

Recognizing and Responding to a Suicide Crisis

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Data from therapists who were treating 26 patients when they committed suicide were utilized to identify signs that warned of a suicide crisis. Three factors were identified as markers of the suicide crisis: a precipitating event; one or more intense affective states other than depression; and at least one of three behavioral patterns: speech or actions suggesting suicide, deterioration in social or occupational functioning, and increased substance abuse. Problems in communication between patient and therapist were identified as factors interfering with crisis recognition. Evaluation of the identified affects and behaviors may help therapists recognize a suicide crisis.

Family and friends of individuals who commit suicide have proven to be a valuable source of information, but in most cases they are not able to provide a detailed picture of the inner life and motivations of those they have lost to suicide (Robins, Murphy, Wilkinson, Gassner, & Kayes, 1959; Barraclough & Hughes, 1987; Rich, Fowler, Fogarty, & Young, 1988). Therapists who treat these patients are a relatively untapped source of such information. Over the course of a professional lifetime, any one psychotherapist may see one or a small number of patients who kill themselves while in treatment. About 20% of psychologists and over 50% of psychiatrists are estimated to have had this experience (Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988; Chemtob,

Bauer, Hamada, Pelowski, & Muraoka, 1989; Alexander, Klein, Gray, Dewar, & Eagles, 2000). What is learned by these therapists remains uncollected and anecdotal.

The Suicide Data Bank of the American Foundation for Suicide Prevention was designed to accumulate and analyze such information in order to better understand patients' thoughts, feelings, and behavior prior to suicide. This report on the first 26 patients in this ongoing project looks at the clinical features that mark a suicide crisis and examines how therapists recognize and respond to the crisis.

METHODS

Therapists who contributed cases learned of the Suicide Data Bank project from a variety of sources, including colleagues, notices in psychiatric publications, mailings from the American Foundation for Suicide Prevention, or relatives of patients who died by suicide. Six of the therapists were known to the investigators: three as colleagues and three as acquaintances. To qualify for inclusion, cases had to be actual sui-

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cides who had been seen by the therapist for at least six visits. Twenty-four of the 26 patients had been seen on a regular basis, 13 were seen two or more times a week, and 11 once a week; the remaining two were seen less regularly. These patients received treatment for periods from 3 weeks to 48 months, with a median duration of 12 months.

Participant therapists prepared a comprehensive, 15 page, narrative description of the case, and completed semistructured questionnaires on the demographic, clinical, and psychodynamic features of the patient and the therapist's reactions to the suicide. Following submission of these materials, three therapists at a time were scheduled to participate in an all-day case presentation workshop with the project clinicians and the project coordinator. Three patients were usually discussed in each workshop; their identities were disguised in the narratives, questionnaires, and other case materials that participants reviewed in advance. As will be seen in the cases discussed later in this article, the therapist's perception of the case was not always shared by the group.

Eleven of the 26 cases were presented within 2 years of the suicide, 12 within 3 to 5 years, and in three cases many years later by therapists who had kept detailed treatment records. Twenty-one of the 26 participating therapists were male; five were female; twenty-one were psychiatrists, four were psychologists, and one was a psychiatric social worker. At the time of the suicide, six therapists had been in practice over 15 years, seven between 10 and 15 years, eight between 5 and 10 years, and five were trainees.

Sample

Half of the 26 patient cases were male, and half were female. They ranged in age from 17 to 63, with a median age of 33.5 years. The demographic distribution of the cases differs considerably from the predominantly male, predominantly older profile of suicide cases in general, likely because women and younger adults more often seek psychiatric treatment.

Nineteen of the cases were outpatients at the time of the suicide; six were inpatients, and one had recently transferred from a hospital to a group home. Two of the inpatients killed themselves on pass from the hospital, two eloped to do so, and two did so in the hospital. Almost all the outpatient cases (16 out of 19) had had at least one psychiatric hospitalization.

