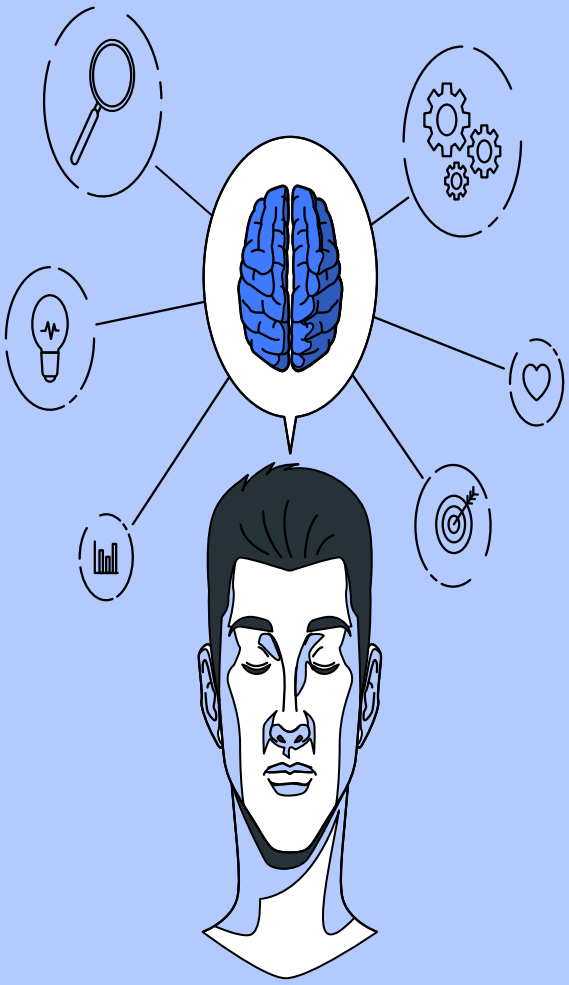

Assessment & Management of Suicidal and Aggressive Patients

Objectives:

- Assessment and Management of Aggressive patients
- Assessment and Management of Suicidal patients

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- Color index: Golden notes - Dr. notes - extra

Most imp in this lecture.

1. Know what is aggression and how to manage it
2. Understand risk factors of suicide both for the course and for life.

Assessment and Management of Aggressive patients

Introduction

- Aggression **should not automatically** be assumed to be psychiatric in origin
- The idea that people with mental disorders are more likely to be violent is a myth almost 60% of the general population connect violence with a psychotic, manic or depressed individual, due to cultural beliefs and scientific research that did not control for other variables (e.g substance abuse) when choosing their controls. Recent research corrected for these errors and found that violence was almost similar between psychiatric patients and the general population.
- Individuals with a mental disorder are much more often are victims of violence rather than being violent themselves.
- Nevertheless, in some cases, **certain mental disorders can result in violence**
- Mental health provider must be ready to evaluate violence and respond to the situation

Why we should study aggression/violence?

- Physicians/Psychiatrists might encounter aggression when patients present for treatment in acutely ill states
- Aggression may present as a complication of medical/ psychiatric condition such as delusional psychosis, dementia, delirium, etc
- It may be a complication of non-psychiatric illness because it can develop when patients feel disregarded, dissatisfied, frustrated, confused, frightened, or angered by perceived mistreatment
- Aggression can be perpetrated by men or women and by individuals of any age (except early infancy)
- It is seen in all patients care settings such as outpatients clinics, inpatients units, rehabilitation programs, and emergency departments (EDs)

Aggression
عدائية

- **Hostile, threatening** ليس بمعنى التلفظ بالتهديد لكن يهدد سلامة الاشخاص **, and violent actions** directed at person(s) or object(s), sometimes with no (or trivial) provocation.
- **Take many forms, such as:**
  - Physical injury
  - Hurt feeling أسلوب بذيء
  - Damaged social relationships passive aggressive
- Is often organized and involves a specific target
- It can be premeditated (someone who has been planning to attack someone else for weeks) or impulsive/unplanned (someone suddenly striking another person during argument)

(Aggressive acts) can sometimes have their roots in a mental disorder; however, it is more often happened as a result of conflict between ordinary people

Violence
عنف

- Overtly aggressive actions directed at person(s) or object(s).
  - Is an extreme form of aggression
- Aggression and violence are best conceptualized as being on a **continuum of severity** with relatively minor acts of aggression (e.g., pushing, verbal, condescending look) at the low end of the spectrum and violence (e.g., homicide, planned mass murder) at the high end of the spectrum
- **All acts of violence are considered instances of aggression, but not all acts of aggression are considered instance of violence**
  - A child pushing another child away from a favored toy would be considered aggression but not violent
  - An extreme act, such as attempted murder, however, would be considered both aggressive and violent
- Some non physical forms of aggression have earned the label "violence" when the consequences are severe
  - Certain types or patterns of verbal aggression are sometimes labeled "emotional/ verbal violence," in an organized process. usually when directed at children or spouse with goal of severely harming the target's emotional or social well-being (self esteem).
  - Upon multiple interviews with the family we may discover an element of antisocial personality, in comparison to aggression caused by substance abuse.

Agitation
تهيج

- State of psychological and physiological tension, excitement, or restlessness that can result in purposeless and disorganized acts of aggression/violence
- Unlike aggression, agitation is associated with medical (e.g pain, sensory impairment with inability to convey the problem) or psychiatric conditions more often than not
- Any psychiatric conditions that result in **confusion or fear** (including psychosis, mania, anxiety, delirium, dementia, and substance intoxication) should be on the differential diagnosis for someone in a state of agitation
- Not intended or provoked. E.g knocking a child down, unknowingly when frightened.

