An Evidence-Based Approach to Evaluating and Managing Suicidal Emergencies

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This article presents a framework for making suicide risk estimations, as well as recommendations for the management of suicidal emergencies, that are useful to the practitioner. It provides a review of existing empirical data concerning factors significantly related to acute suicidal behaviors within high-risk diagnoses. Findings across studies are categorized into risk profiles (as proposed by Clark & Fawcett, 1992) that are meant to aid the clinician in the application of recent research. The profiles are intended as templates in development and clearly require continual updating and clarification as new studies are completed. The article then addresses related management issues such as the importance of viewing risk factors within a comprehensive suicide assessment and the impact of possible negative therapist reactions when working with high-risk patients. © 2000 John Wiley & Sons, Inc. J Clin Psychol 56: 1109–1130, 2000.

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You receive an urgent page from a primary-care doctor who asks you to evaluate a 69-year-old man for risk of suicide. This man has several medical concerns including diabetes, coronary artery disease, and a history of myocardial infarction. The referring doctor explains that the patient has expressed suicidal ideation in the past, but always added that he would not hurt himself due to his wife of 47 years. On this visit, however, he offers no qualifying statement because his wife died suddenly four months earlier.

You meet with the patient who endorses the symptoms of major depression and becomes tearful when you ask how he is doing. He reports that his wife died recently and that he no longer wants to live. He states that he has taken care of his financial concerns

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by turning them over to his eldest daughter and that "everything is arranged." You sympathize with him, talk about the bereavement process, and then ask if he is thinking of hurting himself. He responds by stating that the only reason that he still is living is that he has not thought of a satisfactory way to end his life. He refuses to contract for safety even for a few days, and so you suggest that he be evaluated for hospitalization. The patient becomes very angry, accuses you of jumping to conclusions, and storms out of the room to exit the building. What should you do?

There may be no greater test for the clinician than to be immersed suddenly in the crucible of the one-time emergency evaluation with an agitated or distraught patient who is suicidal and whom the clinician does not know well. Even if he or she does not work routinely in an emergency or crisis setting, any practitioner with an active caseload can have a patient who appears to be at serious risk for suicide. The clinician must estimate the likelihood that the patient or client will attempt to kill him or herself, as Pokorny (1983) so aptly has stated, in the next few "minutes, hours, or days" (p. 128). Under such circumstances, it is very important to have a structure for doing an evaluation and an algorithm or plan for responding to the patient's immediate behavior.

The article that follows attempts to provide such a structure and plan. It is divided into two major sections. In the first section, we describe an empirically based approach to estimating suicide risk (i.e., the use of diagnosis and associated high-risk factors). The second section describes the implementation of this empirically based approach and discusses management issues, namely (1) the need to incorporate such an approach within the context of a more comprehensive clinical evaluation, (2) how to decide when emergency intervention may be needed with the suicidal patient, (3) issues and recommendations related to outpatient and inpatient management, and (4) some of the problems that clinicians may encounter when doing the difficult work of managing the suicidal patient.

Section I: Improving Risk Estimation with High Risk Diagnoses

It is now well established that, with current knowledge and methods, it is not possible to predict accurately rare events such as suicide, which has a base rate of approximately 12 per 100,000 in the general U.S. population and 60 per 100,000 in the psychiatric population (Hilliard, 1995; Murphy, 1984; Tanney, 1992). The problem has to do with the sensitivity and specificity of clinical judgment and existing assessment instruments when base rates are low. For example, let us assume that there is a clinician with such exceptional acumen that he or she could discern who would and who would not commit suicide with 99% sensitivity and 99% specificity, respectively. Out of 100,000 psychiatric patients, this skilled clinician would identify 99,000 who would not commit suicide, and would view the remaining 1000 as at high risk for suicide. Only 59 of the 1000 high-risk patients, however, actually would commit suicide, and the 941 others would be false positives. Thus, even with a level of precision that is well beyond our current capabilities, the rate of false positives still would make suicide unpredictable. As a result, the field has shifted to the more-modest and realistic goal of attempting to improve the ability to estimate levels or probabilities of risk (Motto, 1992).

Clark and Fawcett (1992), as well as Hendin (1986), have proposed the use of diagnosis-specific risk factors as a guide to risk estimation. Their approach seems promising, and this article will use it as a strategy for estimating risk. The approach was developed on the basis of the results of a majority of the large community-based psychological autopsy studies (e.g., Barraclough, Bunch, Nelson, & Sainsbury, 1974; Beskow, 1979; Chynoweth, Tonge, & Armstrong; 1980; Dorpat & Ripley, 1960; Rich, Young, & Fowler, 1986; Robins, Murphy, Wilkinson, Gassner, & Kayes, 1959) in which it has been
found that more than 90% of adult suicides suffered from a major mental or emotional disorder. This rather consistent finding seems to imply that mental or emotional disorders are associated highly with and are very likely factors in suicide. In fact, Tanney (1992), after an extensive review of studies on the relationship between mental disorders and suicide, concluded, "Among the heterogeneity of causes, mental disorders can lay claim to a position in the first rank of the matrix of causation" (pp. 309–310). In the authors’ view, such findings necessarily do not imply that all who commit suicide suffer from a mental illness or that there cannot be a so-called “rational” suicide (e.g., among the terminally ill with intractable pain and suffering). In terms of estimating risk, however, it does indicate that one could narrow the field of search to those with mental disorders and still retain the vast majority of suicidal individuals within it.

Only certain psychiatric diagnoses are associated with a risk of suicide that is significantly higher than that found in the general population. Thus, if high-risk diagnoses can be identified, the field of search can be narrowed further. The diagnoses most often found among the completed suicides in the retrospective studies noted above, as well as in a large prospective study with veterans (Pokorny, 1983), have been, first and foremost, depression (present in an estimated 50% of suicides); second, alcohol and drug abuse (present in an estimated 20–25%); and third, schizophrenia (present in an estimated 10%). These estimates suggest that 80 to 85% of suicide completers have one of these three diagnoses. Other diagnoses associated with significantly elevated rates of suicide include combat-related PTSD and certain personality disorders in the impulsive spectrum.

