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Suicide in the Time of COVID-19: Review and Recommendations

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Abstract

The coronavirus (COVID-19) pandemic presents us with unusual challenges to the global health system and economics. The pandemic may not have an immediate impact on suicide rates, however, given that it is likely to result in a confluence of risk factors for suicide and economic crisis, it is highly possibly that it will lead to increases in suicide rates in the long-run. Elderly persons are more likely to live alone, be socially isolated during COVID-19 and have physical health problems, which are risk factors for suicide. Young children and health professionals may also be population at risk. Isolation, quarantine and the economic crisis that follows may impact mental health significantly. The International Academy of Suicide Research (IASR) is an organization dedicated to promote high standards of research and scholarship in the field of suicidal behaviour to support efforts to prevent suicide globally. This IASR's board position paper gives recommendations for suicide research during the COVID-10 pandemic. Clinical research has to be modified due to COVID-19 shutdown.

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INTRODUCTION

The International Academy of Suicide Research (IASR) is an organization dedicated to promoting high standards of research and scholarship in the field of suicidal behavior to support efforts to prevent suicide on every continent. The worldwide coronavirus (COVID-19) pandemic presents us with unusual challenges to the global health system not experienced in the last 100 years. What we have learned from the occurrence of previous pandemics offers limited advice on what to expect and how to handle the aftereffects of COVID-19. The board of the IASR believes, however, that there is every reason for the international community of scholars and clinicians and everyone invested in suicide prevention to be alert to the challenges we will likely be facing. In this paper we, therefore, summarize some of the most important of these challenges and implications for suicide prevention and we provide recommendations for clinical practice, suicide prevention, and research.

The Challenge

The epidemic that most resembled COVID-19 was the SARS outbreak in 2003, where studies of quarantined people showed a significant increase in mental illness such as depression and posttraumatic stress disorder (PTSD; Hawryluck et al., 2004). Also, studies have shown that pandemics, such as the Spanish flu in 1918 (Wasserman, 1992) and the SARS outbreak (Cheung, Chau, & Yip, 2008), may have been associated with increased suicide rates in high-risk populations. These findings suggest that COVID-19 may have an impact on mental health in general and suicide risk specifically and the need for suicide prevention initiatives and research on these topics. However, it is important to keep in mind that, unrelated to COVID-19, according to the existing models in the scientific literature, suicide and suicide attempts are complex behaviors deriving from numerous factors and primarily a combination of psychiatric disorders (up to 90% of suicides), previous suicide attempts, and negative stressful life experiences. COVID-19 and its consequences such as isolation, coping with death, and economic difficulties may lead to emerging, or have exacerbating effects on, suicidal thoughts and behaviors (Druss, 2020). In the absence of interventional factors—another consequence of the closure of many in-person behavioral health practices and social distancing due to COVID-19—these emerging or exacerbating suicidal thoughts and behaviors may turn into suicide attempts and even suicides.

There are many differences between COVID-19 and previous pandemics, such as SARS and the Spanish flu, in terms of virulence and the speed with which the contagion spreads, associated risk of death, and the level of socioeconomic impact on local communities, nations, and world regions. These differences limit our ability to extrapolate from our experiences with these previous pandemics to the short-term and potential long-term impact of COVID-19. However, the COVID-19 crisis and the distress caused by the uncertainty and threat of infection, isolation, lack of availability of psychiatric services, difficulty in

accessing care, and long-term economic strains raise the necessity to consider the possible impact on the risk for suicide and suicide attempts during and after the pandemic and the need for research and increased suicide prevention efforts.

The COVID-19 pandemic may not have an immediate or short-term impact on the rates of suicide and suicide attempts. However, given that it is likely to result in a confluence of risk factors for suicide and suicide attempt, it is highly possibly that the pandemic will lead to increases in rates of suicide and suicide attempt in the long run (Reger, Stanley, & Joiner, 2020). This lag effect of exposure to distressing situations on the rates of suicide and suicide attempt has been observed for World War 1 (1914–1918), World War 2 (1939–1945), and other natural disasters (Lester, 1994). However, predicting the impact of COVID-19 on decreasing then increasing rates of suicide and suicide attempt are but educated guesses, rather than hypotheses based on satisfactory evidence.

Short-term effects of COVID-19 on suicide rates are difficult to predict and may vary by populations. At times of external danger and when people are busy just surviving, they may focus less on distress and internal pain. In contrast, people living alone, such as many elderly people, may experience deterioration in their well-being and mental health due to their social isolation and dramatically decreased access to community services. While these older people may feel a heightened sense of disconnectedness, others with mental illness may feel paradoxically more connected, describing that their feelings of isolation and anxiety are no longer considered abnormal. Adding to that, the physical distancing policy confines people to their homes with the immediate family, namely, their support system, leading many to experience improvement in their mental health.

