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PREDICTING AND PREVENTING HOSPITAL AND CLINIC SUICIDES

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INTRODUCTION

At various times in the assessment and treatment of suicidal patients in hospitals and clinics key decisions must be made, by the clinician in charge, and by the mental health staff. Examples are hospitalization itself, and the timing of discharge; when should special observation and precautions be instituted, and when should these be discontinued; how make choices among treatment modalities; what is the role of policy and procedure guidelines . The goal of this chapter is to clarify and amplify the decision process and implementation in both their clinical and ethical-legal aspects.

By contrast, the goal of suicide prevention is an ideal. Ideally treatment in psychiatric hospitals would prevent suicides. But in fact suicides occur, sometimes in the hospital itself, and often in the weeks and months immediately following discharge from the hospital. Part of the explanation of course is that we do not completely understand the psychology of suicidal people, nor do we

completely understand our interventions, for example ~~when~~ antidepressant drugs, lithium carbonate, electroshock, and psychotherapy. More importantly, mental illness (and treatment) accounts for only one of many elements in the complex causation and prevention of suicide.

It would be difficult to provide evidence that in-patient hospitalization is a necessary or even always helpful therapeutic intervention for acutely suicidal patients. However, community standards and expert opinions strongly support this route for the high risk patient, and ethical considerations may make a careful study of the problem impossible (Brent, Kupfer, Bromet, and Amanda, 1988). Nevertheless, proper diagnosis and treatment of acute psychiatric disorders could dramatically alter the risk for suicides.

It is fair to say that each suicidal patient is different, and what is helpful for one may be harmful for another. Therefore community standards expect the doctor, assisted by the staff, to give careful consideration to each important decision, weighing the expected benefits against the anticipated risks (and costs), after a competent effort to gather a reasonable amount of information about the patient, and especially about the patient's potential to commit suicide. There is a difference however between an "ideal" performance by the doctor and staff (as might be described in reference books such as this one), and what people can do in real situations. What courts call the

"standard of care" is what the average competent and prudent professional would do, rather than some ideal of perfection.

SUICIDAL PATIENTS

In the argument over which is needed more, research on assessment or research on treatment, my choice is for efforts to improve treatment. We already are able to identify large numbers of suicidal patients, and know of many treatment failures. For example Rich and colleagues (1986) estimated that approximately 20% to 25% of the suicides in San Diego had been in treatment when they killed themselves. Approximately half of the patients admitted to a psychodynamically oriented psychiatric treatment ward in Los Angeles, during the three years I was in charge, came there because they had attempted suicide or communicated thoughts of attempting suicide.

We often identify patients as "suicidal" because of associated "risk factors", which make these "suicidal" patients resemble people who have committed suicide. I have tried to quantify the concept of "suicide risk" as a statement of probability of suicide death within one year (Litman, 1974). For example follow-up research indicates that on average patients who are hospitalized on a psychiatric unit, after a suicide attempt, commit suicide after discharge at the rate of one or two out of one hundred in the next year. This type of risk assessment is based on solid research but is not of much help for the hospital

clinician since any prediction based on statistical factors will predict a 95% probability that even the most suicidal person will still be alive one year later. Moreover, the emergency consultant is usually primarily concerned with evaluating the suicide danger for the next 48 or 72 hours.

EMERGENCY CONSULTATION

Emergency consultations occur in the context of concern and apprehension by the patient and/or relatives and friends, often after a suicide attempt or threat, or because the patient has expressed severe panic or serious depression. The focus of the consultation is on the present problem, its onset, its course, and the most recent cause for concern. Ideally the emergency consultant would have a more complete history of the presenting problem, gathering information from informants whenever possible to supplement the report of the primary patient. The purpose is to arrive at a tentative diagnosis if possible especially to determine whether the present situation represents a true crisis in the life of the patient, or whether this patient is chronically suicidal, what Maris (1981) called living a "career" ~~or~~ OF suicide. In a true crisis the patient has been getting along with a reasonably good adjustment until one of life's hazards, such as a loss, or a threat of loss, or injury, or some trauma, upsets the patient's psychological balance, causing that person to become perturbed, and consider suicide. Persons in crisis should have a great

deal of support and crisis therapy beginning with the emergency consultation, because usually they recover and regain their former psychological level. By contrast, hospitalization is much less effective, as suicide prevention, for persons who suffer from chronic suicidal psychiatric disorders, such as dysthymia with recurrent major depression, schizophrenia with suicidal ideas, alcoholism and drug abuse, or personality disorder (Litman, 1989). The special areas for assessment are stress, support, vulnerability, and suicidality.