Diagnoses

For each case, DSM-IV criteria were used to make a diagnosis of the patient at the time of the suicide. (The first 12 cases, which used DSM-III-R criteria, were reviewed to insure conformity with DSM-IV criteria.) In addition to the treating therapist, each project psychiatrist made an independent diagnosis to make sure the criteria had been followed. In three cases where the therapist's original diagnosis did not conform to the recognized criteria, the diagnosis recorded for the patient was the one agreed upon by the project psychiatrists.

The diagnoses for 16 of the patients was Major Depressive Disorder, and four were diagnosed with Bipolar Disorder, two in mixed states and two in major depressive episodes. Four patients were diagnosed with Schizoaffective Disorder, one had a General Anxiety Disorder, and one an Adjustment Disorder. Nine patients had an additional Axis I diagnosis of Substance Abuse; two had the additional diagnosis of Panic Disorder, and one the added diagnosis of Posttraumatic Stress Disorder.

Fifteen of the 26 patients also had Axis II personality disorder diagnoses. Five were diagnosed with Borderline Personality Disorder, four with Narcissistic Personality Disorder, three with Personality Disorder NOS, two with Avoidant Personality Disorder, and one with Dependent Personality Disorder.

All 26 patients had received an antidepressant or other psychotropic medication, prescribed by a psychiatric consultant for the five patients who were not being treated by a psychiatrist. Not all of the patients, however,

were receiving medications at the time of their death. About half of the patients were correctly and adequately prescribed medications, while in the others medication doses were low and ineffective or not directed to the therapist's primary diagnosis. Detailed evaluation of the psychopharmacological treatment of these patients will be the subject of a separate review.

RESULTS

Crisis Markers

Three factors were identified as markers of the suicide crisis, usually occurring in combinations of two or three in a single patient: a precipitating event; one or more intense affective states; and one or more behavior patterns including speech or actions suggesting increasing suicidal interest, deterioration in social or occupational functioning, or increasing substance abuse (See Table 1, Part A).

Precipitating Event. In 21 of the 26 cases a major life event appeared to precipitate the patient's intense affective response: loss of a relationship on which the patient was dependent, collapse of a career, or the potentially fatal illness of a child. Although in some cases the event intensified a pre-existing affective state, and in others the affective state magnified the importance of the event, more important was the fact that the patients attributed their affective states and behavior to such events.

Patients' Affective States. A depressed mood was present in all 26 patients. The therapist rated the depression as "severe" in 18 cases, "moderate" in six cases, and "mild" in two cases (See Table 2). Chronic affective states typically were interwoven with the patients' depression: a longstanding sense of abandonment or rejection, chronic hopelessness, loneliness, and self-hatred. These were not clear signs of the suicide crisis. The sense of abandonment, seen in 15 patients, was sometimes acute in response to a specific rejection, but more often reflected longstanding feelings of being alone and unsupported.

Consistently linked to the suicide crises were acute, intense affective states associated with real or perceived occurrences in the patient's life. These feelings—desperation, an acute sense of abandonment, anxiety, rage, guilt, or humiliation—appeared to have compounded the patient's depression. The acute affective state most associated with a suicide crisis was desperation. Defined as a state of anguish accompanied by an urgent need for relief, desperation was intense in 22 of the 26 patients.

In three depressed patients with borderline, narcissistic, or mixed personality disorders (Cases 7, 16, and 19), abandonment and rage appeared to be as important as desperation in influencing the suicide. In two other patients, guilt and rage, precipitated in one case by the suicide of a brother (Case 3) and in the other by the diagnosis of leukemia in an infant son (Case 14), were the affects that triggered the suicides. In four patients (Cases 4, 21, 23, and 25), acute humiliation resulting from social or occupational failures played a major role along with desperation in precipitating an already depressed patient into suicide.

Behavioral Manifestations of the Suicide Crisis. In addition to an intense affective state, 21 of the 26 patients showed at least one of three behavioral signs that warned of the suicide crisis. Seventeen patients showed by speech or action that they were contemplating suicide: the form this took varied from a patient (Case 15) who reported suicidal ideation she would not detail, to another (Case 12) who bluntly reported feeling acutely suicidal. Several did not confide their suicidal intent directly to the therapist, but to someone else whom they knew would relay the information to the therapist.

