

Prevention and Management of Suicidal Behaviour

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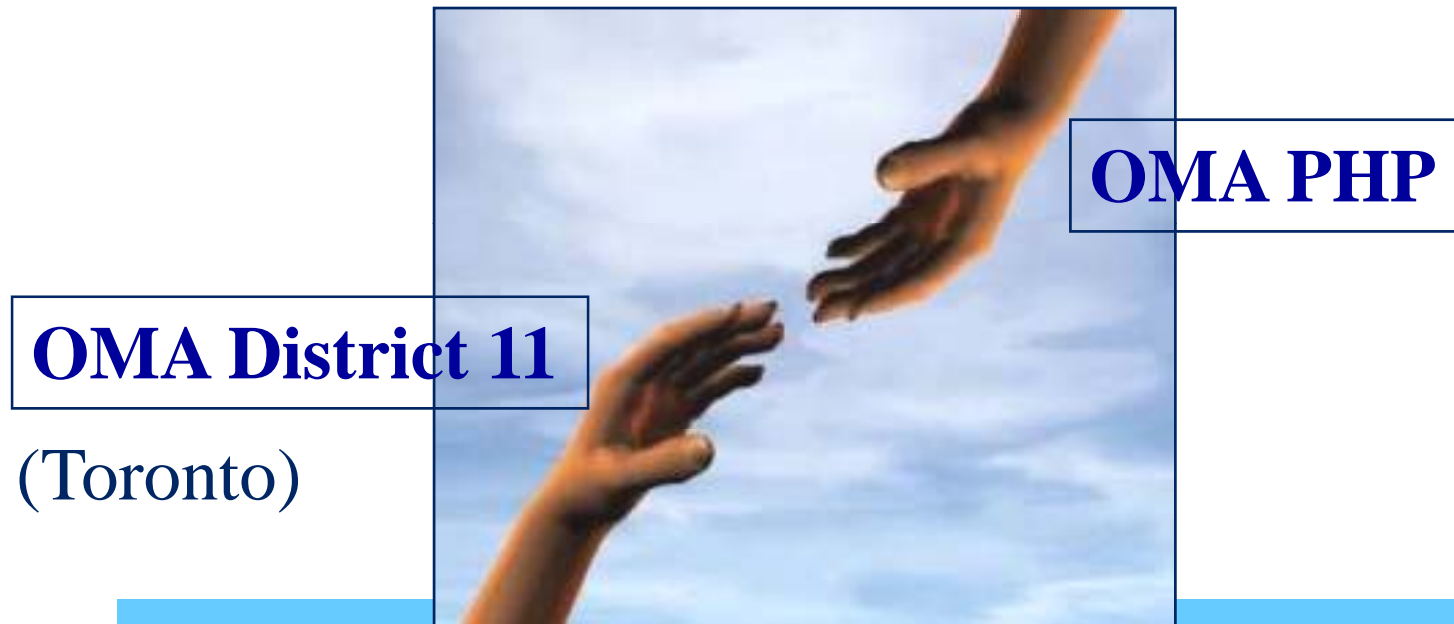
Learning Objectives

- **Improve knowledge and understanding of physicians health issues in the area of depression and suicidal risk**
- **Improve skills in the assessment, management and treatment of depression and suicidal risk experienced by individual physicians,**
 - **Learn to recognize and avoid common practice issues that may arise when treating medical professionals in crisis situations**
 - **Gain improved understanding of the therapeutic issues that arise when treating physician or other medical professional patients**

Learning Objectives

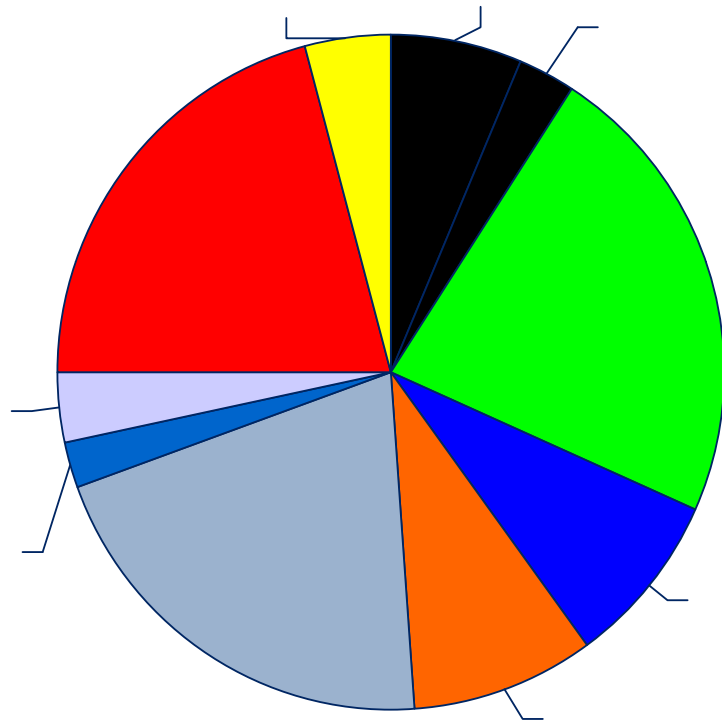
- **Identify psychological and social risk factors contributing to the suicidal risk in physicians**
- **Appreciate contribution of mood disorders and other psychopathology to the increased risk of suicide**
- **Increase awareness of continuum of services and resources to meet physicians and allied professionals health and well being needs**

