The Suicide Complex: Impact on Clinical Care

Eli Merritt, M.D.
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Gillenormand’s unhappiness was rendered more acute by the fact that he contained it wholly within himself, never allowing it any outward expression.

Victor Hugo, *Les Miserables*
Talk About It
Suicide Risk in the Bay Area
A Guide for Families, Physicians, Therapists & Other Professionals

Essential Tools, Techniques, Resources & Referrals

First Edition

Eli Merritt, M.D.

with a foreword by Renée Binder, M.D., President of the American Psychiatric Association
48 Year-Old Female

- 48 year-old female with eight years of sobriety from alcohol
- Chief complaint: “I have been having thoughts of dying.”
- Worsening depression over prior 6 months, triggered by steep rent increase in SF >> downsizing and relocation.
48 Year-Old Female

- 9 months prior: Engaged to be married, called off by finance one week before wedding.
- Divorced; ex-husband died by suicide 3 years prior.
- Brother died at patient age 13, alcohol and drugs, by fall; suicide?
48 Year-Old Female

- Father “heavy, heavy drinker.”
- Mother “huge anger problems.”
- Divorced patient age 15. Father is wealthy but no financial support.
- $12,000 in debt.
- Paternal grandmother died by suicide.
48 Year-Old Female

- History of depression, diagnosed in college. +SI and wish to die but no specific plan or attempt.
- Current strong desire to die. Hopelessness. “I can’t go on.”
- Ideation to jump off Golden Gate Bridge, overdose on sleeping pills and drown, or shoot self.
48 Year-Old Female

- Ruminations of floating in water dead, “at peace, like in a womb.”
- In office she pointed to various places on body with index finger, expressing thoughts of self-shooting. “But where? Where is the pain?”
Goals of Initial Encounter

- ?
- ?
- ?
Goals of Initial Encounter

• Safety
• Assess and manage risk
Elements of Assessment and Management

- Screening
- Formal assessment
- Risk formulation
- Treatment planning
- Treatment
- Plan review and revision
- Ongoing assessment
Assessment

- Suicidal ideation
- Methods, plan, preparation & intent
- History of suicide risk/behavior
- Alcohol and drug use disorder
- Negative life events
- Acute & chronic risk factors
Risk Formulation

- No significant suicide risk
- Low risk
- Moderate risk
- High risk
- Imminent risk
Goals of Initial Encounter

• Calm and confidence
• “Talk about it”—that is, directly encourage in-depth discussion of suicidal feelings and thoughts
• Listen empathically
• Do not attempt to change misperceptions
Goals of Initial Encounter

- Objectify hopelessness
- Objectify suicidal feelings
- Instill hope
- Normalize
- Treatment plan & crisis plan
- Expert empathic relationship
If there is any one secret of success, it lies in the ability to get the other person’s point of view and to see things from their angle as well as your own.
Essential Goal

The ultimate goal must be to engage the patient in a therapeutic relationship.

Aeschi Working Group
SUICIDE COMPLEX
Talk About It
Fear

- Suicide as the #1 fear of mental health professionals
- Anxiety, control, denial, anger, blame
- Helplessness, incompetence
- Malpractice liability
- Lawsuit, being blamed
Countertransference Hate in the Treatment of Suicidal Patients

John T. Maltsberger, MD, Dan H. Bule, MD, Cambridge, Mass

The countertransference hatred (feelings of malice and aversion) that suicidal patients arouse in the psychotherapist is a major obstacle in treatment; its management through full awareness and self-restraint is essential for successful results. The therapist’s repression, turning against himself, reaction formation, projection, distortion, and denial of countertransference hatred increase the danger of suicide. Such antitherapeutic stances, their recognition, and the related potential for constructive or destructive action are the subject of this paper.

Countertransference is inevitable in all psychotherapies. Taken in the broader sense of the term, it comprises the therapist’s emotional response to his patient’s way of relating to him, and to transference which the therapist may form in relation to his patient. Some of the therapist’s countertransference response may specifically arise from the way the patient behaves in the specific therapeutic relationship, and some of it may stem from treatment of “borderline” and psychotic patients, especially those who are prone to suicide. Repeated experience has taught that borderline and psychotic patients have great difficulty with aloneness, hostility, and sadism. Klein has described the mechanism of projective identification encountered in such individuals, and Kernberg, their personality organization and primitive defenses. Searles has emphasized the cannibal instincts as well as the role of an attacking, raging posture as a defense against sadness. The contributions of Winnicott and Guntrip have helped better to understand the aloneness, separation, and fears of abandonment that torture such patients. While no review of this complex subject can be attempted here, we take it as understood that the transference hate manifested by borderline and psychotic suicidal patients relates to a deep sense of abandonment (or expectation thereof), an intense craving for yet horror of closeness (it threatens annihilation through engulfment),
AVOIDANCE
Study the Suicide Complex
Understand the Suicide Complex
Talk About It Anyway
Deep Emotional
Talking About It
Youth

- 4600 deaths per year, ages 10-24
- 13 per day
- 157,000 seek ED care per year
- 430 per day
- High school, 16% seriously considered suicide

CDC 2015
High School Students
(Female versus male)

• Considered suicide:
  • 17.4% versus 10.5%
• Planned suicide:
  • 13.2% versus 8.6%
• Attempted suicide:
  • 8.1% versus 4.6%

CDC, 2009
Youth Suicide
2007-2013

Steady, modest increase from 9.6 deaths per 100,000 to 11.1 per 100,000

Scelfo, Suicide 2015
Father of 16 Year-Old Female

• 16 year-old girl hospitalized at John Muir in Concord
• Ideation of cutting wrists with box cutter. Stated to mother, “I have made my peace with death.”
• Father requesting consultation on 1) best discharge plan & 2) how best to support upon discharge
Father of 16 Year-Old Female

- Junior in high school, excellent grades, but constant worry about tests, college applications, and friends
- Treatment since age 10. History of depression, anxiety, and bulimia.
Father of 16 Year-Old Female

- Current therapist, psychiatrist, and DBT group
- Zoloft 100 mg qd
- “What should we do?”
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Counseling Family Members

• Acknowledge your concern about suicide risk.
• Recognize the obstructive role played in all of us by the “suicide complex.”
• Create space to distill your essence with pen and paper.
• Talk About It
• Listen with judgment or correction.
The Wisdom of Talking

• Diminishment of shame
• Diminishment of fear
• Disentanglement of confusions
• Outside perspectives
• Catharsis—love and grief
• Human connection
Gillenormand’s unhappiness was rendered more acute by the fact that he contained it wholly within himself, never allowing it any outward expression.

Victor Hugo, *Les Miserables*
It is ideas, not locomotives, that move the world.

Les Miserables

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