Stress. In true crisis situations the stress is obvious. An example I encounter frequently is the rejected husband of a divorcing wife. Some men, especially those with a great deal of unadmitted dependency, react with angry destructive threats of suicide or even homicide. There is enough statistical reality to such threats to justify taking them quite seriously. There is some resemblance here to a terrorist threat, at least some wives see it that way. The intelligent response to such a threat is to play for time, to let hot feelings cool, and to negotiate. The emergency consultant may find himself cast as mediator. For example, he may suggest a deal to the parties, if the wife will concede some time and the possibility down the line of a reconciliation, the husband will be agreeable to entering the hospital for a period of cooling off and psychotherapy.

Support. The consultant evaluates the amount and quality of the support available through people, and living circumstances. For example: Some friends with whom he was visiting brought in a journalist who had been found with his head in the gas oven attempting to asphyxiate himself. He was depressed over allegations that he had libeled a former friend in his writing. The author felt the allegation was untrue, but it would take a great deal of time and effort to defend himself. Beyond that he wasn't totally sure whose side his wife was on. There were however numerous friends who rallied to his defense and the people he was visiting said that he could stay with them, and they would not let him out of their sight, so a tentative decision was reached to treat him as an out-patient. I saw him daily, or talked with him on the telephone, and observed that the suicide risk receded rapidly. He was eventually treated as an out-patient.

On the other hand, living alone is a risk factor, and sometimes the hospital is necessary to shelter a suicidal person from a hostile and provocative environment.

Vulnerability. Vulnerability is associated especially with psychiatric pathology, and symptoms such as fear, panic, depression, helplessness and hopelessness. Panic associated with depression has been overlooked in the past as an important danger signal (Weissman and Klerman, 1989) (Fawcett 1988).

My preferred psychodynamic model for suicidal vulnerability is adapted from Menninger - Freud. (Litman, 1989) In this concept the mind is organized in levels or hierarchies of adaptational complexity. At times, in some people's lives, due to stress and disease, the organization falters. The vital balance is upset or perturbed and the person regresses to less complex more primitive levels of adaptation. Suicide then is a result of a regression to the deepest level of adaptational disintegration, or more accurately suicide is the choice of death rather than suffering disintegration. Some people cannot, will not, tolerate the loss of their sense of a coherent self. Beyond the loss of money, health, and love as motivation through pain, there is a sense of threatened identity regained and confirmed by suicide. "If my life can't be my way then it will be no way."

Suicidality. What may be neglected or omitted in the emergency consultation is a painstaking investigation of the patient's suicidality. Where did the idea of suicide originate and how did it develop? What does it mean to the person? Under what circumstances was suicide an option? Under what conditions in the future would the patient actually carry it out? If the patient has already made a suicide attempt, what was the meaning? Was it an appeal? If an appeal has the message been heard, and has there been a reaction? Has there been a change in the patient's

circumstances? What is the patient's estimate of the chance of repeating the suicide attempt? Part of the emergency crisis therapy is to try at least to get involved with the patient and the patient's own idea about the meaning of his/her suicidal thoughts and actions, and to give a supportive interpretation about them, and to offer hope.

THE CASE OF JOSE GARCIA

This is an example of an emergency consultation. The presenting problem is his depression over forced retirement due to injury. His condition is complicated by certain physical problems, diabetes and visual disorder. He has a positive history of resourcefulness and industry, and he has a supportive home and family who are concerned about him. The most serious complication is alcoholism. So the doctor needs to give this patient and family a hopeful attitude with attention to rehabilitation, possibly another type of job with the railroad, and a recommendation that the patient and family should involve themselves with Alcoholics Anonymous and Alanon. The diabetes and visual problems need attention.

