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Suicidal Ideation as a Presenting Complaint
Associated Diagnoses and Characteristics in a Casualty Population

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A prospective study was conducted of all referrals to the emergency psychiatric service of an inner-London hospital over one year. There were 53 individuals who presented with the specific and spontaneous complaint of suicidal ideation without any accompanying act of self-harm. The main diagnoses in this group were personality disorders (40%) and alcohol dependence (15%); only 13% were suffering from depressive illness. Members of the group differed from the other 369 presenters to the service in that they were less likely to be accorded a diagnosis of a defined mental illness, twice as likely to have a criminal record, and more likely to have a previous history of deliberate self-harm. A quarter of the suicidal complainants were admitted to hospital following assessment.

Assessment of suicide risk is an important aspect of psychiatric practice, and the patient at risk of suicide evokes a high level of concern from psychiatric services. The 1971 National Institute for Mental Health task force (Beck *et al*, 1973) proposed a tripartite classification of 'suicidal' individuals into suicidal ideators, suicide attempters and suicide completers. The latter two groups have been extensively studied, both as regards psychological state and socio-demographic characteristics (Robins *et al*, 1959; Dorpat & Ripley, 1960; Barraclough *et al*, 1974; Weissman, 1974; Morgan *et al*, 1975; Kreitman, 1977; Newson-Smith & Hirsch, 1979; Allebeck *et al*, 1988). Of the first group, suicidal ideators, less is known. Suicidal ideation may be common; in a general population survey, 8.9% of people had experienced some degree of suicidal ideation in the year prior to interview (Paykel *et al*, 1974)

In the emergency setting, it is not unusual for people to present to psychiatric services complaining of such ideation. The Amsterdam Crisis Centre classified 15% of 942 consecutive clients as 'threatening suicide'; and the Groningen Psychiatric Emergency Unit identified 12% of cases over a one-year period as presenting with 'threat of suicide' (Cooper, 1979). Such reports accord with our own clinical experience in the emergency setting. However, to the best of our knowledge, such patients presenting as emergencies have not previously been the subject of systematic study, and there exists little information about them. In particular, it is unclear whether the complaint of suicidal ideation is associated with specific diagnoses in the emergency setting or whether it is a general feature of psychological distress in emergency presentations. Although suicidal thoughts are regarded as an important symptom by psychiatrists, it is uncertain whether the complaint of feeling suicidal is a prime determinant of management decisions in the emergency setting.

This paper reports a prospective study of all those presenting to an emergency psychiatric service over a one-year period with the specific and spontaneous complaint of suicidal ideation. The aims of the study were to find out how common such presentations are; to describe the characteristics of the people who present in this way; to discover how these people differ from other emergency presenters; and to ascertain the importance of these symptoms in determining clinical management.

To these ends, two main hypotheses were tested: that those presenting with the specific complaint of suicidal ideation would be suffering from depression or other mental illness, and that such presenters would be more likely to be admitted or followed up than other psychiatric presenters.

Method

The study was conducted at St Mary's Hospital, Paddington, London, the psychiatric unit of which serves a catchment area with a population of 70 700 according to the 1981 census. Despite some local areas of affluence, the district as a whole is characterised by widespread social morbidity. It ranks as either the second or fourth most deprived of the 192 districts in the country, depending on the indices used (Department of the Environment, 1983; Jarman, 1983). The accident and emergency department at St Mary's Hospital receives an emergency psychiatric consultation service 24 hours a day. Referrals to this service are accepted from any doctor or any professional with special responsibility for the mentally disordered. Self-referrals, direct to the duty psychiatrist, are not accepted; such patients are first seen by the casualty officer, who may refer on if appropriate.

