Pain, Disease and Suicide

Incidence

There are over 30,000 completed suicides in the United States each year. Most successful suicides are carried out by men, but women attempt suicide more often (National Center for Injury Prevention and Control, 1999). Suicide is currently the third leading cause of death among young adults ages 15 to 34, and in the United Kingdom, suicide is the second most common cause of death in this age group after motor vehicle accidents (Williams, 1997). Recently, the Surgeon General identified suicide as one of the top public health concerns in the United States (Parker, 1998). Overall, suicide accounts for nearly 9% of males and 4% of females in loss of years of life before the age of 65. This figure is similar for most western countries (Williams, 1997). Clearly, suicide represents a major health concern.

Medical Illness as a Risk Factor

Perhaps more than any other factor, medical illness is associated with an increased risk of suicide (Druss & Pincus, 2000). Psychological autopsies performed on completed suicides have found general medical disorders raise the risk for completed suicide substantially. Although medical illness by itself is associated with an increased risk of suicidality, clearly when co-morbid psychiatric conditions, such as depression and substance abuse are present, along with a number of demographic and life span issues, the risk increases dramatically (Williams, 1997). Persistent pain is another factor in the medically ill patient that can raise suicidal risk. This was demonstrated clearly by Stenager, et al. (1994) who examined a sample of suicide attempters admitted to a department of psychiatry. Each patient underwent a structured interview examining a multitude of factors that may have led up to the suicide attempt. The results show 52% of the patients were shown to have a somatic disease and 21% were taking analgesics daily for pain.

The relationship between somatic disease and suicidality also extends to chronic, non-malignant pain patients. Studies have shown these patients are at greater risk for depression and suicide than the general population. Fishbain (1997) examined 18 studies that looked at the association of chronic pain and suicide. He concluded suicidal ideation, suicidal attempts and suicide completions are commonly found in chronic pain populations. He also noted that chronic pain patients commonly show other suicidal risk factors, especially depression. He concluded that chronic pain is a significant suicide risk factor. He cautioned that a careful search for co-morbid risk factors needs to be conducted when evaluating the chronic pain patient.

Conceptual Framework

Medical illness raises the risk for suicide since somatic disease, especially associated with persistent pain, strains coping abilities. This increases the likelihood the patient will attribute the failures to cope to personal inadequacies, uncertainty about the future and worries that the medical condition will cause further loss and deterioration of the self. This often leads to feelings of depression, especially in individuals sensitive to loss of control (Duggleby, 2000). Depression heightens the

sense of vulnerability since a failure to cope is thought to be more probable. Threat is judged more significantly when a sense of vulnerability increases, leading to increased suffering. Feelings of hopelessness result from the belief suffering will never stop and, as a result, nothing positive will ever come of the future. Suicide is in response to a belief of hopelessness (Chochinov, Wilson, Enns & Lander, 1998). Death is seen as an option to end the suffering and prevent a future without hope.

A considerable body of research has shown hopelessness is correlated highly with suicidal ideation in general medical patients and is a significant predictor of eventual completed suicide (Chochinov, et al., 1998). Physical disease by itself is seldom decisive for the suicidal act (Williams, 1997). Also, depression has been defined differently by various investigators but it is generally associated with measures of discouragement and pessimism and is not based fully on medical prognosis. Chochinov, et al. (1998) defined hopelessness as encompassing the capacity to find purpose in living. Patients experiencing medical illnesses who have lost the capacity to believe the future will change will generally express hopelessness and are at increased risk for suicide.

Treatment Implications

It is important that healthcare providers learn to formally assess and screen for depression and beliefs of hopelessness in general medical populations, particularly in patients with medical conditions where persistent pain is present. Studies have shown when less formal screening is provided, even professionally trained mental health professionals often have difficulty recognizing the presence of depressive symptoms and hopelessness (Haghbin, Streltzer & Danko, 1998).

