Integration of Suicide Prevention Into Outpatient Management of Bipolar Disorder

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Suicide prevention is a critical objective in the treatment of bipolar disorder. This article describes practical mechanisms by which monitoring and management of suicide risk can be integrated into the routine care of patients with bipolar disorder. Suicide risk is assessed in terms of inclination (the drive to commit a self-destructive act) and opportunity (access to lethal means). Intervention strategies are adapted to the needs of bipolar patients across 3 phases of treatment: the acute episode; the continuation phase, when symptom reduction has occurred but adaptive recovery has not; and the maintenance phase, in which optimization of adaptive function and vigilance against impending relapse are paramount. Integration of suicide prevention into the outpatient management plan begins with a routine discussion of suicide risk at the initiation of a treatment relationship, even in the absence of other known risk factors. This discussion paves the way for ongoing assessment of suicidality. Just as the recommended routine monitoring of every euthymic bipolar patient includes at least some minimal assessment for prodromal symptoms of acute mania or depression, every clinical visit can include sufficient probes to determine the need for new interventions specific to suicide prevention. Ongoing assessment of risk and protective factors can be linked to a range of individualized interventions designed to meet the varying needs of patients over time. The intensity of monitoring and interventions reflects the clinician's knowledge of risk factors and may be life saving, but it is also important that patients and others involved in their care understand that monitoring cannot guarantee safety.

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Prevention of suicide is an important objective in the treatment of bipolar disorder. Suicide is the eighth leading cause of death in the United States, where each year approximately 30,000 people die by suicide.[1] For every completed suicide, there are an estimated 25 attempts.[2] According to the Centers for Disease Control and Prevention, almost all people who kill themselves have a diagnosable mental or substance abuse disorder, or both.[2,3] Therefore, early recognition and treatment of depression and substance abuse or other acute psychiatric illness may offer a promising means of preventing suicide and suicidal behavior.

Data indicating high risk for suicide among patients with bipolar disorder in particular make a compelling case for emphasizing recognition and intervention in this potentially deadly illness. Approximately 48% of patients with bipolar disorder make at least one suicide attempt.[4] The majority of suicides among patients with bipolar disorder occur in association with the depressed phase,[5] and most are carried out within the first few years after onset of the illness.[6–8] Although the high rates of suicidal behavior (defined as *suicide*, *suicide attempt*, or *suicidal ideation*) associated with bipolar disorder may be greatly reduced by treatment,[9] the clinical need for assessment and management of suicide risk is never eliminated. To manage the risk of suicide for bipolar patients, the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) has drafted general recommendations for clinicians. The approach offered below is far from comprehensive and is not intended as a clinical or legal standard, but simply aims to encourage ongoing monitoring and provides a range of practical responses applicable to managing the risk of suicide in bipolar patients over a range of common critical clinical decision points.

INTEGRATION OF SUICIDE PREVENTION INTO A MULTIPHASE TREATMENT STRATEGY

This article first considers opportunities for integrating suicide prevention strategies into the general approach to

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Table 1. Suicide Risk Factors