In most countries, the elderly, a group at risk for negative outcomes from COVID-19, constitutes the age group with the highest suicide rate, compared to the rest of the population (Varnik, 2012). Elderly persons are more likely to live alone, be socially isolated, and have physical health problems, all of which are risk factors for suicide attempts and suicide. A study from Hong Kong demonstrating an increase in suicide rates among the elderly following the SARS epidemic indicated that fear of being a burden for their families during the hardships of the epidemic was a motive for suicide in many cases (Cheung et al., 2008).

While the COVID-19 pandemic may provide opportunities for new methods and questions for research (e.g., use of telehealth in the assessment and treatment of the individual with suicidal risk, quantification of risk, and resilience at time of crisis at the population level), there will be challenges and long-term consequences for research.

Potential Implications of COVID-19 for Suicide Prevention and Research

The Academy Board believes that, while short-term suicide rates will remain the same or decrease, this will likely not be the case for the long term. Suicide and suicide attempts may rise after (or possibly even during) the crisis, especially among populations at risk. The reasons may be as follows:

a. Mental health issues among people with psychiatric disorders that went untreated due to fear of visiting clinics during the crisis or due to a temporal redistribution

of mental health resources to other health care sectors, thus reducing peoples' access to care;

b. Decrease in hospitalizations and referrals to psychiatric emergency rooms and difficulties in obtaining medication (similar to the decrease seen in referrals to general emergency rooms, inpatient units, and outpatient facilities due to fear of contagion and difficulties with taking public transportation);

c. Increase in consumption of alcohol in the general population and among high-risk groups given that there is a strong association between rates of alcohol use and suicide rates;

d. Economic hardship, unemployment, and bankruptcies;

e. Illness and grief from loss of relatives and friends who may die from the pandemic;

f. Difficulties due to prolonged isolation;

g. Distress in family relationships due to being closed in together for many weeks without relief; and

h. Overall uncertainty and anxiety about the future.

Unemployment and economic hardship among populations as a whole correlate with rates of suicide and suicide attempt in those groups (Batty et al., 2018).

People with psychiatric illnesses may constitute, at any time, a population at higher risk for COVID-19. This is a vulnerable population, a large part of whom survives on social assistance, that is socioeconomically weak even prior to the crisis. This population comprises a significant portion of those who attempt or die by suicide worldwide.

The elderly represents another population that is highly likely to be in isolation, experience loneliness, be unable to see their loved ones, and lack a proper support system during the COVID-19 pandemic. People living in long-term care facilities are at extremely high risk for the infection and also for loneliness, being cut off from visitors and not allowed to leave the facility.

Children and adolescents who watch their parents distressed, potentially unemployed, anxious for their health, and helpless due to COVID-19 physical distancing policies may experience states of distress with implications for their future development. The younger the child, the greater the likely vulnerability. Children in high-risk families in social isolation during the pandemic may risk experiencing more intrafamilial violence and abuse. In some countries, such as the United States, suicide and suicide attempts in children are on the rise unrelated to the COVID-19 crisis.

Relatives and loved ones of suicide victims are always at greater risk for stress reactions and suicide and require special attention during and after the pandemic.

Medical staff and health professionals are populations whose risk for suicide is nearly double that of the general population. The SARS epidemic experience showed that health

professionals are at the forefront of such crises, causing them to take personal risks and cope with death and loss (Sim & Chua, 2004). These frontline health professionals may experience posttraumatic reactions, depression, and anxiety for up to 3 years after the crisis is over, increasing their risk for suicide and suicide attempts. First responder rescue units are vulnerable to suicide and suicide attempts as well, yet tend to avoid asking for help.

Isolation and quarantine impact mental health significantly. Most reviewed studies (Brooks et al., 2020) report on negative psychological effects, including PTSD symptoms, confusion, and anger. Causes for PTSD include prolonged isolation, fear of contamination, frustration, boredom, shortage of supplies, lack of information, financial loss, and stigmatization of the isolation. Some researchers pointed to long-term impact.

Reliance on digital devices amplifies disparities in access to mental health services, as many of the most disadvantaged do not have Internet access. Further, even those with Internet access may lack the privacy at home during the pandemic to enable them to benefit from telehealth.

Clinical research had to be suspended and/or modified due to the COVID-19 shutdown. Study samples during this time may be biased to only include participants who had Internet access or were motivated by financial research compensation due to unemployment or poverty. Although US federal funding agencies emphasized that review/funding recommendations cannot take into consideration how the pandemic may affect the feasibility of the proposed project, if the pandemic recurs these considerations (e.g., prolonged in-person contact during research procedures) may not be avoidable.

