# SUICIDE

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- A significant number of people see their primary care physician within 3 weeks before they commit suicide.
- They come for a variety of medical problems, but rarely will they state they are contemplating suicide.
- Therefore, the practitioner must pay attention to the entire person; the physician must look for factors in the patient's life beyond the chief complaint.

# Individuals who are suicidal have a number of characteristics, including the following:

1) A preoccupation with death
2) A sense of isolation and withdrawal
3) Few friends or family members
4) An emotional distance from others
5) Distraction and lack of humor
6) Focus on the past
7) Haunted and dominated by hopelessness and helplessness

# Assessing Suicide Risk

- A clear and complete evaluation and clinical interview
- Although risk factors offer major indications of the suicide danger, nothing can substitute for a focused patient inquiry. However, although all the answers a patient gives may be inclusive, a therapist often develops a visceral sense that his or her patient is actually going to commit suicide.
- The clinician's reaction counts and should be considered in the intervention.

# Suicidal ideation

- Determine whether the person has any thoughts of hurting him or herself.

  Suicidal ideation is highly linked to completed suicide.

- Some inexperienced clinicians have difficulty asking this question.

# How do health professionals interview patients to assess suicide risk?

- Three hundred nineteen video-recorded outpatient visits in U.K. secondary mental health care were screened. 83 exchanges about suicidal ideation were identified in 77 visits. A convenience sample of 6 cases in 46 primary care visits was also analysed.

- A gateway closed question was always asked inviting a yes/no response. 75% of questions were negatively phrased, communicating an expectation of no suicidal ideation, e.g., “No thoughts of harming yourself?”. 25% were positively phrased, communicating an expectation of suicidal ideation, e.g., “Do you feel life is not worth living?”. Comparing these two question types, patients were significantly more likely to say they were *not* suicidal when the question was negatively phrased but were not more likely to say they were suicidal when positively phrased.

- 25% patients responded with a narrative rather than a yes/no, conveying ambivalence.

McCabe et.al.BMC Psychiatry (2017)17:122

# Suicide plans

- If suicidal ideation is present, the next question must be about any plans for suicidal acts. The general formula is that more specific plans indicate greater danger. Although vague threats, such as a threat to commit suicide sometime in the future, are reason for concern.

- The plan demands further questions. If the person envisions a gun-related death, determine whether he or she has the weapon or access to it.

# Purpose of suicide

- Determine what the patient believes his or her suicide would achieve. This suggests how seriously the person has been considering suicide and the reason for death.

# Potential for homicide

- Suicide is often thought to represent aggression turned inward, whereas homicide represents aggression turned outward. Because suicide constitutes an aggressive act, the question regarding homicidal tendencies must be asked.

- A mixed-methods study in the UK analyzed 60 homicide-suicides and found that most victims were spouse/partners and/or children. Most perpetrators were male (88%) and most victims were female (77%). Few perpertrators had been in recent contact with mental health services before the incident (12%).

# Additional questions

- Collateral questions should be asked based on the reviewed risk factors. These questions deal with any family members or friends who have killed themselves and include questions about symptoms of depression, psychosis, delirium and dementia, losses (especially recent ones), and substance abuse.

# Signs and risk factors

The following is a list of 12 things that should alert a clinician to a real suicide potential:

1. Patients with definite plans to kill themselves

2. Patients who have pursued a systematic pattern of behavior in which they engage in activities that indicate they are leaving life

3. Patients with a strong family history of suicide

4. The presence of a gun, especially a handgun

5.Being under the influence of alcohol or other mind-altering drugs

6. If the patient encounters a severe, immediate, unexpected loss
7. If the patient is isolated and alone
8. If the person has a depression of any type
9. If the patient experiences command hallucination
10. Discharge from psychiatric hospitals
11. Anxiety in all of its forms
12. Clinician's feelings

# assess for protective factors

1. Involvement in social networks of friends, family, and co-workers – networks support the individual, give meaning to life
2. Having a major long-term goal see small obstacles and losses in a different perspective.
3. Having a pet, such as a dog or cat
4. Having a therapist one feels connected to the key to treatment is talking about and sharing feelings and thoughts, not acting upon them.
5. Having a future event to look forward to
6. Having a strong religious faith that does not sanction suicide and affirms life.
7. Having someone in your life who is dependent on you.

8. Being in a loving relationship or partnership.

9. Refraining from keeping firearms in the house, or making sure that there is no ammunition available.

10. Making sure the individual is never alone Using suicide and crisis hotlines.

11.Seeking effective treatment of the underlying psychiatric disorder.

12.Recognizing that suicide represents a permanent solution to a temporary condition or situation.