Risk Factor	Comment
Factors related to inclination	
Current episode	Suicidal behavior is most associated with current depressive episodes[10]
Alcohol/substance abuse and other comorbid conditions	Untreated alcohol or psychoactive substance abuse greatly increases the risk of suicide.[9] Other comorbid conditions such as panic disorder and posttraumatic stress disorder are also associated with increased risk and warrant treatment[11]
Gender	Completed suicide ratio = 4:1 (male:female) Suicide attempt ratio = 1:3 (male:female)[12]
History of prior (impulsive) attempts	A history of prior suicide attempts characterizes the bipolar subpopulation at the highest risk for suicidal behavior. For this subpopulation, the collaborative care plan serves as a means of increasing the awareness of all those involved in the patients' care of signs and symptoms associated with past high-risk situations. At the outset of treatment, individuals who have expressed suicidal behavior previously are encouraged to establish a specific antisuicide component in their own plans aimed at minimizing inclination and opportunity for self-harm. Patients with history of impulsive self-destructive behavior present a problem for monitoring, since the presence of suicidal ideation is not a reliable indicator of immediate risk. Identification of individual triggers and coping strategies that emphasize reduction of opportunity may benefit some patients. Use of lithium or other medications with impact on impulsivity may also be helpful
Course	Major depressive episode pattern, rapid cycling, mixed episodes
Race/ethnicity	White individuals at higher risk[12,13]
Age	Adolescents and the elderly are high-risk groups[14–16]
Marital status	Higher risk in nonmarried individuals,[17] especially those with no dependents
First year postdiagnosis	Bipolar patients within their first year of diagnosis constitute a group with a special need for education about the potential risk for suicide. Clinical research demonstrates heightened risk in the first year postdiagnosis.[18] Thus, establishing a written collaborative care plan between patient, support network, and clinician is recommended even for first-episode patients without prior suicidal behavior. Recognition of periods of heightened risk such as recurrence of acute affective illness and early intervention are 2 prevention strategies that may reduce the risk of suicide. A collaborative care plan can inform and empower supports designated by the patient to be involved in the prevention of suicide
Factors related to opportunity	
Easy access to firearms (or identifiable lethal equivalent)	Patients in possession of firearms or other lethal equivalents maintain a high opportunity for suicide. The close proximity of access to lethal means creates a high-risk situation in a disorder with a risk of suicide that is, on its own, significant. Action is recommended to reduce access to firearms or other lethal means
Social isolation	Suicide rates are generally highest in areas of low population density and among those with few social supports[19]
Not in treatment	A treatment contract can help maintain therapeutic involvement and can include a specific suicide risk management plan. Support networks are recommended to minimize the amount of time a patient spends in isolation and to limit access to lethal means, thereby limiting a patient's opportunity

treatment with focus on the initiation of a treatment relationship and issues arising during ongoing management in the acute, continuation, and maintenance phases of treatment. More specific recommendations are then offered for assessment and interventions.

Initiation of Treatment

Soon after entry into treatment, psychiatrists often find favorable opportunities to educate bipolar patients about their illness, treatment options, and good mood hygiene strategies. The discussion of bipolar illness can include suicidality as a potential and therefore expectable symptom of the disease and an issue to be addressed when establishing a management plan. An initial individualized plan can be based on a review of current and lifetime risk factors (Table 1) and may draw on interventions such as those offered in Table 2. The treating psychiatrist's review of known current risk factors, organized in terms of inclination and opportunity as outlined in Table 2, should include, but is not limited to assessment of stressors, level of agitation, current mood state, and substance use as well as suicidal ideation. In addition, lifetime risk factors such as presence or absence of prior attempts should be discussed. Time pressures frequently impede the clinician's ability to consistently capitalize on this opportunity. Even when time allows for discussion, memory decay over time often blunts the impact of verbal interventions. Further erosion occurs when the burden of relaying the information and treatment plan to family members and other care providers is taken on by a symptomatic patient. This often leaves the patient without a clear plan or supports at times of greatest need. The simple practical measures described below can help overcome these barriers to assessment.

A written care plan that anticipates as many contingencies as possible can reduce communication problems and sometimes prevent negative outcomes. Routine distribution of enduring instructional materials can increase the frequency, volume, and consistency of information communicated by the treating psychiatrist in regard to suicidality. To achieve this end while minimizing time demands on the treating psychiatrist, STEP-BD provides an informational videotape and written materials in the form of a Collaborative Care Workbook.[20] The workbook is designed to both transmit essential information and enable

