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Keep Socially (but Not Physically) Connected and Carry On: Preventing Suicide in the Age of COVID-19

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Until the beginning of 2020, we believed that our modern societies had replaced microbial epidemics with behavioral epidemics such as depression, opioid use, and the most silent one, suicide.¹ Contributing to these epidemics, as Jeste et al¹ highlighted, the “lethal behavioral toxins of loneliness and social isolation increase the risk of mortality comparable with smoking and obesity.” This explains why in recent years the World Health Organization declared that social disconnection had become a major new public health challenge, and the United Kingdom created a Ministry of Loneliness! Ironically, our beloved globalization brought us a new dystopia, in which the fight against the coronavirus disease 2019 (COVID-19) epidemic is essentially based on social distancing all over the world, with perhaps half of humanity being in quarantine today. While loneliness is already highly prevalent in the general population, it is feared that it will be more pronounced during the COVID-19 outbreak quarantine, leading to dramatic effects on the most vulnerable people, including psychiatric patients. Psychiatrists must be cautious about the negative psychological consequences of quarantine in both the short term and long term.

Indeed, quarantine due to COVID-19 increases the possibility of psychological and mental problems because it gradually distances people from each other. The psychological impact of this imposed “social distancing” should lead us to consider the associated suicidal risk. Indeed, some cases of suicidal acts related to the quarantine have already been reported.² Social isolation (such as living alone) and loneliness, defined as a distressing feeling arising from perceived deficiencies in one’s social relationships,³ are strong contributors to suicidal risk. Durkheim⁴ initially

pointed out that egoistic suicide occurred when an individual was insufficiently integrated within a specific group, ie, had few social bonds. Recently, Joiner’s interpersonal theory of suicide⁵ proposed that suicidal ideation emerges in individuals experiencing simultaneously thwarted belongingness (ie, a lack of desired, reciprocally caring relationships) and perceived burdensomeness (ie, the feeling that one’s friends, family, or society would be better off if the person were dead). Hopelessness regarding future changes in level of social connection and contributions to others was positively correlated to suicide risk.⁶ At the biological level, loneliness and social exclusion have been associated with increased hypothalamic pituitary adrenocortical activity and inflammation, both pathways involved in suicidality. At the brain level, processing of social rejection may differ in patients vulnerable to suicide, engaging regions important for social cognitions and pain tolerance, possibly leading to hypersensitivity to social stress.⁷

In a 2020 review on the psychological impact of quarantine, Brooks et al⁸ reported that the “confinement, loss of usual routine, and reduced social and physical contact with others were frequently shown to cause boredom, frustration, and a sense of isolation from the rest of the world, which was distressing to participants” and “exacerbated by not being able to take part in usual day-to-day activities, such as... social networking activities via the telephone or Internet.” Other stressors of the quarantine have been pointed out: the long duration; fears of infection for oneself and one’s family; the inadequate supplies of basic needs, including the interruption of regular medical follow-ups and difficulties in renewing prescriptions; and the lack of clarity in the information provided by health and government officials. The confinement of individuals possibly induces a fear of being separated from loved ones and caregivers. People may face exacerbated intra-family problems, which are frequent triggers of suicidal acts.⁹ Studies showed that in the early phase of the severe acute respiratory syndrome outbreak, psychiatric morbidities were reported, including persistent depression, anxiety, and panic attacks.¹⁰ COVID-19+ subjects have also reported societal rejection, discrimination, and stigmatization. Brooks et al⁸ also revealed that during quarantine, both medical staff and the public may experience a high prevalence of anxiety, psychological distress, emotional disturbance and exhaustion, depression, irritability and anger, insomnia, posttraumatic stress symptoms, and increased use of alcohol and tobacco. All of these symptoms are suicide risk factors. Transition from

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suicidal ideation to suicide attempt is facilitated by panic disorder or posttraumatic stress disorder. We may expect that the effects of social isolation and loneliness will increase during the pursuit of quarantine. We are thus required to adapt and to prepare an intensification of measures for suicide prevention. Conversely, the widespread application of quarantine across a country, and even across several countries, may strengthen social cohesion and shared values. Feeling that others will benefit from one's situation can make stressful situations easier to bear. It seems likely that this is also true for home-based quarantine. It is important to highlight that periods of war have generally been associated with decreases in suicide rates. A greater social cohesion was thought to explain lower suicide rates in the New York metropolitan area in the months after September 11, 2001.¹¹ Perhaps the war against COVID-19 will reveal similar positive effects by protecting the most vulnerable patients from the consequences of loneliness.

