Application of The APA Practice Guidelines on Suicide to Clinical Practice

By Douglas G. Jacobs, MD, and Margaret L. Brewer, RN, MBA

© 2006, MBL Communications, Inc.
All Rights Reserved
For Electronic Distribution Only.

ABSTRACT

This article presents charts from The American Psychiatric Association Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors, part of the Practice Guidelines for the Treatment of Psychiatric Disorders Compendium, and a summary of the assessment information in a format that can be used in routine clinical practice. Four steps in the assessment process are presented: the use of a thorough psychiatric examination to obtain information about the patient's current presentation, history, diagnosis, and to recognize suicide risk factors therein; the necessity of asking very specific questions about suicidal ideation, intent, plans, and attempts; the process of making an estimation of the patient's level of suicide risk is explained; and the use of modifiable risk and protective factors as the basis for treatment planning is demonstrated. Case reports are used to clarify use of each step in this process.

CNS Spectr. 2006;11(6)447-454

Needs Assessment

In addition to being an exhaustive survey of the current understanding of the topic of suicide, the APA Guideline can be adapted as a routine part of clinical suicide assessments. The charts included provide a quickly understood outline that can inform and be easily adopted into clinical practice.

Learning Objectives

At the end of this activity, the participant should be able to:

- List at least three psychiatric diagnoses associated with increased risk of suicide.
- Identify suicide risk factors which can be modified to reduce suicide risk.
- Focus treatment planning on the patient's immediate safety and on ultimately reducing the patient's risk of suicide.

Target Audience: Neurologists and psychiatrists

CME Accreditation Statement: The Mount Sinai School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide Continuing Medical Education for physicians.

The Mount Sinai School of Medicine designates this educational activity for a maximum of 3 *AMA PRA Category 1 Credit(s)™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

It is the policy of Mount Sinai School of Medicine to ensure objectivity, balance, independence, transparency, and scientific rigor in all CME-sponsored educational activities.

Faculty Disclosure Policy Statement: All faculty participating in the planning or implementation of a sponsored activity are expected to disclose to the audience any relevant financial relationships and to assist in resolving any conflict of interest that may arise from the relationship. Presenters must also make a meaningful disclosure to the audience of their discussions of unlabeled or unapproved drugs or devices. This information will be available as part of the course material.

This activity has been peer-reviewed and approved by Eric Hollander, MD, professor of psychiatry, Mount Sinai School of Medicine. Review Date: May 11, 2006.

To Receive Credit for This Activity: Read this article, and the two CME-designated accompanying articles, reflect on the information presented, and then complete the CME quiz found on pages 474 and 475. To obtain credits, you should score 70% or better. Termination date: June 30, 2008. The estimated time to complete this activity is 3 hours.

Dr. Jacobs is the founder and president of Screening for Mental Health in Wellesley Hills, Massachusetts, associate clinical professor of psychiatry in the Department of Psychiatry at Harvard Medical School in Boston, Massachusetts, clinical associate in psychiatry at McLean Hospital in Belmont, Massachusetts, and chairperson of the American Psychiatric Association (APA) Practice Guidelines on Suicide. Ms. Brewer is a consultant to the Suicide Research Division at Screening for Mental Health.

Disclosure: Dr. Jacobs is a consultant to McNeil and Pfizer. Ms. Brewer does not have an affiliation with or financial interest in any organization that might pose a conflict on interest

Acknowledgements: The authors would like to thank the APA for use of the tables from the APA Practice Guidelines on Suicide.

Submitted for publication: March 6, 2006, and accepted on April 4, 2006.

Please direct all correspondence to: Douglas G. Jacobs, MD, Screening for Mental Health, 1 Washington Street, Ste. 304, Wellesley Hills, MA 02481; Tel: 781-239-0071, ext. 101, Fax: 781-235-6390; E-mail: djacobs@mentalhealthscreening.org.

INTRODUCTION

The American Psychiatric Association's Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors[1] distills an exhaustive survey of current understanding of the topic. The entire document is essential for appreciating the complexity of the subject. However, a summary of highlights can be adapted for everyday use in most situations calling for a suicide assessment by a psychiatrist. The steps illustrated in this review are:

- A thorough psychiatric evaluation with the identification of risk and protective factors;
- Specific questioning about suicide;
- Estimation of the level of suicide risk; and
- Treatment planning focused on modifiable risk factors

Case reports will demonstrate the utility of the Guideline.