Other patients communicated their impending suicide through their actions. Seven patients (3, 5, 12, 13, 15, 21, and 24) made actual suicide attempts within three months of their suicide and while in their current therapy. Others engaged in escalating self-mutilating or self-destructive behaviors. One patient (Case 26) dealt with his anxiety every night by drinking and burning

TABLE 1
Crisis Markers and Other Factors Indicating Risk of Suicide

Case #	ID	Diagnosis	Status*	Precipitating event	Intense affective state	Behavioral manifestations of a crisis				B: OTHER FACTORS INDICATING RISK		
						Speech/action	Deteriorating functioning	Increasing substance abuse	Number of previous attempts	Impulsivity	Current substance abuse	
												A: CRISIS MARKERS
1	34M	PTSD, MajDep, SubsAbuse (cannabis & alcohol)	op	●	●	●	●	●	●	3	severe	●
2	33F	GenAnxDiis, SubsAbuse(alc), BPD	op	●	●	●	●	●	●	3	moderate	●
3	17M	AdjDisorder, SubsAbuse, Dys-thymia, BPD	ip	●	●	●	●	●	●	1†	severe	●
4	53M	Bipolar (mixed), PersDisNOS	op	●	●	●	●	●	●		severe	
5	21M	MajDep, recur, PanicDis, Avoid-antPersDis	ip	●	●	●	●	●	●	1†		
6	37F	MajDep	op	●	●	●	●	●	●		moderate	
7	32F	Schizoaffective, BPD	op	●	●	●	●	●	●	4		
8	22M	MajDep, Bulimia	ip	●	●	●	●	●	●		severe	
9	56F	MajDep, w psychotic features	op	●	●	●	●	●	●			
10	26M	Schizoaffective, PanicDis	ip	●	●	●	●	●	●			
11	39M	Bipolar w psychot fs, NarcPers-Dis	gh	●	●	●	●	●	●	1		
12	27F	MajDep, recur w psych, Bulimia	ip	●	●	●	●	●	●	5†	moderate	●
13	23F	MajDep, Dysth, SubsAbuse (alcohol), PersDisNOS	op	●	●	●	●	●	●	4†	severe	
14	34M	MajDep, mixed mood disorder due to meds.	op	●	●	●	●	●	●		severe	
15	23F	MajDep (atypical), Dysthymia, BPD, NarcPersDis	op	●	●	●	●	●	●	3†		
16	44F	MajDep, recur, SomatizDis, Dysth, BPD, SubsAbuse (sed & analg)	op	●	●	●	●	●	●	6	moderate	●

TABLE 2
Therapists' Ratings of Patient's Affective State Prior to Suicide

Case #	Status*	ID	Depression	Desperation	Rage	Anxiety	Abandonment	Hopelessness	Self-hatred	Guilt	Loneliness	Humiliation
1	op	34M	severe	intense	intense	intense	intense		intense	intense		
2	op	33F	moderate	intense	intense	intense	intense	intense	intense	intense		
3	ip	17M	severe	intense	intense	intense	intense	intense	intense	intense		
4	op	53M	severe	intense	intense	intense	intense	intense	intense	intense	intense	intense
5	ip	21M	severe	intense	intense	intense	intense	intense	intense	intense	intense	intense
6	op	37F	severe	intense	intense	intense	intense	intense	intense	intense	intense	intense
7	op	32F	severe	intense	intense	intense	intense	intense	intense	intense	intense	intense
8	ip	22M	severe	intense	intense	intense	intense	intense	intense	intense	intense	intense
9	op	56F	severe	intense	intense	intense	intense	intense	intense	intense	intense	intense
10	ip	26M	mild	intense	intense	intense	intense	intense	intense	intense	intense	intense
11	gp	39M	severe	intense	intense	intense	intense	intense	intense	intense	intense	intense
12	ip	27F	severe	intense	intense	intense	intense	intense	intense	intense	intense	intense
13	op	23F	severe	intense	intense	intense	intense	intense	intense	intense	intense	intense
14	op	34M	severe	<i>intense</i> †	intense	intense	<i>intense</i>	<i>intense</i>	intense	intense	intense	intense
15	op	23F	severe	<i>intense</i>	intense	intense	intense	<i>intense</i>	intense	intense	intense	intense
16	op	44F	severe	intense	intense	intense	intense	intense	intense	intense	intense	intense
17	op	22F	moderate	intense	intense	intense	intense	intense	intense	intense	intense	intense
18	op	49M	moderate	intense	intense	intense	intense	intense	intense	intense	intense	intense
19	op	63F	severe	intense	intense	intense	intense	intense	intense	intense	intense	intense
20	op	49F	mild	intense	intense	intense	intense	intense	intense	intense	intense	intense
21	op	58F	moderate	intense	intense	intense	intense	intense	intense	intense	intense	intense
22	op	17M	moderate	intense	intense	intense	intense	intense	intense	intense	intense	intense
23	op	44M	moderate	<i>intense</i>	intense	<i>intense</i>	intense	intense	intense	intense	intense	intense
24	ip	27F	severe	intense	intense	intense	intense	intense	intense	intense	intense	intense
25	op	41M	severe	intense	intense	intense	intense	intense	intense	intense	intense	intense
26	op	21M	severe	intense	intense	intense	intense	intense	intense	intense	intense	intense
				22	18	16	15	15	11	10	10	9

