جامعة الملك سعود
King Saud University

MEDICINE 438's REVIEW OF

CLINICAL PSYCHIATRY

Assessment & Management of Suicidal and Aggressive Patients

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Objectives

- To know the life-threatening psychiatric conditions.
- To understand their etiology, presentation, severity, and complications.
- To know the lines of management of such conditions.

EDITING FILE

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IMPORTANT | TEXTBOOK | LECTURER'S NOTES | EXTRA | GOLDEN NOTES

Assessment & Management of Aggressive Patients

◄ Introduction

- Aggression should not automatically be assumed to be psychiatric in origin.
    - Being mentally ill doesn't necessarily increase the risk of aggression
- The idea that people with mental disorders are more likely to be violent is a myth
    - Most are law-abiding and nonviolent
- Individuals with a mental disorder are much more often are victims of violence.
- 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.

◄ Aggression Vs. Violence Vs. Agitation

- **Aggression:** Hostile, threatening, and violent actions directed at person(s) or object(s), sometimes with no (or trivial) provocation.
- 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.
    - Take many forms, such as:
        - Physical injury.
        - Hurt feeling.
        - Damaged social relationships.
    - 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 (someone suddenly striking another person during argument).

❖ **Violence:** 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) at the low end of the spectrum and violence (e.g., homicide) 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 violence," usually when directed at children or spouse with goal of severely harming the target's emotional or social well-being.

◄ Aggression vs. Violence vs. Agitation

- **Agitation**: 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 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 nor provoked.

- **Disinhibition:** A state in which individual's capacity for pre-emptive evaluation and restraint of behavioral responses is decreased or lost. (particularly impaired in assessing the consequences of their actions. (Frequently seen prefrontal cortex lesions e.g., the curious case of Phineas Gage)

- **Impulsivity:** A state characterized by a proneness to act without thought or self-restraint; a habitual tendency toward "hair-trigger" actions. (can appreciate the consequences of their actions but they have trouble in exerting control over it)
    - Seen in psychotics (hyperactive mesolimbic reward system = desire for immediate awards), (hypoactive mesocortical reward system = impaired delayed gratification)

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

◄ 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).

◄ Disorders That are Associated With Aggressive Behavior

- Psychosis (mania, depression, schizophrenia, delusional disorder).
    - Extremes of age (elderly may be aggravated due to their dependance, very young children express their melancholic states in agitation)
- Personality disorders (antisocial, borderline, paranoid, narcissistic).
- Substance use disorder (alcohol, phencyclidine, stimulants, cocaine).
- Epilepsy.
- **Delirium.**
- Dementia.
- Neurodevelopmental disorders (intellectual disability, autism and ADHD).

◄ Assessment of Dangerousness (Predictors & Risk Factors)

- Past history of violence or aggression (single best predictor).
- Male sex[1], young age, poor impulse control.
- Alcohol or drug abuse/intoxication/withdrawal.
- Family history of aggression.
- Recent stressors, poor social support.
- Available means (e.g. Weapons).
- Verbal or physical threats (statement of intent).
- Paranoid features in psychotic patient.
- 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.

◄ How to Interview an Aggressive Patient?

- Consider security precautions, including not being in the room 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?).
- De-escalate angry behavior[2]. Will come in details in the next slide.
- Build an therapeutic alliance.
- Solve problems.
- If patient seems too agitated terminate interview.

FOOTNOTES

1. Contrary to common belief, increased levels of androgens (e.g., testosterone) does not result in elevated levels of aggression. Biobehavioral studies have correlated testosterone with the maintenance of an acquired behavior (e.g., if a person is already aggressive, testosterone surges will enhance his aggressive behaviour, if a person is not predisposed to aggression, testosterone surges will not enhance his aggressive behavior). Therefore testosterone is a reinforcer rather than a primary influencer of aggression.
2. Wait until the person has released their frustration and explained how they are feeling. Look and maintain appropriate eye contact to connect with the person. Incline your head slightly, to show you are listening and give you a non-threatening posture. Nod to confirm that you are listening and have understood.

◄ Communication-Based De-Escalation Techniques

- De-escalation is a behavior aimed to prevent the escalation of conflicts, either intrapersonal or interpersonal.