Table 2. Interventions

Nonspecific interventions
To reduce inclination
Sustain therapeutic relationships
Sustain periods of wellness
Abstain from alcohol and unprescribed use of mood-altering substances
Treat substance abuse
Create a treatment contract with doctors and significant others, to empower them in high-risk situations
Keep a daily mood chart
Develop a list of triggers to depressive episodes
List 25 pleasurable activities and choose at least 1 each day
Maintain contact with treating doctors
Assess suicidal ideation at each clinical visit
Allow time for recovery before returning to work or school
Tell people ahead of time not to take offense at provocative statements
Ask supports not to ask you to do things that will be more of a burden on you
Plan future-oriented activities
To minimize opportunity
Restrict access to firearms
Minimize access to lethal means
Educate significant others about risk of suicide
Encourage social contact
Specific interventions
To reduce inclination
Treat acute episodes (specifically depression)
Sustain periods of wellness
Minimize time spent in isolation
Increase social contacts
Assess suicidal ideation at each clinical visit
Activate treatment contract
Maintain adherence to medication treatment
Attend Alcoholics Anonymous/Narcotics Anonymous meetings
Keep home alcohol- and drug-free
Participate in religious affiliation
Maintain good sleep hygiene and regular schedule
Maintain good personal hygiene
Consider psychotherapy
Learn a thought-stopping technique
Keep a journal
Limit caffeine intake
Exercise
Implement problem-solving and coping skills
To minimize opportunity
Remove firearms, toxins, drugs
Eliminate stockpile of potential toxins (drugs)
Educate significant others about current risk of suicide
Encourage social contact
Minimize time spent in isolation
Include a contingency plan for responding to missed appointments
Include a contingency plan to manage decisions to end therapeutic relationships
Consider hospitalization

the patient to establish a written treatment plan. Other suitable enduring materials are available from patient advocacy groups and professional societies and can be used as a means to provide information about suicidal behavior.[21,22] These resources are summarized in Table 3.

Discussion of suicide risk with new patients takes place with the aim of including risk reduction strategies in the patient's written treatment plan. The plan can then be distributed to supports designated by the patient. The inclusion of other supports empowered by the patient is an important feature of the plan. Such supports make it possible to avoid the obvious limitations of plans that rely solely on the patient's judgment to recognize danger and formulate an action plan. Thus, under optimal conditions, the patient and supports have considered the issue of suicide risk and have an existing care plan that includes an individualized suicide risk management plan. This plan can be activated whenever necessary. Under less optimal circumstances, the recommendations provided below can be modified for immediate use by patients without a prior Collaborative Care Plan. Using the template provided in the Collaborative Care Workbook, an initial "default plan" can often be formulated in a matter of minutes. Since the clinician may determine the need for specific interventions at the first visit, the rapidity and efficiency derived from the availability of a template can enhance the safety of options less restrictive than involuntary hospitalization.

Table 3. Resources for Suicide Prevention Strategies

Organization	Telephone Number	Web Site
Suicide Crisis Center	1-800-SUICIDE (784-2433)	http://suicidehotlines.com
SA\VE (Suicide Awareness Voices of Education)	1-952-946-7998	www.save.org
AFSP (American Foundation for Suicide Prevention)	1-888-333-AFSP (2377)	www.afsp.org
Covenant House	1-800-999-9999	www.covenanthouse.org/en/standard/index.htm
Suicide and Suicide Prevention	...	www.psycom.net/.depression.central.suicide.html
National Mental Health Association	1-800-433-5959	www.nmha.org
AAS (American Association of Suicidology)	1-202-237-2280	www.suicidology.org/understanding suicide.htm

Multiphase Treatment Strategy

By applying the treatment phases defined by Kupfer et al.[23] for unipolar illness to bipolar illness, suicide prevention strategies can be integrated into the multiphase treatment strategy STEP-BD uses across all phases of bipolar illness (for a more complete description of these useful concepts, see Sachs[24,25]). This multiphase treatment strategy adds clarity to the complex task of treatment planning by prioritizing patient needs separately during the acute, continuation, and maintenance phases of treatment (Table 4).

During the acute phase of treatment, the priorities are safety and amelioration of acute symptoms that frequently include suicidality. The task of sustaining therapeutic optimism in the face of nihilism can be made easier when shared by a team of well-informed supports armed with a long list of potential interventions (see Tables 5 and 6).

