SOME THOUGHTS ON SUICIDE: How do you go about detection in general practice?

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The phenomenology of suicidal assessments is more complicated than meets the eye. As a psychiatrist I know that it is vital to always ask about suicidal thinking but what is the best way to go about it in general practice?

My approach firstly is to defray the patient’s likely anxiety about being regarded as crazy and/or certifiable by explaining that as a psychiatrist I need to ask such questions as a matter of routine. I then explain that before they respond they need to understand that there is a difference between suicidal thoughts and suicidal intent. Suicidal thinking, I say, is not wanting to be around, while intent is planning to act on such thoughts. So do you have suicidal thoughts?

Often if people are having thoughts or intent they become distressed, so I ask what it is they’re upset about. At that point they often divulge their thoughts but if the train of thought is hazy it needs to be clarified. Often people will admit initially to thoughts but not intent so it pays to be inquisitive. What thoughts do you actually have at such times? Is there anything in particular that ignites them? What sustains you? Have you ever acted on those thoughts?

Sometimes I reassure people by saying that suicidal thoughts are common, which they are. If you think that suicidal thinking is present but unacknowledged it’s then important to enquire along the lines of nihilism and anhedonia. These phenomena are the basis to most depressive suicides.

Anhedonia is the inability to take pleasure in normally pleasurable activities and includes sexual anhedonia. It is either pervasive or non-pervasive. The latter is still being able to take pleasure in the children or a relationship but little else. If the person is incapable of even that it is often a sign of profound depression and your antennae should start to quiver. If there’s no pleasure at all in life then there’s no point to it, is there?

Nihilism is the belief that everything will come to nothing and is derived from the Latin “nihil” meaning nothing. In my opinion, it is probably normal if a person is in severe and unremitting physical pain, is at the end-stage of a terminal illness or is so old and frail that there is no quality of life. Treatable depressive illnesses need to be excluded of course. Nihilism is regarded as an overvalued idea in the context of most depressive presentations, whereas delusional nihilism is a psychotic belief that one’s body is rotting or that the world has come to nought to the point of wanting to kill yourself and possibly take others with you because you’re doing them a favour. Many murder-suicides are on the basis of such altruistic but misguided motives.

There are of course delusional beliefs leading to suicide in other major illnesses but the majority occur with major depression which is a common illness. Personality disorder and drug-related problems also lead to suicide at times. Finally there are the concepts of anomie and existential despair which crossover with philosophical and social concepts.