Toronto Physician Health Project



Collaboration between OMA District 11 and the OMA Physician Health Program

Problem Type 2004 (N=275)



CMA Code of Ethics

- **Fundamental Responsibilities**

promote and maintain your own health and wellbeing

- **Responsibilities to Oneself**

seek help from colleagues and appropriately qualified professionals for personal problems that might adversely affect your service to patients, society or the profession.

Protect and enhance your own health and wellbeing by identifying those stress factors in your professional and personal lives that can be managed by developing and practicing appropriate coping strategies

Assumptions and Beliefs (Attributional style)

- The superman/superwoman syndrome:
“I don’t have the limits of normal people.”
- The workaholic syndrome:
“I am worth more when I work.”
- The striving syndrome:
“I must always keep striving to improve myself.”
- The tough syndrome:
“Big boys/girls don’t cry.”



Psychosocial Stressors

- **Rapid changes in the health care system / hospital closures, mergers, scapegoating, loss of flexibility**
- **Information overload – maintenance of competence**
- **Financial responsibility**

Psychosocial Stressors

- **Occupational hazards: long hours of work, violence, sexual harassment, risk of disease/ infection**
- **Family stressors: substitution of personal interaction and presence by expectation of living standards**
- **Patients: demanding, unappreciative, require intense emotional contact**



Burnout

Definition: A response to chronic emotional stress and strain.

Stages:

- Emotional exhaustion
- Depersonalization
- Reduced personal accomplishments

Stress-Related Symptoms

Central nervous system

- Tension/migraine headaches
- Insomnia/disturbed sleep
- Irritability/inability to concentrate
- Fatigue/physical exhaustion
- Stuttering or other speech difficulties

Respiratory

- Shortness of breath
- Throat discomfort/swallowing difficulties
- Rapid, shallow breathing

Genito-urinary

- Frequency of urination
- Impotence/sexual difficulties

Muscles and joints

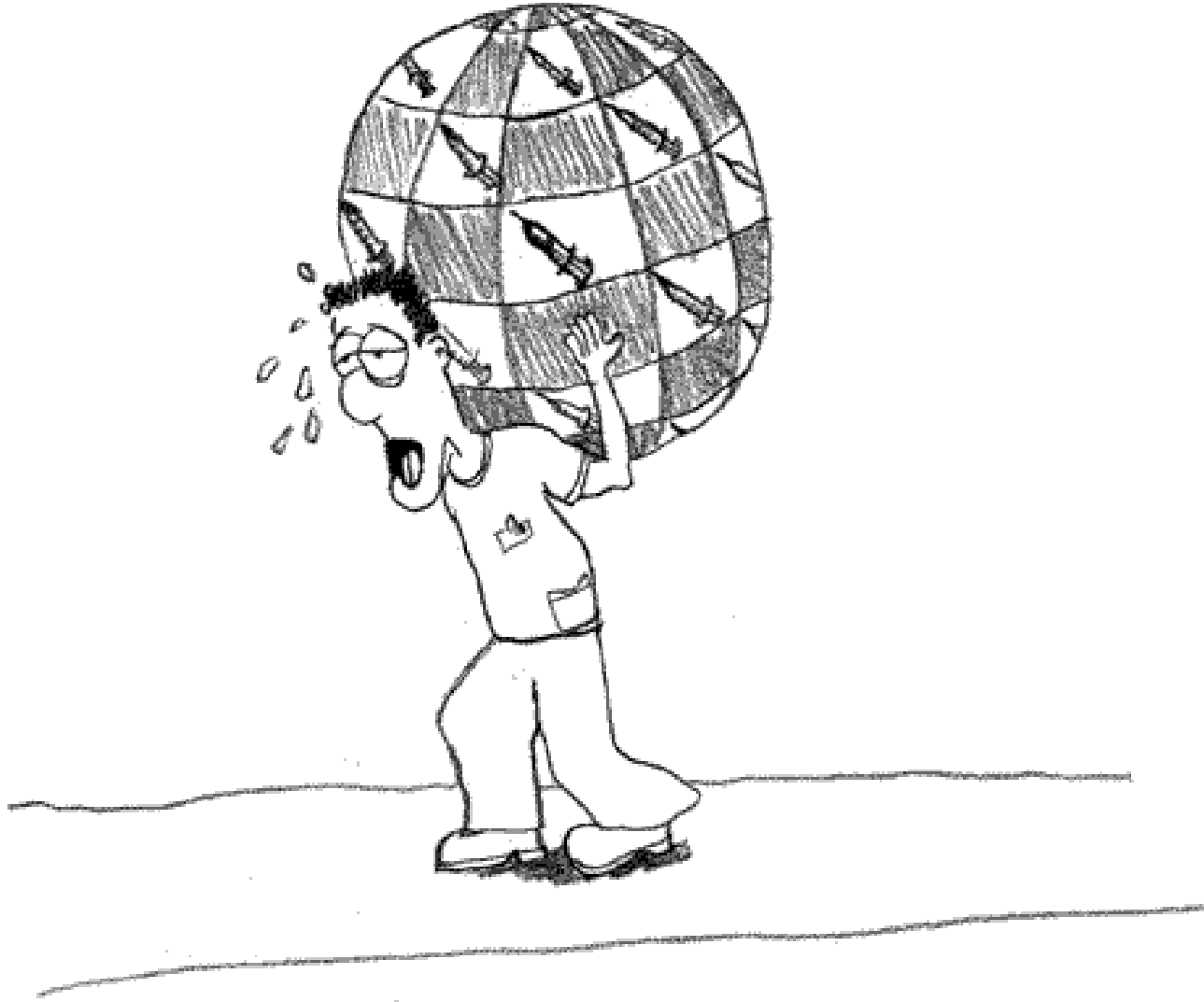
- Tense muscles (especially neck, shoulders and back)
- Vague aches and pains (in the muscles and joints)
- Grinding teeth/clenching jaw
- Facial twitches/tics

