Suicide and Life Stress: Past and Present
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This issue of Psychiatric Annals focuses on life stress and suicidal behavior and is guest edited by Holly C. Wilcox, PhD.

Suicide occurs across the diagnostic spectrum most frequently, but certainly not only in the presence of mood disorders. Studies have demonstrated many other risk factors, both chronic and acute. The importance of factors such as angry impulsivity, severe anxiety, and history of prior or recent suicide attempts or suicidal ideation — particularly specific thoughts plans or rehearsals — has been established. A recent cross-national epidemiologic study found that suicidal ideation alone did not predict suicide attempts, but when ideation is combined with impulsive disorders and anxiety, suicidal behavior is more likely.

The role of life stress, such as from physical or sexual abuse before the age of 16 years, can lead to increased risk of suicide. Other acute forms of stress, such as a recent diagnosis of cancer, a major financial loss, a real or anticipated major loss, is frequently present in relation to suicide or suicide attempts. This issue also reviews these connections and correlates them with suicidal behavior.

The assessment of acute risk for suicide is a very difficult task for the clinician, and stressful events and how the patient is coping may be among the most important clues to pursue in assessing that risk; the impact of actual or anticipated adverse events that can precede suicide by months or days may be of key importance.

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We can improve the effectiveness of our suicide assessment by doing a more comprehensive inquiry of adverse or loss events and actively exploring the patients’ reactions to them, especially since patients may not spontaneously present this information and will often not express their full reaction to such events. We should explore with them what their outlook of the stressful event is and whether they have thoughts that life is no longer tolerable.

When does the presence of a stressful event interact with a patient’s clinical state, amplifying psychic pain to the point where escape seems the only option? In this situation, the clinician is limited by the amount of information that can be gleaned from the patient. Yes, suicide and when or if it will occur cannot be predicted in an individual, but can we improve our capacity to uncover the ultimate acute risk state by being more persistent in our inquiries?

The papers presented here this month, I believe, can help us to think more thoroughly about how all the most salient stressful events in our patients’ lives might be affecting their will to live today. It is incumbent upon us to be as thorough as we can be.

Contact me with your thoughts and comments at psyann@slackinc.com.

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