Information Gathered from a Thorough Psychiatric Evaluation

The Guideline strongly emphasizes that a thorough psychiatric evaluation is the foundation of a suicide assessment. The psychiatrist's knowledge of suicide risk factors and protective factors is used during the evaluation process to identify relevant factors for the individual patient. Areas to be evaluated include the patient's current and past psychiatric diagnoses (with special attention to comorbidity); history of suicidal thoughts and actions; family history of suicide, attempts, and mental illness; personal strengths and vulnerabilities; acute and chronic life stressors; and; current complaints, symptoms, and mental state. The psychiatric symptoms of hopelessness and anxiety can be particularly relevant and substance use should also be assessed. Table 1 provides a concise summary of the wealth of information that comes from the psychiatric evaluation of patients with suicidal behavior.

Specific Questioning about Suicide

Direct and specific questions about suicide are essential in suicide assessment. The psychiatrist should ask about suicidal thoughts, plans, and behaviors. Accepting a negative response to an initial question about suicidal ideation may not be enough to determine actual suicide risk. A denial of suicidal ideation that is inconsistent with the patient's presentation or current depressive symptomatology may indicate a need for additional questioning or collateral sources of information. The following questions may be helpful when asking about specific aspects of a patient's suicidal thoughts, plans and behaviors (Table 2).

Estimation of the Level of Suicide Risk

Suicide occurs infrequently, even in high-risk populations. This statistical rarity makes suicide prediction, based on risk factors, either alone or in combination, impossible. Psychiatrists, however, can use the assessment of relevant suicide risk factors to help determine appropriate treatment settings and individual treatment plans. The objective of suicide risk assessment is to clarify the presence or absence of relevant risk and protective factors, and then estimate the patient's individual risk for suicide. The primary and ongoing goal of this assessment is to reduce the patient's suicide risk (Table 3).

Treatment Planning with a Focus on Modifiable Risk Factors

After the patient's risk factors and protective factors are identified the clinician can focus on those factors that can be modified in order to reduce suicide risk. Immutable risk factors, such as the patient's history, family history, and demographic characteristics, need to be recognized but they cannot be modified. Circumstantial risk factors that are difficult to modify, at least in the short term, include unemployment and marital difficulties. The focus of intervention needs to be factors that can be changed, risk factors that can be lessened, and protective factors that can be strengthened. Initial treatment should attend to the patient's immediate safety and address their psychiatric disorders (mood disorders, psychotic disorders, substance use disorders, and personality disorders) and symptoms, such as anxiety, agitation, hopelessness, or insomnia. Reducing these risk factors will reduce the patient's risk of suicide. Strengthening of protective factors, such as the social support system, is often done by educating family members or arranging for additional care through a hospital or day program. The treatment plan and each suicide assessment should be accurately documented (Table 4).

CASE REPORT 1

A 68-year-old white widower is brought into the Emergency Department after he was prevented from shooting himself by his son (Table 5).

© MBL Communications Inc.
All Rights Reserved.
For Electronic Distribution Only.

Step 1: History and Diagnosis

The psychiatric evaluation reveals a likely diagnosis of major depression, recurrent, severe and a history of one prior suicide attempt, an overdose, shortly after his wife died 3 years prior. He was hospitalized and treated with antidepressant medication and referred to a bereavement support group. He responded well and has not been on any medication for 2 years. (He was tapered off of his selective serotonin reuptake inhibitor [SSRI] after 1 year of treatment. He had experienced minor side effects.) Three months prior he had retired and he found the unstructured time to be more of a burden than a freedom. He began worrying more

© 2006 MBL Communications, Inc. All Rights Reserved. For Electronic Distribution Only.

