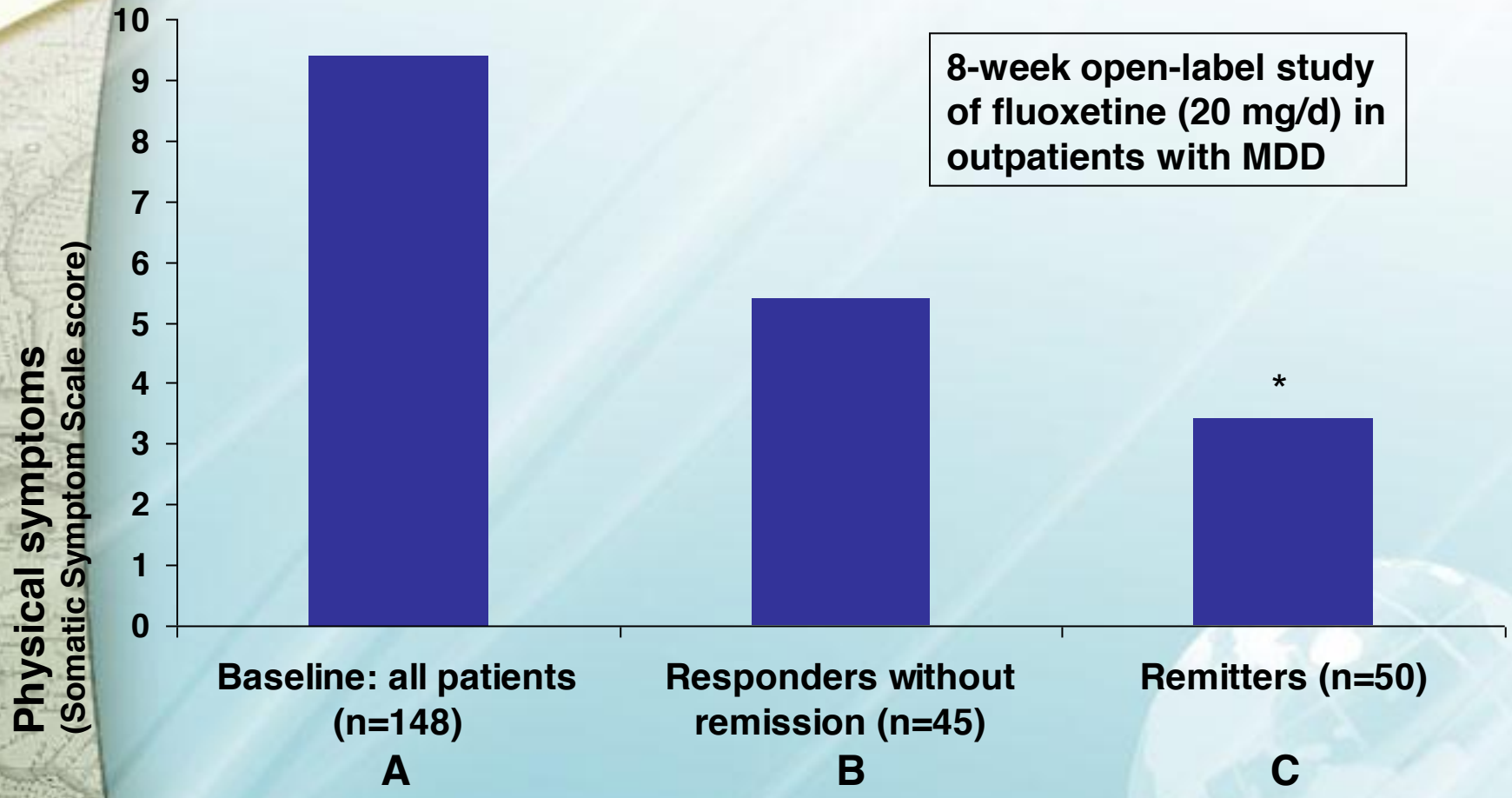
↑ Risk of depression

↓ Association with stressful life events

*Odds ratio for depression given at least one stressful life event.

Kendler KS, et al. *Am J Psychiatry*. 2000;157:1243-1251.