Depression and Anxiety in Physicians

- **More vulnerable to depression**
- **Trainees and women physicians more at risk**
- **Often unreported and untreated**
- **Self-treatment**
- **Risk of suicide**

Recognizing Depression

- **Female physicians – 1/2 met the criteria for primary affective disorders at some point**
- **Male physicians – 1/3**
- **5 % of U.S. physicians die as a result of suicide**



Risk Factors

Biological:

- **Gender** F > M
- **Age** 20 - 40 yr.
- **Family history**
- **Physical illness**
- **Sleep, food intake**

Chemical Dependence

- **Life-time prevalence – 10-12% in health professionals**
- **Addicted health professionals die 12 years earlier than controls**

Women in Medicine

- **More women are choosing medicine as a career**
- **The stresses for women physicians come from struggling to balance competing demands of work environment, home life and the role strain**
- **The end result of stress is burnout that can lead to serious physical and emotional problems**
- **Stress has to be actively addressed in order to successfully manage it.**

Mamta Gautam, Director, Faculty Wellness Program, University of Ottawa

Specific Stressors for Women Physicians

- **Lifestyle consideration**
- **Role strain – primary role in managing the household**
- **Marital issues:**
 - **sense of guilt**
 - **problems with intimacy/sexuality**
 - **husbands feel belittled if earn less**

Specific Stressors for Women Physicians (continued)

- **Discrimination: harassment, microinequities**
- **Cultural stereotypes: adjust our personal style to be less threatening**
- **Lack of mentors/role models**
- **Academic medicine: fewer full-time professors, less protected time for research**

Psychiatric Disorders

- **Mood disorders, including bipolar**
- **Anxiety disorders**
 - panic, OCD, social, PTSD
- **Eating disorders**
- **ADHD**
- **Adjustment disorders**
- **Personality disorders**
- **SUD**
- **Comorbidities /course/adherence**

Prevalence:

Psychiatric disorders:

- **Depression / anxiety in young doctors: 30%**
Tyssen, Vaglum; Mental Health Problems Among Young Doctors: An Updated Review of Prospective Studies, Harvard Rev. Psych 2002; 10:154-65
- **Depression in female doctors, lifetime: 19.5%**
Frank, Dingle, Self-Reported Depression and Suicide Attempts Among U.S. Women Physicians; Am J Psychiatry 1999; 156: 1887-1894

Patients at high risk for MDD

Chronic pain

- **Chronic physical illness (diabetes, heart disease, etc.)**
- **Unexplained somatic symptoms**
- **Frequent visits**
- **Postpartum state**
- **Psychosocial stressor**

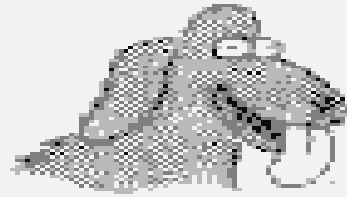
Medications causing depression

Steroids and hormones

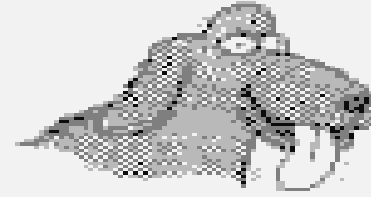
Corticosteroids
Danazol
Oral contraceptives
Norethisterone
Triamcinalone
Cancer Drugs
Cardiac and antihypertensive drugs
Sedatives, hypnotics, antipsychotics,
neurological
Stimulants
Analgetics/anti-inflammatory