The one glaring omission in the consultation is the failure to investigate the potentiality for suicide. To what extent has Mr. Garcia thought about ending it all, or that he would be better off dead? Could there come a time when he feels that he might take his own life? If he has some fear that this might happen, it would be a good idea to

get the guns out of the house. Sometimes with a patient like Jose Garcia we discover, in the emergency consultation, that he has indeed had suicide thoughts, and even taken out his gun and gone through a type of rehearsal, thinking how he might kill himself. If the issue of hospitalization is raised and then rejected by the patient and the family, or postponed by both the patient and the doctor, it is important that the patient and family be warned that there is a danger of suicide, and somebody should be with that patient and keep an eye on the patient, and again that the guns should be removed.

THE DECISION TO HOSPITALIZE

Once the decision has been made to hospitalize the patient, care should be taken to implement this as rapidly and safely as possible, since this is a time of great tension and often ambivalence on the part of the patient and family. In making this decision the patient and the family have to be informed of their treatment options, and the special reasons that hospitalization is indicated, and they must give informed consent.

The advantages of hospitalization are many. In the first place the patient is taken out of a toxic environment, especially drugs and alcohol, removed from stress temporarily at least, and given shelter and safe haven in the hospital. In the hospital there is time and relative safety to assess the situation, consider options, recall

past strengths and regain perspective. The hospital is where many different treatment resources are concentrated, in addition to the supportive milieu. For example there is psychological testing and psychological therapy, group therapy and various other specialities such as occupational and art therapy, counseling for family, and overall observation by the nurses and other members of the staff who can keep track of the patient from hour to hour. Consultation through case conferences and other physicians is also easily available, and there are opportunities for physical examinations and treatments, and laboratory studies.

At the same time hospitalization incurs risks. Hospitals are not always safe. I estimate that there are about 300 suicides a year in psychiatric hospitals (Litman and Farberow,), and several times that number in the immediate post discharge period. Psychiatric hospitals are stigmatizing. For most people they are frightening, at least at first. For many people the psychiatric hospital is felt as a blow to their self-esteem. Some people interpret hospitalization negatively, as a sign that they are a hopeless mental case. Hospitalization may remove patients from their chief sources of psychological support, for example from their family or their work. There may be problems in the patients' lives that have to be resolved sooner or later, and which may get worse while the person is in the hospital. Finally, hospitalization is extremely

expensive financially and this may increase a depressed person's sense of quilt.

The Case of Faye

This case illustrates the value of brief hospitalization for a person who is chronically depressed and recurrently psychotic. It is vital to bear in mind her great fear of hospitals. She is in desperate need of treatment with antipsychotic drugs. Balancing the benefits of hospitalization against the risks I would recommend a short hospitalization aimed at handling the brief psychosis, and quickly discharging the patient. At all times with this patient there is a mild, chronic, suicide risk which must be accepted, since suicide is unlikely unless the patient feels totally helpless and totally exposed to her magical fears and paranoid projections. She does need to be treated with a great deal of tact and kindness and support during the hospitalization, with the assurance that she will soon be discharged. Prolonged hospitalization could be quite damaging for Faye, and it would not be effective as suicide prevention.

The Decision Not to Hospitalize. Many suicidal crises do not require hospitalization, and can be resolved successfully with varying amounts of professional assistance. However if hospitalization has been considered and rejected or postponed, ideally the psychiatrist would

stay in reasonably close touch with the patient, monitoring the progress of the patient and the suicidal feelings, prepared to reevaluate for hospitalization if the patient is not improving, or if there is an obvious barrier to developing a therapeutic alliance.

In the long view, psychiatric treatment in hospitals has little to offer as suicide prevention for persons who are chronically suicidal as a result of certain chronic mental disorders, for example dysthymia with recurrent major depression, addiction, schizophrenia, and suicidal borderline personalities. There is no quick guaranteed anti-suicide prophylaxis, either through interpretation or through medication, and new developments in psychiatry and in public health have not made a dramatic change in the suicide rate. The basic element in treatment is a continuing stable and dependable doctor-patient relationship. I will discuss this later under the heading "Out-patient Treatment".