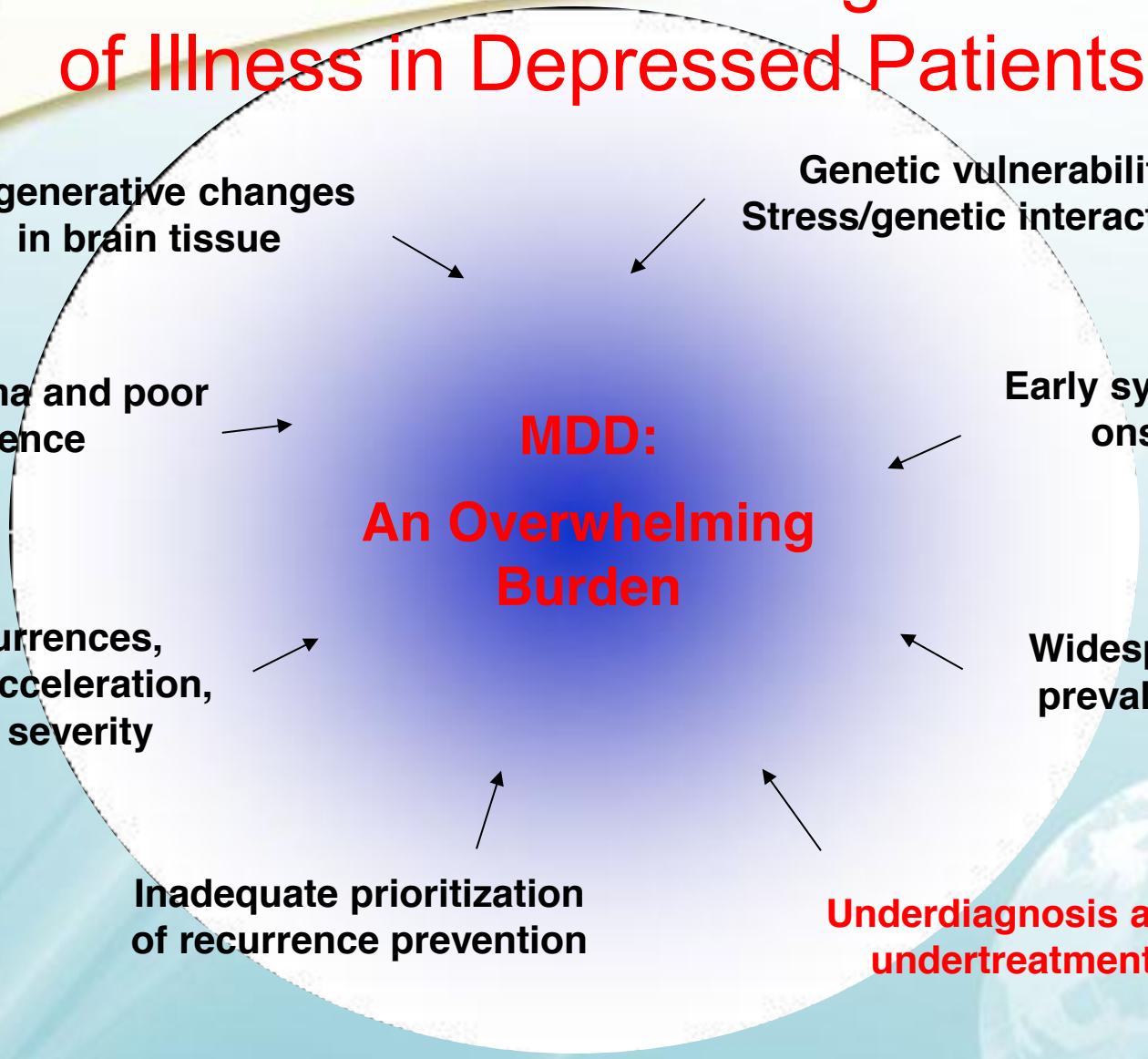
Residual Physical Symptoms Following Acute-Phase Treatment



*$P<0.03$ vs responders.

Denninger J, et al. Presented at: APA Annual Meeting; May 2002; Philadelphia, Pa.

Contributors to the Progressive Course of Illness in Depressed Patients



Adapted from: Greden JF. *J Clin Psychiatry*. 2003;64:5-11.

Signs of Depression

- Loss of interest in normal daily activities
- Feeling sad or down
- Feeling hopeless
- Crying spells for no apparent reason
- Problems sleeping
- Trouble focusing or concentrating
- Difficulty making decisions
- Unintentional weight gain or loss
- Irritability
- Restlessness
- Being easily annoyed
- Feeling fatigued or weak
- Feeling worthless
- Loss of interest in sex
- Thoughts of suicide or suicidal behavior
- Unexplained physical problems, such as back pain or headaches

When diagnosing depression, usually there must be a marked behavioral change lasting for two weeks or longer.

SIG: E-CAPS

Mayo Clinic (Feb 14, 2008). *Depression: Symptoms.*
http://www.mayoclinic.com/health/depression/DS00175/DSECTION=symptoms

Protective Factors for Suicide

- Protective factors → reduce the likelihood of suicide, they enhance resilience and may serve to counterbalance risk factors.
  - Easy access to a variety of clinical interventions and support for help-seeking
  - Effective clinical care for mental, physical, and substance use disorder
  - Restricted access to highly lethal means of suicide
  - Strong connections to family and community support
  - Support through ongoing medical and mental health care relationships
  - Cultural and religious beliefs that discourage suicide and support self-preservation.
  - Skills in problem solving, conflict resolution and nonviolent handling of disputes

Suicide Prevention Resource Center. *Risk and Protective Factors for Suicide. http://www.sprc.org/library/srisk.pdf*

Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Major physical illnesses
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Previous suicide attempt
- Family history of suicide

Suicide Prevention Resource Center. *Risk and Protective Factors for Suicide. http://www.sprc.org/library/srisk.pdf*

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicides that have a contagious influence

Suicide Prevention Resource Center. *Risk and Protective Factors for Suicide. http://www.sprc.org/library/srisk.pdf*

Socio-cultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma)
- Exposure to, including through the media, and influence of others who have died by suicide

Suicide Prevention Resource Center. *Risk and Protective Factors for Suicide. http://www.sprc.org/library/srisk.pdf*

Warning Signs

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risk activities – seemingly without thinking

National Suicide Prevention Lifeline. *What are the warning signs for suicide?* http://www.suicidepreventionlifeline.org/GetHelp/SuicideWarningSigns.aspx

Warning Signs

- Feeling trapped – like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated or unable to sleep or sleeping all the time
- Experiencing dramatic mood swings
- Seeing no reason for living or having no purpose in life.