TABLE 1.
Information from the Psychiatric Evaluation*

Current Presentation of Suicidality
Suicidal or self-harming thoughts, plans, behaviors, and intent
Specific methods considered for suicide, including their lethality and the patient's expectation about lethality, as well as whether firearms are accessible
Evidence of hopelessness, impulsiveness, anhedonia, panic attacks, or anxiety
Reasons for living and plans for the future
Alcohol or other substance use associated with the current presentation
Thoughts, plans, or intentions of violence toward others
Psychiatric Illnesses
Current signs and symptoms of psychiatric disorders with particular attention to mood disorders (primarily major depressive disorder or mixed episodes), schizophrenia, substance use disorders, anxiety disorders, and personality disorders (primarily borderline and antisocial personality disorders)
Previous psychiatric diagnoses and treatments, including illness onset and course and psychiatric hospitalizations, as well as treatment for substance use disorders
History
Previous suicide attempts, aborted suicide attempts, or other self-harming behaviors
Previous or current medical diagnoses and treatments, including surgeries or hospitalizations
Family history of suicide or suicide attempts or a family history of mental illness, including substance abuse
Psychosocial Situation
Acute psychosocial crises and chronic psychosocial stressors, which may include actual or perceived interpersonal losses, financial difficulties or changes in socioeconomic status, family discord, domestic violence, and past or current sexual or physical abuse or neglect
Employment status, living situation, including whether or not there are infants or children in the home, and presence or absence of external supports
Family constellation and quality of family relationships
Cultural or religious beliefs about death or suicide
Individual Strengths and Vulnerabilities
Coping skills
Personality traits
Past responses to stress
Capacity for reality testing
Ability to tolerate psychological pain and satisfy psychological needs

* The Guideline strongly emphasizes that a thorough psychiatric evaluation is the foundation of a suicide assessment. The psychiatrist's knowledge of suicide risk factors and protective factors is used during the evaluation process to identify relevant factors for the individual patient. Areas to be evaluated include the patient's current and past psychiatric diagnoses (with special attention to comorbidity); history of suicidal thoughts and actions; family history of suicide, attempts, and mental illness; personal strengths and vulnerabilities; acute and chronic life stressors; and; current complaints, symptoms, and mental state. The psychiatric symptoms of hopelessness and anxiety can be particularly relevant and substance use should also be assessed. This table provides a concise summary of the wealth of information that comes from the psychiatric evaluation of patients with suicidal behavior.

Reprinted with permission from the *Practice Guidelines for Assessment and Treatment of the Suicidal Patient, Second Edition* from the *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders Compendium*, (Copyright 2004).

Jacobs DG, Brewer ML. *CNS Spectr*. Vol 11, No 6. 2006.

TABLE 2.
Questions about Suicidal Feelings and Behaviors*

Begin with questions that address the patient's feelings about living

Have you ever felt that life was not worth living?

Did you ever wish you could go to sleep and just not wake up?

Follow up with specific questions that ask about thoughts of death, self-harm, or suicide

Is death something you have thought about recently?

Have things ever reached the point that you have thought of harming yourself?

For individuals who have thoughts of self-harm or suicide

When did you first notice such thoughts?

What led up to the thoughts (eg, interpersonal and psychosocial precipitants, including real or imagined losses; specific symptoms such as mood changes, anhedonia, hopelessness, anxiety, agitation, psychosis)?

How often have those thoughts occurred, including frequency, obsessional quality, controllability?

How close have you come to acting on those thoughts?

How likely do you think it is that you will act on them in the future?

Have you ever started to harm (or kill) yourself but stopped before doing something (eg, holding knife or gun to your body but stopping before acting, going to edge of bridge but not jumping)?

What do you envision happening if you actually killed yourself (eg, escape, reunion with significant other, rebirth, reactions of others)?

Have you made a specific plan to harm or kill yourself? (If so, what does the plan include?)

Do you have guns or other weapons available to you?

Have you made any particular preparations (eg, purchasing specific items, writing a note or a will, making financial arrangements, taking steps to avoid discovery, rehearsing the plan)?

Have you spoken to anyone about your plans?

How does the future look to you?

What things would lead you to feel more (or less) hopeful about the future (eg, treatment, reconciliation of relationship, resolution of stressors)?

What things would make it more (or less) likely that you would try to kill yourself?

What things in your life would lead you to want to escape from life or be dead?

What things in your life make you want to go on living?

If you began to have thoughts of harming or killing yourself again, what would you do?

For individuals who have attempted suicide or engaged in self-damaging action(s), parallel questions to those in the previous section can address the prior attempt(s). Additional questions can be asked in general terms or can refer to the specific method used and may include:

Can you describe what happened (eg, circumstances, precipitants, view of future, use of alcohol or other substances, method, intent, seriousness of injury)?

What thoughts were you having beforehand that led up to the attempt?

What did you think would happen (eg, going to sleep versus injury versus dying, getting a reaction out of a particular person)?

Were other people present at the time?

Did you seek help afterward yourself, or did someone get help for you?