Table 4. Integration of Suicide Prevention Strategies Into the Multiphase Treatment Plan

Phase	Treatment Procedures and Goals	
	General	Suicide Prevention
New patient intake	1. Education to understand bipolar illness and treatment options 2. Determine diagnosis a. Current clinical status b. Lifetime diagnosis c. Comorbid conditions 3. Implement initial treatment plan 4. Develop Collaborative Care Plan 5. Encourage support building	1. Discuss bipolar illness as a suicide risk factor and the need to manage risk 2. Assess other risk and protective factors 3. Include suicide prevention module in Collaborative Care Plan 4. Determine need for immediate specific intervention
All follow-up visits	1. Determine current clinical status 2. Monitor a. Stressors b. Comorbid conditions c. Psychoactive substance use d. Treatment response i. Adverse effects ii. Adherence/concordance 3. Determine follow-up interval	1. Assess potential suicidality (monitor inclination and opportunity) 2. Determine need for immediate specific intervention
Acute episode	1. Treatment for depression/mania 2. Implement harm reduction strategies as per Collaborative Care Plan	1. Assure safety a. Review current personal risk factors b. Review/activate personal protective factors c. Choose venue adequate for management of current inclination and opportunity d. Dispense medications in safe quantity e. Determine need to alert supports f. Determine follow-up interval
Continuation phase	Continue acute treatment strategies	1. Continue acute treatment strategies 2. Monitor inclination and opportunity
Maintenance phase	1. Revise Collaborative Care Plan 2. Implement prophylactic strategies a. Monitor for impending episodes b. Manage adverse effects	1. Consider revision of suicide prevention strategies a. Pharmacologic b. Support building c. Formal psychotherapies

Patient and care providers alike can derive strength from the knowledge that many options remain available. Transition from acute depression to continuation phase treatment begins when the patient is minimally symptomatic. Although this transition raises the prospect of an impending recovery, the transition from recovering to recovered status seldom occurs smoothly. The early phase of improvement can potentially heighten the risk of suicide by bringing energy to an otherwise suicidally depressed patient and by exposing the patient to additional stressors. STEP-BD recommends that acute phase strategies be continued until a stable remission has been achieved for at least 8 weeks. For many patients, the early months of recovery include weeks in which the full symptomatology of acute depression returns transiently. Such subsyndromal "relapses" are to be expected and indicate a need for maintaining vigilance regarding the risk for suicide and the need to minimize opportunity for self-harm.

When the indicators of inclination diminish, risk reduction strategies can be gradually tapered. Patients frequently experience the resolution of suicidal ideation on recovery from the acute episode and express desire to reduce the level of suicide precautions. Care providers can, however, be easily fooled by the deceptions of a clever patient intent on carrying out a lethal act. The question of how and when to taper precautions can create a dilemma, since it is always more desirable to err on the side of caution by sustaining the precautions 1 month longer than necessary rather than taper them 1 month too early. By conducting a review and revision of the Collaborative Care Plan during the maintenance phase, the treating psychiatrist can often get the help of the patient and support system in resolving this dilemma. At this time, the general maintenance plan can be reviewed with emphasis on the role of continued prophylactic treatment as part of the suicide prevention strategy.

The objectives of the maintenance phase are to sustain wellness and maximize the patient's quality of life. Success of the prophylactic strategy rests heavily on good mood hygiene, a competent support system, and concordance with/adherence to the pharmacologic regimen. Routine follow-up visits include monitoring for treatment adherence, monitoring for impending new episodes, and active management of adverse effects. The risk of self-harm may be reduced by incorporating strategies for recognition and management into a treatment plan formulated during periods of remission when the patient is less burdened by acute symptoms. In this context, suicidality is discussed as a symptom of the disease rather than a trait of the individual patient, and the Collaborative Care Plan is

discussed as a means of maintaining control in the face of a disabling episode. A proactive approach taken from the beginning can maximize involvement of family and other significant supports who may provide surrogate executive function for the patient during times of impairment.