INVOLUNTARY COMMITMENT TO A PSYCHIATRIC UNIT

This is never an easy decision since it involves a political judgement as much as clinical judgement. Laws vary among the states but essentially provide that a qualified mental health professional can certify a patient to be held for 2 to 4 days, with various provisions for review by judicial authorities. The requirement is that the patient is evaluated as mentally ill and an imminent danger

to himself or others, or so gravely disabled by mental illness as to be unable to care for the most basic needs. Obviously to hold persons behind locked doors against their will is a serious matter calling for a great deal of consideration, carefully weighing the risks against the benefits. For some suicidal people who are obviously delusional, confused, or extremely agitated the benefits are obvious. For some suicide attemptors, commitment delivers a message that we take them seriously, and that in itself is therapeutically beneficial.

Gutheil ( ) has described a process of evaluating competence on one hand, and dangerousness on the other, and recommends involuntary commitment for those subjects who are relatively incompetent (out of control), and highly dangerous. A great disadvantage of involuntary commitment is that it often interferes with the patient-doctor relationship. If there is a threat of incarceration will the patient be open and trusting with the interviewer in describing the patient's suicidal state of mind? Voluntary admission and the least restrictive alternative are preferable options. Often the resistance of a patient to entering the hospital can be dealt with by a sensitive interpretation of the patient's fear of the hospital, which often is paranoid and may be extreme. Keep in mind that in paranoid people it is obvious to them that the hospital is a front for their enemies. Many people are afraid that in the hospital they will be abused, so hospitalization is

interpreted as a threat. Before certifying such a patient the full extent of the possible negative side should be explored. Then the decision is a matter of judgement.

The Case of Mr. Z

This is an emergency case which may well require involuntary hospitalization because the patient is a danger to himself and others. There is a high degree of suicide danger involving a combination of depression and panic in a man who is in a crisis and not responding to standard treatment as an out-patient. There have been five months of unsuccessful treatment complicated by suicidal thoughts and a couple of suicide attempts, and there have been unsuccessful efforts to have the patient hospitalized. As the emergency consultant on this case I would call Dr. Freud and with his cooperation (or not) I would move forcefully toward hospitalization, including involuntary commitment if needed. In the interim I would advise the wife not to let Mr. Z out of her sight. If there is a financial problem he should be taken immediately to the Veterans Administration Hospital. There he should be on suicide observation for the first 48 or 72 hours. The actual level of suicide precautions will be determined by talking with him and observing him at the admission examination. He may be very relieved to be in the hospital in which case only a low level of observation is necessary. Or he may be extremely resistant and panicked in the hospital, in which case a high

level of observation will be necessary. In the hospital he will be placed on antidepressant medication, and he will be observed, and there will be efforts to be supportive and help him develop confidence in himself. There is a possibility that if antidepressants don't work to relieve depression, electroshock treatment will be considered. He has a reasonably good support system to return to when he leaves the hospital, but he does need job counseling and will eventually have to go back to work.

INITIAL ASSESSMENT

The initial assessment takes place over the first 72 hours starting day one. This is the time when the patient is under special stress to adjust to the hospital, and the staff is getting acquainted with the patient. It is important to be alert to the possibility of an unfortunate weekend absentee syndrome when the patient comes in Friday night and is not assessed until Monday morning. Many hospitals have a routine assessment form which calls for a description of the presenting problems of the patient, plus a history of their development. Also included is a personal history and a family history, and a description of the patient's current mental status. The initial assessment includes a provisional diagnosis and a provisional treatment plan, plus the doctor's orders which describe the particular care that this patient will be given. All of this information is necessary for the information of the staff,

and to provide a baseline set of observations against which the patient's progress can be measured.

Many hospitals provide for additional documentation by the hospital staff. For example there is a provision for a nursing plan and a psychosocial history which is developed in association with the patient and the patient's family, looking forward to the time when the patient will be discharged.

