Suicide and bipolar – crossroads of opportunities

Globally, approximately 15-20% of people with bipolar disorder are dying by suicide, with 30-60% making at least one attempt, and attempts that are far more lethal than attempts amongst the general population[1-4]. These rates are not decreasing, despite an overall decline in global suicide rates (Suicide worldwide in 2019 (who.int) , last accessed 29/4/24). Suicide in people with bipolar disorder is associated with psychopathology and causes death, injury, and trauma, alongside wider socio-economic costs. Suicide deaths are a major contributory factor in premature bipolar mortality, which occurs up to 20 years earlier than within the general population. Nevertheless, neither bipolar disorder nor bipolar suicide are research priorities, resulting in major knowledge gaps in both[2,3]. This can and must change. [**See Panel/Vignette below to be included here**]

The shocking statistics above may well underestimate the prevalence of suicide in people with bipolar disorder, given the likelihood of death by suicide before treatment or accurate diagnosis. Diagnosis of bipolar disorder is notoriously problematic, with up to ten-years average delay between seeking help and diagnosis.[1,2] Furthermore, the burden of premature mortality due to suicide in people with bipolar disorder is excluded from Years of Life Lost in key Global Burden of Disease measures,[5] because bipolar disorder is not a recognised cause of death.

Suicide prevention and research are substantially under-resourced. Despite the specificity and scale of bipolar suicide, substantial knowledge gaps remain, resulting in extremely limited evidence-based clinical interventions.[2-4] This situation is even worse in lower-and middle-income countries (LMICs), where high suicide rates (often concealed) and widespread lack of research and awareness amplify the burden of both bipolar disorder and suicide.[7] Mental illness and suicide remain heavily stigmatised and underreported or even criminalised, deterring help-seeking, and hindering research.[6,7]

Known bipolar suicide specific features and risk factors include previous suicide attempts, suicidal ideation, comorbidity, 'mixed states', long episode duration, and family history. Yet, people with bipolar disorder are often assessed as low risk of suicide even in the week prior to suicide, with the individual's own subjective severity of depression often higher than objective clinical assessments.[2-4] This suggests major gaps in understanding suicide in people with bipolar disorder, including divergence between clinical understanding and lived experience. Concealment of ideation and intent is one explanatory factor. Bipolar suicide is commonly experienced as a protracted state, involving obsessive cycles of planning and resistance, with calm calculation often accompanying the final act.[8] Bipolar mixed states, with high suicide risk and prevalence, are often ignored, poorly understood, and subsequently not treated.[2,4]

Another factor seems to be clinical conceptual resistance to accepting direct association of symptom severity and acuity as critical factors driving suicide in people with bipolar disorder. Gaps therefore remain in linking suicide with the psychopathology of bipolar disorder, impaired decision-making capacity, risky behaviours, and loss of control associated with severe illness states.[8] Illness severity itself is a significant explanatory factor for suicide. Yet, psychiatry presents suicide as rare, unpredictable, without true lethal intent, and impossible to understand or link conclusively to severe illness episodes.[9] Such views may serve only to heighten the global impact of suicide stigma. Language and views surrounding suicide remain deeply pejorative and, even in developed nations, responses to suicidal behaviours can involve punitive measures.

In the long-term, research will, we hope, produce more effective treatments for bipolar disorder, reducing severity of symptoms and the incidence of suicide in this population. For now, a scalable approach is to increase understanding of suicide in people with bipolar disorder and associated phenomena, to enable improved recognition and treatment using currently available clinical and other tools. Ideally, this approach should entail multiple perspectives, including more bipolar-specific components. Methodological innovation might help address the current impasse and limitations in our understanding of both suicide and broader mental states and psychopathology in people with bipolar disorder, including mixed states and decision-making.

Stigma-reduction initiatives for suicide and severe mental illness are needed as part of challenging prevalent models of suicidality that are not consistent with suicide in people with bipolar disorder.[6-8] These initiatives should include major linguistic and conceptual restructuring. This means changing evaluative terminology and concepts such as attempts and completed to concepts such as suicide and suicidal incident, regardless of fatality, and suicide survivor to identify those with lived experience of non-fatal suicidal incidents (Wait, Who Is A Suicide Survivor? (speakingofsuicide.com)/last accessed 15/4/24). As with heart attack survivors, for example, this would recognise potential lethality, regardless of outcome.

