

## Can Early Detection of Psychosis Prevent Suicidal Behavior?

Schizophrenia, like major affective disorders, is potentially fatal. With 10%–15% of individuals dying by suicide and 20%–40% making suicide attempts, there is significant need for identification of those at risk (1–3). While the risk for suicide is present over the course of schizophrenia, individuals at greatest risk are younger and earlier in their course of illness (1–4). Suicidal behavior in schizophrenia may result from discomfort with psychotic symptoms (3), and treatment can reduce suicide risk even among those with treatment-resistant schizophrenia who have already engaged in suicidal behavior (5). Thus, early identification and intervention may mitigate the mortality and morbidity from suicide in schizophrenia. The timely article in this issue of the *Journal* by Melle and colleagues, who report on the impact that a multifaceted prevention program (fo-

cus on the early detection of psychosis and treatment engagement) had on suicidal behavior, is a major development.

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Melle et al. conducted an ecological universal prevention program study that compared the rates of suicidal behavior in four communities: two that had an early psychosis detection program and two that did not. The early detection program was extensive and far-reaching and involved repeated contacts, a multimedia approach, and multiple audiences so that it could have the greatest impact. The authors concluded that the rate and severity of suicidal be-

havior were decreased in the early detection communities relative to communities without this program. In an earlier study, Melle et al. had reported that participants from the communities with the early psychosis detection program were younger, less symptomatic, and had shorter durations of untreated psychosis than participants from the communities without the program. These findings suggest that when people are educated about psychosis, they are more likely to seek treatment when symptoms occur. This finding underscores the potential utility of psychoeducational approaches as public health interventions leading to decreased morbidity and mortality.

As expected, the rates of suicidal ideation and attempts were relatively high in both groups: 56% of subjects from the communities without the early detection program and 39% of subjects from the early detection communities reported at least some suicidal behavior, and 16% and 5%, respectively, reported previous suicide attempts. Of note, after initial engagement in treatment (i.e., the first treatment contact) both groups showed equivalent decreases in suicide attempts. This finding demonstrates the power of clinical contact in life-and-death situations. It is remarkable that the subjects from the early detection communities had less suicidal behavior despite a higher rate of drug/alcohol abuse or dependence, typically a significant risk factor for suicidal behavior.

Suicide accounts for most of the excess mortality and premature death in schizophrenia (6, 7). Given the high risk for suicide and the general tendency of researchers to avoid suicidal patients, suicidal behavior has frequently been treated as “a given” consequence of schizophrenia, and suicidal individuals have been excluded from studies of mortality and treatment in schizophrenia. Indeed, some researchers have removed those who have died by suicide from studies of mortality in schizophrenia in an effort to identify “potentially preventable” causes of death, such as mortality due to cigarette smoking and cardiovascular disease (e.g., Brown et al. [7]). Others have suggested that

the allocation of resources to prevent suicide among individuals with schizophrenia is not warranted because not that many people die. In fact, approximately 30,000 individuals die by suicide each year (8), and approximately 10% of them have schizophrenia (i.e., approximately 3,000 people per year). Adolescent suicide, which accounts for less than 5% of deaths by suicide, has spurred a major national research initiative, perhaps because of our hope for their future. It is time to think of suicidal behavior in schizophrenia as an important health concern.

Until recently, studies regarding suicidal behavior in schizophrenia have relied almost exclusively on medical records and postmortem data, applying univariate analytic approaches to a multivariate problem. More current research has included in vivo assessments of suicidal behavior in an attempt to understand the demographic, clinical, and treatment factors that contribute to suicide risk. Investigators have shown what clinicians have reported anecdotally: individuals who are less symptomatic and have a better quality of life are less likely to be victims of suicidal behavior (3, 4). Today we have improved medications and social programs that have the potential to significantly improve the life of a person with schizophrenia. As we make advances in treatment, the future for the individual with schizophrenia brightens.

The study by Melle and colleagues reflects a new era in approaching individuals with psychotic disorders and developing interventions to prevent suicidal behavior in this group. It cannot be determined what led to the lower rates of suicidal behavior in subjects from the early detection communities relative to those from communities without this program. It may be that individuals were identified and brought to treatment at a younger age—before increased risk for suicidal behavior—thereby achieving the goal of an early detection program. It may be that those from the early detection communities were less symptomatic and therefore their risk for suicide was decreased. The findings may simply be an artifact of the younger age of the early detection group such that the older group members from the communities without the early detection program had a longer period of time within which to make suicide attempts. Whatever the reason, subjects from the early detection communities evidenced a lower rate of suicidal behavior than did the subjects from communities without this program. Further research in the area of suicidal behavior prevention in individuals with psychotic disorders and determining the “active” components of such an intervention are necessary and key steps.

