

To the Editors:

## Suicidal risk assessment and depression

We read with interest the series of articles on management of depression in the June 2008 issue of the *CMJ*. We would like to highlight the following issues which we felt were not given due prominence.

Almost one million people die by suicide worldwide each year. The majority attempting suicide suffer from a psychiatric disorder, mainly depression, at the time of the act. Other risk factors are impulsivity, conduct disorders, eating disorders, psychotic illnesses, anxiety disorders and alcohol and drug abuse. Family conflicts and discord, recent loss, academic difficulty, family history of suicide, exposure to suicide in the community and media are particularly important in increasing the risk of adolescent suicidal behaviour, and a depressed adolescent is at an especially high risk [1]. In addition, attempted suicide increases the risk of further attempts (30% over a one year period) and suicidal behaviour is highest during the first few months following the attempt [2,3]. Many of these risk factors are relevant to adult suicide as well.

Even in some developed countries up to half of the primary care patients with depressive disorders are mismanaged. A US study showed that a relatively low proportion of depressed older medically ill patients received antidepressants, and those who did often received potentially dangerous tertiary tricyclics in inadequate doses [4]. Less than 50% of children and adolescents with depression never receive treatment at all [5]. Improper management can give rise to chronicity and resistance, in addition to the risk of suicidal attempts.

Most research on suicide focuses on risk factors. However, there are some protective factors as well, particularly with regard to adolescent suicide, such as a stable family, good parent child connection, a sense of integration with peer groups and community and cultural and religious values [6]. The treatment plan should be multifactorial and highly individualized. It is important to treat the underlying psychopathology vigorously in addition to improving skills on coping with stress, improving the patients' interpersonal relationships and limiting the access to potentially dangerous methods of suicide [1].

It is important that clinicians and parents are aware that the risk of suicidal ideation or attempts (suicidality) may increase among adolescents during the initial period of treatment with some antidepressants (eg. SSRIs). It has been shown that fluoxetine monotherapy was associated with a higher incidence of suicidality in adolescents than cognitive behaviour therapy (CBT) or combined therapy [7]. Psychotherapy such as CBT in addition to SSRIs

(eg. fluoxetine) should be incorporated in the care plan whenever possible as combination therapy has been shown to be more effective in improving symptoms and in achieving functional recovery in adolescents. Adding CBT to fluoxetine seems to attenuate the risk of suicidality [7].

It is also important to pay attention to suicidal communication. This may be divided in to direct and indirect verbal communication and direct and indirect non-verbal communication. Direct verbal suicidal communication means clearly expressed suicidal intentions. Indirect verbal suicidal communication is the expression, in different ways, of the feeling that the individual's situation is hopeless, that life has no meaning, that there is no solution to the current problems and that it is better to die. In direct non-verbal communication, the person engages in preparatory acts for the suicide attempt; these include collecting drug prescriptions, buying pesticides or writing farewell letters. Indirect non verbal suicidal communication includes withdrawal, self isolation, weakening or rupturing ties with family and friends, and taking steps to put personal affairs in order prior to committing suicide [8]. A screening questionnaire may be used to detect suicidal communication. Simple measures such as helping the distressed patient to contact a therapist when the need arises (may be over the telephone) may help to reduce suicidal impulses.

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