Often there is a provision for psychological testing and therapeutic interactions with psychologists, social workers, nurse therapists, and other staff members. All of these people together with the psychiatrist form an interdisciplinary team. I strongly recommend maximum use of the team approach in the hospital treatment of suicidal patients. This provides an opportunity for many different people to observe the patient from different points of view and report back to their colleagues. In modern hospital practice, often the psychiatrist is the leader of the team and participates in planning and especially in ordering and monitoring medications, but the psychological therapy may be administered principally by others on the team. In a sports metaphor, the psychiatrist can be compared to the playing manager of a baseball team who has a participating role as well as a managing role, but is definitely part of a team.

It is important to have harmony and agreement among the members of the team. They need to work out any differences they have in conferences and in discussion. They should

communicate freely with each other and make written notes to each other in the chart as a basic method of keeping track of what is going on. Hospitals can facilitate the ease of communication among the members of the team by providing specific forms designed for the various members of the team, such as: nurses progress notes, social work progress notes, and various special forms, as well as the doctors progress notes and order sheets. Sometimes patients are asked to fill in certain forms, such as: self descriptions for example, or something about their backgrounds and their plans or hopes for the future. These too are included in the chart and can at times be very helpful.

Interdisciplinary staff conferences are usually held at regular intervals, and the patient is reassessed. Ideally then the diagnosis is reviewed, the doctor's treatment plan is brought up to date, and there are modifications in the expectations and attitudes of the entire treatment staff.

THE CASE OF RALPH

As part of ongoing assessment in the hospital, there has been a consultation on Ralph, age 16, focusing on suicide risk assessment. A number of risk factors are noted. Ralph does have a suicide plan. There is a history of alcohol abuse, and at times the suicide risk has been especially high because of feeling helpless and hopeless. I would recommend immediate placement in a youth oriented 12 Step Program, but in addition he should have a full dose of

antidepressant drug. The suicide risk is high and probably chronic, and there will still be a suicide risk when he returns home, so there should be an effort to eliminate guns from the home. It is possible that it would be helpful to consider some sort of school placement out side the home. In summary, this represents a serious, long range, chronic suicidal problem calling for prolonged out-patient case management and therapy, with always a definite suicide risk. It is hard to assess what the auditory hallucinations mean in a 16 year old alcohol abuser. They may not be important or they may be early signs of schizophrenia, and only time will tell. Psychological testing is helpful in evaluating hallucinations in an adolescent.

SPECIAL SUICIDE OBSERVATION

Commonly hospitals have two or three levels of special suicide observation-precautions. The most stringent level is "one on one", in which a specific person is designated to be in constant attendance on the individual patient, and keep the patient in sight at all times. The question of how bathroom privacy should be managed is controversial, and is best left to the policy makers of each separate unit. A second level of observation is observational checks on the whereabouts of the patient every 15 minutes, or a third level might be checks every 30 minutes. It is helpful to have a special form which can be initialed by the staff person to indicate that the observation was made at each

required time. It is the doctor's responsibility to specify in the doctor's order form the exact level of special suicide observation that she considers correct. Other members of the staff, such as nurses, would take this responsibility only in a dramatic emergency. However, since the purpose of observation goes beyond security to providing information about what is on the patient's mind, it is the responsibility of staff to talk with the patient and explore the meaning to the patient of being in the hospital, and of having suicidal plans and ideas. The staff tries to help the patient achieve better relationships and more hope.

It is also the doctor's responsibility to specify "privileges" for the patient, such as: where meals are taken, what clothes can be worn, can the patient be off the ward, when passes are issued, and the doctor authorizes the use of restraints or seclusion. Each decision calls for consideration of the benefits versus the risks, and may require consultation among the staff. Pauker and Cooper (1990) discuss maximal observation as "psychiatric life support", meaning that these are procedures that keep psychiatric patients alive, but are not directed at ameliorating psychopathology. For example maximum observation can actually be harmful for some patients leading them to increased acting out in order to challenge the alertness and dedication of the observers. There is a limit to how long maximum observation can be effective, and at some point the observation measures must be relaxed and

then discontinued. Discussion with the patient can be helpful in reaching the decision to discontinue. A reasonably competent patient who has formed some therapeutic relationship with staff or doctor will usually be able to cooperate in this decision, especially after the first week in the hospital.