The study by Melle and colleagues represents a first step in identifying individuals with psychotic disorders and implementing treatment earlier in the course of illness, before further progression of the illness and symptoms (9). The study by McGlashan and colleagues in this issue demonstrates the potential effectiveness of early treatment. Together, these studies highlight the need for comprehensive universal public mental health interventions aimed at early detection and treatment engagement. Evaluations of such interventions must include an assessment of suicidal behavior and degree of exposure to the intervention as well as an examination of the efficacy of specific components of the intervention. Using this and other approaches, we can make headway in reducing suicide risk, providing early intervention, and improving the quality of life for individuals with schizophrenia and their families.

## References

1. Tsuang MT: Suicide in schizophrenics, manics, depressives, and surgical controls. *Arch Gen Psychiatry* 1978; 35:153–155
2. Caldwell CB, Gottesman II: Schizophrenics kill themselves too: a review of risk factors for suicide. *Schizophr Bull* 1990; 16:571–589
3. Harkavy-Friedman JM, Restifo K, Malaspina D, Kaufmann CA, Amador XF, Yale SA, Gorman JM: Suicidal behavior in schizophrenia: characteristics of individuals who had and had not attempted suicide. *Am J Psychiatry* 1999; 156:1276–1278
4. Malla A, Payne J: First-episode psychosis: psychopathology, quality of life, and functional outcome. *Schizophr Bull* 2005; 31:650–671
5. Meltzer HY: Suicide in schizophrenia, clozapine, and adoption of evidence based medicine. *J Clin Psychiatry* 2005; 66:530–533

6. Allenbeck P, Wistedt B: Mortality in schizophrenia: a ten-year follow-up based on the Stockholm County in-patient register. *Arch Gen Psychiatry* 1986; 43:650–653
7. Brown S, Inskip H, Barraclough B: Causes of excess mortality of schizophrenia. *Br J Psychiatry* 2000; 177:212–217
8. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (producer): Web-based Injury Statistics Query and Reporting System (WISQARS) 2004. (<http://www.cdc.gov/ncipc/wisqars/default.htm>)
9. Melle I, Larsen TK, Haahr U, Friis S, Johannessen JO, Opjordsmoen S, Simonsen E, Bund BR, Vaglum P, McGlashan T: Reducing duration of untreated first episode psychosis. *Arch Gen Psychiatry* 2004; 61:143–150

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## Editor's Note

### New Features for Readers

This month's *Journal* debuts three new features that we hope will appeal to our readers. First, you now have an opportunity to earn CME credits by reading articles in *The American Journal of Psychiatry*. Three articles in each issue will each comprise a short course for up to 1 hour category 1 CME credit each. The course comprises reading the article and answering three multiple-choice questions with a single correct answer. The questions for the three articles in this issue begin in page 948. CME Credit is issued only online. Readers who want credit must subscribe to the AJP Continuing Medical Education Course program ([cme.psychiatryonline.org](http://cme.psychiatryonline.org)), select *The American Journal of Psychiatry* at that site, take the course(s) of their choosing, complete the evaluation form, and submit their answers for CME credit. In the online course, correct answers will be highlighted for the reader's reference; there is no minimum threshold score necessary for the credit. A link from the question to the correct answer in context will be highlighted in the associated article. A certificate for each course will be generated upon successful completion. The site for CME will be available beginning May 12.

The *Journal* is also adding an audio dimension to its online experience. Visit the AJP home page at [ajp.psychiatryonline.org](http://ajp.psychiatryonline.org) and click on the current issue. Accompanying the "In This Issue" page is an audio file that contains highlights and selected findings from the issue in a 30 minute downloadable MP3 format program, selected and narrated by Deputy Editor Susan K. Schultz, M.D.

The third feature is editorial comment on DSM-V. As the American Psychiatric Association committees begin formal work on DSM-V, we welcome brief editorials on issues that should be considered in its formulation. Editorials of up to 500 words can be submitted to the *Journal* at <http://appi.manuscriptcentral.com/>. The first of these editorials, "What's in a Word? Addiction Versus Dependence in DSM-V," by Charles O'Brien, Nora Volkow, and T-K Li, appears in this issue on page 764.