The spreading of negative emotions in the population explains why maintaining the mental health of citizens becomes an important issue. Since noncritical patients were advised not to come to the hospital during the outbreak, the psychological counseling telephone helplines and online consultations played a significant role to maintain good mental health of citizens and to provide psychological counseling (eg, electronic devices and applications).⁹ In both China and Korea, mental health professionals rapidly and widely established online psychological counseling services aiming at providing free services 24 hours, 7 days a week, and online self-help intervention systems, including cognitive behavioral therapy for depression, anxiety, and insomnia.¹²⁻¹⁴ The Korean National Center for Disaster Trauma also distributed leaflets promoting mental health care to alleviate the distress caused by infectious disease outbreaks, listing the warning symptoms that should be evaluated and managed by mental health professionals and providing coping skill recommendations for individuals in quarantine.¹⁵

If medical care is delayed, affected persons may suffer inestimable damage caused by the psychological crisis. Timely mental health care needs urgently to be developed, and timely psychiatric treatments should be provided for those with severe mental health problems.^{10,16,17} Psychiatric history is associated with level of psychological distress after experiencing any disaster-related trauma, and it is likely that people with preexisting poor mental health would need extra support during quarantine. In conjunction with the implementation of a 24-hour/7-days-a-week real time remote (telephone and Internet) consultation network, interventions should be based on a comprehensive assessment of risk factors leading to psychological issues, including history of mental disorder, bereavement, life-threatening circumstances, panic, separation from family, and low household income.¹⁸ Insomnia, very common in such an outbreak, is a well-known risk factor of suicide.¹⁹ It is thus important to restore sleep, and staff and patients should be educated on sleep deprivation and insomnia. Obviously,

psychiatrists should encourage patients to have an adequate supply of their medications, raising the question of the risk of overdose. It may be important to ask family members, when possible, to safeguard those medications. We should be particularly attentive to elderly individuals who combine risk factors for COVID-19 complications, suicide, and social isolation while generally having limited access to Internet- and smartphone-based interventions.

One of the challenges of this quarantine lies in its long-lasting consequences. Some symptoms occurring during the containment may persist for several months, particularly those related to posttraumatic stress.⁸ Additionally, it is now well recognized that the COVID-19 outbreak will generate deep economic and financial consequences including unemployment, and social factors, particularly economic adversity, may modify the influence of many risk factors for suicide. It is thus necessary to ensure that effective mitigation measures are put in place as part of the quarantine planning process. Moreover, care will have to be organized to support individuals (especially psychiatric patients, COVID-19+ patients, and health workers) once the quarantine is lifted. It may be important to expand screening for the population that may require emotional support and management of stress-related disorders.²⁰

Fighting the loneliness epidemic is usually viewed as a good option to enhance individual and societal well-being. When individuals are facing such a crisis, they should feel that they are not alone. It has been suggested that having a telephone support line, staffed by psychiatric nurses, set up specifically for those in quarantine could be effective in terms of providing them with a social network. The ability to communicate with one's family and friends is also essential. In particular, social media could play an important part in communication with those far away, allowing people who are quarantined to update their loved ones about their situation and reassure them that they are well. All efforts to overcome interpersonal isolation, from joke-sharing in the nursing station to conference calls, have important roles in times of severe strain and stress.¹⁶ The challenge we are facing right now is to propose and implement individual-level interventions to reduce loneliness, enhance social support, and increase opportunities for social interactions in order to help people cope with the quarantine. Safe communication channels for patients and their families, such as smartphone communication, should be encouraged to decrease isolation. In recent years, suicide prevention strategies have been developed that aim at maintaining social ties while following up with patients who have attended an emergency department for a suicidal crisis, most often a suicide attempt.²¹ These interventions are typically delivered in 1 session or via several brief in-person contacts in order to provide ongoing support (such as case management and regular communication through channels such as phone calls, postcards, or text messages). In France, such a prevention system (VigilanS) has been gradually implemented throughout the country since 2015.²² The COVID-19 outbreak led the teams involved in these interventions to suspend the usual algorithm by generalizing the calls toward all of the suicide

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attempters monitored (instead of calling only patients with more than one suicide attempt) and to advance the first calls to day 10 instead of day 20. At the same time, incoming calls from patients are increasing in response to the closure of certain services (social, family, or financial difficulties) or in direct connection with containment difficulties (psychiatric disorders, domestic violence, loneliness, etc). Finally, these teams had to broaden their skills by joining forces with the psychological support of carers or support for the bereaved.

Maintaining and sustaining the social bond has quickly become a major concern. Thus, on the initiative of the French

National Centre for Resources and Resilience (<http://cn2r.fr/>), the Cov'Art movement was born: a "collective" of artists and influencers from all horizons who have agreed to make their creations available to the public, under the terms of a charter aimed at broadening the audience for information and prevention messages (suicide, interindividual violence) as well as delivering content to improve everyone's capacity for resilience.

Our hope is that as people stay confined, they can stay connected to their loved ones (via phone call), to social networks, to their psychiatrists, and to culture.

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