Within each high-risk diagnostic category, only a small percentage of patients commit suicide. In a frequently cited, but perhaps dated article, Miles (1977) estimated the lifetime risk of suicide in depression as 15%, in substance abuse as 15%, and in schizophrenia as 10%. Using more current computerized modeling techniques, Inskip, Harris, and Barraclough (1998) arrived at the more modest but still significant lifetime risk of 6% for affective disorder, 7% for alcohol dependence, and 4% for schizophrenia. The question becomes, however, whether there are risk factors related to a particular diagnosis [as Hendin (1986) and Fawcett et al. (1987) have hypothesized] that might be likely to differentiate the suicidal from the non-suicidal and assist in further narrowing the field of search. In this regard, Clark and Fawcett (1992, p.62) have noted, “. . . clinicians should be prepared to think that the suicide risk profile for depressed patients is pronouncedly different than that for alcoholic patients, and again different from that for schizophrenic patients.” It would, in fact, be significant if prototypical risk profiles could be developed for high-risk diagnoses that might assist us in making a closer approximation of the small percentage of depressed patients, alcoholic patients, schizophrenic patients, etc., who commit suicide. Hendin (1986) suggested this approach as a future direction for research and cited studies of risk factors, such as delusions in the suicides of depressed patients and recent interpersonal loss in the suicides of alcoholic patients. Kleespies (1991, 1993) criticized the empirical soundness of the studies cited by Hendin (1986). Fawcett et al. (1987), however, gave fresh impetus to an association between certain risk factors and diagnosis with the publication of their prospective study of clinical predictors of suicide in patients with major affective disorders.

Pertinent to this point, it has been proposed that the high-risk diagnoses noted above are likely to have greater suicide risk at different points in the adult life span (Conwell et al., 1996). Dorpat and Ripley (1960) did a psychological-autopsy study of over 100 suicides and reported that, for those victims under 40 years of age, the most common diagnosis was schizophrenia, for those ages 40 to 60, the most common diagnosis was alcoholism, and for those over 60, the most common diagnosis was depression.
with psychotic features. In a more-recent and more diagnostically sophisticated study of 141 suicide victims, Conwell et al (1996) also examined the relationship between age and Axis-I diagnoses. They found that those victims who were in middle age were most likely to have comorbid affective and substance-abuse disorders, while those who were elderly were most likely to have late-onset-unipolar depression. Thus, some data suggests where in the life course those with particularly high-risk diagnoses may be at greatest risk.

**Acute Risk Factors and Diagnoses**

Despite the need for data on the evaluation and management of imminent risk for suicide, most studies of suicide have investigated lifetime risk factors rather than acute or short-term risk factors (Forster, 1994). This state of affairs is likely because very acute or imminent risk factors are difficult to study. Acutely suicidal patients either are excluded from studies or, once an investigator is aware that a subject may be at grave risk of suicide, he or she is obligated ethically to institute preventive measures (Pokorny, 1983). Nonetheless, there seems to be a growing recognition of the need to study shorter-term risk factors, and there are a number of studies in which the investigators have been able to collect data on risk within six months or a year of suicide. These studies will be highlighted as we discuss acute risk factors associated with particular diagnoses.

**Affective Disorder and Acute Suicide Risk**

As noted earlier, depression is the diagnosis most frequently associated with suicide. In terms of acute, depression-related, risk factors for suicide, the results of the large prospective study by Fawcett et al., (1987) (noted above) indicated that severe anhedonia, global insomnia, diminished concentration, severe anxiety, panic attacks, obsessive-compulsive features, and acute use of alcohol significantly heightened the risk of suicide within 6 to 12 months. In addition, the following factors also were found to be associated with short-term risk:

1. the depression being one of three or fewer lifetime episodes;
2. having no children under the age of 18 in the home; and
3. a current episode of cycling affective illness (i.e., cycling between depression and hypomania or mania without intermittent recovery) (see Table 1).

Findings such as these suggest that, among patients with a diagnosis of affective disorder, those who have profound depression marked by severe anhedonia and insomnia combined with severe anxiety symptoms and/or comorbid alcohol abuse, or those who have the emotional turmoil of continuously cycling moods are at greater short-term risk of suicide. The risk also may be heightened when depressive episodes have not become chronically recurrent, but are as yet relatively infrequent occurrences.

If we integrate the above findings with those on suicide and the life span as reported earlier (Conwell et al., 1996), it would seem that the combination of depression and alcohol abuse represents a greater risk in middle age, while late onset and relatively less-frequent depressive episodes with concurrent anxiety are of greater risk in later life.

**Substance Abuse and Acute Suicide Risk**

In a prospective study of alcohol intake and unnatural death, it has been reported that, for those who drank six or more drinks daily, there was a six-fold increase in suicide
<table>
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<td>• 3 or fewer depressive episodes</td>
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risk relative to nondrinkers (Klatsky & Armstrong, 1993). With respect to acute risk factors (see Table 1), Murphy and Robins (1967), in a large psychological autopsy study, found that 48% of the alcoholic suicide cases in their sample had experienced the obvious loss of an affectional relationship within one year of their suicides, while only 15% of depressed suicide cases had experienced comparable losses. Thirty-two percent of the alcoholic suicides, but only 3% of the depressed suicides, had experienced the loss within six weeks of their suicide. These findings have been replicated in two subsequent studies (Murphy, Armstrong, Hermele, Fischer, & Clendenin, 1979; Rich, Fowler, Fogarty, & Young, 1988), and Duberstein, Conwell, and Caine (1991) extended these findings to include not only losses, but also interpersonal conflicts. Thus, it appears that recent interpersonal loss or disruption may heighten vulnerability for suicide in alcoholics.

Since Murphy and Robins did not analyze for comorbid disorders, Murphy (1992) subsequently re-analyzed their data and determined that comorbid depression is a significant risk factor for suicide in alcoholics. Evidence consistent with this position has been presented by Cornelius et al. (1995), who found that more severe suicidal ideation on initial presentation to a psychiatric facility strongly distinguished depressed alcoholics from nonalcoholic ("pure") depressives and nondepressed ("pure") alcoholics. Since the depressed alcoholics in this study demonstrated a family history of depression similar to that of the "pure" depressives and a family history of alcoholism similar to that of the "pure" alcoholics, the authors have suggested that depressed alcoholics suffer the additive or synergistic effect of two separate high-risk disorders, resulting in a disproportionately high level of acute suicidal ideation.