Had you planned to be discovered, or were you found accidentally?

How did you feel afterward (eg, relief versus regret at being alive)?

Did you receive treatment afterward (eg, medical versus psychiatric, emergency department versus inpatient versus outpatient)?

Has your view of things changed, or is anything different for you since the attempt?

Are there other times in the past when you have tried to harm (or kill) yourself?

For individuals with repeated suicidal thoughts or attempts

About how often have you tried to harm (or kill) yourself?

When was the most recent time?

Can you describe your thoughts at the time that you were thinking most seriously about suicide?

When was your most serious attempt at harming or killing yourself?

What led up to it, and what happened afterward?

(cont. on pg 451)

© 2006 MBL Communications, Inc. All Rights Reserved. For Electronic Distribution Only.

and more about what he would do the next day to fill his time. His sleep was disturbed and he began awakening earlier and earlier each morning; suicide seemed to him to be the only solution.

Step 2: Specific Suicide Inquiry

The patient reluctantly admits to increasingly persistent suicidal ideation over the past 2 months. The thoughts began as fleeting but became more prevalent and intense until he felt he had no choice but to "blow my brains out." His son, who shares a two-family house with the patient, discovered the patient loading his shotgun early one morning.

Step 3: Level of Risk

There is little question that this patient represents a high risk of suicide. He should be admitted to the hospital on strict suicide precautions.

Step 4: Modify Risk Factors

His previous suicide attempt and recent retirement are significant risk factors for this patient. However, those factors cannot be changed. His depression can be treated and has responded to medication in the past. Aggressive treatment of the attendant symptoms of anxiety and insomnia will further reduce his short-term risk of suicide. A careful and well-documented discussion of the availability of weapons should take place with his son before he is discharged. Education of the patient and family should include a discussion of early symptoms of returning depression and the encouragement to seek treatment when symptoms first appear. Given the element of psychosocial precipitants present in both episodes of depression a referral to a psychotherapist would benefit this patient. Additionally, he could be encouraged to add some structured activity to his life, such as part-time or volunteer work. He should be advised to stay on antidepressant medication for a longer time period.

CASE REPORT 2

A 32-year-old married, white woman is referred for a consultation by her obstetrician (Table 6).

Step 1: History and Diagnosis

She is 6-weeks postpartum with her second child and is experiencing symptoms of postpartum depression. After the birth of her first child 3 years ago she experienced some feelings of depression with insomnia and fleeting thoughts of harming

TABLE 2 (cont).
Questions about Suicidal Feelings and Behaviors*

For individuals with psychosis, ask specifically about hallucinations and delusions	
Can you describe the voices (eg, single versus multiple, male versus female, internal versus external, recognizable versus nonrecognizable)?	Have there been times when the voices told you to hurt or kill yourself? (How often? What happened?)
What do the voices say (eg, positive remarks versus negative remarks versus threats)? (If the remarks are commands, determine if they are for harmless versus harmful acts; ask for examples.)	Are you worried about having a serious illness or that your body is rotting?
How do you cope with (or respond to) the voices?	Are you concerned about your financial situation even when others tell you there's nothing to worry about?
Have you ever done what the voices ask you to do? (What led you to obey the voices? If you tried to resist them, what made it difficult?)	Are there things that you've been feeling guilty about or blaming yourself for?
Consider assessing the patient's potential to harm others in addition to him- or herself	
Are there others who you think may be responsible for what you are experiencing (eg, persecutory ideas, passivity experiences)?	Are there other people you would want to die with you?
Are you having any thoughts of harming them?	Are there others who you think would be unable to go on without you?

* Direct and specific questions about suicide are essential in suicide assessment. The psychiatrist should ask about suicidal thoughts, plans, and behaviors. Accepting a negative response to an initial question about suicidal ideation may not be enough to determine actual suicide risk. A denial of suicidal ideation that is inconsistent with the patient's presentation or current depressive symptomatology may indicate a need for additional questioning or collateral sources of information. These questions may be helpful when asking about specific aspects of a patient's suicidal thoughts, plans and behaviors.

Reprinted with permission from the *Practice Guidelines for Assessment and Treatment of the Suicidal Patient, Second Edition* from the *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders Compendium*, (Copyright 2004).

Jacobs DG, Brewer ML. *CNS Spectr*. Vol 11, No 6. 2006.