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All patients referred to the emergency psychiatric service over one year were studied prospectively. Each patient was subject to standard psychiatric interview, at the end of which the assessor completed a 93-item data schedule. This included demographic information, and details of referral, presenting complaint, past psychiatric history, criminal history, history of previous deliberate self-harm, drug and alcohol use, and disposal. Past psychiatric history was taken to mean formal interview with a general adult psychiatrist, as the use of a wider definition including psychotherapy or alcohol counselling would have provided less exact a measure. In addition, ratings were made of the psychiatrists' impressions as to patients' likelihood of self-harm ('suicide risk'), personal distress and manipulativeness. Attitude scales were specially designed. Each quality could be rated on a scale of 0–5 according to specified criteria (see appendix). 'Suicide risk' concerned the likelihood of self-harm within the following week, as judged by the assessing psychiatrist. 'Manipulativeness' concerned the degree to which the psychiatrist felt manipulated and was not an objective measurement of the patient's behaviour.

Diagnosis was recorded in two ways. Firstly, a single preferred ICD–9 diagnosis was allocated (World Health Organization, 1978). The ICD–9 was chosen because a pilot study had shown that attempts to use more exacting criteria were likely to result in numerous failures of classification in the emergency section.

A second axial system was used to allow classification along broader lines than those of the ICD–9 and so that mental illness and personality disorder could be recorded independently should the two conditions co-exist. Personality disorder was defined according to ICD–9 criteria. 'Mental illness' included those conditions described as psychoses or neuroses in ICD–9; it excluded substance abuse. In the axial system, personality disorder and current mental illness were each rated as 'definite', 'probable', 'possible', or 'absent'. In the analysis, 'possible' was included with 'absent' and 'probable' with 'definite'.

The study group comprised those patients referred as psychiatric emergencies whose presenting complaint at the start of the interview was a specific and spontaneous statement of suicidal ideation or intent. Patients were excluded from this group if any act of deliberate self-harm was associated with the presentation. This was done because the purpose of the study was to examine a group complaining of suicidal ideas on which they had not acted. The study group did not include those referred because of a risk of self-harm or suicide perceived by the referrer, or those from whom suicidal complaints were elicited only by direct questioning during the course of interview.

The reference group comprised all other emergency psychiatric cases seen in this setting over the same period, excluding those referred following an episode of self-harm. If a patient was seen on more than one occasion during the study period, data for the first presentation only were included in the analysis.

The characteristics of the study group and reference groups were determined. The two groups were then compared on pre-selected items using the χ^2 test (2-tailed), corrected for continuity.

Results

Over the one-year study period, data schedules were completed for 544 emergency psychiatric consultations. These comprised 85% of all patients who were identified in the casualty ledger as having been referred to the psychiatric emergency service. This estimate of the completeness of the data can be regarded as an underestimate, as not all patients who were referred for a psychiatric opinion remained in the department to be interviewed.

In 82 of the 544 consultations, the patient's presenting complaint was an explicit and spontaneous statement of suicidal ideation or intent. When repeat visits and cases of deliberate self-harm had been excluded, the study group contained 53 individuals and the reference group 369 individuals. No repeat visits with deliberate self-harm were recorded among those in the study group during the period for which data were collected. The length of clinical interview was 10–210 minutes, the average being 38 minutes. The shortest interviews were with floridly psychotic patients exhibiting gross behavioural disturbance who were already known to the assessors. The longest interviews were with those who eventually received diagnoses of personality disorder. For individual items in the data schedule, percentage figures given below relate to endorsed responses. Response rates for each item are specified in the tables.

Demographic data and history

Demographic data are presented in Table 1. In the study group, men, the single and the unemployed were in the majority. The mean age was 38.6 years. A quarter were living in temporary accommodation, usually 'bed and breakfast'; 13% were completely homeless (i.e. on the streets). A quarter were not registered with a local general practioner. The main source of referral was the Casualty Officer; about one-fifth were referred by GPs, and a significant minority (11%) were brought in by the police. There were no significant differences between the study group and the reference group.

Nearly three-quarters of the study group had a history of past contact with general adult psychiatry services, and in over half the last such consultation had been within the preceding two years. The study group did not differ in psychiatric history from the population of casualty presenters as a whole.