The mental state of those who die from bipolar suicide is inaccessible. The population arguably best placed to fill in key gaps in understanding bipolar suicide are people with bipolar disorder, especially the numerous bipolar suicide survivors. Incorporating lived experience of bipolar suicide survivors who either implemented or averted implementing suicidal plans, via research participation or co-production in research design and delivery, offers a potentially valuable and untapped resource. Bipolar disorder is typically episodic, with long periods of relative stability and good insight in between repetitive severe episodes compromising insight and decision-making. Quantitative and qualitative research on advance decision-making in bipolar disorder suggests strong and consistent retrospective insight into mental states and decision-making while severely unwell, including suicidality.[10] Retrospective insight could be used to understand symptoms, cognition, and behaviours associated with bipolar suicide. Perceived barriers to this approach might include ethical concerns about research participation; recall bias; and validity of bipolar suicide survivor experience as proxy for understanding bipolar suicide deaths. Yet we can show why these obstacles may be overestimated and are also developingways to overcome actual limitations.

While suicide remains, for many, an integral part of bipolar illness, societal barriers, gaps in understanding, and multiple challenges seem to have engendered some degree of collective resignation. The high human cost of suicide in people with bipolar disorder and the current impasse create a moral imperative to advance and embrace opportunities for increasing survival.

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Declaration of interest

We (TG, FA, MM) declare no competing interests.

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Panel: Vignette: bipolar disorder & lived experience – surviving suicide against the odds

I write as Director of Research at Bipolar UK, a mental health researcher, and advocate for the bipolar community, but also as someone with lived experience of bipolar suicide. I offer reflections on my personal experience as an illustrative vignette. We also want to show that even in the face of what

seemed insurmountable difficulties, risk minimisation and survival may be possible through enhanced understanding and personalised intervention.

My personal experience of bipolar suicide fits the characteristic profile outlined in this Comment. I was diagnosed with Bipolar I aged 35 years, some 15 years after first seeking clinical help for a severe episode of illness. My severe episodes are characterised by the experience of sudden separation from reality. This leads into protracted acute mixed states and excess mental and physical energy, fluctuating between self-destructive intense agitation and euphoric insights, visions, and disinhibition. These states are accompanied by persecutory delusions, with terrifying auditory and visual hallucinations and complex conspiracy-theories centred around those treating me and those closest to me.

Above all, the most pervasive and devasting feature is obsessive and unrelenting suicidality, which has, all too frequently, culminated in a decision and actions to kill myself. While I am extremely advantaged in social and material terms and can recognise this even while severely unwell and deeply suicidal, these factors neither reduce suicidality nor increase my ability to control it. The first attempt, when I was aged 21 years, was followed by four more, within a sequence of episodes precipitated by perinatal factors both prior to and after finally being diagnosed with bipolar disorder. All attempts took place while I was either an inpatient or under the care of a Crisis or Home Treatment Team and my immediate reaction to survival was combined shock, despair, and anger. I am fortunate beyond belief to have been intercepted or treated, with no lasting physical damage.

Aged around 36 years, I found myself in what seemed, both to me and to the treating clinical team, an impossible situation. Despite now having been correctly diagnosed with bipolar, I did not respond to any form of mood-stabilising medication. I had become a so-called revolving door patient, with repeated severe episodes and patterns of suicidal behaviour with high lethal intent, all combined with a calm articulate presentation when severely unwell. This presentation meant that, despite the best efforts of the clinical team, I had been able to ensure release from supervision each time I had made the decision to end my life.

The key factor leading to underestimation of immediate risk was, above all, the incompatibility of the violence, disturbance, irrationality, and loss of control within my mind with my calm and articulate external presentation. Even if the immediate clinical team could perceive danger, external assessors would judge the risk to be insufficient to warrant involuntary detention and treatment. Aided by a member of the Home Treatment Team, and based on my own retrospective analysis of my episodes of severe illness, I created a self-binding directive or advance choice document [For more on self-binding directives, see Self Binding Directives — Advance Choice Documents or BBC Radio 4 - Bound to the Mast], in which I outlined level of risk, key indicators of illness severity, impaired decision-making and risk. I identified the only medical intervention that had proven effective and highlighted the need for treatment, even if I was unwilling at that time. I also helped guide the clinical team, so that they would know what questions to pose in order to expose and engage with my psychosis and suicidality and monitor risk effectively. Coupled with the removal of immediate means and close supervision within either a home environment or, for short periods of acute risk, inpatient treatment, we created what we hoped might increase my chances of survival.
Since creating my personal advance choice document, I have experienced at least four more severe episodes with similar severity of illness and levels of suicidal intent. However, thanks to the implementation of this self-binding document by the clinical team, I have not again been in a position where I had the means and opportunity to act on my intentions. I am always aware of the very real risk that another severe episode could threaten my life. With my self-binding document in place, I hope that I may, once again, be able to protect myself and my family from the self-destruction of bipolar suicide. Nevertheless, I do recognise that there are no guarantees.

I am amongst the fortunate – first, in surviving multiple attempts to take my own life, and secondly, in being afforded the clinical help and external support to ensure that my suicidal intentions and risks can now be understood and managed. Still, it grieves me deeply to know that so many people are still dying. Why has it proven to be so difficult to reduce bipolar suicide? Why is so little targeted and effective research being done to reduce risks and increase survival?