Miscellaneous drugs

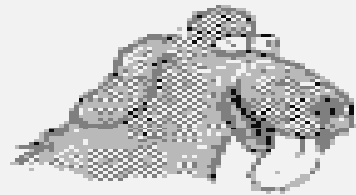
Acetazolamide
Anticholinesterases
Choline
Cimetidine
Cyproheptadine
Disulfran
Isotretinoin
Meclizine
Metaclopramide
Methysergide
Pizotifen
Salbutamol



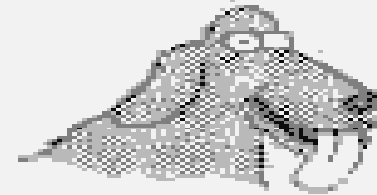
happy



depressed



angry



pensive



excited



suicidal

How to recognize the moods of an Irish setter

Substance Use Disorders SUDs

- **Substance Abuse**
- **Substance Dependence**
- **Dual Diagnosis (psych + SUD)**

Prevalence:

Substance Use Disorders:

- **Lifetime abuse / dependence: 7.9%**

Hughes et al: Physicians Substance Use by Medical Specialty;
Journal of Addictive Diseases, Vol. 18(2) 1999

- **Annual incidence: ½ to 1%**

Brewster, report for the Ontario Medical Association, 1994

Suicide-Latin for Self-Murder

- **Suicidal ideation, intent, attempts**
- **Often preventable and treatable if mental illness diagnosed early**
- **Devastating results on others**
- **Durkheim's Theory-egotistic, altruistic and anomic suicide**
- **Freud-Mourning and Melancholia, suicide represents aggression turned inwards**
- **Beck-hopelessness is one of the more accurate indicators of long term suicidal risk**
- **Biological factors-diminished central serotonin**
- **Genetic factors-Hemmingway, Amish**
- **Parasuicidal behavior-self-mutilation**

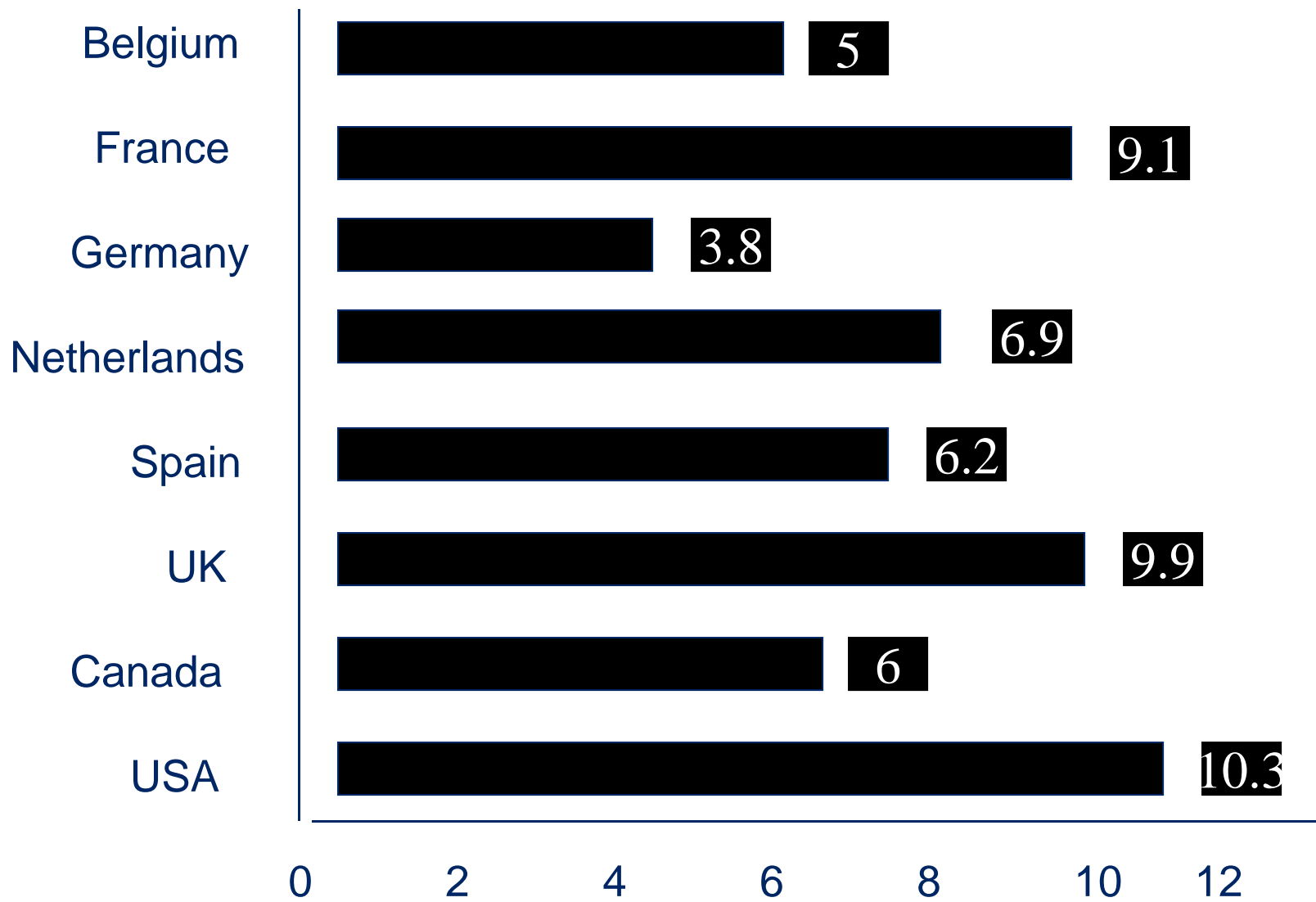
Suicide:

Prevalence:

- **1.5% of U.S. women physicians have attempted (Frank)**
- **36 per 100,000 for U.S. male physicians
(just above matched pop.)**
- **41 per 100,000 for U.S. women physicians (four times
matched population)**

In Simon W; Suicide Among Physicians:

Prevention and Postvention; Crisis 1986; Vol. 7 No 1:1-13



SIX-MONTH PREVALENCE OF MDD ACROSS DIFFERENT COUNTRIES

Risk Factors Associated with Suicide Demographic/Clinical

- **Male**
- **Geriatric age**
- **Social isolation**
- **Single/Separated/Divorced**
- **Poor support network**
- **History and severity of prior attempts**
- **Family history of depression and suicide**
- **Impulsivity/Agitation**
- **Psychotic features**
- **Alcohol and SUD**
- **Personality traits**
- **Chronic illness**
- **Recently discharged**

Risk Factors Associated with suicide

Demographic

Male
Adolescent or geriatric age
Unemployed
Socially isolated
Single/separated/divorced
Poor support network

Clinical

History and severity of prior attempts
Family history of depression and suicide
Hopeless
Impulsive and agitated
Psychotic features
Alcohol and substance abuse
Borderline/antisocial personality traits
Chronic medical or psychotic illnesses
Recently discharged from hospital

Suicide: Schemhammer – metanalysis Dec 04

Am J Psychiatry 2004;161:2296-2302

- **Suicide rates were 41% higher in male physicians than in the general population, the authors report**
- **The suicide rate among female physicians was more than double that in the general population**

Psychiatric Disorders Associated with Physician Suicide

- **Major Depressive Disorder**
- **BAD**
- **SUD**
- **Anxiety Disorders including panic attacks**
- **Borderline personality disorder**

Social Risk Factors Associated with Suicide in Physicians

- **Financial problems**
- **Major professional or personal losses**
- **Dissatisfaction with professional life**
- **Deriving little satisfaction from family and friends**
- **Recently divorced or widowed**
- **Isolation**
- **Increased work strain**

Suicidality assessment from the MINI

<u>In the past month did you</u>			point
C1	Think that you would be better off dead or wish you were dead?	NO YES	1
C2	Want to harm yourself?	NO YES	2
C3	Think about suicide?	NO YES	6
C4	Have a suicide plan?	NO YES	10
C5	Attempt suicide?	NO YES	10
<u>In your lifetime</u>			
C6	Did you ever make a suicide attempt?	NO YES	4

Suicidality assessment from the MINI (continued)

Add the total number of points for the answer [C1-C6] checked
YES and specify the level of suicide risk as follows:

TOTAL _____

SUICIDE RISK - CURRENT

Low 0-5 points

Moderate 6-9 points

High 10 or more points

Suicide Prevention

- **Early recognition, diagnosis and treatment of depression and substance abuse**
- **Educating physicians and trainees about recognising suicidal intent in colleagues and access to treatment**
- **Mentorship in medical school and residency particularly for female physicians**
- **Foster acquisition of coping skills, stress reduction strategies, balancing choices**
- **Adequate follow-up following a depressive episode or hospitalization**

Managing Suicidal Patients

- Adequate assessment and complete psychiatric history
- Inpatient vs outpatient treatment-presence of social support, severity of depression, impulsivity, family coping ability, recurrence of suicidal attempts, lethal means
- Contract-agreement to control suicidal impulses and call if situation changes
- Vigorous treatment with antidepressants and antipsychotics
- Supportive therapy
- Legal and ethical factors
- Survivors of Suicide

Nine principles of management for a major depressive episode

- **Set clear goals for treatment**
- **Assess and treat comorbid medical conditions**
- **Assess suicide risk**
- **Establish a therapeutic alliance**
- **Consider psychotherapy**
- **Choose an appropriate antidepressant**
- **Enhance adherence (compliance) to treatment regimen**
- **Monitor treatment outcome**
- **Maintain response for treatment**