National Suicide Prevention Lifeline. *What are the warning signs for suicide?* http://www.suicidepreventionlifeline.org/GetHelp/SuicideWarningSigns.aspx

Questions about Suicide Assessment

1. How should clinicians use knowledge of suicide risk factors in their assessment of patients at risk?
2. Which diagnoses, risk factors and symptoms should most concern clinicians?
3. Under what circumstances, if any, should a clinician ask a patient to sign a no-suicide contract?
4. Is psychotherapy always recommended for patients at risk for suicidal behavior?

Questions about Suicide Assessment

5. Is it ever acceptable to defer or avoid hospitalizing a suicidal patient?
6. Should we expect medications or neurotherapies to lower suicide risk?
7. What are the most important elements to document in a suicide risk assessment?

Suicide Prediction vs. Suicide Assessment

- Suicide Prediction refers to the foretelling of whether suicide will or will not occur at some future time, based on the presence or absence of a specific number of defined factors, within definable limits of statistical probability.

- Suicide (risk) Assessment refers to the establishment of a clinical judgment of risk in the very near future, based on the weighing of a very large mass of available clinical detail.
  - Risk assessment carried out in a systematic, disciplined way is more than a guess or intuition – it is a reasoned, inductive process, and a necessary exercise in estimating probability over short periods.

Components of Suicide Assessment

- Appreciate the complexity of suicide / multiple contributing factors.
- Conduct a thorough psychiatric examination, identifying risk factors and protective factors and distinguishing risk factors which can be modified from those which cannot
- Ask directly about suicide → *be specific*
- Determine level of suicide risk: low, moderate, high
- Determine treatment setting and plan
- Document assessments

Areas to Evaluate in Suicide Assessment

Psychiatric Illnesses	Affective Disorders, Alcohol / Substance Abuse, Schizophrenia, AMS, Cluster B Personality disorders.
History	Prior suicide attempts, aborted attempts or self harm; medical diagnoses, family history of suicide / attempts / mental illness
Individual strengths / vulnerabilities	Coping skills; personality traits; past responses to stress; capacity for reality testing; tolerance of psychological pain
Psychosocial situation	Acute and chronic stressors; changes in status; quality of support; religious beliefs
Suicidality and Symptoms	Past and present suicidal ideation, plans, behaviors, intent; methods; hopelessness, anhedonia, anxiety symptoms; reasons for living; associated substance use; homicidal ideation

Adapted from APA guidelines, part A, p. 4

Risk Factors (red = modifiable)

Demographic	male; widowed, divorced, single; increases with age; white
Psychosocial	lack of social support; unemployment; drop in socio-economic status; firearm access
Psychiatric	psychiatric diagnosis; comorbidity
Physical Illness	malignant neoplasms; HIV/HCV; peptic ulcer disease; hemodialysis; SLE; pain syndromes; functional impairment; diseases of nervous system
Psychological Dimensions	hopelessness; psychic pain/anxiety; psychological turmoil; decreased self-esteem; fragile narcissism, perfectionism
Behavioral Dimensions	impulsivity; aggression; severe anxiety; panic attacks; agitation; intoxication; prior suicide attempt
Cognitive Dimensions	thought constriction; polarized thinking
Childhood Trauma	sexual/physical abuse; neglect; parental loss
Genetic & Familial	family history of suicide, mental illness, or abuse

Protective Factors

- Children in the home, except among those with postpartum psychosis
- Pregnancy
- Deterrent religious beliefs
- Life satisfaction
- Reality testing ability
- Positive coping skills
- Positive social support
- Positive therapeutic relationship

Comorbidity

- **In general, the more diagnoses present, the higher the risk of suicide**
  - Psychological Autopsy of 229 Suicides
    - 44% had 2 or more Axis I diagnoses
    - 31% had Axis I and Axis II diagnoses
    - 50% had Axis I and at least one Axis III diagnosis
    - Only 12 % had an Axis I diagnosis with no comorbidity
    - What about “triply” diagnosed?

Henriksson et al, 1993

Affective Disorders and Suicide Risk

- High-Risk Profile:
  - Suicide occurs → early in the course of illness and early in course of HCV treatment
  - Psychic anxiety or panic symptoms
  - Alcohol abuse and relapsing drug use
  - First episode of suicidality
  - Hospitalized for affective disorder secondary to suicidality
  - Risk for men is four times as high as for women – with one exception
    - Bipolar disorder where women are equally at risk

Alcohol/Substance Abuse and Suicide Risk

- Suicide occurs later in the course of the illness with communications of suicidal intent lasting several years
  - Men have higher rates of alcohol abuse
  - Women have higher rates of drug abuse
  - Increased number of substances used, rather than the type of substance appears to be more important
- Most have comorbid psychiatric disorders
  - Females have Borderline Personality Disorder
- High Risk Profile:
  - Comorbid depression
  - Active drug use or withdrawal
  - Recent or impending interpersonal loss
  - Character pathology