However certain types of patients are extremely difficult to monitor. Rapidly cycling manic depressives for example can go from elation to deep suicidal depression, sometimes in a few hours or even minutes. Paranoid schizophrenics often react very badly to maximum observation, becoming first suspicious and distrustful, then frightened and desperate.

In general, the presence of other people is the most powerful anti suicide measure. Sometimes when the patient is first admitted, or if there is a brief period of increased suicide ideation, a member of the family can be used to provide company for the patient, at least during daytime hours. Once again this is a considered decision on the part of the clinician because sometimes family members can be toxic to the patient. There have been many suicides in hospitals precipitated by a visit from a rejecting spouse, or from receiving other types of bad news.

Some people advocate the use of seclusion rooms for disturbed and agitated suicidal patients. But use of seclusion rooms calls for extreme caution ( ) and nearly constant observation, because people when they are

alone are able to devise ingenious ways of hurting themselves. Better to have the observation out in the open. Sometimes acutely psychotic persons must be restrained with belts or other types of restraining devices. These can be effective in limited emergency situations for brief periods of time.

The decision to discontinue special observation and precautions is based chiefly on the feedback from the observer team, and an evaluation of the total adjustment of patients to the unit, and the degree of comfort they are observed to show. Also it is important to evaluate the degree that they have developed a therapeutic alliance or a working alliance with therapist and other members of the staff. If there is a need for some extra precautions short of special observation, it is recommended that a patient, especially a new patient, is placed in a room that is easily observable from the nurses station.

SECURITY

There is controversy over what patients should be allowed to wear. For example should they be allowed to wear their belts and their shoelaces? In many states there is a Patient's Bill of Rights which provides that patients shall have their own clothes unless there is some special reason not to. For example, persons who are suspected of trying to elope from the hospital might be put in hospital garments to make them more conspicuous if they run out into the halls or

streets. Some hospital suicides do occur when patients elope from the ward and then jump from a height, but I doubt that their clothing makes any difference. Within the unit itself hanging is the method of suicide, and the most important element that enables people to hang themselves is not the belt or the cord that holds their pants up, or their shoelaces that keep their shoes on, ~~or~~ but rather the opportunity to be alone, usually in the bathroom. People in hospitals and in jails have hanged themselves mostly with articles of clothing such as a shirt, pants, robe, or sometimes strips of sheets and blankets.

It has been advocated that ideally there should be breakaway shower bars and hooks in bathrooms so that people could not suspend themselves from these devices. But I wonder if the gain is worth the cost, since people often hang themselves from the doorjamb or a door knob. Many people asphyxiate themselves without being suspended off the ground at all, in a sitting position. They put their necks through a noose (made for instance from a shirt sleeve), tie the shirt to the bed, and lean forward so that the weight of the body causes them to quickly lapse into unconsciousness and then death.

HOSPITAL POLICIES

Most hospitals have policy guidelines for the staff concerning many of the patient care matters I have just discussed. I had been told that specific suicide

observation policies were required for accreditation by the Joint Commission on Accreditation of Hospitals (in the 1970s), but when I reviewed this subject in 1986 I discovered that all such requirements had been dropped. The reason for this is that the structures and operations of different psychiatric units are so different that no standard set of requirements really fit. I talked to the Joint Commission about this and was invited to submit a set of my own proposals, but it was difficult to meet the challenge.

My recommendation is that hospitals should ask themselves whether they treat persons at special risk for suicide. If they do there must be policies for the management of suicidal persons. These policies are best determined by a committee representing hospital staff, medical staff, and administration. The committee establishes written guidelines after surveying the security areas, and talking with staff and patients. Suicide management policies are then incorporated into the training and supervision of staff.

A reasonable performance requires that the patient be evaluated for suicide risk, that a treatment plan be formulated, and that staff follow the treatment plan according to the hospital's own policies.

