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Contact as a Suicide Prevention Influence: A Method and a Preliminary Report

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Introduction

Self-destructive behavior can be considered a last resort effort to obtain relief from unbearable pain. This behavior generally becomes manifest when two specific conditions exist: firstly, when the person experiencing such pain feels isolated from other persons, and secondly, when he perceives his situation as hopeless. The isolation is necessarily a feeling, which may or may not be consistent with reality. It tends in any case to intensify the sense of hopelessness, because it prevents sources of emotional support from helping the person to maintain hope.

Efforts to reduce the intensity of feelings of isolation, as a suicide prevention measure, are often handicapped by the presence of intense independent striving on the part of the suicidal person. Whether referred to as a "need for independence" or a "fear of dependence," the clinical problem involves refusal to accept a source of assistance, or if accepted, to resist what it has to offer.

Such situations often reflect cultural or family attitudes about the acceptablility of needing help, especially when the person is in a position of considerable responsibility or in a "professional" role, such as a physician, dentist, attorney, or minister. Many suicidal persons demonstrate characteristics which identify them as "professionals" in the sense that is referred to here, in that they are hard working, conscientious, meticulous individuals who tend to set high and uncompromising standards for their own performance regardless of their occupation.

Those who meet this description are a special consideration for suicide prevention programs, as even when in despair they tend to avoid asking for assistance. If they are obliged to do so through pressure by others, or following a suicide attempt, they tend to decline any plans for continuing therapy. If a treatment program is begun, they tend

to discontinue it as soon as possible; too often the next information received about them is of another suicide attempt or a completed suicide.

Other personality patterns may also be identified in suicidal persons who decline assistance even when under incapacitating stress. For example, those who experience severe anxiety in close relationships, adolescents, who would be threatened by loss of peer esteem, elderly persons fiercely protecting their independence, and those who are prone to distrust or to feelings of persecution. Just as in those who experience the very need for help as unacceptable, suicide prevention efforts are severely handicapped under these circumstances.

In an effort to find a means of reducing the handicap of feelings of isolation and the attendent hopelessness, an investigation was formulated based on three hypotheses:

1) A suicidal person's feelings of isolation will be reduced if he experiences regular and longterm contact with another person who is openly concerned about the former's well-being.

2) The contact must be initiated by the concerned person and must put no demands or expectations on the other, in order to be experienced as a sincere expression of unconditional concern.

3) Such a program of contact would include among its effects the exertion of a suicide prevention influence.

Method

Persons admitted to a psychiatric inpatient service because of a depressive or suicidal state are recognized as a high risk population for suicide. From nine such services in San Francisco over a four-year period 1800 persons from this population were identified, interviewed and subsequently divided into two groups, "treatment" and "no treatment," according to their readiness to continue a therapeutic program. "Treatment" patients are those who continue treatment for one month or longer after discharge from the hospital. "No treatment" patients are those who either decline therapy or drop out of a treatment program within one month. These

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The "no treatment" patients are divided randomly into two subgroups, "contact" and "no contact." Those in the "contact" group receive a regular communication from the staff member who interviewed them when they were in the hospital. This is in the form of a telephone call or, more often, a brief letter. The content of the message is simply an expression of concern that the person's life situations is reasonably satisfactory, and inviting a reply if the person wishes to send one. An effort is made to personalize these notes as much as possible, to avoid a "form letter" impression.

The schedule of such contacts is planned to be monthly for four months, bi-monthly for eight months, and tri-monthly for the subsequent 48 months. This rather minimal contact represents an effort to gradually develop a feeling of relatedness even though the person is resistant to formal therapy. The question is whether such contact will exert any suicide prevention effect.

Using the data of the State Department of Health, it was determined which of our patients had died by January 1, 1971. Our preliminary examination of findings utilizes the coroner's certification to ascertain the cause of death, supplemented by information from family and clinical sources. The sample reported here represents an average followup of 18 months.

Results

The process of self-selection for the first 1800 patients resulted in 968 being included in the "treatment" group and 462 in the "no treatment" group, the latter made up of 195 "contact" and 267 "no contact" patients. The final status was "pending" for 228 persons, that is, whether or not they continued a treatment program for a month or longer could not be readily determined due to their not responding to our inquiries. Six persons were known to have died of suicide before they were discharged from the hospital, and ten in less than 30 days following the discharge,

which precluded their inclusion in the predetermined groups and consideration of the influence of contact. Fourteen persons died of non-suicidal causes and 114 were lost to followup.