Personality Disorders and Suicide Risk

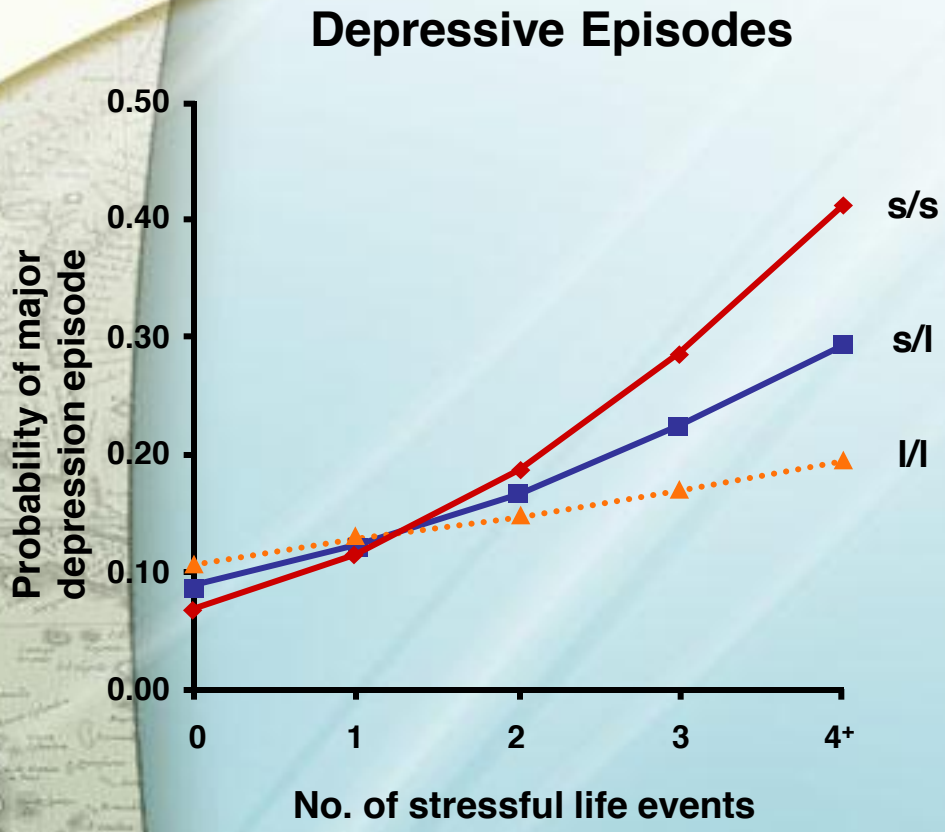
- Borderline Personality Disorder
  - Lifetime rate of suicide - 8.5%
  - A comorbid condition in over 30% of the suicides.
    - With alcohol problems -19%
    - With alcohol problems and major affective disorder - 38% (Stone 1993).
  - Nearly 75% of patients with borderline personality disorder have made at least one suicide attempt in their lives.
- Antisocial Personality disorder
  - Suicide associated with narcissistic injury / impulsivity.

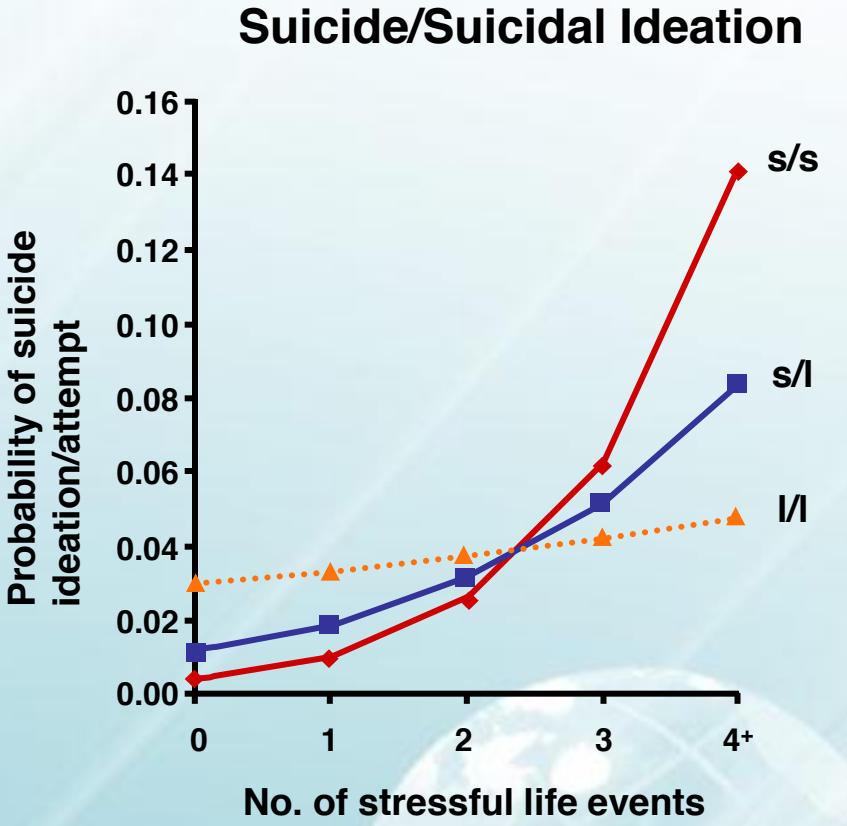
Family History, Genetics, and Suicide Risk

- Relatives of suicidal subjects have a four-fold increased risk compared to relatives of non-suicidal subjects.
- Twin studies indicate a higher concordance of suicidal behavior between identical rather than fraternal twins.
- Adoption studies: a greater risk of suicide among biologic rather than adoptive relatives.
- Suicide appears to be an independent, inheritable risk factor.