*op-outpatient
ip-inpatient
gp-group home
†Italics indicate affects not originally listed by therapist

a pattern across his chest with a heated paper clip. Still another, a Vietnam veteran with Posttraumatic Stress Disorder (Case 1), began shooting at trees while intoxicated. When the police were called, he challenged them to shoot him.

Fourteen of the patients showed a marked deterioration in functioning immediately before their suicide. Two (Cases 9 and 20) gave up long-standing professional careers; one (Case 25) quit a long-held job. Several others were in danger of losing their jobs because of growing absenteeism or were experiencing difficulties with employers or supervisors. Other patients' deterioration were signaled by increasing loss of control and rage explosions. A nurse's aide, for example, who worked with retarded children (Case 7) hit one shortly before killing herself. She was terrified by her loss of control.

Socially, the patients' deterioration was expressed in frequent arguments, break-ups in relationships, or social withdrawal. Two patients (Cases 20 and 25) used the last session before their suicide to announce that they were stopping therapy.

Fourteen of the patients had a history of substance abuse; nine were currently abusing, and in five of these nine an increase in alcohol abuse, used to deal with increasing anxiety, marked the suicide crisis.

As summarized in Table 1, each of the 26 patients showed at least one of these three crisis markers: a precipitating event, an intense affective state other than depression, and a pattern of behavior indicative of the suicide crisis. In 16 of the cases, all three markers were present.

Other Indicators of Suicide Risk

Three other factors contributing to the suicide risk were frequently identified in the patients (See Table 1, Part B). The first was a history of previous suicide attempts, which was more frequent in our sample than in the general population of suicides (discussed later). Seventeen of the patients had made at least one prior suicide attempt; 9 had made two or more attempts.

Impulsivity was the second factor that played a role in determining suicide risk, although it was not a sign of crisis. Therapists rated the patient's impulsivity as severe or moderate in 15 of the cases. Finally, an ongoing pattern of substance abuse, even if not worsening, was seen frequently (nine cases), warranting its inclusion as a suicide risk factor.

Factors Impeding Recognition of the Suicide Crisis

In 14 of the 26 cases, the therapist did not recognize the suicide crisis. In one patient (Case 19), a precipitating event led to an impulsive suicide before the therapist could intervene. Eight of the 14 patients (Cases 2, 4, 6, 9, 14, 17, 20, and 26), however, provided warning signs by their intense affective states, combined with one or more behaviors associated with a suicide crisis. Awareness of the importance of these factors as crisis markers likely would have alerted the therapist to the patient's risk.