ASSESSMENT

Integration of suicide prevention into the outpatient management plan starts at the initiation of the treatment relationship and continues at follow-up visits. For patients with mood disorder, every visit can include at least minimal assessment of suicidality. To accomplish this assessment, STEP-BD uses a standardized "Clinical Monitoring Form" for record keeping, which also assigns the patient a current diagnostic status at each visit.

Determining an appropriate management plan is, however, a challenge. While the research literature has increased our general understanding of risk factors, screening instruments cannot provide sufficient predictive value for clinical use. The problem of prediction becomes truly daunting when the issue is viewed from the perspective of a hypothetical screening instrument. Imagine that a serum suicidality test became available that far exceeds any currently available screening test. If such a test with 99% sensitivity and 99% specificity were used to screen 1 million people in the general population (with a suicide rate of 20/100,000/year), it would detect 198 of the 200 true positive cases. Of the 199,800 true negatives, our serum suicidality test with 99% specificity would yield 1998 false positives. This means that the accuracy of the positive screening test (predictive power = true positives/total positives) obtained in the 2196 cases with positive screening test results would only be 9% (189/2196). What if our imaginary serum screening test were used only in a very high risk population? A hypothetical sample of 10,000 with several risk factors including current hospitalization for a suicide attempt might have a risk for suicide approaching 1000/100,000 per year. In this instance, predictive value for a positive test would rise to 50% (99 true positives/99 true positives + 99 false positives) for the year. The ability to identify patients with these risk factors raises the issue of how to intervene for patients identified as being at high risk. Since our hypothetical screening test results are associated with risk over a 1-year period, immediate management presents another dilemma. Hospitalization offers a safer environment, but currently available predictors do not really inform clinical decision making as to when a high-risk patient should be hospitalized nor when discharge is appropriate. Furthermore, sole reliance on hospitalization as the clinical intervention for suicidality may place the patient in a position that discourages open communication.

In the absence of reliable predictors of immediate risk, what can be done for an individual bipolar patient? The STEP-BD Clinical Monitoring Form supports the assessment of suicidality and assignment of standardized quantitative rating (Table 5) at every visit. Record-keeping conventions for patients at risk recommend simple routine inquiry to gauge the patient's inclination and opportunity for suicide and documentation of any intervention. For this purpose, *inclination* describes the degree to which a patient desires to end his or her life, and *opportunity* refers to the ease to which the patient has access to lethal means. Considering inclination and opportunity separately as dimensions of risk helps to direct the clinician's evaluation of a patient's suicide risk and offers targets for intervention. The outcome of this evaluation structures the first steps in the process of formulating clinical interventions matched to the permutations of inclination and opportunity for self-destructive behavior such as indicated in Table 6.

Primary Considerations for Assessment of Inclination and Opportunity

While many factors may contribute to risk for suicide, in the interest of practicality we have narrowed the list to 12 salient items, summarized in Table 1. Note that, while half of suicides in bipolar illness occur within 6 years of onset, the other half can occur at any time, and there is no completely safe period. Changes in support systems, health, or substance abuse are only a few of the factors that can increase suicide risk even after many years of illness without suicide attempts.

INTERVENTIONS

Encourage Incorporation of Specific Harm-Reduction Strategies Into the Treatment Plan

Since suicide risk reflects both opportunity and inclination, harm reduction strategies can be focused on reducing a patient's access to lethal means (particularly firearms) and ensuring that patients are not isolated. It should be clear to patients that the presence of a lethal means and isolation are associated with in increased risk of self-harm. Patients are encouraged to include provisions in their Collaborative Care Plan to automatically increase the frequency of contacts with supports in response to predefined mood states and suicidality.