(Baldessarini, to be published)

Interaction of 5-HTT Gene Polymorphism and Life Stress in Depression Outcomes





s/s: short/short allele.
s/l: short/long allele.
l/l: long/long allele.
Results of multiple regression analysis estimating the association between number of stressful life events (between ages 21 and 26 years) and depression outcomes at age 26 as a function of 5-HTT genotype.
Caspi A, et al. *Science.* 2003;301:386-389.

Family Psychopathology and Suicide Risk

- Family history of abuse, violence, or other self-destructive behaviors place individuals at increased risk for suicidal behaviors (Moscicki 1997, van der Kolk 1991).

- Histories of childhood physical abuse and sexual abuse, as well as parental neglect and separations, may be correlated with a variety of self-destructive behaviors in adulthood (van der Kolk 1991).

Psychosocial Suicide Risk Factors

- Recent severe, stressful life events associated with suicide in vulnerable individuals (Moscicki 1997).
- Stressors include interpersonal loss or conflict, economic problems, legal problems, and moving (Brent et al 1993b, Lesage et al 1994, Rich et al 1998a, Moscicki 1997).
- High risk stressor: humiliating events, e.g., financial ruin associated with scandal, being arrested or being fired (Hirschfeld and Davidson 1988) – can lead to impulsive suicide.
- Identify stressor in context of personality strength, vulnerabilities, illness, and support system.

All studies are reviews

The Gun Controversy

- Firearms account for 55-60% of suicides (Baker 1984, Sloan 1990).
- Firearms at home increase risk for adolescents:
  - Guns are twice as likely to be found in the homes of suicide victims as in the homes of attempters (OR 2.1) or in the homes of control group (OR 2.2) (Brent et al 1991)
  - Type of gun (handgun, rifle, etc.) was not statistically correlated with increased risk for suicide
- Risk management point: Inquire about firearms when indicated and document instructions and response.

PSYCHOLOGICAL VULNERABILITIES: Clinical Observations

- Capacity to manage affect.
- Ability to tolerate aloneness.
- Ability to experience and tolerate psychological pain (Shneidman) – Anguish, perturbation.
- Ambivalence.
- Nature of object relationships.
- Ability to use external resources

DIRECT QUESTIONING ABOUT SUICIDE: THE SPECIFIC SUICIDE INQUIRY

- Ask About:
  - Suicidal ideation
  - Suicide plans
- Give Added Consideration to:
  - Suicide attempts (actual and aborted)
  - First episode of suicidality (Kessler 1999)
  - Hopelessness
  - Ambivalence: a chance to intervene
  - Psychological pain history

Jacobs (1998)

Components of Suicidal Ideation

- Intent:
  - Subjective expectation and desire for a self-destructive act to end in death.
- Lethality:
  - Objective danger to life associated with a suicide method or action.
  - Lethality is distinct from and may not always coincide with an individual's expectation of what is medically dangerous.
- Degree of ambivalence - wish to live, wish to die
- Intensity, frequency
- Rehearsal/availability of method
- Presence/absence of suicide note
  - Make sure you read it and document you have done so.
- Deterrents (e.g. family, religion, positive therapeutic relationship, positive support system - including work)

Beck et al. (1979)

Characteristics of Suicide Plan

Risk / Rescue Issues:

- Method
- Time
- Place
- Available means
- Arranging sequence of events

Jacobs (1998)

Psychiatric and Psychological Symptoms Associated with Suicide

- Hopelessness
- Anxiety
- Psychotic → command hallucinations
- Impulsivity
- Aggression

PSYCHIATRIC SYMPTOMATOLOGY: HOPELESSNESS

- Research indicates relationship between hopelessness and suicidal intent in both hospitalized and non-hospitalized patients
  - (Beck 1985, Beck 1990)
- Subjective sense of hopelessness was associated with fewer reasons for living and increased risk for suicide
  - (Malone 2000)
- Modifiable through various interventions
- Neil Young → Fernandez musical autognostic triad defining despondency
  - *hopeless, hapless and helpless*

PSYCHIATRIC SYMPTOMATOLOGY: IMPULSIVITY / AGGRESSION

- May contribute to suicidal behavior
- It is important to assess level of impulsiveness when assessing for suicidality
  - (Sher 2001, Fawcett et al, 2012)
- Suicide attempters may be more likely to present traits of impulsiveness / aggression regardless of psychiatric diagnosis
  - (Mann et al 1999)
- Important in assessing risk of murder-suicide

PSYCHIATRIC SYMPTOMATOLOGY: ANXIETY

- Anxiety symptoms (independent of an anxiety disorder) associated with suicide risk:
  - Panic Attacks
  - Severe Psychic Anxiety (subjective anxiety)
  - Anxious Ruminations
  - Agitation
- In a review of inpatient suicides 79% met criteria for severe or extreme anxiety or agitation

PSYCHIATRIC SYMPTOMATOLOGY: COMMAND HALLUCINATIONS

- Existing studies are too small to draw conclusions, patients with command hallucinations may not be at greater risk, per se, than other severely psychotic patients.
- However, the majority of patients with suicidal command hallucinations should be considered seriously suicidal
- Management of patients with chronic command hallucinations requires consultation and documentation

