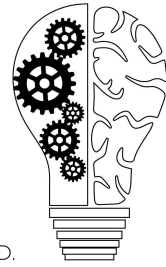


## Episode 054: Suicide Epidemiology, Risk Factors, and Treatments

Jaeger Ackerman, David Puder, MD



DAVID PUDER, M.D.  
**PSYCHIATRY &  
PSYCHOTHERAPY**

This PDF is a supplement to the podcast “Psychiatry & Psychotherapy” found on [iTunes](#), [Google Play](#), [Stitcher](#), [Overcast](#), [PlayerFM](#), [PodBean](#), [TuneIn](#), [Podtail](#), [Blubrry](#), [Podfanatic](#)

There are no conflicts of interest for this episode.

*On this week’s episode of the podcast, I interview Jaeger Ackerman, 4th year medical student about suicide risk factors and treatments.*

## **Treatment for Suicidal Patients**

As a therapist, attempt to closely approximate their reality of feeling suicidal with words. When I first hear their thoughts and feelings, I try to clarify with the patient to make sure I’m understanding their feelings. I usually try to put it into other words, and echo back to them. I’ll say something like, “I hear that you feel like there’s no other way out, that you feel lost and like it’s a very dark time for you.” I ask myself continually how to be present with them in their feelings, in the moment.

I often hear therapists say that they feel uncomfortable putting it so strongly, and try to soften their response to their patients. In reality, a patient feeling heard and understood can meet them where they are, rather than making them feel like they are being agreed with. It creates an empathic connection, which, in turn, can make a difference.

I also try to give them a little bit of hope. I tell them **we** haven’t exhausted all of the opportunities to feel better, and that I will be with them through it.

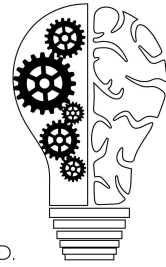
I’ve seen people at their darkest times come back from deep depression or trauma and suicidal thoughts and return to a healthy life. But that takes time. And we won’t have time if they commit suicide. Statistics and numbers sometimes can distance us from the person who is struggling with suicide. However, I think it is important to identify populations at risk, and to use science to help those the most people we can.

## **The Epidemiology of Suicide**

## **Episode 054: Suicide Epidemiology, Risk**

### **Factors, and Treatments**

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In the United States, suicide is the 10th most common cause of death in adults, and the 2nd leading cause of death for persons age 15-24. Nearly 1.7% of deaths in the US general population are because of suicide, and there are over 45,000 suicides per year ([Drapeau and McIntosh 2016](#)). Rates are higher in the western states and lowest in the mid-atlantic states. Internationally, rates are highest in eastern European countries like Scandinavia and Hungary, and are lower in countries with large Catholic or Muslim populations. The highest rates of suicide peak in late spring, with a smaller secondary peak in the fall. Economic factors tend to influence suicide rates as well, with some of the greatest rates seen during the Great Depression ([Mann, Apter et al. 2005](#), [Yip, Caine et al. 2012](#), [Black and Andreasen 2014](#)).

## **General Risk Factors in Suicide: SAD PERSONS**

The SAD PERSONS mnemonic is a helpful way to remember some of the most significant risk factors for suicide ([Patterson, Dohn et al. 1983](#)).

### **This stands for:**

**Sex:** Males are 4x more successful at completing suicide, while women attempt 3x more often

**Age:** a bimodal distribution with greatest rates between age 15-24 and in males older than 75

**Depression:** rates are 20x greater in depression than in the general population

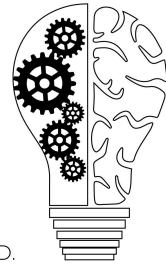
**Prior History:** 80% of completed attempts are preceded by prior attempts

**Ethanol abuse:** substance abuse in general is associated with a 2.5x greater suicide rate

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**Rational thinking loss:** cognitive impairment secondary to intoxication, delirium, or decreased sensorium may increase impulsivity and decrease inhibitions which increases suicide risk

**Support System loss:** including divorce, widowers, deaths of relatives, and isolation in general

**Organized plan:** those with a methodical plan are at greater risk of completing suicide

**No significant other:** spouses, parents, and children serve as protective factors against suicide

**Sickness:** about 5% of suicide completers have serious physical illness at the time of suicide

As a caveat, access to firearms should also be considered a significant risk factor for suicide. More than half of completed suicide in the US are completed using firearms ([Miller and Hemenway 2008](#)).

## **Mental Illness and Suicide**

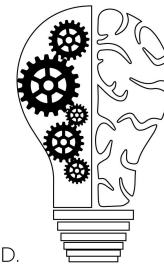
90% of suicide completers had a major psychiatric disorder diagnosed at the time of suicide, and over 50% are clinically depressed ([Black and Andreasen 2014](#)). With regards to **Major Depression Disorder** (MDD), 10-15% of patients who are hospitalized for depression will go on to commit suicide. MDD may be further characterized as melancholic, catatonic, with anxious distress, or atypical features and each has a unique association with suicide risk to be familiar with. Melancholic depression is more common in the inpatient setting and predicts a good response to antidepressants or ECT.