Determine Follow-Up Interval and Treatment Venue

Local standards and clinician judgment determine acceptable intervals for follow-up. In most circumstances when new medical treatment is initiated, a follow-up interval of 1 to 2 weeks is appropriate for managing most outpatients. Patients should know how they can readily reach the clinician in case of emergency. Patients with mild-to-moderate depression and good support systems may be more safely managed at longer intervals than severely ill patients who lack reliable supports, but all depressed pa-

Table 5. (A) Probe Questions and (B) Conventions for Rating Suicidal Ideation on the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) Clinical Monitoring Form[a]

A. Probe Questions

Were there times when you were feeling so bad that you felt life was not worth living?

What about actually thinking about suicide or harming yourself?

(Narrative note required if code > 1/4. If passive or active suicidal ideation present, document details and plan for safety. *Suicidal ideation* defined as patient's being weary of life, feeling that he/she would be better off dead, morbid preoccupation, thoughts of harming self, plans for self-destruction, or urge to end life.)

B. Rating Conventions

Code[b]	Frequency	Intensity
0	No suicidal ideation/ no morbid preoccupation	Not applicable
± 0.25	Rare, fleeting	Life not worth living
		Passive suicidal ideation (thoughts of death without plan for self-destruction, no action or urge to act)
± 0.5	Several days, fleeting	Life not worth living
		Passive suicidal ideation (thoughts of death without plan for self-destruction, no action or urge to act)
		Active suicidal ideation (suicidal thoughts with plan for self-destruction but no action or urge to act)
	Several days, persistent periods	Passive suicidal ideation (thoughts of death without plan for self-destruction, no action or urge to act)
± 1 (moderate)	Nearly every day, persistent most of the day	Life not worth living
	Nearly every day in any persistent period	Passive suicidal ideation (thoughts of death without plan for self-destruction, no action or urge to act)
	Several days, brief	Active suicidal ideation (suicidal thoughts with plan for self-destruction but no action or urge to act)
± 1.5	> 1 Persistent period	Active suicidal ideation (thoughts of death with plan for self-destruction but no action or urge to act)
± 2 (much more)	Nearly every day, persistent	Active suicidal ideation (thoughts of death with plan for self-destruction but no action or urge to act)
	Any	Active suicidal ideation with urges to harm self or has been self-destructive (not superficial gesture)

[a]Adapted with permission from Sachs and Conley.[26]
[b]Use only "0" or positive numbers.

Table 6. Inclination-Opportunity Matrix and Some Possible Interventions

	Opportunity		
Inclination	Low No readily available lethal means and frequent close scrutiny	Moderate Some lethal means available or frequently alone	High Lethal means readily available and frequently alone
High (moderate-to-severe depression/active suicidal ideation)	Treat acute episode; consider electroconvulsive therapy or medication to reduce suicidal ideation Use supports to manage nihilism	…	Eliminate access to lethal means; hospitalize unless supports are adequate to assure safety
Moderate (mild-to-moderate depression/ passive suicidal ideation)	…	Reduce access to lethal means; treat current episode	…
Low (not acutely depressed; manic or mixed episode)	Avoid unnecessary exposure to lethal means; prophylactic treatment	Avoid unnecessary exposure to lethal means; prophylactic treatment (lithium)	Reduce unnecessary exposure to lethal means; prophylactic treatment (lithium)

tients are at risk for self-destructive behavior. Patients with active suicidal ideation or other signs of high inclination warrant aggressive treatment aimed at reducing the depression and may require hospitalization since none of the currently available antidepressant treatments for outpatients delivers reliable results in less than 3 weeks and risk of suicide may increase in early improvement of depression. If measures are taken to adequately monitor the patient and reduce opportunities for self-harm (e.g., eliminate access to firearms and other lethal agents), many acutely depressed patients can be managed without hospitalization. Hospitalization should be offered as a reasonable means of reducing opportunity (1) if suicide is contemplated as a solution to problems, (2) if the patient is

actively planning for death, or (3) if the patient recently made an attempt to end his or her life.

Patients refusing hospitalization can be offered less restrictive treatment under circumstances in which supports are able and willing to provide adequate assurance of safety. Involuntary hospitalization can be life saving when no other reliable means are available to reduce opportunity, but is not in itself treatment, nor does hospitalization assure complete safety.