Other
Related to excitement

Disinhibition مشكلة في إدراك العواقب :

- A state in which individual's capacity for pre-emptive evaluation and restraint of behavioral responses is decreased or lost.غير قادر على تقدير عواقب وتبعات سلوك أو تصرفه
- E.g manic patients are unable to appreciate that actions such as talking or behaving in a condescending fashion are wrong, Can't predict consequences.

Impulsivity اندفاعي another way to describe someone who is violent or agitated :E.g ADHD, children.

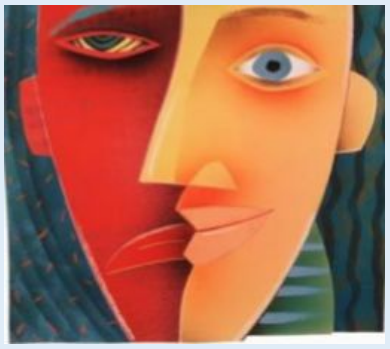
- A state characterized by a proneness to act without thought or self-restraint; a habitual tendency toward "hair-trigger" actions. someone who is explosive or acts without thinking.
- They can appreciate the consequences but the actions occur before they can control it.

Irritability متنرفز أو مستثار

- A state of abnormally low tolerance in which the individual is easily provoked to anger and hostility can reach aggression or violence.

Disorders are associated with Aggressive Behavior

- Psychosis (mania, depression: extremes of age (children or elderly) have a form of agitated depression that can reach to aggression. e.g: because children cannot express their feelings appropriately they may be angry or resort to tantrums or throwing things (aggression towards objects). Adolescents may engage in peer fights. In elderly, aggression may stem from being dependent on others after being independent, or because of limited resources such as sensory impairment, or physical disabilities. Schizophrenia, delusional disorder)
- Personality disorders (antisocial, borderline, paranoid, narcissistic)
- Substance use disorder (alcohol, phencyclidine, stimulants, cocaine)
- Epilepsy pre or postictal status
- Delirium confusion or fright
- Dementia
- Neurodevelopmental disorders (intellectual disability, autism, ADHD)



Assessment of Dangerousness (Predictors & Risk Factors)

- Past history of violence or aggression (single best predictor)
- Male sex, young age , poor impulse control gambling or drinking
- Alcohol or drug abuse/intoxication/withdrawal

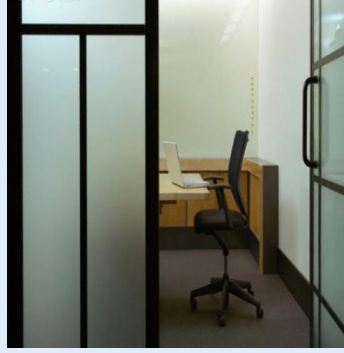
To a lesser degree:

- Family history of aggression bad neighborhood
- Recent stressors , poor social support
- Available means (e.g., Weapons) soldier outfit may indicate easy access
- Verbal or physical threats (statement of intent) التصريح
- Paranoid features in psychotic patient نظرات ترقب و خوف
- Brain disease (e.g., Dementia)

Prevention Policy

- Never attempt to evaluate an armed patient
- Carefully search for any kind of offensive weapon (by the security)
- Anticipate possible violence from hostile, threatening behavior, & from restless, agitated abusive patients We have to predict it first so we can prevent it

How to Interview an Aggressive Patient



- Do not be alone
- Do not be in closed room
- Sit near the door
- Have security guard nearby or in the room
- Sit limits (Look, I want to hear what's wrong and help fix it Could you lower your voice please so I can think better?) in a confident, gentle, humane but firm manner.
- De-escalate angry behavior
- Build an therapeutic alliance
- Solve problems
- If patient seems too agitated terminate interview immediately

Communication-based de-escalation techniques

Communication	Tactics
Nonverbal: • Maintain a safe distance • Maintain a neutral posture do not seem on edge • Do not stare; eye contact should convey sincerity • Do not touch the patient it can aggravate. • Stay at the same height as the patient • Avoid sudden movements. **Verbal:** • Speak in a clam & clear tone • Personalize yourself: introduce yourself • Avoid confrontation e.g saying you're not thinking straight in a critical or judgmental way; offer to solve the problem but don't give false hope	**Debunking:** try to explore whatever is leading to this aggression and try to acknowledge it. E.g: we understand we were late and that you are in pain. • Acknowledge the patient's grievance • Acknowledge the patient's frustration • Shift focus to discussion of how to solve the problem Aligning goals: • Emphasize common ground e.g: we are here to help you find a solution. Focus on the big picture **Monitoring:** • Be acutely aware of progress Know when to disengage • Do not insist on having the last word may evolve into an argument.

10 Domains of De-escalation (Richmond et al, 2012)

1. Respect personal space
2. Do not be provocative e.g: insisting on having the last wordnor using inappropriate tone
3. Establish verbal contact
4. Be concise
5. Identify want and feelings
6. Listen closely to what the patient is saying
7. Agree to agree to disagree
8. Lay down the law and set clear limits e.g here I'm the doctor, and my job is to help you but you must give me some space to think and try to lower your voice and be seated in the place I allocate (in a humane, considerate but firm way)
9. Offer choices and optimism within our limits
10. Debrief the patient and staff recap

Management of Aggressive patients

- Doctors, Nurses, Security should treat such patient with understanding & gentleness as possible
- Adequate security e.g: weapons, availability of panic button, exits
- Availability of more staff decrease struggle if further steps are required
- Clear prevention policy to all
- Remain calm & non-critical
- Use minimum force with adequate numbers of staff originally the rule was to avoid ' hands on' , but if efforts to de-escalate were unsuccessful, active management is required. In this case always explain to the patient what's happening and offer clear instructions to the patient and team.
- Calm patient down
- Do not argue with the patient use short clear decisions

Seclusion

- Not as a punishment
- More beneficial in psychiatry patient, restraint can be appropriate for delirious patients.
- For the safety of patient, staff, property & others
- Always explain to the patient.
- Avoid bargaining!. Always ask them to stop the behavior, if they do not comply you will put them in seclusion without threatening with seclusion
- Regular check up on the patient
- Attend for the patient basic needs e.g water, food and restroom.
- Evaluation of the condition by a Doctor if they still require seclusion
- Monitor patient through a screen to make sure he is not harming himself

Physical Restraint

- Assign one team member to each of the patient head and extremities
- Be humane but firm, don't bargain e.g for bargaining: saying you did not calm down therefore we are restraining you, because at this stage it's almost impossible for the pt to calm down,
- Use minimum force
- Start together to hold the patient and accomplish restraint quickly requires practice

Medication

chemical restraint

Avoid the using a small dose as you are just prolonging the patient misery while not protecting others.