The findings cited above suggest that alcoholics are particularly vulnerable to suicide when they have a comorbid depression and/or when they have experienced a recent significant interpersonal loss or disruption. This vulnerability usually is not manifest early in the course of the disorder, but often after 25 or 30 years of drinking that has resulted in increasing isolation and decreasing interpersonal connectedness (Murphy, 1992). Hence, as noted earlier, there is a heightened suicide risk in middle age for those with comorbid alcoholism and depression. Typically, although perhaps not always (see Conwell et al., 1996), the alcoholic person is in an active period of drinking when he or she commits suicide.

Those who abuse other drugs, particularly in combination with alcohol, also have an elevated risk of suicide. Cocaine abuse especially has been noted in this regard. In a New York City psychological autopsy study, one in five persons under the age of 60 who committed suicide had used cocaine in the days prior to death (Marzuk et al., 1992). One half of the cocaine abusers also used alcohol. The investigators were uncertain as to whether the cocaine abusers were at highest risk in the intoxicated phase or in the withdrawal phase; however, they noted clinical reports that suggested that the greatest risk might have been to chronic, heavier users who experienced withdrawal syndromes (e.g., depressive symptoms).

While alcoholic suicides most likely are to occur in middle age, polysubstance abuse and "pure" drug-abuse suicides tend to occur earlier in the life span (Rich, Fowler, & Young, 1989). In the psychological autopsy data investigated by Porsteinsson et al. (1997), the mean age at suicide for polysubstance abusers was 30.7 years, while the mean age for alcoholics was 49.7 years. The reasons for this mean age difference are unclear, but hypotheses range from polysubstance abuse having a more negative influence on interpersonal relations to polysubstance abuse having a more destructive effect on neurotransmitters like serotonin.
Schizophrenia and Acute Suicide Risk

While the incidence of suicide in alcoholism and unipolar depression reaches a peak in middle age and older age, respectively, the incidence of suicide in schizophrenia reaches a peak in young adulthood (or relatively early in the course of the disorder). In prospective studies, Cohen, Test, and Brown (1990) noted a 10% incidence of suicide in the first ten years of schizophrenia as opposed to a 15% lifetime incidence, while Westermeyer, Harrow, and Marengo (1991) found that 60% of schizophrenics who committed suicide did so within six years after their first hospitalization. In a summary of eight demographic studies of schizophrenic suicide, Weiden and Roy (1992) reported a mean age at death of 32 years.

Numerous studies have indicated that schizophrenic patients who commit suicide are predominantly white males who have never married. Another frequent finding has been that suicide among schizophrenics is associated with feelings of disappointment and frustration about the quality of their lives and the chronic nature of their disorder (Cohen et al., 1990; Drake, Gates, Whitaker, & Cotton, 1985; Westermeyer et al., 1991). It is felt that the lack of full recovery after the first few psychotic episodes can lead to hopelessness and despair in some patients, especially those who have a higher level of intelligence, are better educated, and have greater expectations for themselves. Cohen et al. (1990) found that schizophrenics who committed suicide had endorsed significantly more hopelessness, depression, obsessive–compulsive features, and paranoid ideation, as well as less life satisfaction on standardized tests. In addition, Haas (1997) has characterized schizophrenic suicide completers as having highly negative attitudes toward treatment. Previous suicide attempts have been found to lead to an eight-fold greater likelihood of subsequent completion in schizophrenics when compared to patients with other diagnoses who made previous nonfatal attempts (Weiden & Roy, 1992). Therefore, a history of suicide attempts should be taken quite seriously in a schizophrenic population (see Table 1).

In a comprehensive review, Caldwell and Gottesman (1990) characterized schizophrenic risk factors as follows:

... being young and male, experiencing chronicity of illness with numerous acute exacerbations and remissions, postdischarge course with high levels of psychopathology and functional impairment, realistic awareness of the deteriorative effects of schizophrenia and a nonendogenous assessment of the future (during a nonpsychotic phase), fear of further mental deterioration, excessive treatment dependence, or loss of faith in treatment. (p. 578)

One component of this characterization (i.e., that schizophrenic suicide occurs in the nonpsychotic phase) has been called into question by a recent psychological autopsy study in Finland (Heila et al., 1997). The investigators in this study found that the majority of schizophrenic suicide victims in their sample were in the active phase of the disorder at the time of their deaths. They attributed the difference in their findings to their ability to obtain information on mental state close to the time of suicide.

As the above synopsis indicates, information about a schizophrenic risk profile has increased; however, there has been little investigation of acute risk factors. Relative to acute risk, Peuskens et al. (1997) recently reported an increase of depression in schizophrenic suicide victims immediately prior to death, as well as an increase of apparent attempts to treat the depression. Corroborating evidence has been presented by Heila et al. (1997), who found a depressive syndrome in nearly two-thirds of their schizophrenic suicides. It would seem, then, that with young, male, schizophrenic patients who have higher levels of intelligence, higher expectations of themselves, and higher awareness of the debilitating effects of their disorder, the presence of depression should be taken very seriously as a short-term risk factor.
Post Traumatic Stress Disorder and Acute Suicide Risk

The impact of Post Traumatic Stress Disorder (PTSD) most often has been examined in studies of veterans who have experienced combat trauma. In a recent large-scale study of Vietnam veterans, Bullman and Kang (1994) found combat veterans to be seven times more likely to die from suicide than individuals in the general U.S. population, and those diagnosed with PTSD were four times more likely to take their own lives than combat veterans without PTSD.

In the interest of further profiling high-risk individuals, researchers have attempted to delineate the characteristics of veterans with PTSD who engage in suicidal behavior. One such approach involved the investigation of the specifics of trauma that led to the diagnosis of PTSD. Bullman and Kang (1996) proposed that individuals who endured a higher severity of trauma would be most likely to engage in suicidal behavior. They measured severity with number of reported combat wounds and type of treatment needed (hospitalization vs no hospitalization). They found that subjects with the highest risk of suicide were white veterans who were wounded more than once and were hospitalized for treatment of at least one of those wounds. In fact, these individuals were five times more likely to engage in suicidal behavior than a group of lower risk, nonwhite veterans wounded once and never hospitalized. This study suggests that severity of trauma (as measured by number of wounds and treatment) is an important variable in assessment of suicide risk in combat veterans.