The IASR Board Recommendations

The Academy Board’s view is that suicide risk assessment during the pandemic and isolation can be done from afar by video conferencing using a secure system that received government approval. Clearly, an in-person assessment is superior, but in times when such meetings are restricted our view is that video-based suicide risk assessment is a good alternative to having no risk assessment.

Suicide risk assessment via video-conferencing is preferred, compared to via teleconferencing, because it allows for the observation of visual cues. However, if videoconferencing is not an option, suicide risk assessment via phone consultation is better than no consultation at all.

Long-distance assessment of a patient has to be fully documented in the medical file, as is commonly done for any medical assessment. If access to the medical file is not immediately available, then documentation should be done in any personal form and should be rewritten into the medical file as soon as possible.

When quarantine or isolation is found to be necessary, authorities should instruct on maintaining the situation only for the absolutely necessary period and no more. In addition, a clear rationale for the quarantine or isolation should be provided and protocols should be followed. The sense of altruism should be strengthened via reminders of the benefits of the

isolation to the society at large, since a sense of altruism was found to have beneficial effects (Wu et al., 2009).

Studies among elderly people during the SARS epidemic (Sim & Chua, 2004) found that this population requires special attention during isolation and physical distancing. The Academy Board calls on all those who work with and support the elderly to keep in mind the relationship that was found between loneliness and suicidal behavior. It is crucial to find a solution for virtual or long-distance meetings with the elderly in isolation, while observing the directives of the local health authorities and maintaining the persons' safety. Ongoing supplies of medications and basic needs as well as screening for suicidal ideation are of great importance.

The Academy Board recommends that the media should continue to follow guidelines regarding reporting of deaths by suicide during the COVID-19 pandemic and be careful to accurately report changes in suicide rates. While the number of COVID-19 deaths are available almost immediately, the number of suicide deaths are often not available for a year. Finally, it is recommended to use the term "physical distancing" and emotional closeness rather than "social distancing."

REFERENCES

Batty GD, Kivimaki M, Bell S, Gale CR, Shipley M, Whitley E, & Gunnell D (2018). Psychosocial characteristics as potential predictors of suicide in adults: An overview of the evidence with new results from prospective cohort studies. Translational Psychiatry, 8(1), 22. doi:10.1038/s41398-017-0072-8 [PubMed: 29353878]

Brooks SK, Webster RK, Smith LE, Woodland L, Wessely S, Greenberg N, & Rubin GJ (2020). The psychological impact of quarantine and how to reduce it: Rapid review of the evidence. Lancet (London, England), 395(10227), 912–920. doi:10.1016/S0140-6736(20)30460-8

Cheung YT, Chau PH, & Yip PS (2008). A revisit on older adults suicides and Severe Acute Respiratory Syndrome (SARS) epidemic in Hong Kong. International Journal of Geriatric Psychiatry, 23(12), 1231–1238. doi:10.1002/gps.2056 [PubMed: 18500689]

Druss BG (2020). Addressing the COVID-19 pandemic in populations with serious mental illness. JAMA Psychiatry, 77(9), 891. doi:10.1001/jamapsychiatry.2020.0894 [PubMed: 32242888]

Hawryluck L, Gold WL, Robinson S, Pogorski S, Galea S, & Styra R (2004). SARS control and psychological effects of quarantine, Toronto, Canada. Emerging Infectious Diseases, 10(7), 1206–1212. doi:10.3201/eid1007.030703 [PubMed: 15324539]

Lester D (1994). Suicide rates before, during and after the world wars. European Psychiatry, 9(5), 262–264. doi:10.1017/S092493380000362X

Reger MA, Stanley IH, & Joiner TE (2020). Suicide mortality and coronavirus disease 2019-a perfect storm? JAMA Psychiatry. Advance online publication. doi:10.1001/jamapsychiatry.2020.1060

Sim K, & Chua HC (2004). The psychological impact of SARS: A matter of heart and mind. CMAJ: Canadian Medical Association Journal = journal de l'Association medicale canadienne, 170(5), 811–812. doi:10.1503/cmaj.1032003

Varnik P (2012). Suicide in the world. International Journal of Environmental Research and Public Health, 9(3), 760–771. doi:10.3390/ijerph9030760 [PubMed: 22690161]

Wasserman IM (1992). The impact of epidemic, war, prohibition and media on suicide: United States, 1910–1920. Suicide & Life-Threatening Behavior, 22(2), 240–254. [PubMed: 1626335]

Wu P, Fang Y, Guan Z, Fan B, Kong J, Yao Z, … Hoven CW (2009). The psychological impact of the SARS epidemic on hospital employees in China: Exposure, risk perception, and altruistic acceptance of risk. Canadian Journal of Psychiatry. Revue canadienne de psychiatrie, 54(5), 302–311. doi:10.1177/070674370905400504 [PubMed: 19497162]