In the study group, 55% of patients had a history of deliberate self-harm, as opposed to 28% in the reference group ($\chi^2 = 14.27$, 1 d.f., $P = 0.0002$). Of the self-harming patients in both groups, most had harmed themselves on more than one occasion.

In the study group, 38% of patients admitted to a history of criminal activity leading to conviction, as opposed to 19% in the reference group ($\chi^2 = 8.31$, 1 d.f. $P = 0.0039$).

Intoxication at interview

Intoxication with alcohol or drugs (mainly benzodiazepines) was conspicuous at interview in 23% of the study group.

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Table 1
Demographic and historical data

	Study group ($n=53$)	Reference group ($n=369$)
Men: %	60.4	49.3
Women: %	39.6	50.7[1]
Age		
Range	17-64	16.94
Mean	38.6	39.1
s.d.	13	15.6
Marital status		
% single, separated, divorced	62.3	73.1
% married/cohabiting	37.7	26.9[2]
Employment status		
% employed	30.2	24.9
% not employed	69.8	75.1[2]
Accommodation		
Permanent: %	62.3	66.2
Temporary: %	24.5	23.5[3]
Homeless: %	13.2	10.3
General practitioner		
% registered	75.5	75.6
% not registered	24.5	24.4[1]
Source of referral: %		
Casualty Officer	58.5	45.3
General practitioner	20.7	18.5
Police	9.5	18.2[1]
Others	11.3	18.0
Previous psychiatric history		
% yes	71.7	73.2
% no	28.3	27.8
% within past two years	54.7	53.0
Previous deliberate self-harm		
% yes	54.7	27.9
% no	45.3	72.1[1]
% more than once	45.3	19.8
Admitted to criminal record: %	37.7	19.2[1]

1. Response rate 95-100%.
2. Response rate 90-94%.
3. Response rate 85-89%.

Table 2
Diagnosis and assessment scales

	Study group: %	Reference group: %
ICD-9 diagnoses	($n=53$)	($n=369$)
Personality disorder (301)	39.6	17.9
Alcohol dependence (303)	15.1	4.6
Acute stress and adjustment reactions (308, 309)	13.2	2.4
Depressive disorders (296, 300.4, 311)	13.2	16.8
Schizophrenia and paranoid states (295, 297)	5.7	29.5
Organic disorders (290, 291, 292, 293)	3.8	11.1
Drug abuse (304, 305)	7.5	3.3
Other[1]	1.9	14.4
Axial diagnostic system	($n=52$)	($n=349$)
Completed responses	98.1	94.6
Personality disorder		
Yes	55.8	28.9
No	44.2	71.1
Mental illness		
Yes	25.0	58.7
No	75.0	41.3
Suicide risk		
Low	41.5	88.1
High	58.5	11.9
Personal distress		
Low	37.7	45.3
High	62.3	54.7
Manipulativeness		
Low	44.4	73.4
High	56.6	26.6

1. Includes 'no diagnosis appropriate'.

Diagnosis and clinical data

The ICD-9 diagnoses are summarised in Table 2. In those presenting with suicidal ideation, personality disorder ($\chi^2=12.08$, $P=0.00005$), alcohol dependence ($\chi^2=7.36$, $P=0.0067$) and adjustment reaction (Fisher's exact $P=0.00013$) were each significantly more common than in the reference group. Depressive disorders were not significantly common in either group, occurring in only 13% of the study group. These disorders comprised neurotic depression (ICD 300.4) and depression not otherwise specified (ICD 311): there were no cases of depression recorded under ICD 296 (affective psychoses). In the reference group, 17% of patients were found to be suffering from depressive illness. Of these, 10 cases were 'psychotic' (ICD 296), 11 were recorded as neurotic and 41 as depression not otherwise specified (ICD 311). While diagnoses of schizophrenia or other non-affective functional psychoses were accorded to nearly a third of patients in the reference group, such diagnoses were uncommon in the study group. The range of diagnoses was wider in the reference group.