Perhaps more important for the assessment of acute suicidal risk are studies that have focused on the present psychological state of veterans with PTSD who engage in suicidal behavior. Hyer, McCranie, Woods, and Boudewyns (1990) found that individuals who reported higher levels of guilt, emotional liability, and lower levels of psychological adjustment, including paranoia and feelings of confusion, most likely were to engage in suicidal behavior. Similarly, Hendin and Haas (1991) found increased levels of guilt, depression, and anxiety to be associated with elevated suicidal risk in PTSD veterans. Both of these studies identified guilt as an important factor in identifying individuals at risk for suicide. Hendin and Haas (1991) further described the guilt that veterans reported as either related to combat actions or survival. They indicated that most individuals who reported guilt related to combat also reported survival guilt, and that the combination was associated most strongly with suicidal behavior.

The impact of PTSD on suicidal ideation in populations other than veterans has not been studied extensively. There is emerging evidence, however, that trauma, particularly childhood abuse, may play an important role in the development of suicidal behavior in adolescents. In a study of Australian high-school students, Martin (1996) found that sexual abuse reported via questionnaire was associated with multiple attempts at suicide. In a comprehensive review of the literature, Wagner (1997) reported that there is consistent evidence that a history of physical or sexual abuse is a risk factor for suicidal behavior in children and adolescents.

In sum, evidence is accumulating that suggests that PTSD and exposure to trauma are important risk factors for suicidal behavior. Seemingly significant in the assessment of acute suicide risk is the presence of increased levels of guilt (combat related and survival guilt) and a distressed psychological state as indicated by increased emotional lability, poor psychological adjustment (paranoia and confusion), depression, and anxiety.

It is important to note that comorbidity in the combat-related PTSD population is high. Although Hendin and Haas (1991) and Hyer et al. (1990) do not address comorbidity per se, both mention depression and anxiety as concurrent risk factors. Some (e.g., Fontana & Rosenheck, 1995) have maintained that PTSD is significant in its affect on
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Suicide, but indirectly insofar as it contributes to the development of other psychiatric diagnoses. Be this as it may, Bullman and Kang (1994) found that combat veterans with PTSD and a concurrent psychiatric diagnosis were almost ten times more likely to die from suicide than those without PTSD. These investigators cited substance abuse and depression as disorders that frequently co-occur with PTSD.

**Personality Disorders and Acute Suicide Risk**

Through a review of published studies, Duberstein and Conwell (1997) estimated that 30 to 40% of individuals who commit suicide have an Axis-II disorder. One of the most frequent Axis-II disorders associated with suicidal behavior is borderline personality disorder (BPD). Frances, Fyer, and Clarkin (1986) estimated the rate of completed suicides for individuals with borderline personality disorder (including those with no history of parasuicidal or nonlethal suicidal behavior) to be between 5 and 10%. Stone (1987) has stated that this rate is doubled for BPD patients who display parasuicidal behavior.

Risk factors within the diagnosis of BPD include impulsivity and a history of childhood abuse, something that has been correlated positively with number of suicide attempts (Brodsky, Malone, Ellis, Dulit, & Mann, 1997). The estimation of suicidal risk in the BPD population, however, is complicated, since such individuals also display a high frequency of nonfatal suicidal behaviors (i.e. parasuicidal acts). The determination of particular risk factors includes a careful elucidation of factors that are correlated with serious and/or fatal suicidal acts. Soloff, Lis, Kell, and Cornelius (1994) found that a high degree of medical lethality was predicted by the number of lifetime suicide attempts, older age, and dysphoria, while low lethality attempts were associated with high degrees of anger.

Other researchers have attempted to establish the difference between serious and nonserious suicidal behavior by comparing the underlying characteristics of BPD individuals who actually have committed suicide to those who have not. Paris, Nowlis, and Brown (1989) looked at 100 BPD patients. They compared characteristics of those who committed suicide (14 individuals) with those who did not and found the most significant predictors of completed suicide to be previous attempts and higher education. Kehrer and Linehan (1996) noted that

... individuals with histories of parasuicide acts tend to be more cognitively rigid than non suicidal psychiatric control populations, display less capacity to solve abstract problems, and exhibit more cognitive impulsivity and field dependency. Those who suicide are further characterized as indecisive and as having difficulties concentrating attention. (p. 154)

In summary, it is clear that individuals diagnosed with borderline personality disorder carry with them an elevated risk of suicide. Previous attempts, childhood abuse, education, level of anger, and inability to solve interpersonal conflicts all have been found to be important predictive factors. Furthermore, there is some evidence to suggest that the comorbidity of Axis-II and Axis-I disorders heightens risk. Tanney (1992) has reported on several studies of borderline personality disorder in which suicide attempts were more serious when there was a comorbid affective disorder or substance-abuse disorder, while Runeson (1989) found that 48% of the substance-abuse suicide completers in his sample also met criteria for borderline personality disorder. Research in this area, however, remains relatively undeveloped, and researchers are left to observe caution about potential suicidal ideation in any patient diagnosed with borderline personality disorder, especially those with the comorbid-Axis-I diagnoses of depression and substance abuse.
Axis-II disorders also have been shown to be important predictors of suicidal behavior in adolescents. For example, Zlotnick, Donaldson, Spirito, and Pearlstein (1997) found higher levels of affect dysregulation and a greater number of self-mutilative behaviors (traits associated with BPD) to be indicative of adolescents who attempted suicide. Similarly, Brent et al. (1994) found a higher incidence of personality disorders (specifically those in Cluster B) in adolescents who committed suicide. The investigators also found that such individuals had a higher level of lifetime aggression and violent impulsivity. Adolescents with these traits often are diagnosed with antisocial or conduct disorders. It is not surprising that such disorders, especially when paired with Axis-I symptoms, have been correlated highly with suicidal behavior. Kovacs, Goldston, and Gatsonis (1993) found that 45% of youth diagnosed with conduct/substance-use disorders and depressive disorders made suicide attempts, compared to only 22% of youth with depressive disorders alone and 10% of youth with no depressive disorders. Beau-trais, Joyce, and Mulder (1996) also found an elevated level of serious suicide attempts among individuals with diagnoses of affective, substance-use, and antisocial disorders.