Communication

- **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.
  - Stay at the same height as the patient.
  - Avoid sudden movements.
- **Verbal:**
  - Speak in a clam & clear tone.
  - Personalize yourself (e.g., introduce yourself and make yourself relatable)
  - Avoid confrontation; offer to solve the problem.

Tactics

- **Debunking:** The technique of exploring the the triggers for aggression and discussing its possible solutions.
  - 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.
  - Focus on the big picture.

Monitoring

- Be acutely aware of progress.
- Know when to disengage.
- Do not insist on having the last word.

◄ 10 Domains of De-Escalation

1. Respect personal Space.
2. Do not be provocative.
3. Establish verbal contact.
4. Be concise.
5. Identify wants and feelings.
6. Listen closely to what the patient is saying.
7. Agree or agree to disagree.
8. Lay down the law and set clear limits.
9. Offer choices and optimism.
10. Debrief the patient and staff.

◄ Management of Aggressive Patients

- Doctors, Nurses, Security should treat such patient with understanding & gentleness as possible.
- Adequate security.
- Availability of more staff.
- Clear prevention policy to all.
- Remain calm & non-critical.
- Use minimum force with adequate numbers of staff.
- Calm patient down.
- Do not argue with the patient.
- **Physical Restraint:**
  - Assign one team member to each of the patient head and extremities. (to prevent biting)
  - Be humane but firm, don't bargain.
  - Use minimum force.
  - Start together to hold the patient and accomplish restraint quickly.
  - It's an emergency measure rather than a punishment.

- **Seclusion:**
  - Not as a punishment.
  - For the safety of patient, staff, property & others.
  - Regular check up on the patient.
  - Attend for the patient basic needs.
  - Evaluation of the condition by a Doctor.
  - Monitor patient through a screen.

- **Medications:**
- Once you have reached the decision to use medications treat aggressively (adequate doses)
- Important to use IM in critical situations.
- Oral drugs can be given during the de-escalation stage (or if the patient is cooperative)
  - 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 (may be added to antipsychotics to achieve a rapid strong response):
    - Diazepam 5-10 mg IV.
    - Lorazepam 1-2 mg PO/IM
    - **Best strategy in agitated patients:** high-potency antipsychotics + benzodiazepine every 30 minutes as needed, common combo: Haloperidol and lorazepam.
      - In epilepsy, withdrawal of alcohol or barbiturates.
      - Surgery if seizure is caused by a mass
  - CNS depressants: Barbiturates (e.g., phenobarbital), paraldehyde, or diphenhydramine: patients allergic or non-responsive to antipsychotics and benzodiazepines
  - Beta-blockers and lithium
- **Hospitalization:**
  - Admission may be needed to a secured psychiatric ward for further assessment and treatment.

Assessment & 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".***
- ***"The thought of suicide is a great consolation; by means of it one gets successfully through many a bad night". —Friedrich Nietzsche***

◄ Introduction

- Suicide risk assessment is a core competency that psychiatrists are expected to acquire.
- 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 before they die.

◄ Definitions

- **Suicide:** Self-inflicted death with evidence (either explicit or implicit) that the person intended to die. (Translated from the Latin word for self-murder)
- **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 (explore every stage of the plan)
- **Suicidal attempt:** Engagement in potentially self-injurious behavior in which there is at least some intent to die.
- **Suicidal intent:** Subjective expectation and desire for a self destructive act to end in death.
- **Deliberate self harm:** Willful self-inflicting of painful, destructive or injurious acts without intent to die.
- **Parasuicide:** Patient who self-mutilate themselves with no intention of dying.