© 2006 MBL Communications, Inc. All Rights Reserved. For Electronic Distribution Only.

herself and her baby. She was treated with an SSRI by her obstetrician and responded well. Her symptoms resolved. She was tapered off of the medication after 9 months and she was aware of the risk of recurrence with the birth of her second child and was started on antidepressant shortly after she began experiencing insomnia, 2-weeks postpartum. She is on a full dose of medication but her symptoms have not responded. She has trouble sleeping, worries about the safety of her children, has no appetite, and has anhedonia.

TABLE 3.
Guidelines for Selecting a Treatment Setting for Patients at Risk for Suicide or Suicidal Behaviors*

Admission generally indicated: high risk of suicide	
After a suicide attempt or aborted suicide attempt if:	
Patient is psychotic	Patient has limited family and/or social support, including lack of stable living situation
Attempt was violent, near-lethal, or premeditated	Current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident
Precautions were taken to avoid rescue or discovery	Patient has change in mental status with a metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting
Persistent plan and/or intent is present	
Distress is increased or patient regrets surviving	
Patient is male, >45 years of age, especially with new onset of psychiatric illness or suicidal thinking	
In the presence of suicidal ideation with:	
Specific plan with high lethality	High suicidal intent
Admission may be necessary: moderate risk of suicide	
After a suicide attempt or aborted suicide attempt, except in circumstances for which admission is generally indicated in the presence of suicidal ideation with:	
Psychosis	Need for skilled observation, clinical tests, or diagnostic assessments that require a structured setting
Major psychiatric disorder	Limited family and/or social support, including lack of stable living situation
Past attempts, particularly if medically serious	Lack of an ongoing clinician-patient relationship or lack of access to timely outpatient follow-up
Possibly contributing medical condition (eg, acute neurological disorder, cancer, infection)	In the absence of suicide attempts or reported suicidal ideation/plan/intent but evidence from the psychiatric evaluation and/or history from others suggests a high level of suicide risk and a recent acute increase in risk
Lack of response to or inability to cooperate with partial hospital or outpatient treatment	
Need for supervised setting for medication trial or electroconvulsive therapy	
Release from emergency department with follow-up recommendations may be possible: lesser risk	
After a suicide attempt or in the presence of suicidal ideation/plan when:	
Suicidality is a reaction to precipitating events (eg, exam failure, relationship difficulties), particularly if the patient's view of situation has changed since coming to emergency department	Patient has stable and supportive living situation
Plan/method and intent have low lethality	Patient is able to cooperate with recommendations for follow-up, with treater contacted, if possible, if patient is currently in treatment
Outpatient treatment may be more beneficial than hospitalization: lesser risk of suicide	
Patient has chronic suicidal ideation and/or self-injury without prior medically serious attempts, if a safe and supportive living situation is available and outpatient psychiatric care is ongoing	

* Suicide occurs infrequently, even in high-risk populations. This statistical rarity makes suicide prediction, based on risk factors, either alone or in combination, impossible. Psychiatrists, however, can use knowledge of suicide risk factors to help determine appropriate treatment settings and individual treatment plans. The objective of suicide risk assessment is to clarify the presence or absence of risk and protective factors, and then estimate the patient's individual risk for suicide. The primary and ongoing goal of this assessment is to reduce the patient's suicide risk.

Reprinted with permission from the *Practice Guidelines for Assessment and Treatment of the Suicidal Patient, Second Edition* from the *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders Compendium*, (Copyright 2004).

Jacobs DG, Brewer ML. *CNS Spectr.* Vol 11, No 6. 2006.

© 2006 MBL Communications, Inc. All Rights Reserved. For Electronic Distribution Only.

Step 2: Specific Suicide Inquiry

She has suicidal ideation accompanied with a feeling of persistent guilt about having a second child. She feels she is being punished for this "selfish decision". She thinks about driving her car off a bridge with her children in it. This began as a passing thought but has become so frequent that the patient no longer drives. She has not thought about any other methods.

Step 3: Level of Risk

This patient is a moderate to high suicide risk and could rapidly become high risk for both suicide and homicide. She is resistant to hospitalization and has significant family and community support. Her mother moved in with the family and is able to stay for another month or so. Her husband is able to take family leave after her mother leaves. Both her mother and her husband understand the diagnosis and the need for close monitoring of the patient. The patient consents to information exchange between the psychiatrist and her mother and husband. Frequent visits and phone contact with the patient and her family members may be an alternative to hospitalization.