In sum, it appears that adolescents who demonstrate Axis-II traits—specifically borderline and/or antisocial behaviors and who also suffer from Axis-I disorders such as depression or substance abuse—have a much higher risk of suicide. Such individuals show poor affect tolerance and are quick to act out violently. Again, the research in this area is relatively undeveloped and, while the findings are offered to clinicians as a framework for estimating risk, caution must be maintained for any individual who presents with suicidal behaviors.

Comorbidity and Increased Risk of Suicide

In reviewing the evidence for diagnosis and associated suicide risk factors, one cannot avoid being impressed by the prevalence of comorbidity as a contributor to heightened risk. If we use the term comorbidity in the sense that Moscicki (1995) has (i.e., to mean comorbid psychiatric diagnoses or a primary psychiatric diagnosis plus high levels of other psychiatric symptoms), then comorbidity is an additional significant risk factor with each of the high-risk diagnoses noted above. Such is the case with major depression and anxiety symptoms, alcohol abuse and depression, schizophrenia and depressive symptoms, PTSD and substance abuse or depression, as well as with the impulsive-spectrum personality disorders and substance abuse or depression. As noted earlier, comorbidity suggests an additive or interactive effect of two or more pathological processes. The fact that only certain disorders or combinations of disorders contribute to heightened risk should help us to begin to formulate what sort of complex affective states and associated clinical features form the basis for a suicidal state.

Section II: Clinical Implementation and Management

The risk profiles described above provide a framework for categorizing the factors that may contribute to imminent risk of suicide. It is advisable to use them within the context of a comprehensive evaluation. Such an emergency evaluation has been described at length by Kleespies, Deleppo, Mori, and Niles (1998), which will not be repeated in its entirety here. Rather, we will focus on some of the more essential elements of this type of evaluation.
Emergent vs. Nonemergent Crisis

The clinician is well advised to approach all situations of alleged suicide or violence risk as potential emergencies until convinced otherwise. One of the major tasks of the emergency evaluation is to determine if the situation is a behavioral emergency or might perhaps be termed more appropriately a behavioral crisis. It is important to understand the distinction between these concepts because it assists our thinking and decision-making when confronted with an apparently urgent clinical situation. A behavioral emergency occurs when an individual reaches a state of mind in which there is an imminent risk that he or she will do something (or fail to do something) that will result in serious harm or death to self or others unless there is some immediate intervention. High-risk suicidal states are one such emergency.

A behavioral crisis, on the other hand, is a serious disruption of a person’s baseline level of functioning such that his/her usual coping mechanisms are inadequate to restore equilibrium. However, it necessarily does not imply danger of serious physical harm or life-threatening danger. When a patient presents in a crisis, one of the clinician’s tasks is to assess the likelihood that the patient’s efforts to resolve the crisis will lead to life-threatening behavior or whether that likelihood is small. In the latter case, a crisis-intervention strategy with a referral for further outpatient treatment may be sufficient, while, in the former case, emergency intervention may be necessary to protect the patient or others.

Containing the Patient’s Emotional Turmoil

Determining whether the patient is likely to be in an emergency condition should evolve from efforts to define the patient’s problem. When a patient presents under conditions of perceived urgency, however, it often is necessary to help the patient regain self-control or to make efforts to contain the patient’s emotional turmoil and impulsivity before one can make such a determination. The first level of response, of course, is to try to form a working alliance, and Kleebies et al. (1998) have described the issues and factors involved in such an engagement process. These verbal efforts can fail, however. In this regard, it is important to have a predetermined algorithm or decision tree for managing a patient’s difficulty with self-control (e.g., if a patient escalates and attempts to hurt him or herself, the clinician knows how to go about contacting someone to prevent such an action). Such a priori strategies must be flexible enough to fit the setting and the situation, yet allow for a timely response without the need to contemplate what an appropriate intervention might be. Having an emergency-intervention strategy saves valuable time, reduces stress, and improves the clinician’s ability to maintain control of a situation that could become chaotic (Kingsbury, 1987).

Lethality Assessment

The approach of examining what Clark and Fawcett (1992) have referred to as diagnosis-specific risk factors is assimilated easily into and complemented by the more-comprehensive assessment framework provided by Rudd and Joiner (1998). These authors proposed conceptualizing the factors that may have a bearing on suicidal ideation in three domains (i.e., predisposing factors, risk factors, and protective factors). Predisposing factors are long standing and invariable (e.g., gender, family history of suicide, high-risk diagnosis). Risk factors, for the most part, consist of acute symptoms, stressors, or conditions, some
of which have been discussed above in the context of a risk profile (e.g., anxiety during a depressive episode, a recent loss for a chronic and actively drinking alcoholic). Protective factors, if present, decrease risk, but, if weak or absent, may increase risk (e.g., lack of a social-support network, the absence of children under the age of 18 in the home).

Based on the weight or number of factors in each of the above domains, Rudd and Joiner (1998) propose a gradation of suicide risk ranging from nonexistent (or perhaps minimal) to extreme. Thus, a person at minimal risk might have no known predisposing factors or acute risk factors and multiple protective factors, while someone at moderate risk might have some predisposing factors, some acute risk factors, and some protective factors that are beginning to weaken. Those in the severe-to-extreme range are more likely to be at imminent risk. Such a person might show evidence of a number of predisposing factors (e.g., a 30-year history of alcohol abuse, a history of divorce, a family history marked by a brother who committed suicide, a history of having been abused as a child), multiple acute risk factors (e.g., recent job loss due to alcohol problems, recent loss of a relationship with a significant other, depressed mood, a plan for suicide with serious intent), and a dearth of protective factors (e.g., homelessness, alienation from family and friends, noncompliance with treatment).