◄ Epidemiology

- Globally, an estimated 11.4/100,000 people commit suicides every year, resulting in 804,000 deaths.
- Individuals who reports suicide ideation 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 vary 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.
- About 2/3rds of suicide completers are men
- Males: Risk increases steadily and reaches its peak after 75 years
- Females: Risk increases steadily and reaches its peak in the late 40s or early 50s

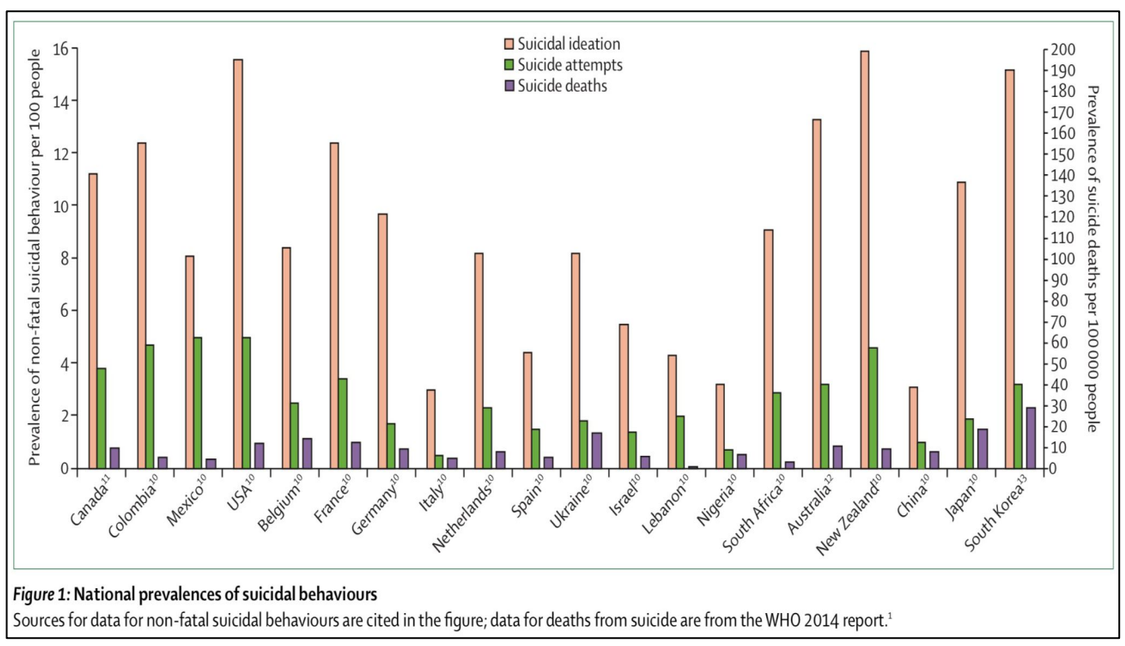
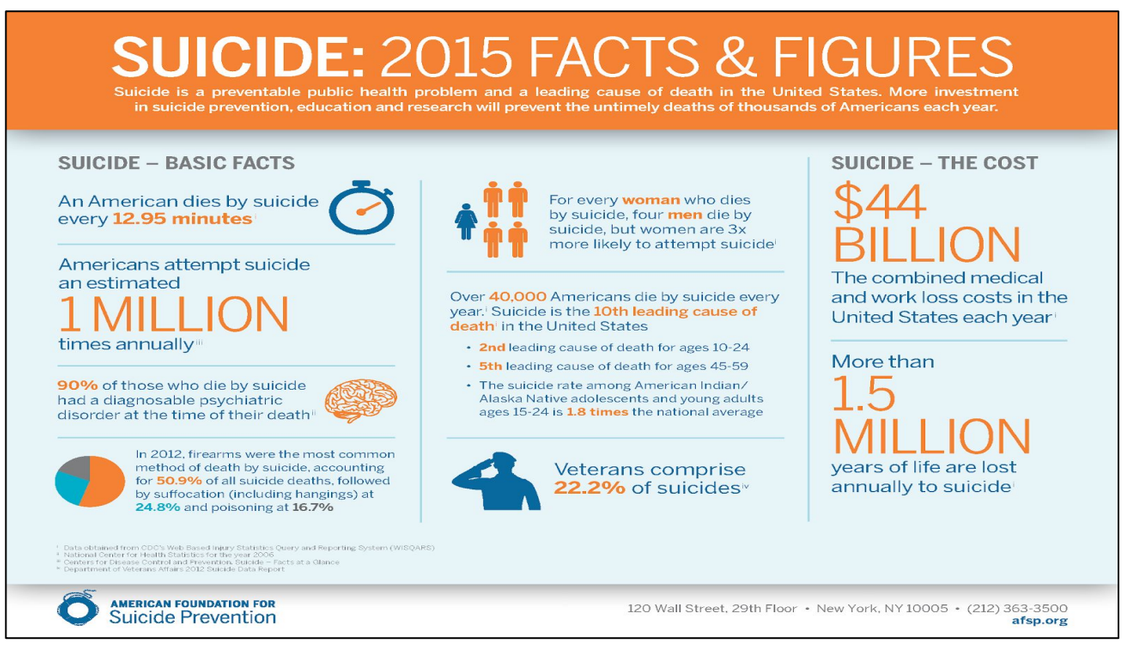