**Catatonic depression** has potential risk for malnutrition, exhaustion, and self-harm as many of these individuals lose the drive to eat or drink entirely. One study found a 60-fold increased risk of premature death, including suicide, in adolescents with catatonia ([Cornic, Consoli et al. 2009](#)).

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**Anxious distress** is associated with higher suicide risk, longer duration of illness, and greater likelihood of treatment noresponse. Anxiety sensitivity, or the fear of anxiety related symptoms, has been associated with a small-to-moderate increase in suicidal ideation and suicide risk ([Stanley, Boffa et al. 2018](#)).

**Bipolar Disorder** has even higher rates of suicide than MDD with 29.2% attempting suicide and 4.78% completing suicide ([Baldessarini, Tondo et al. 2019](#)). Risk for suicide is high both in the manic state and in the post-manic or depressive state when the individual becomes remorsefully aware of inappropriate behavior that occurred during the manic episode. In general, patients with bipolar type 2 have higher levels of suicidal ideation, however, bipolar type 1 is associated with a greater number of attempts.

**Schizophrenia** has a high suicide comorbidity. Up to 50% of schizophrenics will attempt suicide and 10% will commit suicide. Those at highest risk are unemployed males under 30 with chronic disease course and history of depression or substance abuse. Interestingly, **akathisia** is an independent risk factor for suicide. Akathisia is a sensation of both internal and external restlessness that may occur as a side effect of antipsychotic medications used to treat schizophrenia ([Drake and Ehrlich 1985](#)).

**OCD** is associated with a suicide rate of 14.25% and suicidal ideation is seen in 44% of individuals with OCD ([Albert, De Ronchi et al. 2018](#)).

**Borderline personality disorder** is the most frequent personality disorder and is diagnosed in 15-50% of psychiatric inpatients. Suicide rates are between 5-10% and the majority of borderline patients will attempt suicide multiple times. Self mutilating behavior, which occurs in 50-80% of borderline personality disorder is associated with about a 2x greater suicide rate than in borderlines without self-harm behavior ([Oumaya, Friedman et al. 2008](#)).

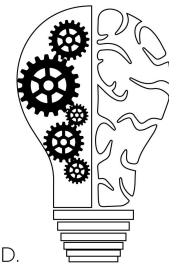
There is a significant positive relationship between **primary psychopathy** and history of suicide attempts ([Verona, Patrick et al. 2001](#)). The DSM5 goes out of its way to state that individuals with Antisocial Personality Disorder (ASPD) are more likely than

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members of the general population to die by violent means. The suicide rate in ASPD is close to 5% and the attempt rate is 11% ([Frances, Fyer et al. 1986](#)).



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## **Substance Use and Suicide**

The lifetime risk of suicide attempts in **alcohol dependence** is estimated at 7% ([Inskip, Harris et al. 1998](#)), while any substance use disorder is associated with a 2.47x greater risk of completed suicide ([Ilgen, Bohnert et al. 2010](#)). Current substance use disorders signal increased suicide risk, especially among women, and may be important markers to consider including in suicide risk assessment strategies ([Bohnert, Ilgen et al. 2017](#)).

Evidence from a large-scale study in Quebec shows that the acute phase prior to entering treatment programs for addiction is a particularly high risk timeframe. Rates up to 33.3% for ideation and 5.7% for suicidal attempts was observed in patients within 30 days of entering treatment ([Simoneau, Menard et al. 2017](#)).

Data from the Veterans Health Administration informs us of the specific hazard ratios for individual substance use and risk of suicide. This study found that the overall rate of suicide was **75.6/100,000** individuals in veterans with any substance use disorder, as compared to **11/100,000** in the general population. Females were found to be especially susceptible to an increased risk, and opiates (8.19) or sedative hypnotics (11.36) had the greatest hazard ratios ([Bohnert, Ilgen et al. 2017](#)).

Substance use in physicians should also be addressed in association with suicide. In one large-scale study, 27% of all physician suicides had one or more illicit drugs detected at autopsy or had a blood alcohol level greater than 0.8%. Physicians were at significantly higher odds of having antipsychotics, benzodiazepines, or barbiturates present on toxicology testing ([Gold, Sen et al. 2013](#)). This begs the question of whether or not these drugs were ingested for therapeutic or toxic purposes prior to the suicide. Evidence from this previous study is in line with other studies demonstrating a higher risk of poisoning or overdose deaths among physicians, presumably due to easier access to these drugs ([Hawton, Clements et al. 2000](#)).