The group presenting with suicidal ideation contained a greater proportion of personality-disordered (56%) than did the reference population (29%) ($\chi^2=13.67$, 1 d.f., $P=0.0002$). Conversely, the study group contained significantly fewer cases of defined mental illness (25%) than the remaining casualty presenters (59%) ($\chi^2=19.43$, 1 d.f., $P<0.0001$). Concurrent mental illness and personality disorder was found in only 6% of the study group and 10% of the reference group.

The suicide-risk scores for the two groups are illustrated in Fig. 1. There is a highly significant difference between them (Kendall's $S=13\,457$, approximate normal deviate $=8.51$, $P<0.0001$). The points on the suicide-risk scale (see appendix) were then combined to form two groups, 'low risk' (scores 0, 1 and 2) and 'high risk' (scores 3, 4 and 5). In the study group, 59% of patients were rated as high risk, compared with 12% in the reference population ($\chi^2=62.62$, 1 d.f., $P<0.0001$).

No significant difference was found between the two groups as to the psychiatrist's assessment of personal distress.

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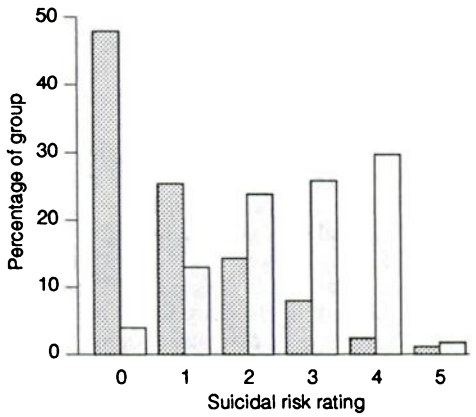


Fig. 1 Suicidal risk ratings (▨ reference group, □ study group).

In the study group 57% obtained scores of 3 or greater on the 0–5 manipulativeness scale (see appendix) compared with 27% in the reference population ($\chi^2 = 18.40$, 1 d.f., $P < 0.0001$).

Following emergency psychiatric consultation, a quarter of the study group were admitted to hospital, 36% were assigned to psychiatric out-patient follow-up or referral to other agencies, and 40% were discharged with no arranged follow-up. In the reference population, nearly half were admitted ($\chi^2 = 10.14$, $P = 0.0015$), and less than a quarter were discharged completely ($\chi^2 = 7.17$, $P = 0.0074$) (Table 3).

An extra analysis was performed to examine the effect of diagnosis upon disposal. Of those diagnosed as mentally ill (by the axial system), 69.2% were admitted in the study group and 66.3% in the reference population ($\chi^2 = 0.02$, 1 d.f., NS). Of those with personality disorder, 10% in the study group were admitted compared with 26.7% in the reference group ($\chi^2 = 6.55$, 1 d.f., $P = 0.0185$). Analysis of management in terms of suicidal risk rating shows that, of the high-risk patients in the study group, 32.3% were admitted and 26.7% discharged without follow-up; of the low risk patients, 13.6% were admitted and 54.5% discharged without follow-up. Thus, overall, individuals who were considered by the psychiatrist to be at high risk of suicide were less frequently discharged and more often admitted.

Table 3
Result of emergency consultation: percentage of patients

	Study group ($n = 53$)	Reference group ($n = 369$)
Admitted	24.5	48.9
Out-patient appointment	17.0	12.0
Day hospital referral	1.9	6.5
Referral to other helping agency	17.0	10.9
Discharged	39.6	21.7
Missing data	00.0	00.3

Discussion

Any expectation that presentation with the complaint of suicidal ideation would be strongly associated with depressive illness was not borne out by the study. Only 13% of those presenting with suicidal ideation were suffering from depressive illness. The main diagnoses were personality disorder (40%) and alcohol dependence (15%). Psychotic conditions were uncommon. At interview, 23% of patients were intoxicated with drugs or alcohol.