Two Caveats in Suicide-Risk Assessment

In daily practice and in the suicide-risk-assessment literature, one of the most frequently cited risk factors is a history of prior suicide attempts, and it is clear that those who have made prior suicide attempts have an elevated risk of suicide. A caveat, however, is that the absence of a history of suicide attempts should not be taken as diminishing risk. As Maris (1992) has noted, suicide completers and suicide attempters seem to represent separate but overlapping populations. It is estimated that the relatively high rate of 10 to 15% of suicide attempters complete suicide; however, an estimated 60 to 70% of suicide completers have no known history of prior attempts and commit suicide on the first known attempt. Thus, a history of a prior suicide attempt should be taken as a risk factor, but its absence should not necessarily be taken as a sign that the individual will not cross the so-called thought–action barrier and commit suicide.

A second caveat has to do with the frequent reliance in clinical practice on the patient’s verbal denial of suicidal ideation. As Clark (1998) has pointed out, the clinician cannot dismiss the possibility of high suicide risk when the patient reports not having suicidal ideation. He cites the prospective study by Fawcett et al. (1990) in which depressed patients who committed suicide within one year of assessment (on clinical indices of suicidal thinking, recent suicide attempts, and the seriousness of recent suicide attempts) were judged to be less suicidal than depressed patients who continued to live for the next five years. The complete meaning of such findings is not clear; however, they do suggest that a good evaluation for suicidal risk is not complete because the patient states that he or she has no suicidal ideation. As Clark (1998) has said:

Clinicians who undertake emergency evaluations must therefore school themselves in the clinical research pertaining to suicide risk in the absence of frank suicidal thoughts or behavior, and they must constantly apply this knowledge to estimate suicide risk independently of available information about frank suicidal thoughts and behavior. (p. 87)

It would seem that the emergency clinician must be alert to the individual whose diagnosis and related risk factors suggest a profile of someone who easily could develop suicidal ideation or a suicidal state. He/she then can manage this patient with greater caution and attempt to understand what events might precipitate increased suicidality.
Involving Family and Friends in the Evaluation

If the potentially suicidal patient has family or friends available (in person or by telephone), there may be a number of good reasons to seek out the information that they can offer about the patient. Before doing so, however, there are a few questions to consider. First, does the patient give his or her consent for the clinician to speak to his/her relatives or friends? Second, if the patient refuses consent, is there sufficient reason to override the right to confidentiality because of the potential risk or emergency nature of the situation? Third, are there any contraindications to involving family or friends such as situations in which the patient may have been intimidated or abused by those close to him or her (Perlmutter & Jones, 1985)?

There are several advantages of having access to the patient’s family or friends. First, contact with family and friends can be an initial step toward reducing the social withdrawal and isolation that is so often a part of the problem. Second, family and friends can provide, at times, crucial information about precipitants to the patient’s condition, about his or her recent functioning, and about various aspects of his or her past history, all of which the patient may have been unable or unwilling to offer. Third, those who care about the patient should be made aware of the nature of the risk and that decisions about the patient’s treatment are made by weighing the risks and benefits. Finally, family and friends may have a role to play in the future in terms of being observant of signs of renewed risk and providing a safety network.

The “Contract for Safety”

It now is common clinical practice to ask the patient who seems to be at risk to harm self or others if he or she can “contract for safety.” In inpatient settings, clinicians often ask if the patient can contract for safety in the hospital, while in outpatient settings, they may ask if the patient can contract for safety until the next appointment. Part of this agreement usually is that if urges to commit suicide or violence to others become strong, the patient will inform the clinician or another available staff member before acting.

While it is likely that this practice initially was thought of as an intervention (Clark, 1998), we maintain that it has taken on evaluative properties for many practitioners. If the patient can make such an agreement, it is taken as a sign that suicide risk is not imminent. While this thinking makes sense intuitively, it is important to keep in mind that there is as yet no empirical evidence that those who can contract for safety are any less likely to commit suicide than those who say that they cannot. This, of course, is not to say that it may not be clinically useful to have the patient go through the process of arriving at a contract for safety. Stanford, Goetz, and Bloom (1994) have suggested that it can enhance the working alliance. Moreover, it may introduce inhibition to action for some patients. It can let the patient know that the clinician wants to know about acute increases in suicidal thoughts. In case of a negative outcome, it indicates that the clinician and the patient discussed the level of risk and the patient denied that it was immediate. Given the uncertain value of these “contracts” in estimating risk, however, the clinician would seem well advised to avoid their use as the sole evaluation of imminent risk for suicide and use them only within the context of a more extensive consideration of risk factors and the formulation of a risk profile.

The Issue of “Defensive” Practice

“Defensive” practice is practice that is driven by fear of malpractice actions. It refers to the clinician’s act or omission that is not done for the benefit of the patient, but solely to
provide a good legal defense if needed. In the intense atmosphere generated by the evaluation for imminent suicide risk, it is easy to see how the clinician’s decision making could be influenced by such fears and concerns. According to Simon (1987), there is both “positive” and “negative” defensive practice. Positive defensive practice means taking actions solely to prevent or limit liability as, for example, in perfunctorily hospitalizing a patient at the first mention of suicidal ideation when further inquiry might lead to a lower estimate of risk and less drastic action. Negative defensive practice entails avoiding engagement with the patient at risk, again in an effort to prevent becoming the object of a liability claim. Thus, the clinician might disengage immediately with the caller who alludes to suicidal ideation, or he or she might accept a contract for safety at face value without further evaluation. Those who evaluate suicidal emergencies must endeavor to avoid either the extreme of overreacting or that of underreacting, while realizing that the best defense against legal claims simply is to provide the best care that one can while documenting the rationale that you have for any significant decision. If the clinician especially is concerned, it is wise to seek a consultation with a peer or colleague. As Bongar, Greeney, and Peruzzi (1998) have noted, consultation and documentation are the twin pillars of risk management.

Outpatient Management or Emergency Intervention: How Do We Decide?

There is no absolute rule for when a suicidal patient can be treated on an outpatient basis or when one must make an emergency intervention, something that often results in hospitalization. One needs to be guided by a carefully considered estimate of the level of risk. The following sections offer some direction for making the difficult decision of whether to proceed on an outpatient basis or to hospitalize.

When Is Outpatient Management Feasible?