Accordingly, it is best to initiate treatment with a follow-up interval that avoids dispensing large amounts of potentially lethal medications (especially lithium and tricyclic antidepressants).

Interventions for Reducing Inclination

Depression is a risk factor for suicide even in patients evidencing no current self-destructive urges. Limiting the quantity of medication prescribed at any one time to amounts that would not be lethal if the entire amount dispensed were ingested does not by itself assure safety, but can lessen one potential source of lethality. Dispensing amounts of medication sufficient to ensure supply to the next appointment may require extra safety measures. Pharmacologic interventions have proven efficacious for treatment of depression and mania and for prophylaxis.

Mood stabilizers. Experts generally recommend that a mood stabilizer be included in the treatment regimen of bipolar patients in every phase of their illness.[27] Effective prophylactic treatment may reduce the risk of suicide by reducing the recurrence of new episodes, particularly depressive and mixed episodes. Some mood stabilizers may have specific antisuicide effects. Lithium, for example, reduces the risk of suicide in selected patients from about 30 times to about 6.5 times the risk in the general population.[28] This robust reduction (approximately 80%) in risk of suicide suggests the use of lithium as part of the maintenance treatment for bipolar patients in high-risk subgroups. Lithium does not, however, completely eliminate the risk of suicide, and risk of suicide increases in the year after discontinuation of lithium.[28] The benefit of other mood stabilizers is not well established.[29]

Antidepressants and electroconvulsive therapy. There are as yet no data suggesting a specific antisuicide benefit for any antidepressant medication in patients with bipolar disorder. Standard antidepressant agents are, however, effective for treatment of acute depressive episodes and for this reason may be useful in reducing the heightened inclination associated with depressive episodes. Overall, the efficacy of approved standard antidepressant medications is equivalent.[30] Therefore, the choice of medication for a specific individual is often based on considerations such as adverse effect profile, allergy, cardiac status, insurance restrictions, cost, and safety in overdose. Tricyclic antidepressants, particularly desipramine, are recognized for their lethality in overdose, and their use requires caution.[31–33]

The early phase of recovery is a period of potentially increased risk. Theoretically, suicidal behavior might occur during the resolution of the depressive syndrome if improvement in psychomotor retardation precedes the lifting of depressive mood and cognitions. There are no clear data supporting suggestions that some classes of antidepressant medication can cause or worsen suicidal ideation. Nonetheless, concern about the possibility of treatment-emergent worsening can be included along with other cautions when prescribing antidepressant medications. For patients at high risk for suicide, electroconvulsive therapy represents the safest, fastest, and most effective treatment option.

Antipsychotic medication. Patients with delusions, hallucinations, and severe agitation often benefit from adjunctive antipsychotic medications. Even in the absence of frank psychotic symptoms, antipsychotic medications may be useful in reducing acute suicidal ideation because of their effectiveness in reducing overstimulation.[34] Data from trials involving schizophrenic patients indicate that olanzapine, risperidone, and quetiapine may be more beneficial than haloperidol for this purpose.[34,35] Neuroleptic medications, particularly at high dosages, can increase dysphoria in some patients. Akathisia contributes significantly to dysphoria and may heighten the motivation for suicide as a means of eliminating intolerable suffering.[36] Akathisia occurs less often during use of atypical antipsychotic agents than during use of conventional antipsychotic agents.

Anxiolytic agents. Reduction of anxiety may be of benefit in management of patients with suicidal ideation. Despite their potential for abuse and the possibility of releasing the patient from protective inhibitions, benzodiazepines are often employed as short-term treatment. This class of medication has the advantage of rapid onset and appears to be reasonably safe when used judiciously. In the absence of a history of drug-induced disinhibition, the risk of harm from acute treatment with benzodiazepines is usually overshadowed by the benefit derived from the remission of overwhelming anxiety.