13.Having someone to talk with and who listens “I hear you.”

14.Having and seeking meaning in your life (Viktor frankls method)

# Elevated inflammation index in patients with major depressive disorder

- O'Donovan A et al found that individuals with major depressive disorder (MDD) who attempt suicide or successfully achieve it have elevated inflammation compared with nonsuicidal patients.

- tumor necrosis factor-α, interleukin-6, interleukin-10, and C-reactive protein.

# Other sources of information

- Utilize all of the information available when assessing suicide risk including family interviews or interviews with friends or coworkers.

# Mental Status Review

**Appearance :**

dress and hygiene of patients who are depressed (eg, disheveled, unkempt and unclean clothing), the clinician should assess these individuals for other signs of suicide risk. First, look for physical evidence of suicidal behavior. This includes wrist lacerations and neck rope burns. Be aware that more than 1 sign can indicate suicidal behavior.

# Mental Status Review

**Affect :**

Depression and anxiety are commonly seen in people who are suicidal. One specific emotion of concern is the patient exhibiting a flat affect when describing his or her thoughts and plans of suicide and self-destructive behavior.

# Mental Status Review

**Thoughts :**

## Three types of thought changes represent areas for major focus and concern:

- The first consists of command hallucinations telling the patient to kill himself or herself. These are usually auditory in nature and often take the form of the deity's voice.
- The second type consists of delusions. These include, "The world and my family would be better off with me dead" or "If I take my life, I will be reunited in heaven with my mother."
- The third type of thought involves the obsession of a patient wanting to take his or her own life. Some patients focus their lives on their suicide.

# Mental Status Review

**Suicide and homicide:**

- Inquiring into suicide potential is an absolute requirement.

# Mental Status Review

**Judgment, insight, and intellect:**

- An assessment of the patient's judgment is important. How a person has handled stress and how he or she will handle it in the future are major concerns. Keep in mind that the less judgment the patient has, the greater the potential for suicide. Impaired decision making is associated with suicidal behavior in both adults and adolescents.

- The key idea with intellect assessment is to determine whether the person understands the sequences of his or her behavior. For example, did the person know that walking into traffic would be dangerous?

# Mental Status Review

**Orientation and memory:**

- The focus of this part of the mental status review is to determine if the person is delirious or has dementia. In either case, the patient, as a result of disorientation and loss of recollection, can perform many self-destructive behaviors.

# سوالات شایع و کلیدی برای شروع و ارزیابی خطر در فرد با افکار یا اقدام به خودکشی:

**الف) سوالات برای فکرو احساس به زندگی**

**بعضی وقتها مردم فکر می کنند زندگی ارزش زیستن ندارد، می توانید به من بگوئید شما در مورد زندگیتون چه حسی دارید؟**

**چه جنبه هایی از زندگی شما، آن را برایتان ارزشمند می کند؟**

**چه جنبه هایی در زندگی شما هست که سبب می شود فکر کنید زندگی ارزش زیستن ندارد.**

**آیا اکثرا آرزوی رهایی از این زندگی را داشته اید؟**

**چه اتفاقی و احساسی شما را به این نتیجه رسانده است؟**

# سوالات در مورد آسیب به خود - خوکشی و مرگ

**تا به حال به مرگ فکر کرده ای به آسیب زدن به خود چطور؟ به نظرت این افکار عملی هم هستند؟**

**از کی این افکار و احساسات را دارید؟ اتفاقی افتاد؟ مثل افسردگی یا از دست دادن و سوگ و ..**

**هر چند وقت یکبار این افکار سراغتون می یاد؟**

**آیا مزاحم زندگی عادی شما می شوند، چقدر قوی هستند؟و نزدیک به عمل آیا می توانید این افکار را متوقف کنید و خودتان را سرگرم مسئله دیگری کنید؟**

**آیا هیچوقت بر اساس این فکر و احساساتتان عمل کرده اید یا تا نزدیک عمل پیش بروید و منصرف شوید. مثل این که قوطی دارو را بردارید و قبل از خوردن قرصها آن را دوباره سرجایش بگذارید؟**

**چه چیزی کمک می کند به این فکر عمل نکنید؟**

تصوری از افرادی که دوستشان دارید و برایتان مهمند بعد مرگ خودتان دارید؟

برنامه ریزی دقیقی دارید؟

آیا قرص، چاقو یا هر وسیله ای که بتوانید به خود آسیب بزنید دم دست دارید؟

آیا تا کنون وصیت نامه یا نامه قبل خودکشی نوشته اید؟

آیا فکر و احساساتتان را با کسی در میان گذاشته اید؟

آیا کسی در این افکار و احساسات هست که بتواند به شما کمک کند؟