- Once you have reached the decision to use medications treat aggressively.
- Important to use IM in critical situations.
- Oral drugs can be given during the de-escalation stage

Typical antipsychotics:

- Chlorpromazine 50-100 mg IM
- Haloperidol 5-10 mg IM or IV
- Clopixol Aquaphase 50-100 mg IM action continues for 48-72 hours. Used to give the family time to arrange for admission.

Atypical antipsychotics:

- Risperidone 4 mg
- Olanzapine 10 mg IM

Benzodiazepine:

- Diazepam 5-10 mg IV.
- Lorazepam 1-2 mg PO/IM
    - In epilepsy, withdrawal of alcohol or barbiturate and in agitation

Usually we combine an antipsychotic with benzo.

Hospitalization

Admission may be needed to a secured psychiatric ward for further assessment and treatment.

Assessment and Management of Suicidal patients

Suicide and Psychiatrists

" It is a clinical axiom that there are two kinds of psychiatrists - those who have had patients complete suicide and those who will"
(Preventing Patient Suicide: Clinical Assessment and Management)

Introduction

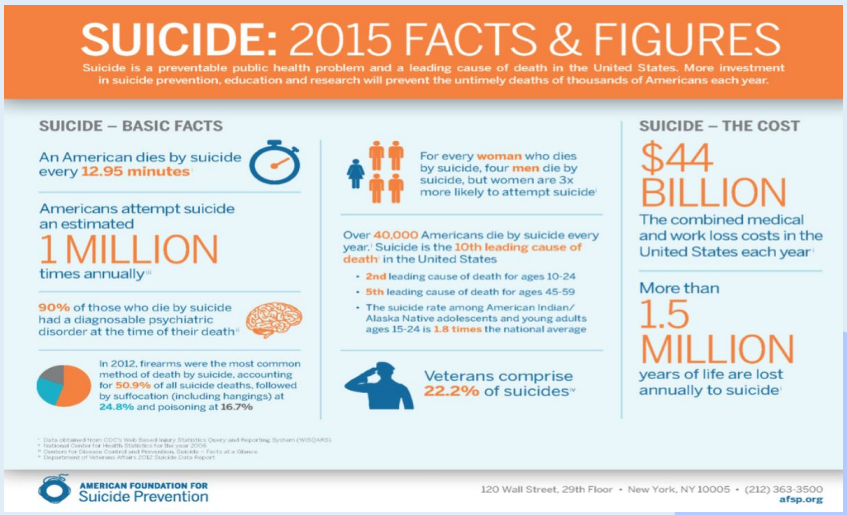
- Suicide risk assessment is a core competency that psychiatrists are expected to acquire
  A skill physicians **everywhere** should at least know how to screen for and when to refer to a psychiatrist.
- **Most common psychiatric emergency**
- 50 % of all urgent psychiatric consults being related to suicidal thoughts or attempts
- **All mental disorder increase the lifetime risk of suicide**
- Screening for suicidal ideations should be done on every patient presenting with a mental health concern
- Suicide are among the most traumatic events in a psychiatrist's professional life
- Most people who commit suicide communicate their suicidal intentions to and see physicians, not necessarily a psychiatrist, before they die
- Diagnosis with a psychological disorder is not necessary, it can be caused by severe adjustment disorders where the individual was not able to adjust to severe stress, leading to suicide.

Suicide - Definitions

Suicide	• **Self inflicted death** with evidence (either explicit or implicit) that the person intended to die.
Suicidal Ideation	• **Thoughts of engaging** in behavior intended to end one's life.
Suicidal Plan	• **Formulation** of a specific method through which one intends to die plans vary in their complexity. We explore every stage of the plan.
Suicidal Attempt	• **Engagement in potentially self-injurious behavior** in which there is at least some intent to die. He may know this will not kill but this is the only way he can reach out for help. • Can end up in completed suicide, if the patient survive then its an attempt.
Suicidal Intent Passive suicidal wishes	• Subjective **expectation and desire** for a self destructive act to end in death. • E.g, I will not speed in the car, but I hope an accident occurs and I die.
Deliberate Self Harm	• **Willful self-inflicting of painful,** destructive or injurious acts without intent to die.