Verbal Interventions

In addition to pharmacologic treatments, psychosocial interventions may also play an important role in the treatment plan. Medication effects are not immediate. Adjunctive psychosocial intervention can both augment the medication regimen and provide immediate management of suicidal urges. However, psychotherapy should not be expected to be a cure for suicidal ideation. More modest aims are for psychotherapy to decrease inclination and help the patient and support members activate protective factors of the treatment contract.

While psychotherapy during acute periods of suicidal ideation can help both patient and family to minimize inclination and opportunity, it might be more helpful during

periods of wellness. During this time, a treatment contract can be developed to help protect the patient. Specific forms of psychotherapy that have been used in bipolar disorder are cognitive-behavioral therapy,[37,38] family-focused therapy,[39,40] and interpersonal and social rhythm therapy.[41,42]

Acknowledgment of suicidal ideation is an important element of any mode of therapy utilized to reduce suicidality. Elements from these formal therapies can be incorporated in the routine psychotherapeutic approach used by treating psychiatrists who carry out clinical management without traditional psychotherapy. Yet, it can be difficult for clinicians and family members to sustain participation when patients talk persistently about their suicidal thoughts. Frequently, the response to the chronic expression of nihilism is not constructive. Especially when several treatment options have been tried without success, care providers demoralized by the patient's lack of progress may find themselves agreeing with the patient's hopelessness. Others may cope by attempting to ignore or avoid the individual. The shortcomings of these strategies are obvious. Constructing a long contingency list of potential treatments and scheduling time (e.g., 15–60 minutes per day) for the patient to express nihilism and discuss suicidal ideation may offer a more sustainable and safer alternative plan for maintaining therapeutic optimism. Supports can learn to acknowledge the patient's hopelessness as a feeling state while questioning its standing as an unchangeable reality. This plan provides the patient assurance of being heard and reduces the widespread fear among supports that, once started, conversation will lead to an endless downward spiral. Clinical experience suggests that setting time boundaries is effective in managing inclination and progressing to activities that will further decrease suicidal behaviors. In practice, this strategy also restores the opportunity for supports to structure the patient's time with distractions more pleasurable than spending time ruminating on aspects of a life that appears not to be worth living.

A patient's opportunity to act on suicidal ideation can be reduced by removing access to lethal means and minimizing the time spent in isolation. A reduction in a patient's inclination for suicide can be a more daunting task for clinicians and support members. Following acknowledgment of suicidal thoughts, reminding the patient that suicide is not the final answer may be effective in lessening suicidal ideation and redirects discourse toward alternative ways to resolve threatening situations. Remaining mindful of positive aspects in a patient's life can be key in sustaining hope during times of heightened suicidality.

SUMMARY

The risk of suicide in bipolar patients is high. Despite the identification of numerous risk factors, there is no clinically useful screening tool to determine immediate individual risk and no means to guarantee absolute long-term safety. Although much of what is suggested above is offered in the absence of evidence, there are many opportunities to integrate practical, low-cost suicide prevention strategies into the outpatient treatment plan for bipolar patients. The 3 basic elements are (1) routine assessment of inclination and opportunity for suicide, (2) education of patient and family regarding risk factors, and (3) integration of suicide prevention strategies into a written treatment plan. Well-intentioned recommendations for education of patients and supports can have greater impact when translated into practical, written, time-efficient procedures. Use of written materials like the STEP-BD Collaborative Care Workbook can aid the patient and treatment team by providing enduring reference materials and fostering the development of a personalized written treatment plan. Knowledge of risk and protective factors and identification and empowerment of supports who can act as surrogates performing executive functions at times when illness diminishes the patient's capacity are central to a successful treatment plan.

Drug names: desipramine (Norpramin and others), haloperidol (Haldol and others), olanzapine (Zyprexa), quetiapine (Seroquel), risperidone (Risperdal).

Disclosure of off-label usage: The authors have determined that, to the best of their knowledge, no investigational information about pharmaceutical agents has been presented in this article that is outside U.S. Food and Drug Administration–approved labeling.

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