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Suicide during therapy

LEDER

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When someone is driven by a suicidal urge, psychiatry is expected to help.

In a study conducted in the Agder counties, Vegard Øksendal Haaland and collaborators provide an account of the contact that victims of suicide in the years 2004–2013 have had with mental health care or interdisciplinary specialised addiction therapy (1). Altogether 67 % had such contact, 41 % had a contact during their last week of life and 29 % immediately prior to their suicide.

In general, approximately 90 % of those who commit suicide are found to suffer from a mental disorder (2). Affective disorders are the most common form, but may also include short-term crises such as acute stress reactions (F 43.0), which commonly recedes after some hours or days, or adjustment disorders (F 43.2), which may last for up to six months. According to the study from the Agder counties, however, one-third of those who ended their own lives had *not* been in mental health care or specialised addiction therapy (1).

Interventions in suicidal behaviour in any case need to be more comprehensive than making a psychiatric diagnosis and treating it, not least since this is a matter of interpersonal, social, occupational and existential problems.

Many of those who engage in suicidal behaviour do not seek psychiatric help, for a variety of reasons. Risk of suicide is one of the criteria for being granted an appointment at a district psychiatric centre (DPS). When a referral is rejected, the reasons for referral are most likely issues other than the risk of suicide. Perhaps the most likely reason why so many have chosen not to seek help is that they had little confidence in – or awareness of – the ability of the health services or others to help them, or they may have become overwhelmed by suicidal urges in an acute crisis, and acted on these.

In the study from the Agder counties, altogether 29 % had contact with therapists in the time before the suicide. One may ask whether this figure is high or low. Suicidal behaviour is a lethal condition, and deaths may be expected to occur during therapy, just as for other lethal conditions. Before drawing any conclusions in this regard, thorough investigations should be undertaken to see whether these suicides were predictable or whether any professional errors were committed – and above all: what we can learn from this.

It is also worth noting that 7 % (24/329) were hospitalised or were on leave when they took their own lives. Could these suicides have been prevented? The material has been collected over a period of ten years, meaning that each year, on average two patients committed suicide while hospitalised. Since hospitalised patients are probably deemed to be at the highest risk of suicide, we may perhaps be content with having managed to prevent suicide in all but two each year. Some will play down or deny their suicidal intentions to avoid being prevented. Others may express serious suicidal intentions over a long period without being regarded as acutely suicidal. They may suddenly choose to act, with no possibility for the therapists to see that the day this happened was different from any other day.

For 13 patients (4 %), the therapy was terminated at discharge. This is not a high figure, but it is hard to understand why no outpatient follow-up was indicated, especially after a condition deemed sufficiently serious as to warrant hospitalisation.

Having a patient die from suicide is a greater burden on therapists than deaths from other causes. After a suicide, it is easy to think that more could have been done to detect the risk of suicide and prevent it from happening. Theoretically, it is nearly always possible to imagine a course of events that would not have resulted in death. This may give rise to feelings of guilt and inadequacy. Such feelings may be reinforced if criticism is voiced by next of kin, colleagues or inspectorates, which may happen irrespective of whether there is just cause or not. It is thus crucial that a therapist who loses a patient to suicide be given an opportunity to review the course of events, both to learn and to receive support.

Therapists may also feel powerless and inadequate when working with patients who struggle with suicidal thoughts and hopelessness over time, although they may not be acutely suicidal and end up by taking their own lives (3). Perhaps one key reason for the patient to persevere could be that the therapist perseveres? This is another reason to support therapists who may feel alone and perhaps harbour excessive expectations of the patient as well as themselves. The GPs also play a key role when it comes to patients with suicidal behaviour, and the collaboration between GPs and the specialist health service could doubtless be improved.

We will not succeed in preventing all suicides. Some suicides come as a result of professional failure. However, this should not overshadow the fact that very many receive help and very many therapists deliver excellent care. But neither should we accept that so many people take their own lives, while in psychiatric care or otherwise.

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