Among the other five patients in whom the suicide crisis was not recognized (Cases 5, 10, 15, 18, and 22), problems in communication appeared to contribute to the lack of recognition. In a number of cases, including the two that follow, disrupted or flawed communication between patient and therapist led the patient to deliberately conceal suicidal feelings and intention. In one case, what had been good communication between patient and therapist was disrupted by the threat of hospitalization, misleading the therapist to assume a suicide crisis had been resolved when it had actually intensified. In the second, restrictions by the hospital treatment team prevented the patient from communicating the intensity of his suicide crisis.

The therapist had treated this 23-year-old woman (Case 15) with Major Depressive Disorder and Borderline Personality Disorder for two years subsequent to her hospitalization for a suicide attempt. Discussing suicide earlier

in treatment, the patient sought assurance this would not alarm the therapist into putting her into a hospital. She was reassured by the therapist's affirming that while she was committed to the patient's living, she could not force her to remain alive. The young woman again became suicidal after two years of therapy, but said she would no longer discuss her desire for suicide because the therapist would try to dissuade her. This time the therapist replied that if the patient could not share such feelings, she would have to be hospitalized.

The patient related feeling alarmed and threatened by the therapist's response but said that she would not kill herself. She seemed more cheerful in the following weeks and denied any suicidal intentions but then proceeded to tape a long suicide message to her parents just before killing herself: "Dr. (X) sort of threatened me. She said that if I didn't open up to her, she was going to have me put in the hospital... I stopped trusting her and started acting. I'm not that good an actress, but I just tuned out the part that I didn't want to tell her, but I did let myself get all emotional about how bad I was feeling and seemed like I was really opening up to her, but I started planning then about suicide. . . . I lost faith in Dr. (X) and I couldn't come up with any reason to change those plans. . . . It's going to be harder to work out the problems in my life after having lost the connection with Dr. (X) in which I had really felt sort of committed to tell the truth, so I just stuck with those plans."

The therapist did not observe any strong affective state in the patient prior to the suicide. The taped message, however, reveals the patient's feelings of desperation, hopelessness, rage, and abandonment. The therapist's anxiety over the patient's disclosure that she was withholding her thoughts of suicide led to the threat of hospitalization, blocking the patient's communication with the therapist and forcing the patient to dissemble, like "an actress." Had this threat not impeded their communication, this patient

may not have needed hospitalization. A simple statement that if the patient did not talk about her feelings the therapist could not help her, might have been sufficient.

A young man of 21 (Case 5) was treated for nine months on an inpatient unit for Major Depressive Disorder with severe anxiety and Avoidant Personality Disorder. A few months before his death he exhibited aggressive behavior and made several suicide attempts. His treatment team was frustrated by his persistent reference to himself as "brain dead" and his demand for electroshock therapy. He was told he would be transferred if he continued his suicidal behavior, and was required to sign a contract that he would no longer refer to himself as "brain dead." His behavior seemed to improve and he was allowed supervised excursions with other patients. He disclosed to his therapist, a resident who was leaving the ward, that his improvement was a masquerade to conceal and control his rage and agitation. Her note in the patient's chart was seemingly not read or understood because soon afterwards he eloped from a group excursion and killed himself in a motel with stockpiled medications.

In his multiple suicide attempts, his statements that he felt "brain dead," and his insistence on electroshock therapy, this patient was telling his caregivers that his medication and therapy were not helping him. This obviously needed to be heard, and not suppressed by a contract or the threat of expulsion from the hospital. Like the previous patient, he felt obliged to put on a masquerade to hide his feelings. In both these cases, coercion on the part of treatment providers resulted not only in concealment of the suicide crisis, but also in a power struggle in which the patient distorted suicide into a victory.

A different kind of communication problem was seen in a hospital inpatient whose symptomatic improvement in the period preceding his death served as an impediment to recognizing his suicide crisis.

A 26-year-old man (Case 10) was intensively treated in a private hospital for 4 years for Schizoaffective Disorder and Panic Disorder. Although when delusional he feared being murdered and talked of himself as already dead, he never attempted suicide, never talked of suicide nor of suicidal ideation and, apart from severe anxiety, showed no other warning signs or affects associated with suicide. He became one of the first patients to be treated with clozapine. He showed marked improvement in both the positive (delusions and hallucinations) and negative symptoms (emotional withdrawal) of his disorder, although he was still intermittently delusional and continued to have panic attacks that were only partly relieved by clozapine and klonopin. He seemed to accept the plans being made for his discharge, but while on pass he threw himself in front of a train.