THE TREATMENT PLAN

The treatment plan is individualized according to diagnosis and according to the circumstances that led to the hospital admission. In general there is an effort to relieve stress, improve support, and strengthen the patient's vulnerabilities. For crisis patients the general principles of crisis treatment apply. The staff tries to be understanding, empathic, supportive, optimistic, and to help the patient toward increased relationship, increased problem solving, increased self-confidence. The work is primarily reparative. The staff offers an environment of friendship and structure, and emphasizes the strengths of the patients rather than the weaknesses. I feel that confrontation techniques with suicidal people are more dangerous than they are helpful. For example, facilitating helpless and dependent patients to get in touch with their anger at the families upon whom they depend, is not helpful unless the unit is prepared to hold these patients for many months or years of character building. My recommendation is for flexible supportive therapy along the lines of cognitive therapy and/or interpersonal therapy models. I save the deeper psychodynamic interpretations for the long term therapy usually in out-patient practice. Standard treatment of suicidal patients in hospitals usually includes medication, often antidepressants or antipsychotics or both where they are appropriate. I have already mentioned the optimal use of the interdisciplinary team. It is important

to emphasize that discharge planning should start early during the hospitalization, and should continue. One of the main roles of the team leader is to track the progress of the patient, and evaluate the effectiveness of the different treatment modalities. Modern treatment in hospitals emphasizes short term hospital stays, and there is no evidence that prolonging hospitalization is effective as suicide prevention, although it may be necessary for other reasons. (Yamamoto, Roath, and Litman, 1973)

DISCHARGE PLANNING AND DISCHARGE

There is a definite predictable mortality by suicide following the discharge of patients from psychiatric units. Motto ( ), Roy ( ), Pokorny ( ), Fawcett ( ), all report about .5% of the discharged patients committed suicide in a year, with a decreasing but noticeable suicide rate thereafter. The problem is how to reduce the suicide rate to a minimum. Ideally the decision to discharge the patient would be a team decision and it should be made when the patient has achieved maximum hospital benefit. There are great advantages to a smooth transition from the in-patient to the out-patient status. More often than not a new out-patient doctor will take over treatment of the patient from the hospital doctor. In the current psychiatric scene it is common for in-patients to be treated by hospital psychiatrists who make that their chief speciality, while other psychiatrists are out-patient

specialists. One reason for this is that in order to be an effective in-patient psychiatrist one needs to be acquainted with the nurses and the staff personnel, the hospital policy, and one has to attend numerous staff meetings. If an out-patient psychiatrist only has one patient in the hospital, it is not an effective use of his time to become acquainted with the staff and attend all the staff conferences. So that while it might be closer to the ideal for the same doctor to follow the patient out of the hospital, there usually has to be a transition. Ideally the out-patient therapist might visit with the patient once or twice while the patient is in the hospital. Certainly there should be communication between the hospital doctor and the out-patient doctor. It is important to prepare the patient and family for the transition out of the hospital. During this transition period passes out of the hospital to visit home are useful for testing how the patient does, and it is important to get feedback from the family or friends concerning what happened during the visit. Both the patient and family should be given a realistic appraisal of the patient's progress and need for follow-up treatment.

OUT-PATIENT TREATMENT

Often for patients who were in a true crisis the hospitalization and brief follow-up is sufficient. They readjust and go on with their lives. They will usually have returned to fairly normal functioning. Or the patient may

elect to continue in therapy in order to strengthen himself of herself, so as to be able to handle better some future stress event.

It is the chronically suicidal patients who present special problems for long-term out-patient treatment. Examples are many: dysthymic persons suffering from chronic apathy and anhedonia; schizophrenic persons who feel abandoned to their persecutors; alcoholic persons who face the reality of trying to be sober; borderline personality PATIENTS – who use the threat of suicide to control their environment. These patients feel trapped in a hostile milieu with inadequate resources and limited hope, and so they fantasize about death, not only as an escape from pain, but also often as a final vindication. Chronically suicidal patients often express appreciation for the doctor's efforts, while still maintaining an inner conviction that sooner or later they will commit suicide.

I estimate that 20% to 25% of these chronically suicidal individuals eventually terminate their lives. But in any one year the suicide rate is only 1% - 2%, even for high risk patients. I use this statistic when I treat suicidal persons. For example talking with persons who have recently made a serious suicide attempt after being suicidal much of their lives I may say something like this: "According to the statistics you are a high risk for suicide patient. This means that there is a 2% to 5% chance that you will commit suicide in the next two to five years.

