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Editorial

Listen to the patient: challenges in the evaluation of the risk of suicidal behaviour

Suicide is an important mental health problem, listed as the 15th leading cause of death worldwide, and this makes suicide prevention *a global imperative* as stated by the World Health Organization (1). When signing Mental Health Action Plan (2), all countries in the world committed themselves to aiming at a 10% reduction in suicide rate between year 2013 and year 2020.

There are many different risk groups for suicide, but at least in high-income countries people with mental disorders constitute a very large risk group (3) with a high level of absolute and relative risk for suicide. With only small differences between disorders, the absolute long-term risk for suicide in schizophrenia, bipolar disorder, and major depression is approximately 7% for men and 5% for women (4), and a history of deliberate self-harm approximately doubles the risk. In the general population, the long-term risk of suicide is <1%. Depression is far more common compared to schizophrenia and bipolar disorder (3), which makes prevention of suicide among people with a history of depression a high priority area.

Register-based studies have identified factors such as increasing age, male sex, mental disorders including substance abuse, history of deliberate self-harm, family history of mental illness and suicide, newly diagnosed severe somatic illness, divorce, loss of a spouse, loss of a child, loss of job, low income, homelessness, conviction of crime, being imprisoned, being gay and lesbian, and many more. Identification of these risk factors can help national health planners to get a better framework for planning of interventions. To follow-up on the endorsement of common aim to reduce suicide rate with 10%, health ministers from all over the world should transform knowledge about risk factors to action plans for suicide prevention. Such plans should definitely include initiatives to reduce suicide risk in mental disorders by improving treatment and care especially in high-risk periods such as phases of clinical exacerbation, during inpatient stay, when sent home after visits to emergency room visits, and shortly after initiation of pharmacological treatment.

For clinical practice, identification of the abovementioned risk factors is less useful, as the majority of people with the risk factors do not attempt suicide during a given time period, and therefore, each risk factor has a very low predictive power. In clinical practice, we are most often still left trying to find the needle in a haystack. We need more clinical relevant information to detect those who are at immediate high risk.

In this issue of Acta Psychiatrica Scandinavica, Wakefield et al. (5) presents results of a large prospective study of people with depression which included clinical variables, and at least some of them cannot be captured in register-based studies. The authors identified clinically meaningful risk factors such as worthlessness, suicidal ideation (not significant), and previous suicide attempt. The odds rations were high (worthlessness 6.96 (CI 1.04–46.07), suicide attempt 10.0 (CI 3.9–25.8)).

Also in this issue, Jiménez et al. (6) presents results of a cross-sectional study of a group of 215 patients with euthymic bipolar disorder. The results of the study indicate that motor impulsivity, high number of admissions, and poor controllability of suicidal thoughts were associated with increased risk of suicide attempt among those who had suicidal ideations. The study underlines the importance of paying close attention to clinical risk factors and that in bipolar disorder, not all risk factors for suicidal behaviour are related to depression.

Suicide is a major focus point in psychiatry, but even in this high-risk group, suicide is a relatively rare event. Most patients do not die by suicide, that is, the basic condition for the prediction of suicide. There are rare selected populations such as people with mental disorders who have attempted suicide with hanging, who have a more than 50% risk of dying by suicide during a long-term follow-up period (7), but luckily the majority of people with one or more risk factors will not end their life with suicide. In clinical practice, we will need to accept that prediction of suicide will never be perfect. It is actually consoling for human race, as it leaves us with possibilities for will-based actions.

We will never reach high sensitivity, high specificity, and high positive predictive value at the same time, no matter how we combine different risk factors. It is generally accepted that we will need to evaluate risk factors that have a low predictive value. More often, it has been criticized if risk assessment failed to identify persons, who died by suicide, and thus rather than focusing on high specificity and high predictive value, the most important success criterion for the evaluation of risk of suicide should be high sensitivity. In the study by Wakefield et al., the positive predictive value remained low, because sense of worthlessness was present in the majority of the whole patient group and previous suicide attempt was not uncommon either, but the sensitivity of the variable worthlessness was high, and more than half of the depressed participants in the study reported feelings of being unworthy.

In assessment of risk for suicide in clinical practice, the main focus should be on short-term risk, as the clinical decisions are especially relevant in the nearest future. We will need to consider a rather large group of patients as being at risk for suicidal behaviour. Many studies have confirmed that many people who attempted suicide often stated that they wanted to escape an unbearable situation, which makes it important for clinicians to increase awareness of patients being in such situations. This will often imply desperation, sense of worthlessness, guilt feelings, and sometimes delusions of being blameworthy, lack of hope for the future. Such risk factors should be examined, and we should focus on the current state. Moreover risk factors include a history of suicide attempt, especially recent suicide attempts, suicidal communication and thoughts, and suicidal impulses and plans. In the Collaborative Assessment and Management of Suicidality (CAMS) (8), suicidal patients are asked to list reasons for living and reasons for dying. In particular, reasons for dying are interesting as immediate treats to life. Statements such as 'I am an unworthy person', 'I have no future to look forward to', 'My children can face a better life without me', 'I have harmed people and done unforgiveable things', 'I am a failure' should be considered as very dangerous alarm signals.

In quality assessment, investigations have focused on lack of transfer of clinical relevant information between staff members and between different wards in the hospitals, and failure to comply with safety precautions such as identification of means that can be used for suicide. This is valuable and can improve planning of procedures. However, the clinical skills are the hallmarks of a trained psychiatrist: to be able to ask empathically about sense of desperation, meaninglessness, worthlessness, blameworthiness, lack of hope for the future, death wishes, suicidal thoughts, and plans. But also to be aware of his or her own perception of the patient's risk of suicide, which can be present in spite the patient answering no to all the above-mentioned risk factors. Sometimes a patient will try to conceal with suicidal ideations in order to avoid hospitalization.

To improve suicide prevention in psychiatric in and outpatient facilities and in psychiatric emergency rooms and crisis teams, training and research should focus on clinical variables, aiming to make staff member able to detect immediate suicide risk. There should be a major focus on listening to the patient's suicidal thoughts and sense of worthlessness and other clinical manifestations of high risk of suicide. Moreover, the clinician should listen carefully to signs and signal indicating unspoken risk of suicide.

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