Epidemiology

- Globally, an estimated 11.4/100,000 people commit suicides every year, resulting in 804,000 deaths
- Individuals who reports suicide ideation تفكير او رغبة في الموت with pervious 12 months have significantly higher 12 - months prevalence rates of suicide attempts (15.1% in high-income countries and 20.2% in low-income countries)
- Suicide is the second leading cause of death in individuals age 15-29 years
- Suicide rates very within and between countries, with as much as a ten- times difference between regions; this variation is partly correlated with economic status and cultural differences
- Cultural influences might TRUMP geographic location, because the suicide rates of immigrants are more closely correlated with their country of origin than with their adoptive country



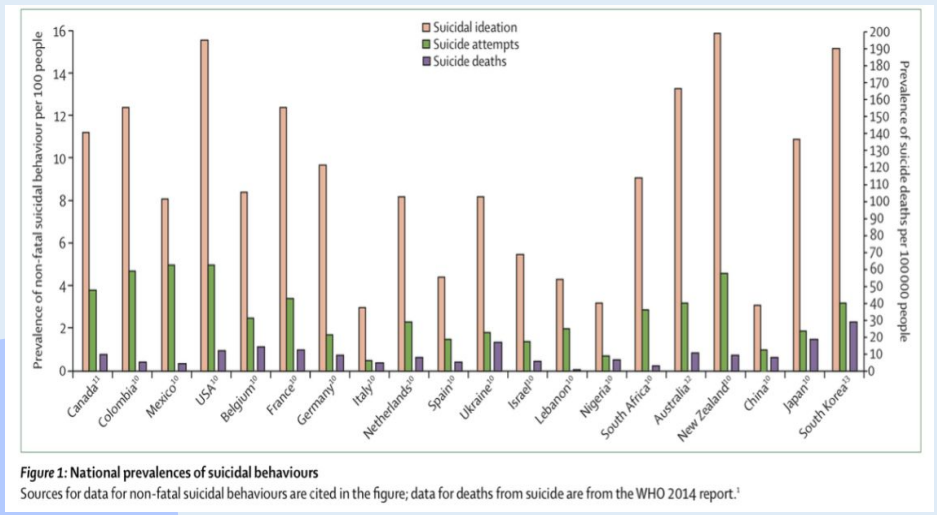


Figure 1: National prevalences of suicidal behaviours
Sources for data for non-fatal suicidal behaviours are cited in the figure; data for deaths from suicide are from the WHO 2014 report.[1]

Risk Factors for Suicide: importan. During inquiry about previous attempts we must ask about all those details to evaluate his seriousness.

- **Age > 45 years old** very serious, tend to plan and try to arrange all circumstances leading to sure death.
- Male > Female
- Separated, divorced, widow > single > married lack of support.
- **Previous suicide attempts or behavior** best predictor.
- **Family history of suicide behavior**
- Current psychopathologic conditions: Severe depression/ Substance abuse/ Psychosis/ Personality disorder.
- Concurrent serious or chronic medical condition involving pain and being dependent.
- Lack of social support
- **Suicide note** requires conditions. E.g, I'm leaving. Not come and help me I did something towards myself .
- Planning with precautions against discovery E.g. choosing a crowded time to cover up his actions. Strong intent to die

SAD PERSON Scale

SAD PERSONS Scale

Factor	Points
Sex	1 if male
Age	1 if 25-44 or older than 65
Depression	1 if present
Previous attempt	1 if present
Ethanol/Drug use	1 if present
Rational thinking loss	1 if psychotic for any reason
Social supports lacking	1 if lacking, especially recent loss
Organized Plan	1 if plan with lethal weapon Note is one of them
No spouse	1 if divorced, widowed, separated or single male Especially if recent
Sickness	1 if severe or chronic

May come in the exam as **what is the screening tool for suicide?** But they won't ask you to calculate.

Score of
- 6-8: full emergency psychiatric evaluation
- 9 or greater: immediate psychiatric hospitalization.

Suicide Risk Factors:

Static and stable suicide risk factors	Dynamic suicide risk factors
• **Age >45 and Gender male** • **History of previous suicidal attempts** • History of self-harm • Seriousness of pervious suicidality inquire about details of previous attempts: with who, where, time,.. • Previous hospitalization • **History of mental illness** • **History of alcohol/substance use disorder** • **Personality disorder/traits** • **Childhood adversity** significant childhood trauma e.g rape, neglect, violence, traumatic foster care. • **Family history of suicide**	• Current suicidal ideations, communication, and intent • **Marital status** • **Feeling hopeless** • Active psychological/psychiatric symptoms e.g a schizophrenic with a flare up in the disease • Treatment adherence • **Current substance use disorder** • **Psychosocial stressors** • Access to weapon/firearm • **Chronic medical problems** • **Chronic intractable pain**

Suicide Risk Factors:

Age	• In high-income countries, suicide is common among **middle-age and elderly men.**
	  ○ Particularly among those with physical disorders, depression, and anxiety.
	• The incidence of suicide ideation and behaviour peaks in **adolescents and young adults (15-29 years old)**.
	  ○ Lifetime prevalence of suicidal ideation (12.1 high income countries -33%) and of suicidal behaviour of (4.1- 9.3%)

Gender	• Higher rates of **ideation and suicide attempts among women.** • **Rate of suicide deaths are generally higher in men** (15/100,000 men vs 8/100,000 women, worldwide).
Marital Status	• **Widowed, divorced, or separated** adults are at the greater risk for suicide than are single adults, who are at greater risk than married adults • Married adults with young children appear to carry the lowest risk i.e having young children is a protective factor
Hx of Previous Suicidal Attempt	• Is one of the **most powerful risk factors** for completed and attempted suicide • 10-20% of people with prior suicide attempts, complete suicide • The risk for completed suicide following an attempted suicide is almost 100 times **that of the general population** in the year following the attempt. It then declines but remains elevated throughout the next 8 years • People with prior suicide attempts are also at greater risk for subsequent attempts and have been found to account for approximately 50% of serious overdose.
Hx of Alcohol/ Substance Use Disorder	• 15-25% of patients with alcohol or drug dependence complete suicide. ○ 84% of the 25% suffer from both alcohol and drug dependence. • 20% of people who complete suicide are **legally intoxicated** at the time of their death • Associated with **more pervasive suicidal ideation, more serious suicidal intent, more lethal suicide attempts, and a greater number of suicide attempts.** • Use of alcohol and drugs may **impair judgment and foster impulsivity.**
Personality Disorder/ Traits	• 4-10 % of patients with **borderline personality disorder** commit suicide. • 5 % of patients with **antisocial personality disorder** commit suicide. • Risk appears to be greater for those with co-morbid depression or alcohol abuse. • Often make **impulsive suicidal gestures or attempts.** • Attempts may become progressively more lethal if they are not taken seriously. • Even **manipulative gestures can turn to be fatal.** Do not start with a true suicidal plan as much as manipulation, but with miscalculations or impulsiveness may turn into suicide.