Figure 1: **National prevalences of suicidal behaviours**
Sources for data for non-fatal suicidal behaviours are cited in the figure; data for deaths from suicide are from the WHO 2014 report.[1]



◄ Risk Factors for Suicide in BRIEF

- Age > 45 years old.
- Male > Female.
- Separated, divorced, widow > single > married. Lack of support
- Previous suicide attempts or behavior.
- Family history of suicide behavior.
- Current psychopathological conditions: Severe depression/Substance abuse/Psychosis/Personality disorder.
- Concurrent serious or chronic medical condition. Involving pain or being dependent
- Lack of social support.
- Suicide note.
- Planning with precautions against discovery.
- Strong intent to die.

◄ Risk Factors for Suicide in DETAILS

- **Static and stable suicide risk factors:**
  - Age and Gender.
  - History of previous suicidal attempts. (best predictor)
  - History of self-harm.
  - Seriousness of pervious suicidality.
  - Previous hospitalization.
  - History of mental illness.
  - History of alcohol/substance use disorder.
  - Personality disorder/traits.
  - Childhood adversity.
  - Family history of suicide.

- **Dynamic suicide risk factors:**
  - Current suicidal ideations, communication, and intent.
  - Marital status.
  - Feeling hopeless.
  - Active psychological/psychiatric symptoms.
  - Treatment adherence.
  - Current substance use disorder.
  - Psychosocial stressors.
  - Access to weapon/firearm.
  - Chronic medical problems.
  - Chronic intractable pain.

- **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 (12.1-33%) 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.

◄ Risk Factors for Suicide in DETAILS

- **History of pervious suicidal attempts:**
  - 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.

- **History of alcohol/substance use disorder:**
  - 15-25% of patients with alcohol or drug dependence complete suicide.
  - 84% 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.

- **Family history 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 or shared family environment in which modeling and imitation are prominent.

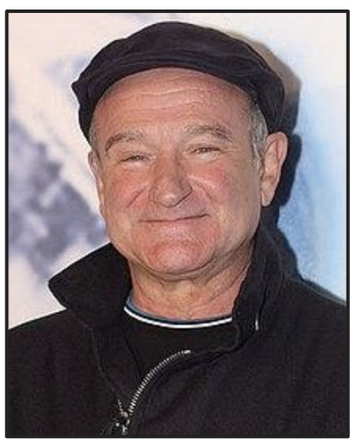
- **History of mental illness:**
  - Most consistently reported risk factor.
  - It is the most powerful risk factors for completed and attempted suicide.
  - All psychiatric disorders, except for intellectual disability, associated with increased risk.
  - 90% of individuals who die by suicide had an identifiable psychiatric disorder before death.
  - Severity of psychiatric illness is associated with increase risk of suicide.
  - Increased risk with multiple psychiatric comorbidities.
  - Most individuals with a psychiatric illness do not die by suicide, but some psychiatric illnesses are more strongly linked to suicidal behaviours than others.
  - Some patients may not have a history of a mental illness and may attribute their suicide to a logical conclusion due the futility of life.
    - An example would be of a patient with terminal cancer with no hope of being cured and wishes to die instead of being subjected to futile sessions of chemotherapeutic agony

◄ Risk Factors for Suicide in DETAILS

- **History of 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 lifetime disorder.
    - Early in depressive episode.
    - In the first week following psychiatric hospitalization.
    - In the first month following hospital discharge.
    - In the early stages of recovery.
      - Believed to be highest during the recovery phase, the patient may regain sufficient energy to finally carry out their suicide plan
  - The risk may be elevated by comorbid psychosis.
  - 15-20% of patients with anxiety disorder complete suicide.
    - Up to 20% of patients with panic disorder attempt suicide.