Clinicians may be disposed to hospitalize suicidal patients because they feel it is safer, and, as noted earlier, if they have a high index of concern about liability issues. Many patients with suicidal ideation, however, can be treated successfully on an outpatient basis, and, as also noted earlier, level of risk is the key issue in making this decision. Generally, outpatient management for patients at either mild or moderate suicide risk has been found to be feasible and safe (Rudd, et al., 1996; Slaby, 1998). An example of a patient at moderate risk might be someone with some predisposing factors (e.g., a diagnosis of chronic schizophrenia, male gender, age less than 40), some acute risk factors (e.g., discouragement about difficulties in functioning, mild-to-moderate hopelessness about the future, episodic suicidal ideation with a plan but no immediate intent), and some protective factors that are beginning to weaken (e.g., the individual lives with supportive parents who are aging and having health problems that increasingly impair their functioning). For such patients, Rudd and Joiner (1998) have suggested the following contingencies in outpatient treatment planning:

- an increase in outpatient visits and/or an increase in telephone contacts,
- frequent assessment of suicide risk,
- recurrent evaluation for hospitalization while the risk continues,
- 24-hour emergency availability,
- reevaluation of the treatment plan as needed,
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- consideration of changes in the medication regimen, and
- use of professional consultation as warranted.

For patients at milder risk, they suggested that recurrent evaluation and monitoring of suicide potential might suffice.

A time-limited outpatient treatment aimed at problem solving and adaptive coping has been examined with suicidal adolescents and young adults (Rudd et al., 1996). The findings support the efficacy of adopting such an approach to resolving the episode of suicide risk. Linehan (1993) has advocated an approach oriented toward learning skills to help regulate strong emotions, and has reported that, with such treatment, patients with borderline personality disorder who are suicidal can be treated as outpatients without a high frequency of hospitalization (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991).

When Is Emergency Intervention Necessary?

As Callahan (1998) has noted, emergency intervention is necessary when the level of suicide risk becomes severe. It usually consists of a single session intended to reduce or eliminate the imminent danger of life-threatening behavior. In this sense, we distinguish emergency intervention from crisis intervention, which is a form of brief therapy designed to resolve a crisis in one to six sessions. Crisis intervention is not intended as an immediate response to avert serious injury or death, while emergency intervention is.

Emergency intervention often begins with an effort to resolve or reduce a crisis that has precipitated an increase in suicidal intent. At times, it is possible to achieve such a resolution and have the patient pursue outpatient follow up as described in the section above. As Comstock (1992) has pointed out, however, hospitalization is indicated when it is not possible to establish or reinstate a treatment alliance, when crisis intervention techniques fail, and when the patient continues to voice intent to commit suicide in the immediate future. Typically, one or two hours with a patient who maintains imminent suicidal intent are sufficient to convince clinicians to hospitalize.

Since most suicidal patients seem to have ambivalence about taking such final action, the majority who require hospitalization agree to voluntary admission. When patients evaluated at imminent risk refuse to be hospitalized, however, the clinician is confronted with a decision about involuntary commitment. This decision can be difficult since we know that the estimation of suicide risk is not always reliable, and involuntary hospitalization may create barriers to effective treatment in the form of heightened resistance to forming or maintaining a therapeutic alliance (Comstock, 1992). The situation can become even more complex if family and/or friends support the patient in his or her resistance. As Kleespies, Deleppo, Gallagher, and Niles (1999) have noted, however, it nonetheless remains the clinician’s responsibility to decide if hospitalization is needed. In the final analysis, the decision to hospitalize involuntarily must be based on a sound clinical judgment that considers the risk–benefit ratio and the estimated imminence and severity of the suicidal risk. In making such trying decisions, it may be helpful to keep in mind that once hospitalization has occurred, resistant patients often begin to perceive the caring nature of the clinician’s actions and reestablish a treatment alliance.

Inpatient Management of the Suicidal Patient

Kleespies et al. (1999) have discussed in some detail the inpatient management of the patient at imminent risk of suicide. What follows is a presentation of the essentials of that discussion.
While suicide in the hospital is far less frequent than suicide in the community (Litman, 1982), it must nevertheless be borne in mind that even on an inpatient psychiatric unit there is no absolute protection from suicide. Vigilance is necessary for all patients who present with acute suicide risk, and the most effective means to provide it is through direct observation and supervision until the patient is in better self-control. The level of supervision will vary according to the acuity of the risk and might range from restraints to one-to-one continuous observation to intermittent observation (e.g., every 15–30 minutes), etc. Although methods such as restraints are very restrictive and should be used as infrequently as possible, the clinical staff must keep in mind that some patients can be so despairing and intent on suicide that verbal interventions are not sufficient to ensure safety.

Given the current pressure to reduce length of hospital stay, it is important to initiate assessment and intervention quickly. As we have noted, the majority of suicidal individuals carry a major psychiatric diagnosis, and often comorbid diagnoses. The clinician must evaluate for provisional diagnoses and related risk factors and arrive at a formulation of the patient’s suicidal intent. Medication and psychotherapeutic intervention then can be introduced in the hope of diminishing the clinical symptoms and emotional pain that have contributed to the suicidal state. It should be emphasized, however, that psychopharmacological interventions should be introduced as part of a consideration of psychosocial factors that also may be affecting the patient (Silverman, Berman, Bongar, Litman, & Maris, 1998). Treatment of the acutely suicidal patient is best accomplished with a team approach that is informed by a good assessment of the background biopsychosocial data. With the goal of resolving the issues that precipitated the suicidal state, crisis intervention, problem solving, brief cognitive–behavioral, and ego-supportive/enhancing approaches seem most effective. Family sessions also can be very helpful in clarifying and resolving problems and conflicts that have contributed to the patient’s suicidal condition.