The distribution of suicidal deaths in the various categories of patients is indicated in Table 1.

Table 1.

Distribution of Sample: Eighteen Month Mean Followup

CATEGORY	Total in Category	Number of Suicides
Treatment	968	25 (2.7%)
No Treatment		
Contact	195	3 (1.5%)
No Contact	267	4 (1.5%)
Suicide before discharge		
On ward	3	3
On pass	2	2
AWOL	1	1
Status pending > 30 days after discharge	228	2 (0.9%)
Suicide < 30 days after discharge	10	10
Non-suicidal deaths	14	
Lost to followup	114	
TOTAL	1802	50

Discussion

It is clear from the results so far obtained that the effect of contact as suggested here has yet to be demonstrated. Several observations can be made at this point, however, in view of our present data and our experience in gathering it.

The concept of generating a feeling of attachment to objects outside ourselves is necessarily a longterm effort. We estimate a five-year period as a minimum time to achieve this to a demonstrable degree, and the 18-month mean followup

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	3	3
	2	2
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	114	
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reported here may be insufficient to show any effect. Jerome Frank, in a critical assessment of therapeutic factors in psychotherapy, refers to the various longterm interview therapies as giving patients "a sense of identity and of connectedness to others, so essential to mental health." (1) Helmutt Kaiser calls this indispensable element a "delusion of fusion." (2) Since this is primarily a process of growth, it is difficult to hasten it. Of course the nature and frequency of our contact procedures may be inadequate, especially in the period immediately following discharge from hospital. These procedures were set up with the idea of permitting a small number of persons, not necessarily health "professionals," to provide an effective service to a large population at risk with minimum expense.

The striking incidence of suicides in the months immediately following discharge from the hospital is consistent with prior fendings, characterized by a sharp drop in the suicide rate of a high risk group following the few months after discharge from care. (3) In the present sample 14 persons (28% of the suicides) completed the act within 30 days of the time of discharge, 8 (16%) at one month and 7 (14%) at two months. Seventy-six percent of the suicides occurred during the first year after discharge, 14% the second year, 8% the third and 2% the fourth.

Though not a new observation, this pattern may have implications for the current emphasis on "crisis intervention" which tends to minimize inpatient care and return the patient relatively quickly to his own resources. If a heavy load of patients interferes with providing adequate support for suicidal persons, this approach may increase the incidence of post-discharge suicide. With a smaller sample and five- to eight-year followup of a similar patient population, carried out at a time when longer duration of hospital care (and frequently state hospitalization) was common practice, we found no such pattern, but rather a steady suicide rate for the cohort over the entire period. (4)

The mobility of our population led to 19% (342) of our sample falling into the "pending" and "lost" categories, which emphasizes the need for large samples to provide clear

results from this population. As the exposure to risk and the effect of contact procedures increases with time, however, the avilable sample should give us much more information about our investigative goals. Private and university affiliated units have provided more stable populations, and larger "treatment" groups compared with urban mental health centers.

That nearly 60% of the sample and 50% of the suicides were in the "treatment" group suggests that the therapy and management of suicidal states is far behind the recognition of suicidal risk. A shift in emphasis of investigative efforts may thus be indicated.

We find a large number of subjects and their families come to regard the source of contact letters as a resource for a variety of functions. For example, legal matters, insurance, references, communication among family members, and (most important) a non-threatening source of assistance if the person's life situation begins to get unbearable. The letters seem to form a bond that helps overcome one's resistance to accepting another's interest and concern.

We are convinced that the ties which bind us to other persons are the principal element which give meaning to life itself. As difficult as it is to develop ways of establishing and strengthening such ties, the effort to do so is rightly coming to occupy a central role in the work of suicide prevention.

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The Samaritan Contribution

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England

Firstly I wish to su
antisuicide services cut s
drop in suicide in England
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Table One

	Popula-tion in millions England & Wales	No. of suicides England & Wales
1959	43.39	5,207
1960	45.76	5,112
1961	46.17	5,200
1962	46.67	5,588
1963	47.02	5,714
1964	47.40	5,566
1965	47.76	5,161
1966	48.08	4,994
1967	48.39	4,711
1968	48.67	4,584
1969	48.83	4,370
1970	48.94	3,939

Drop

Suicide Reduction Looking
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