- **History of schizophrenia:**
  - Approximately 10% of patients with schizophrenia complete suicide.
  - Mostly during periods of improvement after relapse or during periods of depression.
  - The risk of suicide appears to be greater:
    - Among young men who newly diagnosed.
    - Who have a chronic course and numerous exacerbation.
    - Who discharge from hospitals with significant psychopathology and functional impairment.
    - Who have a realist awareness and fear of further mental decline.
  - 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.

- **History of chronic medical condition;**
  - 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.
  - 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.



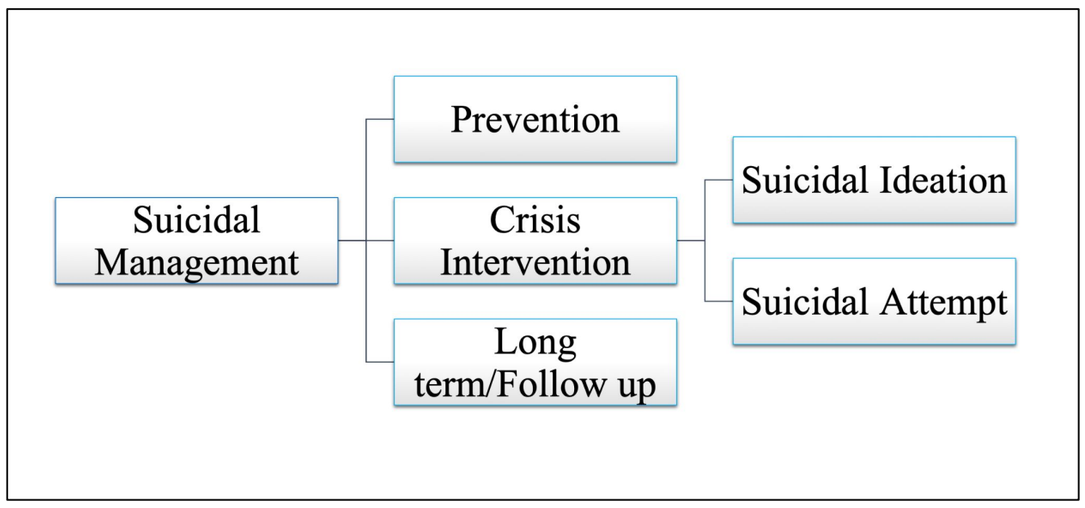
Williams died by suicide in 2014 at 63 years old. He had been diagnosed with Parkinson's disease, but an autopsy showed he had Lewy body disease.

◄ Risk Factors for Suicide in DETAILS

- **Feeling hopeless:**
  - Hopeless, or negative expectations about the future, is a stronger predictor of suicide (a finding independent of psychiatric diagnosis).
  - 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.
- **Psychosocial stressors:**
  - Personal losses (including diminution of self-esteem or status) and conflicts also place individuals, particularly young adults and adolescents 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:**
  - Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma).
  - Local epidemics of suicide.
  - 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.
  - **Freud's Theory:** Suicide is aggression turned inwards.
  - **Durkheim's Theory:** suicide is divided into 3 categories:
    - Egoistic suicide: people who are not integrated in social groups (e.g., lack of family)
    - Altruistic suicide: people who are excessively integrated in social groups (e.g., a solider's sacrifice for their country)
    - Anomic suicide: people with disturbed integration into social groups (e.g., social instability and financial troubles)
- **Biological:**
  - Serotonin abnormalities (Serotonin deficiency):
    - Decreased CSF level of 5-HIAA (5-hydroxyindoleacetic acid).
    - Result from a breakdown product of serotonin.
    - Increased 5-HT2A receptors. Upregulation.
    - Linked with impulsivity and aggression.
  - Hyperactive hypothalamic-pituitary adrenal axis
    - Depression is associated with chronically elevated levels of cortisol
    - Abnormal response to dexamethasone suppression test (high peripheral cortisol or strong central stimulation of its release or both)
    - Chronic stimulation of adrenal gland by its secretagogues leads to its hypertrophy in depressed individuals
  - PET Scan, fMRI:
    - Abnormal metabolism in prefrontal cortex.
  - Genetics:
    - Familial association beyond risk for specific diagnoses.
    - Acid cystein proteinase inhibitor (ACPI) gene and tryptophan hydroxylase enzyme (TPH) gene