It is important to also recognize in the assessment process that a general medical illness increases the likelihood of suicide and having more than one physical illness raises the risk of suicide substantially (Druss & Pincus, 2000). Even when depression and alcohol use are adjusted, the relationship between medical illness and suicidality persists. As Druss and Pincus suggest, maybe depression and alcohol use do not necessarily mediate the relationship between suicide and medical illness. Possibly other intermediate factors, such as disability, disruption of social supports and chronic pain, may cause an individual to regard his life as no longer worth living.

It is worth emphasizing that while studies have shown depression and suicide are related, most patients admitting to suicidal behavior do not meet criteria for major depression. This strongly suggests assessing for suicidal ideation and intent, aside from examining for signs of depression (Druss & Pincus, 2000).

It is imperative healthcare professionals, not just mental health professionals, need to talk openly about depression, death and suicide with their patients. There is no evidence these discussions will trigger suicidal behavior (Henderson & Ord, 1997). In fact, there is more evidence these discussions help correct misconceptions, establish a strong rapport between the clinician and patient and improve a patient's sense of personal control (Henderson & Ord, 1997).

In cases where a patient admits to thoughts of suicide, either through formal screening or in discussions with the patient, referral to a psychologist, psychiatrist or other appropriate mental health professional should be made. The discomfort many health professionals feel about initiating this type of referral needs to be addressed, mostly by the professional since generally the author has found if talked about in an open and honest manner, patients are not offended or upset but generally see the importance of addressing psychosocial issues.

Thoughts of suicide and the risk of suicide should be assumed by the clinician when working with the medical patient experiencing persistent pain. Addressing the problem directly, assessing for it aggressively in an open and honest manner and applying solid pain management techniques in an interdisciplinary setting, including attention to behavioral medicine issues, are appropriate measures for dealing with the potential problem of suicide. This requires attention to effective pain management practices including educating the patient about better ways to manage and cope with pain,

reducing the ambiguity and uncertainty about the future and the medical illness associated with the pain, eliminating medications likely to precipitate depression and confusion and encouraging the patient to increase levels of activity using the skills of pacing.

It is important that under certain circumstances extraordinary measures need to be taken to prevent the possibility of suicide, particularly when patients express depression, beliefs of hopelessness, excessive alcohol use and are reporting severe levels of anxiety and/or panic attacks. Recent losses of close personal relationships, global insomnia and a sense their medical condition is deteriorating are signs the clinician needs to be particularly aware of. Additionally, patients out of work and unable to find a job, patients who are unskilled and feel disenfranchised and mothers with few social supports are particularly prone to attempt suicide (Williams, 1997).

An examination of the many risk factors for suicide reveals the prevalence of these signs within the pain population. Although single-modality, unidimensional treatment approaches might be appropriate for short-term transient pain, they are inappropriate for persistent pain, especially since pain is rarely a symptom that exists in isolation. For the nonmalignant chronic pain patient, education, attention to emotional factors, focus on function rather than cure and attention to other problems such as sleep disturbance, is important in managing pain and should reduce the risk of suicide. These same general treatment recommendations are suitable for the cancer patient except the physician should make every effort to prevent the pain and to relieve pain promptly. Also, fears about cancer need to be addressed and like the nonmalignant pain patient, what patients think about is important, especially in efforts to alleviate their fears and correct misconceptions.

The essential focus of treatment, however, starts with the recognition that the problems of patients in pain are not alleviated by attention just to the sensation of pain. They are best dealt with when attention is directed to a multitude of other factors. It is up to the clinician to formulate what problems are best managed to affect a change in patients. For example, in certain patients, treating the depression and beliefs of hopelessness with cognitive restructuring techniques might be the most effective approach; whereas, other patients might benefit more from reducing their fears through simple physical therapy activities. Still, in other patients, attention to social factors and isolation might be the best approach that would affect the change in mood, pain, sleep, and hopefully suicidal risk.

Whatever specific treatment measures are applied to affect change, it is important that they sustain hope, reduce uncertainty, contribute to pain acceptance and in some cases encourage patients to turn attention to their spiritual needs (Duggleby, 2000).

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