The improvement of this patient's psychotic and depressive symptoms on clozapine seemed dramatic and the absence of any previous history of suicide made anticipation of danger more difficult. Nevertheless, his chronic intense anxiety appears to have been exacerbated by his impending discharge, and the therapist subsequently realized that this should have been addressed. In retrospect, the therapist thought that the patient was overly compliant about his discharge to please the therapist and his overburdened family, and that more active elicitation of the patient's fears of trying to make a life outside of the hospital might have led to recognition of the suicidal danger.

Therapeutic Responses to the Suicide Crisis

In twelve of the 26 patients, the therapists identified crises that were propelling their patients toward suicide. The following cases illustrate two of the most common problems therapists experienced in attempting to respond to the crisis.

Suggestion of Hospitalization. In five cases in which therapists suggested hospitalization because of a patient's suicidal intentions, the suggestion was rejected by the patient and the suicide soon followed. The following case is illustrative.

A 44-year-old single male with Bipolar Disorder (Case 23) was in considerable debt because of his grandiose and unrealistic plans to open an art gallery. He and his friends also faced eviction from lofts they occupied illegally. One year earlier he was hospitalized for a psychotic episode when he became agitated and threw furniture while drinking. It took a month until he could be discharged, but he made a good recovery. Subsequently, however, he discontinued his prescribed medications.

He began therapy by reporting his intent to kill himself if he could not make a success of his gallery. He also indicated that he owned a handgun but that he had pawned it. After a brief improvement, he relapsed, and told his mother he was going to get the gun back. When the therapist confronted him, he said he would not kill himself without telling the therapist. The therapist proposed hospitalization; when the patient declined, the therapist offered to drive him to visit a prestigious hospital, and the patient agreed to consider this. Early in the morning after this conversation the patient hung himself in his studio.

This patient's refusal of hospitalization, while agreeing to the therapist's request to consider it, suggests that his demurral and apparent cooperation masked a determination to kill himself and a fear that the therapist might prevent his suicide by involuntary hospitalization. In other cases, therapists arranged family meetings to elicit support for hospitalizing the patient. These efforts were largely controlled by the patient, however, and were not successful.

Failure to Address Factors Underlying the Suicidal Intent. In several cases where the suicidal intent was apparent, the therapist's response did not adequately address the pa-

tient's desire to die. In the following case, the therapist appeared to be more attentive to the needs and feelings of the patient's mother rather than to those of the patient himself.

A 39-year-old man (Case 11) with a history of Bipolar Disorder since the age of 17 never managed to establish a life independent of his mother. He had been hospitalized 20 times for his illness, and at the age of 21 he attempted suicide. He was treated by his current therapist for ten months, first while in the hospital, and then while living in a group home and attending a day hospital. His mother was actively involved in his therapy and insisted he should leave the group home, get his own apartment and a full-time job, and become financially independent.

When the patient told other residents in the group home that he was feeling suicidal, they called the therapist, who went to see him there. The patient showed him the rope and cinder blocks he was planning to use to drown himself. The therapist saw this suicide threat as a test of the commitment to free the patient of his dependency on the hospital, while recognizing it as a response to the pressure he and the patient's mother had been exerting. Although the therapist confiscated the blocks and the rope, he indicated to the patient that his reactions to discharge should be worked through in treatment with no change in plans. When the therapist reported what occurred to the mother she replied, "He'd be better off dead if this is the way it's going to be for the rest of his life."