◄ Protective Factors for Suicide

- Children in the home.
- Sense of responsibility to the family.
- Pregnancy.
- Religiosity
  - Protestants and Jews have higher suicide rates than Catholics and Muslims
- Life satisfaction.
- Reality testing ability.
- Positive coping skills.
- Positive problem solving skills.
- Positive social support.
- Positive therapeutic relationships.



◄ Prevention of Suicide

- 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 detect 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 or 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 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.

◄ SAD PERSONS Scale

Letter	Meaning	Number of Points Assigned
S	Sex: male	1
A	Age: < 19 or > 45 years	1
D	Depression or hopelessness	2
P	Previous attempts or psychiatric care	1
E	Excessive alcohol or drug use	1
R	Rational thinking loss	2
S	Separated/divorced/widowed	1
O	Organized or serious attempt	2
N	No social supports	1
S	Stated future intent	2

* Reference (57).

Each risk factor that is present is accorded a score of 1 point, for a maximum of 10 points.

Patterson et al[13] recommended:

- Close monitoring for patients with scores of 3 to 4
- To strongly consider hospitalisation for those with scores of 5 and 6
- Hospitalisation for further assessment for patients with scores of 7–10

Note: Regardless of the score obtained, overall clinical assessment is still paramount and the primary care physician should err on the side of caution.

◄ If Patient Present With Suicidal Ideation

- Use SAD PERSON Scale to identify current suicide risk factors.
- Assess suicidal ideations:
  - Passive suicidal ideation. E.g I wish I sleep and never wake up
  - Active suicidal ideation. Has a plan to commit suicide
    - 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).

◄ If Patient Present With Suicidal Attempt

- 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?
- Assess what patient did after this suicidal attempt?
- Looking for possible triggers (like in suicidal ideation)
- **Lithium** is the only mood stabilizer to reduce suicide risk in bipolar patients
- **Clozapine** is the only antipsychotic to reduce suicide risk
- **ECT** is recommended for the treatment of depression in suicidal individuals due to its quicker onset of action .

◄ Warning Signs

- The person making a will.
- Getting his or her affairs in order.
- Suddenly visiting friends or family members.
- Buying instruments of suicide like a gun, hose, rope, medications.
- **Sudden and significant decline or improvement in mood.**
- 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.
- Arrange follow up.
- Long term plan: Frequent follow up (depend on patient's need).
  - In each visit monitor:
    - Suicidal ideation/plan.
    - Psychiatric symptoms.
    - Trigger/Precipitating factors:
      - Substance/alcohol.
      - Medication adherence.
      - Pain/medical problems.
      - Psychosocial stressor.

◄ Suicidal Risk Documentation

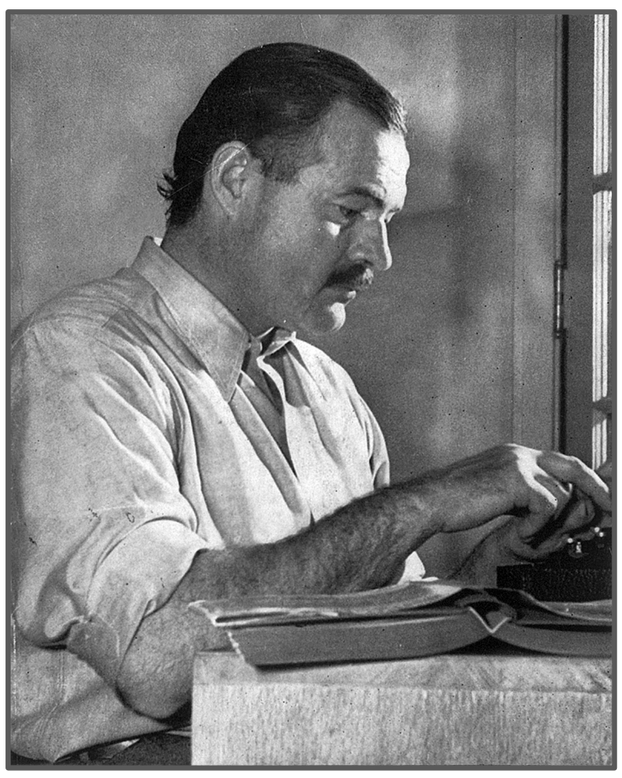
- Risk assessment including documentation of risk/protective factors.
- Record of decision making process.
- Record of communication with other clinicians and family members.
- Medical records of previous treatment.
- Address firearms.
- Consultation in difficult cases.