Specific Suggestions in Working with the Physician Patient

- Respond quickly to requests for help
- Encourage to find a family physician
- Ensure confidentiality
- Be empathic and acknowledge their courage
- Discuss who is in control
- Treat like any other intelligent person
- Anticipate and address defence mechanisms
- Maintain appropriate boundaries
- Avoid sharing more personal info than with other patients
- Take care of yourself and learn to disengage from pain
- Be aware of transference and countertransference

Helpful web resources for depression [Level 3]

- **The Blue Pages (Australia)**
www.bluepages.anu.edu.au
- **Canadian Network for Mood and Anxiety Treatment**
www.canmat.org
- **MacArthur Foundation Initiative Primary Care (USA)**
www.primary-care.org
- **Mental Health on the Internet (Canada)**
www.mentalhealth.com
- **National Institute of Mental Health (USA)**
www.nimh.nih.gov
- **PsychDirect (Canada)**
www.psychdirect.com
- **STAND (Stress, Anxiety and Depression; UK)**
www.depression.org.uk

Recommendations for augmentation strategies in treatment-resistant depression

<u>Therapeutic choice</u>	<u>Recommendations</u>	<u>Dose</u>	<u>Evidence</u>
First	Lithium	600-900 m	Level 1 or to therapeutic serum levels
	Olanzapine	5-15 mg	Level 1
Second	Risperidone and probably other novel antipsychotic agents	0.5-2 mg	Level 3
	Triiodothyronine (T ₃)	5-50 micrgr	Level 2

Recommendations for augmentation strategies in treatment-resistant depression (continued)

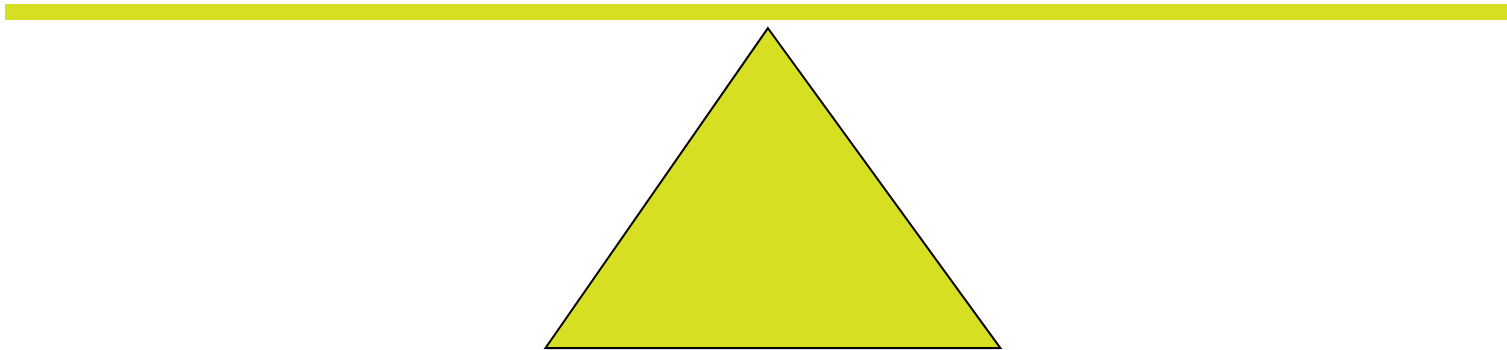
Therapeutic choice	Recommendations	Evidence
First	SSRI + mirtazapine/mianserin	Level 2
Second	SSRI/SNRI + bupropion SR	Level 3
Third	SSRI + TCA (caution for increased serum TCA levels with some SSRIs)	Level 2
Third	SSRI + RIMA (reversible inhibitor of monoamine oxidase A) (caution for serotonin syndrome)	Level 3

Recommendations for augmentation strategies in treatment-resistant depression (continued)

Therapeutic Choice	Recommendations	Dose	Evidence
Third	Buspirone	Usual doses	All Level 3
	Lamotrigine	Usual doses	All Level 3
	Psychostimulants	Usual doses	All Level 3
	Trazodone	Usual doses	All Level 3
	Tryptophan	Usual doses	All Level 3
Not recommended	Pindolol	n/o	Level 1