However there is a 95% chance that five years from now you will not have committed suicide, and that you will still be alive, and I am gearing this treatment toward that 95% chance." Note that I am already thinking in terms of a five year survival, recognizing that we are dealing with malignant, potentially life threatening disease processes and our efforts may only postpone suicide rather than prevent it.

Chronic Depression.

Mostly recommended in the treatment of chronic depression (Litman, 1989) is a flexible combination of medication and psychotherapy. I employ a variety of psychotherapy tactics, depending on the patient's needs. For patients sunk in passivity and apathy, I prescribe specific activities and participation diaries, along with continuing reeducation efforts to break the habit of negative thoughts and pessimism and to substitute more realistic and optimistic appraisals of self and the world on a cognitive therapy model. I also encourage efforts to improve interpersonal relationships and melt the affective blocks that tend to freeze these persons out of the warmth they might obtain from personal relationships. These patients have often failed to respond to extensive trials of antidepressant drug therapy, but I usually continue trying other drugs, seeking a combination that will work, and offering hope that maybe a new product will be successful.

Several years ago, trazodone became available and helped some chronically depressed patients. More recently, floxetine has been successful for others.

There is a subpopulation of dysthymic patients who respond well to dextroamphetamine (20 mgs/day) over a long period of time. Unlike most people, these patients sleep *better* with dextroamphetamine. They do not lose weight. It improves their energy and mental concentration and does not precipitate mania. Most importantly, they do not develop tolerance and the need for increased amounts of medication to produce the same effect. A trial of dextroamphetamine quickly reveals its suitability for a patient.

A team approach. Ordinarily psychiatric treatment, especially psychotherapy, is a two person confidential relationship between patient and doctor. But when suicide has become an important chronic issue, the doctor must avoid feeling isolated with the patient. Psychiatrists retain responsibility for treatment, but they share responsibility for suicide prevention, mainly with their patient and also with the social network and the treatment team. The team includes many people not just the psychiatrist. I usually talk with the family, especially the spouse, and sometimes others who can be of help. I hope they will be available if needed as ancillary therapists, and to communicate information that the index patient may not reveal - for example that the patient is not taking prescribed medicine,

or that family tension has increased. Because suicides often occur when the therapist goes on vacation or is otherwise absent or unavailable, it is prudent to arrange for backup therapists who are acquainted with the patient to serve as substitutes or consultants. The team concept helps dilute the dependency transference which becomes dangerous if it is too intense and too ambivalent. Intensity is generally not desirable in the treatment of these patients. Using a sports metaphor, we are involved in a marathon not a sprint so endurance, consistency, and steadiness are the essential parameters.

Monitor the transference and the countertransference. Dysthymic patients form stable positive dependency transferences and persist in treatment. Countertransference problems arise when the therapists become weary with the treatment's lack of success. The transference problem with suicidal schizophrenic patients is that they become totally dependent on and then paranoid toward the treating psychiatrist. The countertransference problem is that the psychiatrist becomes terrified by the psychotic projections. Therapists treating suicidal borderline patients find themselves feeling responsible for the life of the patient as suicidal threats and attempts escalate. The antidote is consultation, case review, sometimes transfer of the patient. Brief hospitalization is a creative option during a transference - countertransference suicidal crisis.

Record keeping. Early in treatment the therapist should record the patient's history, mental status, and the ~~expiration of~~ ideas, fantasy and plans about suicide. Also included are the therapist diagnostic impression and treatment plan. Later the notes may record only significant changes or significant events in the patient's life or treatment, and the results of periodic reassessments. After several years of treatment these records will enable the therapist to reevaluate the original complaints, check the effectiveness of medications, and determine seasonal variations ~~and~~ IN symptoms. The records will reinforce the therapist's reminder to patients that there has been progress or that there have been up periods as well as downs. Finally, the records are the assurance to the therapist that his decisions and his work have been conducted in a careful, competent and prudent manner.