◄ 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.
- Once suicidal, always suicidal.
- Those who threaten it, don't do it.

◄ Inevitable Suicide

- Relies on the premise of some suicides being inevitable and may not be preventable
- Refers to patients who received the best care possible yet carried on with implementing their suicidal ideations
- Controversial, some consider the concept to be representative of therapeutic nihilism
- Most important predictor is a strong genetic history
  - Other predictors: history of emotional or sexual abuse and the increased number of risk factors
  - The patient must have received the best standard of treatment and the treatment must have failed to consider the suicide inevitable



The case of the nobel laureate Ernest Hemingway serves as a classical example of probable inevitable suicide

- His brother, sister, father and granddaughter all killed themselves
- One of his sons suffered refractory depression treated with several rounds of ECT
- Ernest Hemingway was hospitalized several times for suicide attempts
- He suffered from persecutory delusions (thought that people were following him with harmful intentions)
- His case was refractory to treatment with ECT, antidepressants and psychotherapy
- Before being discharged from a hospital for a suicide attempt he was reportedly heard to have said: “You and I both know what I am going to do to myself one day”.
- He killed himself with a shotgun six days after being discharged from the hospital for a suicide attempt

Quiz

1. Which of the following is most contributive to suicide prevalence rates?
   a. Depressive disorders
   b. Anxiety disorders
   c. Adjustment disorders
   d. Psychotic disorders

2. Which of the following markers is highly associated with aggressive behavior and suicidality?
   a. 5-HIAA
   b. ACh
   c. Dopamine
   d. Epinephrine

3. Which of the following statements is true regarding the epidemiology of suicide?
   a. It's more common in females
   b. Its incidence peaks during adolescence in both sexes
   c. Its incidence peaks during late 40s and early 50s in females
   d. None of the above

4. What does the term suicidal ideation best refers to?
   a. Thoughts of engaging in behaviour intended to end one's life
   b. Thought of engaging self-destructive behaviour without the intent to die
   c. Formulation of a specific method through which one intends to die
   d. Subjective expectation and desire to die

Answer Key: 1) A, 2) A, 3) C, 4, A

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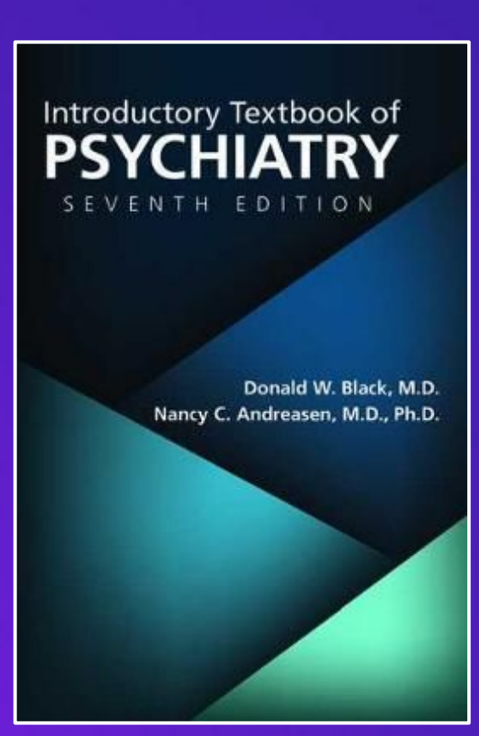

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