WORK

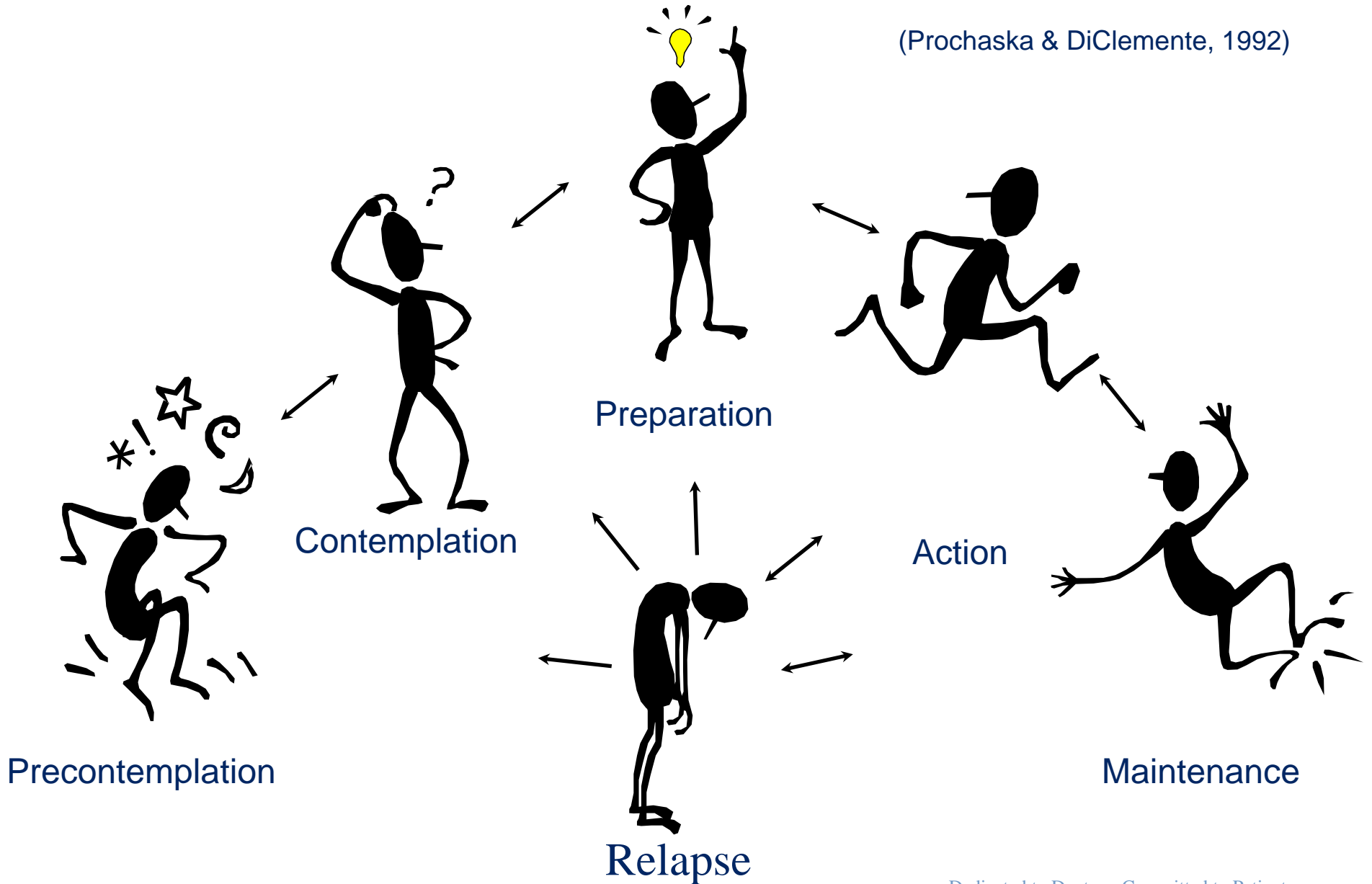
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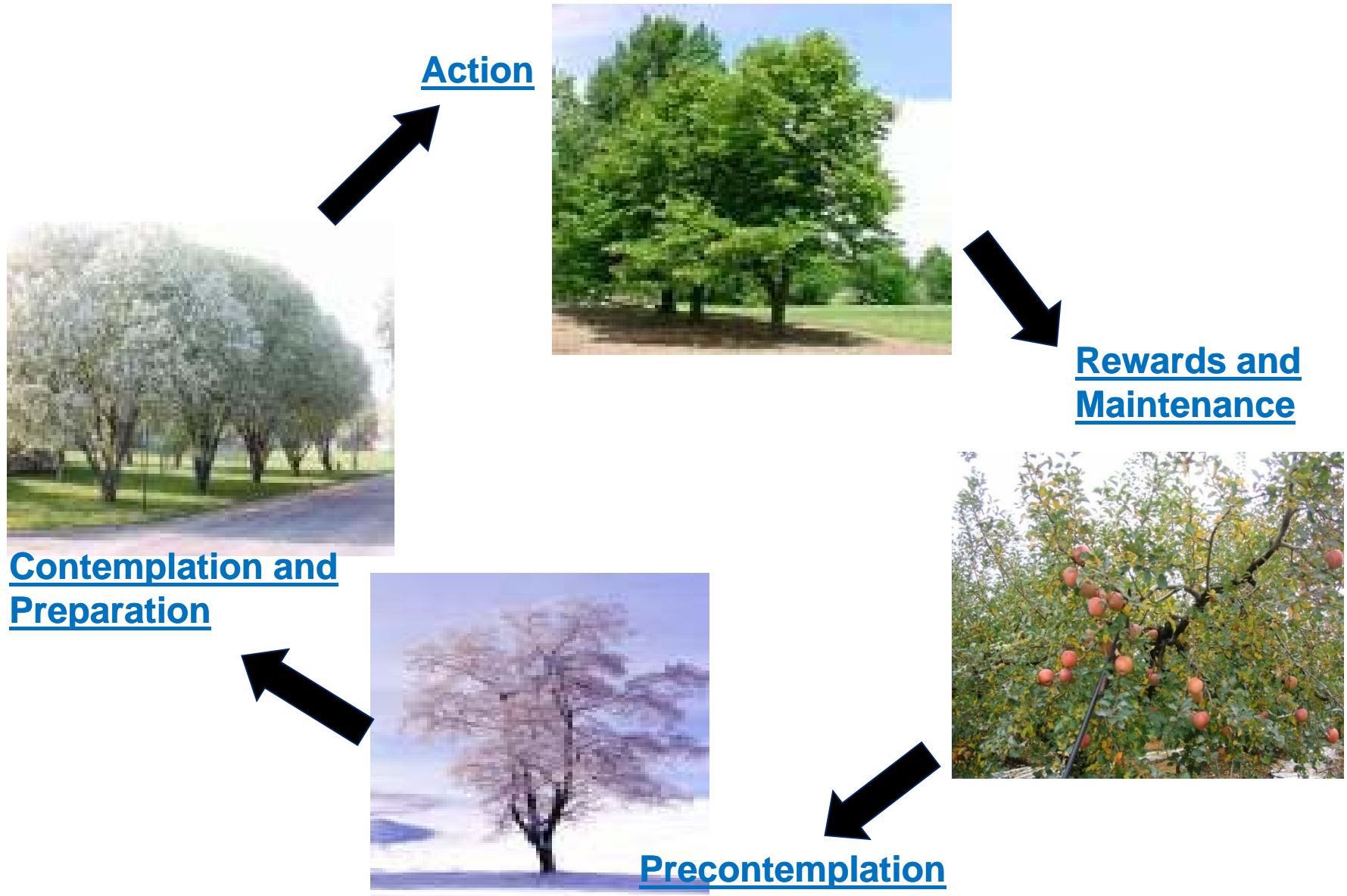
A Balanced Life