Problems in Disposition Planning with the Suicidal Patient

Negative Reactions to the Suicidal Patient

Working with suicidal patients is not only anxiety provoking, but also time consuming. This type of work often includes unexpected interruptions of scheduled appointments, important meetings, and the personal plans of the involved clinician. Even the most-experienced clinician likely is to develop a negative reaction to such patients at one time or another. Particularly difficult in this respect are personality-disordered patients, and even more specifically, individuals with borderline personality disorder who are adept at pushing the limits of the therapist–patient relationship. Maltsberger and Buie (1974) warned that difficulty concentrating on what a patient says, experiencing the impulse to give up or to be self-devaluing, thinking that the patient is beyond help, or having urges to rescue the patient all may be indications of what they label “countertransference hate.” They warn that attention to such countertransference issues is essential to the proper management of these patients. Identification of such issues, however, often is complicated, especially if one is dealing with the reactions of an entire inpatient team. Inpatient psychiatric teams usually are comprised of professionals from many different fields, including support staff who may not have training in transference issues. This can be dangerous during treatment. Most health providers agree that strict limits must be set with BPD patients so that the staff is not manipulated in ways that can lead to an increase in the patients’ dependence and regression.
Many inpatient psychiatric teams use involuntary discharge as a type of limit setting. However, as reported by Kullgren (1988), such limit setting can be extremely risky. He found that 5 of 11 inpatient suicides from one community hospital were preceded with a threat of an involuntary discharge from inpatient treatment. Although his sample is small, this is a worrisome finding, and several hypotheses can be suggested for its explanation. The five individuals who committed suicide also had longer hospital stays. This could mean that they had developed a stronger dependence on hospital staff and consequently experienced more difficulty separating from staff and treatment when discharged. The fact that they had longer hospital stays also could indicate that these individuals were more disturbed than the other patients were. A more-troubling hypothesis is that transference and countertransference issues contributed in a negative way to the patient’s treatment and to a premature discharge. Progress notes from staff indicated that “it was believed that the patients aggravated their symptoms and complaints in order to stay in treatment or it was considered that they would benefit from a discharge for social or other reasons” (p. 42). It is not possible to analyze retrospectively the negative reactions (or countertransference issues) that the staff may have experienced with these patients, or to know exactly how these suicides could be prevented. This report, however, highlights the need for clinicians to be extremely cautious with BPD patients and in how they set treatment limits. The entire staff should have an understanding of transference and countertransference issues. Limit setting, and specifically involuntary discharge plans, should be discussed at length, with special attention given to how negative reactions to a patient may influence treatment planning.

Clinically, BPD patients are said to respond well to structured environments. Yet, most clinicians warn that hospitalization of BPD patients should be avoided in all but extreme cases (Callahan, 1996), as it can increase the patient’s dependency and often exacerbate symptoms. Unfortunately, there is no empirical data to suggest that decreased hospitalization decreases suicidal ideation or saves lives in BPD individuals. This lack of evidence leaves the clinician with a difficult decision about how to treat a suicidal BPD patient. It often is difficult to discern between parasuicidal behaviors and more-serious intentions and/or suicidal attempts. It is not uncommon for a clinician to hospitalize a BPD patient to make certain they are safe. In either type of treatment, inpatient or outpatient, current treatment guidelines suggest that strict treatment parameters be set with the BPD patient. Callahan (1996) suggested that at the beginning of treatment, BPD patients be informed clearly of the frequency, length, and timing of therapy sessions. The maximum amount of in-between-session contacts and how they will be instigated also should be agreed upon, along with how the patient will deal with suicidal impulses. Strict guidelines of treatment are thought to decrease the patient’s ability to manipulate staff, and therefore hopefully decrease the negative reactions. The desired result of strict guidelines is a less-complicated treatment environment that will provide for focused attention to the central psychological needs of the patient.

Cost Containment, Limited Access to Hospitalization, and Reduced Length of Stay

In this era of cost containment and the shift to more-economical outpatient treatment, it can be difficult to access inpatient care for the suicidal patient. The clinician often must contend with not only the patient’s crisis, but also with issues such as whether the patient has health insurance and, if so, what its limits may be. It can be difficult to convince a hospital intake worker to accept a patient who has few financial resources. If the patient belongs to a managed-care plan, the clinician needs to obtain approval for hospitalization
from a case reviewer for the managed-care company, and the case reviewer may be more of an advocate for the company than for the patient. Issues such as these can make it difficult for the clinician to meet his or her ethical and legal responsibilities to the patient (Appelbaum, 1993).

If the patient is hospitalized, there is pressure to keep more-expensive inpatient care to a minimum in terms of length of stay. Although this pressure can have the benefit of reducing dependency and fostering more autonomous functioning, it also can put the patient at risk of a precipitous discharge without adequate time to resolve issues related to his or her suicidal thoughts.

Post-Discharge Planning

When the patient seems emotionally stable and no longer reports suicidal ideation, it generally is assumed that he/she is ready for discharge from inpatient care and for the resumption of life in the community. In the majority of cases, this is true; however, a number of studies have highlighted the period of transition from inpatient to outpatient status as a time of increased risk of suicide. Those who required hospitalization for their suicidal ideation are most likely a higher risk group. In this regard, Fawcett, Clark, and Busch (1993) found in their long-term prospective study that most of the affective-disorder patients who completed suicide during the first year of follow up had been inpatients rather than outpatients on entry into the research program. Roy (1982) studied former inpatients who subsequently took their own lives and found that 44% of the suicides occurred within one month of hospital discharge, 70% within four months of discharge, and 89% within one year of discharge. This data suggests that some patients may have a lingering wish to die that no longer is being verbalized, or that some patients can regress quickly to an acute suicidal state. Continued treatment on an outpatient basis clearly is important for the patient who has been hospitalized for suicidal intent. Moreover, outpatient treatment providers who take on the care of a patient who recently was hospitalized for a suicidal episode cannot assume that hospitalization has eliminated the risk to the patient. Close monitoring for suicidal ideation and intent must continue in the post-discharge period.

Concluding Remarks

As noted earlier, an approach that employs empirical evidence for high-risk diagnoses and associated acute risk factors seems to have potential for improving suicide-risk estimation in the clinical setting. Better risk estimation needs to be coupled with sound judgment about how best to manage and keep the high-risk patient safe. As mentioned in the preceding section, management of the high-risk patient does not end necessarily with the apparent cessation of an acute suicidal episode and/or with discharge from the hospital. Nonetheless, in the current era of cost containment, it often is difficult to find the type of follow-up care needed by the patient who recently has been suicidal and may be vulnerable to relapse. To meet his or her obligations to the patient, an inpatient clinician often must work exceedingly hard and with definite time constraints to arrange this sort of care. Healthcare systems would do well to observe the heightened risk during the transition from inpatient to outpatient treatment (Kleespies, Marshall, Pokrajac, & Amo- dio, 1994) and to strengthen efforts at rapid and sustained outpatient engagement to meet the needs of the patient in the aftermath of a suicidal episode.
References