In many respects, those complaining of suicidal ideation were similar to other patients presenting as psychiatric emergencies. Yet, there were significant differences. The study group contained more patients with personality disorder, with a criminal record and with a history of deliberate self-harm, and fewer individuals with a defined mental illness. These differences suggest that the complaint of suicidal ideation does not occur randomly in the population presenting with psychological distress, but has specific associations.

Possible methodological influences on the results were considered. There are obvious difficulties attached to clinical interview in the emergency setting, where circumstances may restrict the scope of clinical interview, particularly at night. The average length of interview was 38 minutes, although some interviews lasted for two hours or more, generally in cases where no psychotic disorder was present. The reliability of diagnoses in emergency settings has been demonstrated, at least for the major diagnostic categories (Lieberman & Baker, 1985). But given the limited availability of background information on many patients, it is possible that in both groups the diagnosis of personality disorder in our series may have been less reliable than that of mental illness. In the study group, rates of personality disorder were high and depressive illness low. It has been suggested that depression may be under-diagnosed in character-disordered patients (Silver *et al*, 1971; Goldney *et al*, 1981; Caroll, 1982). Our data schedule permitted the recording of both mental illness and personality disorder, but only 6% of the study group were judged to exhibit both. It is possible that diagnostic bias occurred, but we do not consider that this could have been systematic or could have accounted for the differences observed between these two groups. We looked at the categories of depressive illness diagnosed in the study and noted that a number of cases were given the ICD grouping 311 ('Depression not otherwise specified'). This can be used as a 'waste bag' category, but a re-examination of the cases suggested simply that the form of depressive illness present in a number of our patients

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did not fall neatly into the main ICD categories for depression.

Patients who had harmed themselves as part of their presentation were excluded from this study, which concerned those complaining of suicidal ideation which had not been acted upon. A re-analysis of the data was made to include in the study group those who complained of suicidal ideation and had also harmed themselves as part of their presentation. This revealed no new differences, but the magnitude of the existing differences was increased.

The hypothesis that those presenting with the complaint of suicidal ideation would be more likely to be admitted or followed up was not supported by the results. Once psychiatric referral had been made, only 25% of the study group were admitted, and 40% were discharged with no follow-up. There do not appear to be any previous studies of similar groups of patients with which to compare our results. Figures for the related phenomenon of self-poisoning show that between 13.5% and 41% of cases are sent home direct from the accident and emergency department (Blake & Bramble, 1979; Gardner, 1980; Lintner, 1985; Owens & Jones, 1988).

Diagnosis has consistently been identified as an important determinant of disposal in the psychiatric emergency clinic (Marson *et al*, 1988). Patients with personality disorder are experienced unfavourably by psychiatrists (Lewis & Appleby, 1988) and are unwelcome clients for psychiatric services (Cooper, 1979). Self-harming patients are experienced negatively by doctors (Patel, 1975) and may be seen as hostile to those around them (Farmer, 1987). The study group contained a high proportion of patients with personality disorder and members of the group were given high scores on the manipulativeness rating, which suggests that they were indeed experienced in an unfavourable way. But management appears to be influenced by more than just the diagnosis, as there are differences in disposal even when the diagnosis of personality disorder is controlled for.

Another factor which may determine management is treatability. Treatment of those with personality disorder is always problematical, and as Podgorny (1981) has pointed out, admission to mental hospital may be contra-indicated for certain types of personality disorder, even in the presence of suicidal thoughts. It may be that most of those in the study group, although distressed and experiencing suicidal ideation, exhibited few features to indicate that they could be helped within the services available.