Adapted from A.P.A. Guidelines, Part A, p. 20-21

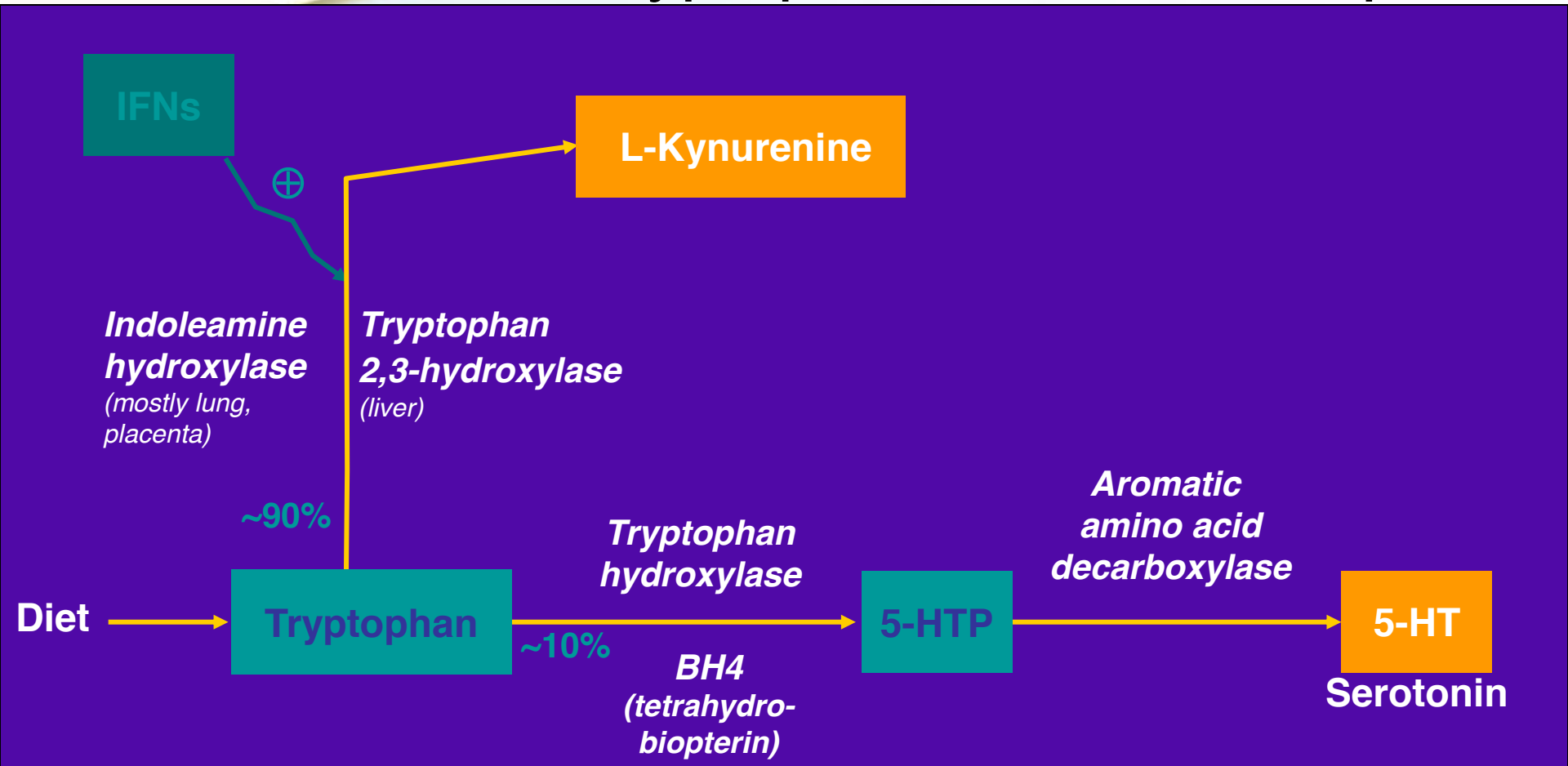
Determination Of Level Of Risk

- Clinical judgment based upon consideration of relevant risk factors, present episode of illness, symptoms, and the specific suicide inquiry.
- Seek consultation / supervision as needed
- Suicide risk will need to be reassessed at various points throughout treatment, as a patient's risk level will wax and wane.

Determination Of Level Of Risk

- The evaluation of suicide risk in patients with HCV undergoing IFNα treatment requires consideration of:
  - Prescence or development of depression
  - The emergence of psychosis
  - Alterations in serotonin (5-HT) metabolism

Etiology of IFN-Induced Depression: Possible Tryptophan-Serotonin Depletion



Tryptophan Metabolic Pathway

Bonaccorso et al. *J Clin Psychopharmacol*. 2002;22:86-90.
Capuron et al. *Mol Psychiatry*. 2002;7:468-73.

HCRC VA Hepatitis C Resource Centers

Determine Treatment Plan

- Attend to issue of patient's safety.
- Assess treatment plan/setting/alliance.
- Somatic treatment modalities:
  - ECT – used to treat acute suicidal behavior
  - Benzodiazepines – may reduce risk by treating anxiety
  - Antidepressants
  - Lithium, Anticonvulsants
  - Antipsychotics, recent study on Clozapine
- Psychotherapeutic intervention – widely viewed as helpful for suicidal patients, evidence is limited except for CBT.
- Provide education to patient and family.
- Monitor psychiatric status and response to treatment.
- Reassess for safety and suicide risk frequently.

