

## Suicide and Violence Risk Assessment

Phillip J. Resnick, M.D.

### I. Long term risk factors for suicide:

- A. Family history
- B. Males 3:1 ratio to females for completed suicides
- C. White race
- D. Unmarried status
- E. Living alone
- F. Lack of social support
- G. Alcohol abuse
- H. Medical illness

Persons with chronic illness suicide more than those with terminal illness.

- I. Unemployment
- J. Fall in social or economic status
- K. Rejection by spouse or lover
- L. Previous suicide attempts

Unprovoked suicide attempts (attempts that occurred without any negative events occurring) may be especially indicative of high risk for later suicide.

- M. Anniversary of important losses
- N. Freedom from responsibility for children under age 18.

### II. Acute risk factors associated with suicide:

- A. Severe psychic anxiety
- B. Anxious ruminations
- C. Global insomnia
- D. Psychosis with delusions of poverty or doom
- E. Recent alcohol abuse

### III. Suicidal ladder

How bad do you feel?

Do you wish you were dead?

Have you had thoughts of ending your life?

How often do you have these thoughts?

When do they come up?

How long do they last?

Have you thought about a particular way to end your life?

Do you have access to this means to do it?

How close have you come to committing suicide?

1999 Suicide Study by Kessler, et al.

The cumulative probabilities of going from suicidal ideas to a suicidal plan was 34%.

26% went from suicidal ideas to an unplanned attempt.

72% went from a suicidal plan to an attempt.

### IV. Evaluation of deterrents to suicide (protective factors).

- A. Responsibility to family -- caring for them and not wanting to induce guilt.

The effect on one's children.

- B. Fear of the actual act of killing oneself.
- C. Fear of the unknown.
- D. Fear of social disapproval.
- E. Religious beliefs that it is wrong.

V. Suicide risk assessment in mental status exam

- A. Specify risk as:

Minimal

Moderate

Severe

- B. Example: Although Mr. Jones denies any suicidal ideas, his risk is moderate due to his history of 2 past suicide attempts, severe depression with delusions, and acute anxiety.
- C. If moderate or severe, order some suicide precautions.

VI. No-suicide contracts

- A. Unwillingness of the patient to agree is significant.
- B. There is no research evidence that they are effective.
- C. They are unlikely to be successful unless there is a positive working alliance between the clinician and the patient.
- D. They are contra-indicated in an agitated psychotic or impulsive patient.
- E. They should not be relied upon if a prior suicide attempt has occurred in spite of a no-suicide contract.
- F. More than half the successful inpatient suicides had no-suicide contracts in force (Busch et al., 1993).
- G. If you do enter into a safety contract with a patient, specify the reason for it in the chart.

For example, you may attempt to use it to act as a deterrent in a patient with whom you have a strong therapeutic alliance; or you may use it as an assessment tool of the patient's ambivalence and to see if the patient is unwilling to enter a "no-suicide" contract.

#### VII. Patient attitude toward therapist

- A. Ally -- when patient has a desire to live.
- B. Adversary -- once the patient has decided to die by suicide.
  - 1. The patient's goal is to die by suicide.
  - 2. The therapist's goal is to prevent the suicide.
- C. Two-thirds of inpatients who die by suicide had denied any suicidal intent or ideation, even shortly before their deaths.

Most had denied suicidal intent as their last communication before their death.

- D. Although the patient may deny suicidal thoughts when questioned by clinicians, the patient may directly or indirectly express them to significant others.
  - 1. Thus, clinicians should routinely question close relatives of suicide prone patients about suicidal communication.
  - 2. Communications of suicidal ideation in completed suicides were 60% to their spouses, 50% to relatives, and only 18% to helping individuals like physicians.

#### VIII. Suicide malpractice risk reduction:

- A. Out-patient suicide risk reduction:
  - 1. If a suicidal patient must stay at home, having a relative stay with them reduces sharply the risk of a suicide attempt.
  - 2. In an out-patient with significant suicidal risk, the clinician should consider suggesting that any firearms in the patient's possession are placed in

the hands of a third party (Bongar, Maris, and Berman, 1992).

3. Increasing frequency of office visits means placing less reliance on long term estimates of the likelihood of suicide.
  4. Ask for permission to brief supportive family or friends.
  5. Have the patient check in by telephone periodically between sessions.
- B. Document a risk/benefit analysis about your treatment decisions.
1. Benefits of hospitalization include:
    - a. Reduced risk of suicide.
    - b. Time away from stressful situation.
  2. Risks of hospitalization include:
    - a. Stigma which can affect the patient's view of himself.
    - b. Stigmatization in the eyes of others because the patient is away from work.
    - c. Financial burden.
    - d. Disruption of the therapeutic relationship in an unwilling patient.

## IX. Demographics of Violence

Age - violence peaks in late teens and early 20s.

Sex - males more than females.

Social class - the lower, the more street violence.

IQ - the lower, the more violence.