Family Hx of Suicide	• 7-14% of persons who attempts suicide have a family history of suicide.
	• This increased suicide risk may be mediated through:
	  ○ **Shared genetic predisposition** for suicide, psychiatric disorders, or impulsive behaviour.
	  ○ **shared family environment** in which modeling and imitation are prominent.

Suicide Risk Factors cont:

Hx of Mental Illness

- **Most consistently reported risk factor.**
- It is the most powerful risk factors for completed and attempted suicide.
- All psychiatric disorders, except for intellectual disability, associated with increased risk
- **90% of individuals who die by suicide had an identifiable psychiatric disorder before death**
- Severity of psychiatric illness is associated with increase risk of suicide.
- Increased risk with multiple psychiatric comorbidities e.g a patient in the beginning of psychosis that is dissociating from reality and noticing how his condition is deteriorating and has insight will have comorbid depression because of his situation.
- Most individuals with a psychiatric illness d**o not die by suicide,** but some psychiatric illnesses are more strongly linked to suicidal behaviours than others e.g. command type hallucinations in psychosis and risky behaviors in mania

Mood disorder (Major depressive disorder "MDD" and Bipolar disorder)

- are responsible for approximately **50 % of completed suicide**
- Up to **15 % of patients with MDD or bipolar disorder** complete suicide, almost always during depressive episode
- The risk appears to be greater:
  - Early in the course of a life-time disorder
  - Early in depressive episode
  - In the first week following psychiatric hospitalization
  - In the first month following hospital discharge a difficult experience, they will have other things to deal with (e.g. how to return back to work) but they are still depressed.
  - In the early stages of recovery he is still not feeling quite well but he has the energy to execute a plan.
- They know that this will continue for 7 months and they may need to be admitted, they try to commit suicide before they lose the ability to want to take the action. Whereas in severe depression there is psychomotor retardation, they don't reach the suicide stage.
- The risk may be **elevated by co-morbid psychosis**
- 15-20 % of patients with anxiety disorder complete suicide.
  - Up to 20 % of patients with panic disorder attempt suicide

Schizophrenia:

- **Approximately 10 % of patients with schizophrenia complete suicide**
- Mostly during periods of improvement after relapse or during periods of depression or early on in the illness
- The risk of suicide appears to be greater:
  - Among young men who newly diagnosed
  - Who have a chronic course and numerous exacerbation have not reached steady state, they are in and out of relapses
  - Who discharge from hospitals with significant psychopathology and functional impairment significant decline in cognition
  - Who have a realist awareness and fear of further mental decline or knowledge that psychosis is a downhill prognosis
- The risk may also be increased with akathisia and abrupt discontinuation of antipsychotic
- Patients who experience command hallucinations in association with schizophrenia are probably at great risk for self-harm and suicide

Chronic Medical Problems

- Medical illness, especially of a **severe or chronic nature**, is generally associated with an increased risk of suicide & considered a risk factor for completed suicide
- Medical disorders associated with **35-40 % of suicides and up to 70 % of suicide in those older than 60**
- AIDS/HIV, cancer, head trauma, epilepsy, multiple sclerosis, Huntington's disease, Rheumatoid arthritis,...etc debilitating illnesses associated with pain and significant limitation of function
- Suicide risk might be increased due to:
  - Poor diagnosis & poor pain control
  - Fatigue
  - Associated depression
  - Feeling hopeless
  - Recent loss or functional impairment
  - Delirium
  - No social/family support

Suicide Risk Factors cont:

Feeling Hopeless	• Hopeless, or negative expectations about the future, is a **stronger predictor of suicide (a finding independent of psychiatric diagnosis)** Doesn't meet criteria of disease. • May be both a short-term and long-term predictor of completed suicide in patients with major depression • Almost, all individuals who intentionally end their lives, irrespective of whether or not they meet structured criteria for a psychiatric disorder, show evidence of hopelessness, depressed mood, and suicidal ideation • Association with lethality of attempt • Interventions to reduce hopelessness may decrease suicide potential e.g CBT focusing on hopelessness

Psychosocial Stressors	• **Personal losses** physical or abstract(including diminution of self-esteem or status) and conflicts also place individuals, particularly young adults and adolescents (can't ontrol their coping strategies and skills) at greater risk for suicide.
	• **Grief / Bereavement** following the death of a love one increases the risk for suicide over the next 4-5 years.
	  ○ People have psychiatric history and receive little family support.
	• **Unemployment** accounts for as many as one-third to one-half of completed suicide.
	  ○ Particularly elevated among men.
	• **Financial & legal difficulties** also increase the risk for suicide.

Social suicidal risk factors:

- Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma Asian countries
- Local epidemics of suicide no longer a taboo
- demographics (shared poverty, and similar education) may play a role.
- Barriers to accessing mental health treatment
- Easy access to lethal methods.
- Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts

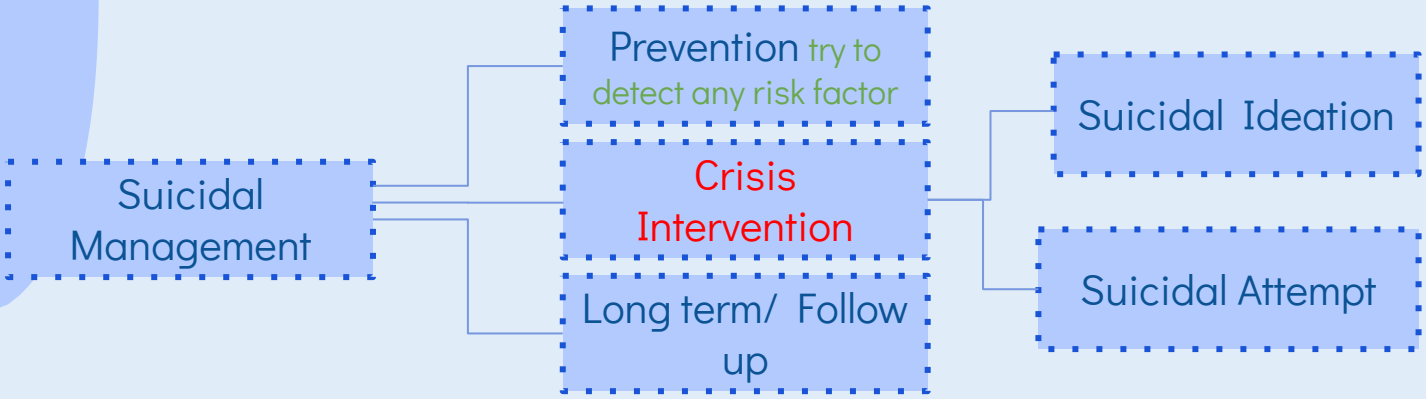
Biological Factors:

- Serotonin abnormalities (Serotonin deficiency)
  - Decreased CSF level of 5-HIAA (5-hydroxyindoleacetic acid) serotonin precursor
    - Result from a breakdown product of serotonin
  - Increased 5-HT2A receptors
  - Linked with impulsivity and aggression
- PET Scan:
  - Abnormal metabolism in prefrontal cortex
- Genetics
  - Familial association beyond risk for specific diagnoses unrelated to disorders or demographics

Suicidal-Protective factors:

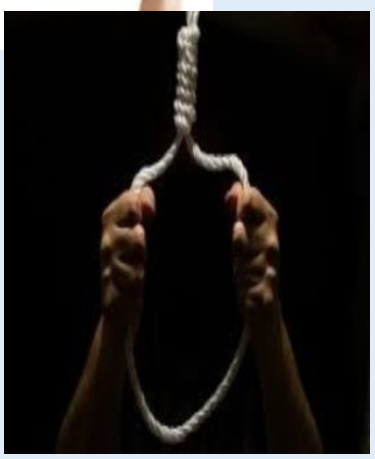
- Children in the home
- Sense of responsibility to the family
- Pregnancy
- Religiosity
- Life satisfaction
- Reality testing ability not psychotic.
- Positive coping skills even even if he is psychotic he still can differentiate.
- Positive problem solving skills
- Positive social support
- Positive therapeutic relationships

Suicide Management



Ask about all the details of the attempt, reason, and how we can help them (holistic approach).
Once there was an attempt they will need a long term follow up and paying attention to the same risk factors of the first attempt

Prevention



- To build a **therapeutic alliance** with patient.
- **Diagnose and manage** different psychiatric illnesses.
  - Psychotropic medications.
  - Psychotherapy.
- **Identify high risk** patients from the beginning.
- **Identify and detec**t suicidal ideations from the beginning.
- Treat/manage modified/dynamic suicide risk factors from the beginning.
  - Substance/alcohol abuse.
  - Medical problems.
  - Chronic pain.

Crisis Intervention

- We have two possible scenarios:
  - Patient present with suicidal ideations.
  - Patient present with suicidal attempt.
- Assess current suicidal risk: Inpatient treatment vs outpatient treatment
- **General approach:**
  - Ensure patient/staff safety
  - Build a therapeutic alliance with patient
  - Take comprehensive history and physical examination
  - It is very important to have a Collateral information/history from patient's family/friends or from to know more about what's happening and how much family support he is getting, and what are the resources that you can make use of.
  - his/her medical file
- If patient comes with suicidal attempt
  - Patient should be medically stable before taking a full/comprehensive history
    - Physical examination
    - ECG
    - bloods works....etc

Crisis Intervention

First scenario if patient present with suicidal ideation:	Second scenario if patient present with suicidal attempt:

• Use SAD PERSON Scale to identify current suicide risk factors
• Assess suicidal ideations:
  ○ Passive suicidal ideation e.g I wish I die
  ○ Active suicidal ideation e.g outings with my reckless friend in the car
  ■ Is there any organized plan??
  ● Methods is accessible or not ?? Weapon/drugs/rope
  ● Rehearsal
  ■ Is there any intention to carry out this plan?
  ○ Any current protective factors
  ○ Looking for possible triggers:
  ■ New onset/Worsen psychiatric symptoms:
  ● Depression/anxiety/ mania/ psychosis
  ■ Current substance/alcohol abuse
  ■ Uncontrolled pain/medical problems
  ■ Psychosocial stressors (loss, financial difficulty)
	• Use SAD PERSON Scale to identify current suicide risk factors
	• Assess suicidal attempt:
	  ○ Impulsive vs planned
	  ○ Assess if it was an organized plan
	  ■ For how long he/she was thinking about this plan?
	  ■ Is there was any preparation?
	  ■ Any step/steps was taken to avoid discovery ?
	  ○ Assess suicide methods: lethal (in patient mind) or not?
	  ○ Was patient intoxicated or not during this attempt?
	  ○ Assess what was the real goal from this attempt? Other gain or truly wanting to die?
	• Assess what patient did after this suicidal attempt ? Follow up after: were they remorseful or glad they are alive?
	• Looking for possible triggers (see the previous slides)

Warning Signs:

- The person making a will.
- Getting his or her affairs in order esp in elderly.
- Suddenly visiting friends or family members.
- Buying instruments of suicide like a gun, hose, rope, medications.
- Sudden and significant decline or improvement in mood he was so helpless and found his salvation in suicide therefore he felt refreshed
- Writing a suicide note