Step 4: Modify Risk Factors

The family should be educated about removing any guns or other potential methods of self-harm from the home. Increases in

TABLE 4.
Treatment Planning with a Focus on Modifiable Risk Factors

Demographic	Male; widowed, divorced, single; risk increases with age; white
Psychosocial	Lack of social support; unemployment; drop in socioeconomic status, access to firearms
Psychiatric	Psychiatric diagnosis; comorbidity
Physical Illness	Malignant neoplasms; HIV/AIDS; peptic ulcer disease; hemodialysis; systemic lupus erythematosis; pain syndromes; functional impairment; diseases of nervous system
Psychological Dimensions	Hopelessness; psychic pain/anxiety; psychological turmoil; decreased self-esteem; fragile narcissism and perfectionism
Behavioral Dimensions	Impulsivity; aggression; severe anxiety; panic attacks; agitation; intoxication; prior suicide attempt
Cognitive Dimensions	Thought constriction, polarized thinking
Childhood Trauma	Sexual/physical abuse; neglect; parental loss.
Genetic/ Familial	Family history of suicide, mental illness, or abuse

HIV/AIDS=human immunodeficiency virus/acquired immune deficiency syndrome.

Reprinted with permission from the *Practice Guidelines for Assessment and Treatment of the Suicidal Patient, Second Edition* from the *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders Compendium*, (Copyright 2004).

Jacobs DG, Brewer ML. *CNS Spectr.* Vol 11, No 6. 2006.

TABLE 5.
Case Report 1

Evaluation: History, Diagnosis And Risk Factors	Risk factors include affective illness, previous suicide attempt, Psychosocial loss, and symptoms of anxiety and insomnia
Specific Suicide Inquiry	Suicidal ideation intensified and led to an interrupted suicide attempt by lethal method
Level of Risk	High
Treatment Plan to Modify Risk Factors	Aggressive treatment of depression, symptoms of anxiety and insomnia Removal of weapons from the home Education of the family and patient about early symptoms of recurrence Referral to psychotherapy

Reprinted with permission from the *Practice Guidelines for Assessment and Treatment of the Suicidal Patient, Second Edition* from the *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders Compendium*, (Copyright 2004).

Jacobs DG, Brewer ML. *CNS Spectr.* Vol 11, No 6. 2006.

TABLE 6.
Case Report 2

Evaluation: History, Diagnosis And Risk Factors	Risk factors include recurrent postpartum depression, increasing symptoms of insomnia and anxiety, and unresponsiveness to medication
Specific Suicide Inquiry	Increasing suicidal and homicidal ideation
Level of Risk	Moderate to high for both suicide and homicide
Treatment Plan to Modify Risk Factors	Aggressively treat depression and symptoms of anxiety and insomnia. Educate the family about worsening symptoms and about seeking immediate help if needed

Reprinted with permission from the *Practice Guidelines for Assessment and Treatment of the Suicidal Patient, Second Edition* from the *American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders Compendium*, (Copyright 2004).

Jacobs DG, Brewer ML. *CNS Spectr.* Vol 11, No 6. 2006.

©2006 MBL Communications, Inc. All Rights Reserved. For Electronic Distribution Only.

medication dosage and augmentation with another agent should be considered. Specific treatment for anxiety and insomnia will reduce her suicide risk by addressing those risk factors. The patient is breast-feeding and wishes to continue doing so. Therefore, psychotherapeutic interventions may be more acceptable to her than additional medications. Electroconvulsive therapy would be an appropriate treatment consideration if her depression continues. Frequent re-assessment is necessary with the understanding that more aggressive intervention may be needed. The patient and family might benefit from additional support at home, such as a nurse for the infant or a home health aide.

CONCLUSION

The APA Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors offers both an extensive discussion of the current understanding of the subject and a practical outline for conducting suicide assessments. It is suggested that the reader review the complete Guideline. This brief example of uses for the Guideline does not encompass the breadth and scope of the original nor does it offer the benefit of the extensive bibliography. The complete Guideline is http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm. ***CNS***

REFERENCE

1. American Psychiatric Association. *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors.* 2nd ed. In: *Practice Guidelines for the Treatment of Psychiatric Disorders Compendium.* Arlington, Va; 2004: 835-1027.

© 2006 MBL Communications, Inc.
All Rights Reserved.
For Electronic Distribution Only.