Medical Therapies

ECT	Evidence for short-term reduction of suicide, but not long-term.
Benzodiazepines	May reduce risk by treating anxiety
Antidepressants	A mainstay treatment of suicidal patients with depressive illness / symptoms. No conclusive evidence of suicide reduction
Lithium and Anti-convulsants	Lithium has a demonstrated anti-suicide effect; anticonvulsants do not
Antipsychotics	Evidence for Clozapine reducing suicidality in schizophrenia and schizo-affective disorders

Psychotherapy

- Regardless of theoretical basis, key element is a positive and sustaining therapeutic relationship
  - Recommended (primarily from clinical consensus)
    - To target issues
      - Denial of symptoms
      - Lack of insight
    - To manage high risk symptoms
      - Hopelessness
      - Anxiety
- Effective treatment in high risk diagnoses
  - Depression
  - Personality disorders (use of D.B.T.)

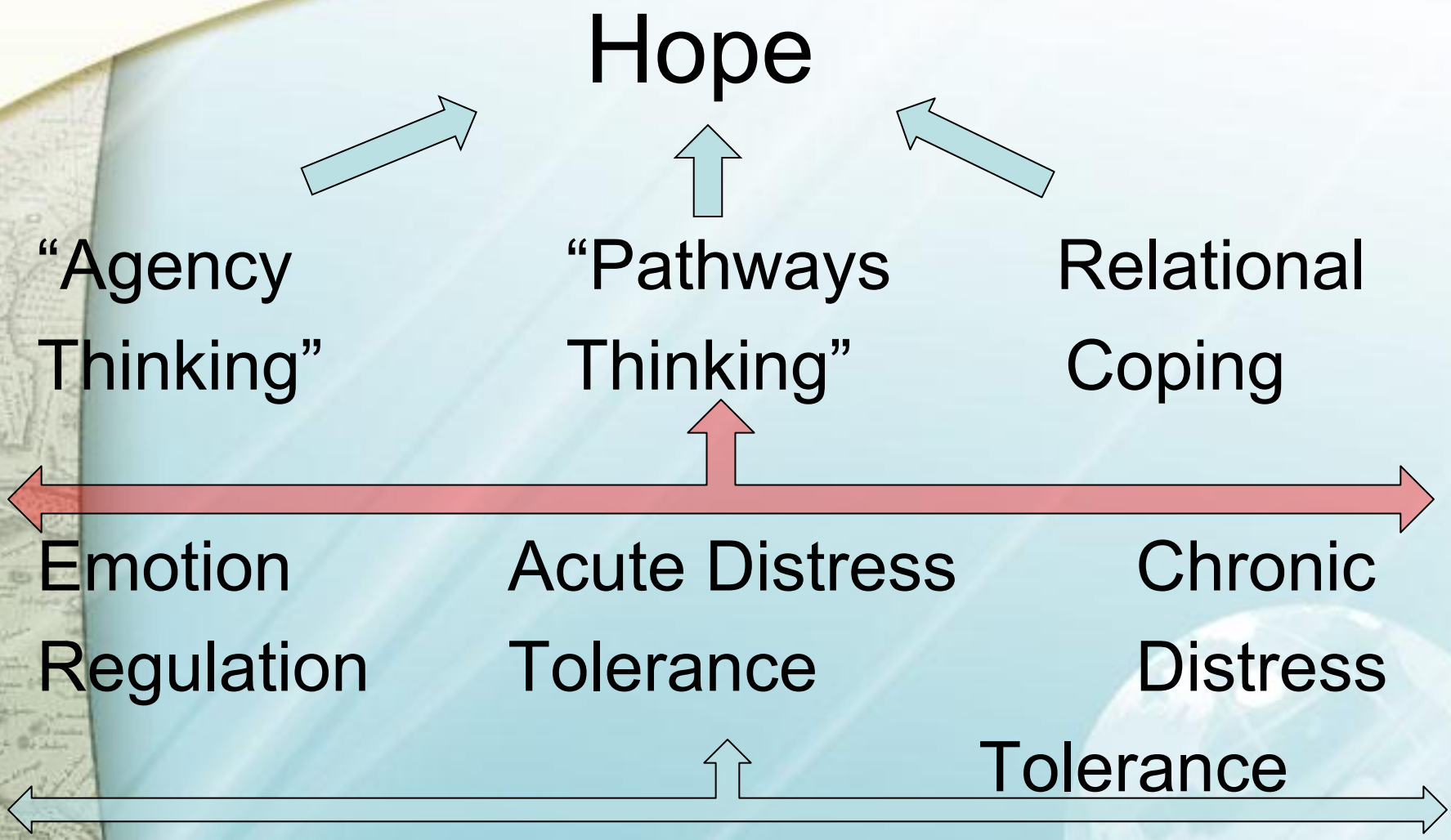
Adapted from APA Guidelines, Part A, p. 40

Clinical Neuroscientist as Psychiatrist Humanist

Cognitive and Social Neuroscience of Daily Life

- Executive Functions
- Implicit/Explict Memory
- Emotion Regulation
- Sociobiological Systems for Attachment, Social Dominance, Kin Recognition (in-group/out-group), regulation, In-Group Bonding (peer, filial)
- Mentalization, Empathy, Compassion
- Attention Control Systems (hypnosis, placebo, “normal dissociation”)

