

Phillip J. Resnick, MD, on

Recognizing that the suicidal patient views you as an 'adversary'

Preventing suicide in the severely depressed patient is tricky. Usually a suicidal patient won't tell you of his or her intent before completing the suicide, making prevention all the more challenging.

Psychiatrists too often assume that their patients see them as allies in treating their depression, even suicidal depression. However, once a patient decides to die by suicide, he or she is likely to see the psychiatrist as an adversary. Indeed, the psychiatrist and suicidal patient are working toward conflicting goals: preserving and improving quality of life versus ending it altogether.

Psychiatrists need to recognize this fundamental change in the patient-psychiatrist relationship once the patient decides to die by suicide. Failure to do so can have fatal results. Busch et al found that two thirds of psychiatric inpatients who died by suicide denied any suicidal intent or ideation shortly before their deaths.¹

For that reason, look for objective evidence of mood improvement or deterioration, rather than relying on the patient's word. Sleep patterns, eating habits, and changes in affect should be scrutinized.

Before accepting that the depressed patient is improved to any extent, ascertain what has objectively changed in the patient's situation. For example, has a spouse who planned a divorce relented or has a financial crisis been resolved?

Consult the patient's family

Since the suicidal patient is your "adversary," establishing a relationship with his or her family becomes critical. That's because, based on my experience, patients who are considering suicide are much more likely to communicate their intent to spouses than to clinicians.

Family members are a particularly vital source of information in inpatient management. When the patient is hospitalized for depression, close relatives should be

instructed to immediately notify the nursing staff of any suicidal communications that occur during visits. Nurses then have a duty to notify the psychiatrist. Even an isolated, seemingly off-handed remark from the patient (e.g., "If I don't feel better soon I'll kill myself") should be reported.

In treating a potentially suicidal outpatient, consider seeking permission from the patient to contact a close relative as a means of follow-up. The relative should be requested to notify you if the patient talks of suicide or new feelings of hopelessness.



Dr. Resnick is professor of psychiatry and director of the Division of Forensic Psychiatry at Case Western Reserve University, Cleveland, Ohio.

Beware of no-suicide contracts

About 1/3 to 1/2 of psychiatrists and other psychotherapists employ no-suicide contracts,² which are agreements by patients to let therapists know if they become suicidal rather than killing themselves.

Such contracts are dangerous because they can create a false sense of security in therapists. What's more, nothing in the research literature shows that no-suicide contracts work. Half of the completed inpatient suicides had a no-suicide contract in place.¹

Suicidal patients make great sacrifices to take their lives. They lose their future, stigmatize their children, and accept the possibility of eternal damnation. It is foolhardy to think that a patient determined to commit suicide would keep a promise to notify you of his or her intent, particularly if that patient does not have a longstanding relationship with you. Once the patient views you as an adversary rather than an ally, the contract has little value.

Finally, in malpractice cases resulting from suicide, juries are quick to brand a psychiatrist as unwise for relying on a no-suicide contract.

References

1. Busch K, Clark D, Fawcett J, Kravitz HM. Clinical features of inpatient suicide. *Psychiatric Ann.* 1993;23:256-262.
2. Kroll J. Use of no-suicide contracts by psychiatrists in Minnesota. *Am J Psychiatry.* 2000;157(10):1684-6.