Transtheoretical Model

(Prochaska & DiClemente, 1992)



Process of Change:



Precontemplation



Anger Management

PREPARATION PHASE:

- Internet search
- Calls to find out where help is available
- Reading a book on anger management
- Seeks advice of colleague

ACTION PHASE:

- Joined anger management group
- Reduced hours of work
- Marital therapy for marital discord

Workaholism

PRE-CONTEMPLATION:

- Denial, “I am worth more when working”

CONTEMPLATION:

- “There must be more to life than work”
- “Work is not life”
- “I should stop postponing my hobbies and interests”
- “I’m tired a lot lately, am I working too much?”

Workaholism (continued)

PREPARATION:

- Review schedule
- Review commitments
- Decision to decrease time in non-productive meetings/committees

ACTION:

- Revise schedule
- Consult with MD management
- Substituted excessive work with health-promotion activities: exercise, hobbies, relaxation techniques
- Seeing counselor/therapist to regain balance in life

Dealing with Stress

1. Identify the stressor: time, change, overcommitment
2. Recognize that you have more control than you think
3. Identify what parts of the stressors you can and cannot control
4. Focus on what you can control; accept what you cannot
- 5 Mindfulness Meditation

ACTION

Depression/Anxiety/ Mental Illness

PRECONTEMPLATION

“I am just tired, will take a vacation and feel better”

CONTEMPLATION

“I am not myself, unable to sleep, low energy, miserable mood. Should I see my doctor?”

Depression/Anxiety/ Mental Illness (continued)

PREPARATION

- Reading, web info
- Booking an appointment

ACTION

- Ongoing therapy and medication
- Risk reduction (stress management)
- Time off work to heal

CONTEMPLATION
AND PREPARATION





ACTION

REWARDS

- **Better health**
- **Better balanced life**
- **Improved relationships**
- **Improved productivity at work**

Resilient Professionals

- **Altruism**
- **Balancing work/life**
- **Strong attachments**
- **Optimism**
- **Adaptable to change**
- **Self-care/self-image**
- **Humour**
- **Creative and athletic outlets**
- **Personal integrity**
- **Problem-solving and conflict resolution ability**

Resilient Physician

- **Manage proactively one's life, career and learning**
- **State of mindfulness and nonjudgmental intention and attention**
- **Self-Discipline**
- **Recognition of reciprocal interconnection of one's life and work to physical, mental, and spiritual health**
- **Finding meaning, purpose, commitment, integrity, identity**
- **Practice reflection and gratitude**

SUMMARY

- **Suicide prevalence is higher in older male physicians and female physicians**
- **Underlying risk factors include poor support network, recent losses, impulsivity and hopelessness, history of prior attempts, MDD and SUD**
- **Suicide prevention should focus on early identification and management of burnout, MDD and SUD**
- **Mindfulness/awareness of suicidal risk in colleagues and trainees**
- **Building resilience starting in medical school and residency .Work/life balance.**

*We cannot
change the
direction of the
wind, but we
can adjust the
sail.*