Follow up

- **Family involvement is very crucial in this process.**
- Immediate/ short term plan:
  - Gun/weapon removal
    - Designate a willing responsible person to remove guns.
    - Direct contact with designated person confirming removal.
    - Do not discharge suicidal patient till confirmation that the harmful method is removed or modified by family.
- Arrange follow up
- Long term plan: Frequent follow up (depend on patient's need) depending on the patients needs, if there was deliberate self harm or seeking attention, we can lengthen the interval between visits but they remain continuous.
  - In each visit monitor:
    - Suicidal ideation/plan
    - Psychiatric symptoms.
    - Trigger / Precipitating factors: that's why the therapeutic alliance is very important
      - **Substance/alcohol**
      - **Medication adherence**
      - **Pain/medical problems**
      - **Psychosocial stressors**

Suicide Risk Documentation

- Risk assessment including documentation of risk/protective factors
- Record of decision making process why I decided to discharge them?
- Record of communication with other clinicians and family members
- Medical records of previous treatment
- Address firearms
- Consultation in difficult cases

Myths about suicide

- Discussing suicide will provoke it
- Suicide strikes only the rich
- Showing generosity and sharing personal possessions is showing sign of recovery
- Suicide is always impulsive
- It is a painless way to die it is not
- Once suicidal, always suicidal can increase the risk but the risk decrease with time
- Those who threaten it, don't do it

Manual of Basic Psychiatry by Prof. Al-Sughayir

AGGRESSIVE / VIOLENT PATIENT

صحيفة سبق الأليكترونية- مكة المكرمة (٢٧ محرم ١٤٣٤هـ) : أكدت جماعة المسجد أن الجاني كان حريصاً على الصلاة في المسجد جماعة ولا يفارقها، ويواصل مكوثه بالمسجد بعد الفجر يقرأ القرآن إلى طلوع الشمس ، وأمّ المصلين فيه عدة فروض، وشهد في الفترة الأخيرة تغيرات نفسية، وكان يراجع مستشفيات للصحة النفسية، وفي يوم الجريمة قابل الباكستاني في الطريق، وأطلق عليه النار وأرداه قتيلاً، ومن ثم دخل المسجد وبيده المسدس وباليد الأخرى عصى، وطلب من المصلين الخروج من المسجد، وهو يردد "اليوم ذبح"، وقتل الضحية الثانية، وطرد إمام المسجد بعد أن حاول ضربه، وأغلق على نفسه الباب وأوضحوا أنه تمت محاصرة الموقع من قبل الجهات الأمنية ، وبعد مفاوضات مع الجاني باءت بالفشل تدخلت الجهات الأمنية بقيادة قوات الطوارئ الخاصة، ودخلت المسجد ، وسيطرت على الجاني بعد محاصرته من أذان العصر إلى ما بعد صلاة العشاء ، مستخدمة الغازات المسيلة للدموع ، وشهد الموقع وجود مساعد مدير شرطة العاصمة المقدسة لشؤون الأمن.

Aggressive patients are frequently seen in emergency departments and in the medical and psychiatric wards.

DDx of Causes:

1. Brief psychosis /schizophreniform disorder /acute schizophrenia.
2. Substance abuse (intoxication / withdrawal).
3. Acute organic brain syndrome (e.g. delirium).
4. Mood disorders; mania - severe agitated depression.
5. Personality disorders (e.g. borderline personality disorder).

Medications:

Major Tranquilizers e.g. :

Olanzapine 5-10mg IM,

(Haloperidol 5 - 10 mg IM or

Chlorpromazine 50 - 100 mg IM.)

Benzodiazepines: e.g. diazepam 5-10 mg (slow IV infusion to avoid the risk of respiratory depression). However, benzodiazepines may aggravate hostile behavior in certain susceptible people (release of inhibitory mechanisms).

Hospitalization:

For further assessment and treatment.

Approach:

–Arrange for adequate help.

–Appear calm and helpful.

–Avoid confrontation.

–Take precautions:

- Never attempt to evaluate an armed patient.
- Other persons should be present (security guards or police officers).
- Keep the door open for an unavoidable exit.
- Restraints if needed by an adequate number of people using the minimum of force.
- Carefully search for any kind of offensive weapon.

–Aim to save patient and others.

- Anticipate possible violence from hostile, threatening behavior and from restless, agitated abusive patient.

– Do not bargain with a violent person about the need for restraints, medication or psychiatric admission.

- Reassure the patient and encourage self-control and cooperation.

Restraint Technique: Enough staff should be available. If restraint becomes necessary, assign one team member to the patient's head and to each extremity. Be humane but firm, and do not bargain, start together to hold the patient and accomplish restraint quickly.

Video

SUICIDE (international self-murder) Sui: self, Cide: murder

Ms. Amal's mother reported that; Amal sometimes experiences death wishes, and suicidal ideation.

Common Underlying Factors: Depressive disorder- Substance abuse - Schizophrenia - Personality disorder - Serious chronic physical disease - Social isolation and lack of support - Financial problems

Suicide Methods: Hanging / Shooting / Burning / Poisoning/Rushing in front of running vehicles/Jumping from high places.

Who requires suicide evaluation? Any patient who

- has recently attempted suicide.
- presents with suicidal ideation.
- reveals suicidal ideas only when asked.
- has behavior indicating possible suicidality.

Risk Factors for Suicide: These risk factors should be recognized, assessed and utilized in conjunction with careful clinical assessment in deciding the suicidality of a patient.

1. Age > 45 years old.
2. Male > Female.
3. Separated, divorced, widow > single > married.
4. Previous suicide attempts or behavior.
5. Family history of suicide behavior.
6. Current psychopathologic conditions: Severe depression/Substance abuse/Psychosis/Personality disorder
7. Concurrent serious or chronic medical condition.
8. Lack of social support.
9. Suicide note.
10. Planning with precautions against discovery.
11. Strong intent to die.