Hope Modules



Psychiatrist's Mission to Treat Disease and Alleviate Suffering

"Psychiatric Disorders"

- Major Depression
- PTSD
- Adjustment Disorder
- OCD
- Personality Disorder

"Normal Suffering"

- Demoralization, Grief, Loneliness, Spiritual Anguish
- Emotional shock
- Normal Stress responses
- Moral guilt
- Humiliation due to injustice, loss of dignity, stigmatization, discrimination

Griffith JL, & Norris L. Distinguishing spiritual, psychological, and psychiatric issues in palliative care: Their overlap and differences. *Progress in Palliative Care (In press, 2012).*

Existential Postures of Vulnerability and Resilience

How Does This Affect You?	*How Did You Respond?*
Vulnerability	***Resilience***
Confusion	Coherency
Isolation	Communion
Helplessness	Agency
Despair	Hope
Meaninglessness	Purpose
Resentment	Gratitude

-- Griffith & Gaby, *Psychosomatics*, 2005

Suicide Contracts

- Problems:
  - Commonly used, but no studies demonstrating ability to reduce suicide.
  - Not a legal document, whether signed or not.
  - Used pro-forma, without evaluation by psychiatrist.
- Possibilities:
  - Useful when there is positive therapeutic relationship (do not use when covering for colleague).
  - If employed, outline terms in patient's record.
  - Useful when they emphasize availability of clinician.
  - Rejection of contracts have significance.
- Bottom line → still considered within standard of care but usage is questionable and possibly difficult to defend in court.

When To Document …

- At first psychiatric assessment or admission.
- With occurrence of any suicidal behavior or ideation.
- Whenever there is any noteworthy clinical change.
- For inpatients:
  - Before increasing privileges/giving passes
  - Before discharge
- The issue of firearms:
  - If present - document instructions
    - *Safety: His wife has a handgun which is unsecured in the home – discussed need to have in a safe location, such as a lockbox.*
  - If absent - document as pertinent negative

What To Document?

- Document:
  - The risk level
  - The basis for the risk level
  - The treatment plan for reducing the risk

Example:

This 36 y.o., recently separated man with HCV infection is experiencing his first episode of major depressive disorder and expressing a passive death wish. His main complaints are of insomnia, anxiety, and hopelessness. Finds himself having trouble keeping up with things due to subjective sense of “inefficiency”. Substance use is denied. MMSE = 24/30.

How Best To Document …

- **PERTINENT DATA:**
  - **Psychosocial situation:**
  - **Psychological symptoms/Signs:**
- **SUICIDE RISK ASSESSMENT:**
  - Current ideation: YES (passive)
  - Past attempts: denies
  - Hopelessness: YES
  - Helplessness: denies
  - Access to firearms: denies
  - Family history: denies
  - Recent substance use: denies
  - Affective disorder: YES
  - Concomitant symptoms: YES (anxiety and insomnia)
  - Psychotic disorder: no
  - Cognitive disorder: YES
  - Overall risk: moderate at present
- **Homicidal Ideation?:** None


CURRENTLY ON
95
Zoloft
79
Prozac
Paxil
Buspar
Celexa

Treatment of IFN-α induced depression

- Paroxetine significantly reduced development of MDD in pts receiving high-dose IFN-α for malignant melanoma (Musselman et al, 2001).
  - N=40
  - Paxil vs. placebo
  - 2 wks before, and continuing during, treatment with IFN-α.
  - After 12 wks 45% in placebo group had MDD, vs 11% in paxil group
  - also effective in preventing tx discontinuation due to neuropsychiatric adverse effects.
- Similar findings shown in an open trial of pretreatment with citalopram except pts had past psych hx. (Schafer et al, 2000).

Treatment Recommendation for IFN-α induced depression

- Reasonable to initiate SSRI treatment:
  - Depressive symptoms begin to emerge once IFN-α therapy has commenced especially when IFN-α is administered in lower doses, or in pegylated preparations.
  - Patient had at least one week of continuous depressive symptoms of mild or greater severity (Raisson et al, 2005) .
  - Pre-treatment with IFN-α

In The Aftermath of A Suicide

- Despite best efforts at suicide assessment and treatment, suicides can and do occur in clinical practice
- Approximately, 12,000-14,000 suicides per year occur while in treatment.
- To facilitate the aftercare process:
  - Ensure that the patient's records are complete
  - Be available to assist grieving family members
  - Remember the medical record is still official and confidentiality still exists
  - Seek support from colleagues / supervisors
  - Consult risk managers

Drug-Drug Interactions – Inclusive of Psychoactive Agents

- www.hep-druginteractions.org
- University of Liverpool, Hepatitis Pharmacology Group

HCV on the Web

- VA National Hepatitis C Program
  www.hepatitis.va.gov
- Northwest HCRC, Portland
  www.va.gov/portland/Mood-Disorders-Center/ifn.htm#hcrc
- Centers for Disease Control & Prevention
  www.cdc.gov/ncidod/diseases/hepatitis/c/
- Hepatitis C Advocate www.hcvadvocate.org
- American Liver Foundation
  Www.liverfoundation.org
- Hepatitis Education Project website:
  www.hepeducation.org
- Drug company websites and patient support programs: Roche 1-877-PEGASYS, Schering Commitment to Care 1-800-521-7157

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