An epidemiologic study by Swanson et al., (1990) provided a survey of over 10,000 persons in the community regarding self reported violence in the last year.

Violent Behavior in the Last Year

<u>Diagnosis</u>	<u>Percent</u>
No disorder	2
Obsessive-compulsive disorder	11
Panic disorder	12
Major depression	12
Mania or bipolar disorder	11
Schizophrenia	13
Cannabis abuse or dependence	19
Alcohol abuse or dependence	25
Other drug abuse or dependence	35

The combination of substance abuse with other major psychopathology is more volatile than either alone.

X. Components of Dangerousness

- A. Magnitude
- B. Likelihood
- C. Imminence
- D. Frequency

XI. Psychosis and violence:

- A. Paranoid schizophrenics in the community are more violent than other diagnostic categories.

However in hospitalized patients, non-paranoid patients are more likely to be violent.

In paranoid patients with delusions, their violence is usually well planned and in line with the

delusion.

The violence is directed at a specific person who is seen as persecuting the patient, often relatives or friends.

Paranoid patients are more likely to be dangerous because they often have recourse to weapons, since they are more likely to be in the community.

Paranoid schizophrenics are likely to commit the most serious crimes because of their ability to plan and their retention of some reality testing.

#### B. Hallucinations and Violence

Hallucinations that evoke negative emotions (anger, anxiety, sadness) generate more violence.

Violence is associated with having less successful strategies to cope with voices.

Command hallucinations are associated with violence.

#### C. Compliance with command hallucinations:

1. Increased with a hallucination-related delusion.
2. Increased if the voice is familiar.
3. Dangerous commands are obeyed less often.
4. Increased with history of compliance.

#### D. Delusions and violence:

More violence is due to delusions than hallucinations.

Risk of violence is increased by:

- (1) Patients who either fear imminent harm, or
- (2) Experience external forces as overriding their personal control.

"Threat/control-override" symptoms associated with increased aggression include:

Mind feels dominated by forces beyond your control.

Feelings that thoughts are being put into your head.

Feelings that there are people that wish you harm.

Psychotic delusions not associated with increased aggression:

Feeling dead, dissolved, or not existing.

Feelings that your thoughts are broadcast.

Feelings that thoughts are taken by external force.

Violence is more likely if delusions are:

Persecutory.

Systematized.

Preceded by fear or anger.

Acted on before.

### XII. Assessment of Risk of Future Violence

The history should include:

#### A. Careful assessment of the patient's past use of violence.

Past violence is the single best predictor of future violence.

##### 1. Patient's account of prior violence.

What is the most violent thing you have ever done?

Frequency of violent acts.

Assess each prior violent act.

Who said what?

Degree of injury.

##### 2. Obtain collateral information.

(a) Talk to family to gather information.



Are you concerned that Mr. X might hurt someone?

(b) Victim's account of details of past violence.

B. Look for patterns of violence.

1. Violence may occur only in acute psychotic episodes.
2. Assess whether the past violence was precipitated by an interpersonal condition which diminished the patient's self-esteem.
3. Ego dystonic vs. ego syntonic attitudes toward violent impulses.

Is there remorse for past violence?

4. Affective vs. predatory aggression

C. Evaluate the use of drugs and alcohol.

Amphetamines, PCP and alcohol diminish controls.

Stimulants predispose to violence through disinhibition, grandiosity, and paranoia.

XIII. Tarasoff v. U.C. (1976)

When a therapist determines, or should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim from danger.

XIV. Summary:

Focus on acute risk factors for suicide.

Remember that once the patient has decided to die, you will be perceived as an adversary, not an ally.

You should document a complete suicide risk assessment.

Take a formal violence history.

Look for increasing fear in a paranoid psychotic.

Formulate a formal violence reduction plan.

## Risk Assessment Exercise

## BACKGROUND FOR VIEWING VIDEOTAPE FV 100

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The patient is a twenty-eight year old African American man who was admitted to the Cleveland VA Hospital with a chief complaint of increased thoughts of killing his supervisor at work. Mr. Smith was employed for the same company for about two years. He had a note with him leaving his property to his wife. He said that if he were killed by the police, his family would be able to collect his insurance.

The patient had a history of binge drinking, primarily on weekends. Three weeks before admission, the patient was separated from his wife often years by mutual agreement because they "got on each other's nerves." Mental status examination revealed no defect in cognitive functions. No delusions were evident and the only phenomenon resembling a hallucination was the patient's statement about a single voice telling him to kill his supervisor.

On the sixth hospital day, he got into a physical altercation with another patient. He was placed on "special watch" for two days. He showed remorse about the incident and thereafter remained in good control. The videotape was made on the tenth hospital day.

Please identify as many violence risk factors as you can from the videotape and this background sheet. Put a star by the single most ominous risk factor.

If you were the treating clinician, what steps would you take to protect the supervisor, George, before discharging the patient?

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