Indeed, the study group is not a random selection of all individuals in the district troubled by suicidal thoughts. It largely consists of those who chose to present to health professionals. Priest (1976), in a study of homeless persons with psychological problems, found that, paradoxically, those who had presented to medical services tended to be the ones least likely to benefit from treatment. Similarly, of those in the general population suffering suicidal ideation, it may be that those least amenable to treatment are more inclined to seek it as an emergency. The decision of a non-specialist doctor then to refer on for psychiatric opinion is not determined solely by the current mental state and diagnosis (Hoehn-Saric *et al*, 1980; Murphy *et al*, 1984; Khuri & Wood, 1984). Suicide is an emotive issue, and it may be that a referring doctor feels obliged on medico-legal grounds to refer for a psychiatric opinion anyone who presents with the complaint of suicidal ideation, regardless of whether or not any other features usually associated with inception into psychiatric care are found to be present.

Emergency management is affected by resource availability (Marson *et al*, 1988). All parts of the psychiatric service in our district were hard-pressed (National Health Advisory Service, 1988), and the doctors were constantly faced with conflicts over resource allocation. Opportunities for crisis intervention were few. Bed occupancy in the district was uncomfortably high and this was reflected in a correspondingly high threshold for admission. No specific crisis-intervention or counselling services existed. Most patients presented out of hours and there was no social worker available at these times except for statutory duties. Such pressures cannot account for the differences in management found in the study, but the contrast between the groups may have been heightened. In more affluent areas with less pressure on resources, there may be more scope for attempting intervention, even where the prospects appear poor. Yet the characteristics of those presenting with suicidal ideation suggest that they are less likely to be found in affluent populations; and it would be wrong to assume on available evidence that such patients are managed differently outside the inner city.

One interpretation of the disposal figure might be that those presenting with the complaint of suicidal ideation were not considered to be genuine by the assessing psychiatrists. But this does not fit with the data. The study group were, by and large, considered by the assessing doctors to be a high risk of serious harm (Fig. 1), and we detected no significant difference in levels of distress between this group and the other casualty patients. In fact, the casualty population as a whole were, according to risk-factor studies, at increased risk of serious self-harm in the longer term. This illustrates the low specificity and limited value of risk factors in the clinical setting

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(Friedman *et al*, 1981; Murphy, 1986; Hawton, 1987). It appears that the presenting complaint of suicidal ideation in our study was likewise felt by the psychiatrists concerned to be of limited specificity in a population at above-average risk.

Conclusion

In this inner city series, presentation to the emergency psychiatric services with the specific complaint of suicidal ideation accounted for one referral in six. This presentation proved less closely associated with depressive illness than with long-standing maladjustment as evidenced by personality disorder, criminality, substance abuse and recurrent deliberate self-harm.

Suicidal ideation is common in mental illness. A quarter of those presenting to our service with this spontaneous complaint required admission to hospital. Yet, although the complaint of suicidal ideation may be sensitive as an indicator of suicide risk, it is not of high specificity. In this study, it was associated with characteristics which, although indicating an increased risk of serious self-harm (at least in the long term), render psychiatric intervention problematic and likely to prove of limited success. Suicidal ideation as a presenting complaint may frequently occur in the absence of mental illness and it is not the prime determinant of management decisions in the emergency setting.

Appendix: Attitude scales

Suicide risk

Rates the psychiatrist's belief as to the risk of the patient engaging in potentially life-threatening behaviour within one week of interview.

0 No risk
1 Very low risk: self-harm highly unlikely
2
3 Significant risk: occasions concern
4
5 Very high risk: overwhelming likelihood of self-harm.

Manipulativeness

Concerns the degree to which the psychiatrist feels manipulated, and is not an objective measure of the patient's behaviour. Includes feeling emotionally pressured, seduced or threatened.

0 Not manipulative at all
1 Mildly manipulative: psychiatrist feels patient aware of effect upon clinician
2
3 Moderately manipulative: psychiatrist feels subject to efforts to influence management decisions
4
5 Extremely manipulative.

Patient distress

Rates degree of patient's distress, however it arises, based upon current symptoms and observed features of mental state and behaviour.

0 No distress
1 Mild distress: a little nervous or unsettled
2
3 Moderate: overtly distressed
4
5 Severe distress: distraught and inconsolable; overwhelmed with fear or panic.

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