Assessment of Suicide Risk

1. **Evaluation of intentions:** Asking about suicidal intentions is very important. It will not make suicide more likely. Sympathetic approach, which also helps the patient feel better understood and hence may reduce the risk of suicide. Systematic enquires (thought/feeing >> intention >> act): Thoughts whether life is worth living/ hopeless towards the future >> any wishes to die >> suicidal ideation >> suicidal intent >> suicidal specific preparatory acts (e.g. planning with precautions against discovery) >> actual suicidal trial.

2. **History of intentional self-harm.** Serious deliberate self-harm. Repeated dangerous attempts. Continuing wish to kill or harm self. Writing a farewell suicidal note.
3. **Presence of mental disorders:** Severe depression with guilt feelings hopelessness and helplessness. Depressed patient may not be able to plan and commit suicide while severely depressed. However, it was found that suicide might occur during recovery from severe depression. Schizophrenia: on recovery from acute phase or in chronic schizophrenic illness. Substance abuse with psychiatric and physical complications. Personality disorders (e.g. borderline personality disorder; these patients have poor impulse control and chronic emotional instability).

4. **Presence of adverse social and medical conditions:** Social factors (e.g. home, work, finances…) should be assessed. Medical problems (especially if they are painful disabling or rapidly deteriorating in spite of medical interventions).

5. **Presence of homicidal ideation:**
   E.g. to kill the spouse, children or parents, in order to spare them intolerable suffering after committing suicide (some severely depressed suicidal patients have homicidal ideas).

Video

Video

Management of suicide :

- Proper assessment of suicidal risk.
- Every suicidal ideation, impulse, gesture or attempt should be taken seriously.
- Hospitalization: for patients with serious suicidal risk.
  - Prevent access to all means of harm (sharp objects, ropes, drugs…). Search the patient thoroughly.
  - Appropriate close one to one observation: vigilant nursing staff with good communication.
  - Treat any psychiatric disorder (**ECT**/ antidepressants/ antipsychotics)

If the risk does not seem to require hospitalization:

- Counseling /Problem solving/Ensure good support &positive view of the future.
- Relatives: responsible, reliable and understanding.
- Treat underlying psychiatric condition and keep regular follow up visits.

For only limited periods suicidal persons remain suicidal, thus the value of early detection and restrain.

Whatever carefully the correct procedures have been followed, some patients commit suicide.

PARASUICIDE; إيذاء الذات بما دون القتل

PARASUICIDE; also called: "Attempted suicide" & "Non-fatal deliberate self-harm".

Definition: any act of self-damage carried out with the apparent intention of self- destruction; yet ineffective, half-hearted and vague.

- **Etiology**:
  - Impulsive behavior: seen commonly in borderline personality disorder.
  - Unconscious motives: to influence others, a signal of distress or a cry for help seen commonly in histrionic personality disorder.
  - Failed suicide: 25 % of cases.
  - Risks Factors: young (15 – 35 years), commoner in females, personality problems (e.g. borderline personality disorder) and Situational stress (e.g. arguments with parents, spouse…).
- **Methods**:
  - Drugs overdose (e.g. paracetamol) is the most common method.
  - Self-injury e.g. laceration of wrist.
  - Jumping from heights.
- **Management:** each case should be assessed thoroughly;
  - Thoughts /intentions /plans /psychosocial stresses /personality problems /available support/possibility of repetition
- Treat any psychiatric disorder
  - Inpatient or outpatient depending on the case.
- Problem solving and counseling
  - To resolve current difficulties.
  - To deal better with future stresses.
- Prolonged follow up is required for some cases who are at risk of repetition of self-harm and suicide those with personality disorders and long-term adverse psychosocial situations.

youtube.com/watch?v=KY7GKUD31UY

Questions:

1- Which one of the following psychiatric disease has the highest chance for suicide?

A. Major depressive disorder (MDD) B. Schizophrenia C. Illness Anxiety Disorder D. Delirium

Ans: A

2- A 31-year-old women was admitted to the psych. In-patient because of depression and suicidal thoughts. Which one of the following mental state findings would go with the diagnosis?

A. Delusion of control B. Somatic delusion (Nihilistic) C. Time disorientation D. Grandiose delusion.

Answer: B

3-: A 74 years old diabetic patient became progressively paranoid and aggressive for several months. What to do?

A. Check blood glucose B. Hospitalize C. Measure BP D. Screen for depression

Answer: B

2. A depressed man is lying on the couch with a debilitating illness (possibly paralyzed) crying while telling the doctor he feels very sad and useless. He mentioned suicidal ideation.

Q1: Give observations you would typically find in his MSE:

Poor grooming, sad facial expression, Avoid eye contact, psychomotor retardation, low and depressed mood, low blinking

Q2: Give two dddx and why.

Major depression disorder (due to his sadness, debilitating medical condition and suicidal ideation) Bipolar disorder (it could be that he has bipolar but in depressed episode)

Case: A 42-year-old man was brought unconscious to the emergency department. He is not known to have any history of mental illness. (video shows man trying to get out of the room while a psychiatrist tries to de-escalate the situation)

Q1-Mention 3 positive mental state findings.

Agitated, Uncooperative, Disoriented to place and person, Anxious.

Q2-Mention 3 things the doctor did right to de-escalate the situation

Speak in calm and clear tone, not touching the patient, stay in the same height as pt, maintain safe distance, show empathy, and avoid confrontation

Q3-If you were to interview the pt, mention 3 things to be safe.

Sti near the door, not stay in closed room, and have security near the room.

Q4- If the patient becomes aggressive, mention 2 classes of drugs that can be used and give an example for each.

Typical Antipsychotic: Haloperidol.

Benzodiazepine: Lorazepam.