In his last session, the patient discussed his continuing anxiety about moving out on his own. The therapist praised him for continuing to work at a part-time job despite his anxiety. The patient related a dream: "My father is sweeping me into the mouth of a big fish, and I get stuck in the fish's throat . . . or maybe I do get swallowed, I'm not so sure." The therapist's notes reported that in an earlier dream, the patient represented himself as trying to swim under water with weights

attached to his body, an image that suggested how impossibly burdened he felt by his condition. The current dream suggested the patient's awareness that the therapist was actively participating in permitting his mother to control what was happening. He may have felt that the therapist was as helpless to deal with her as were he and his father, who had long been invalidated with multiple sclerosis. Perhaps he hoped that his death would at least stick in her throat. The patient left the session and drowned himself in the manner he had indicated to the therapist.

The therapist recognized that in pursuing a strategy dictated by the patient's mother, he did not heed the dramatic warning the patient conveyed in showing how he intended to kill himself, nor did he pay attention to the anxiety and anger reflected in the patient's dream.

CONCLUSIONS

The 26 suicide cases we studied suggest that therapists working with suicidal patients frequently fail to recognize the severity of the emotional crises they experience. Our data indicate that only a small percentage of persons who are intent on killing themselves while in treatment give the therapist little or no indication of their crisis. We anticipate that consideration of the specific markers we have identified may aid therapists in recognizing the immediate danger of a suicide crisis.

A suicide crisis is a time limited occurrence signaling immediate danger of suicide. Suicide risk, by contrast, is a broader term that includes factors such as age and sex, psychiatric diagnosis, past suicide attempts, and such traits and behaviors as impulsivity (Åsberg, Schalling, Traskman, Berodz, & Wagner, 1987; Apter, Plutchik, & Van Praag, 1993) and substance abuse (Murphy, 1986; Flavin, Franklin, & Frances, 1990), known to be correlated with suicide.

While therapists look at past events and ongoing behaviors in evaluating suicidal patients, our schema is designed to encourage evaluation of a range of current behaviors and intense affects to help identify a suicide crisis. Rage, hopelessness, and guilt, for example, have been shown to distinguish depressed patients who are suicidal from those who are not (Plutchik & Van Praag, 1990; Hendin & Haas, 1991; Beck, Steer, Beck, & Newman, 1993). Anxiety has been shown to be a better short-term predictor of suicide than hopelessness (Fawcett, Scheftner, & Fogg, 1990). Our study suggests, however, that a wider range of acute intense affects including desperation, abandonment, humiliation, guilt, rage, and anxiety, often in combination, contribute to generating a suicide crisis with immediate danger to the patient.

In our analysis, problems in patient-therapist communication were central in preventing therapists from recognizing a suicide crisis and in impeding their effective response when they did. When patients appeared to be considering suicide but did not confide this to the therapist, asking if they were suicidal usually elicited an automatic "no" response that patients believed the therapist wanted to hear, or believed would deter the therapist from interfering with their plan for suicide. It would probably be more useful in this situation for therapists to indicate their awareness of the patient's mood, or to convey their impression that the patient is considering suicide. Whatever the patient's response, it is likely to be more informative. Asking the patient at such a time to agree to a suicide contract or to reaffirm a prior contract may relieve the therapist's anxiety, but is likely to be seen by the patient as primarily serving the therapist's need for reassurance and may unwittingly substitute for more careful clinical evaluation (Stanford, Goetz, & Bloom, 1994).

In a number of the cases, the therapist's anxiety on hearing patients discuss their suicidal intent blocked communication and derailed the therapy. The communication of suicidal intent, however, is usually a patient's

dramatic way of informing the therapist how desperate he or she feels. The first response should be to try to understand the nature and source of the desperation.

Hospitalization was often presented to patients as necessary to prevent their suicide—a motivation patients may not share with their therapists—rather than as a way for the patient to gain relief from desperation, anguish, and anxiety. If a therapist is unable to persuade a patient to be hospitalized and is convinced there is an immediate threat of suicide, it seems warranted to initiate an involuntary hospitalization at once and not permit the patient to go home to think about it. Involuntary hospitalization might damage the relationship between therapist and patient so that a change in therapists is necessary, but it is worse to continue outpatient treatment when inpatient admission seems required. Obviously, hospitalization is not a guarantee of safety, but it may be the best possible way to address and resolve an acute suicide crisis.

Recognizing the suicide crisis is clearly as important in treating inpatients as well as outpatients. Although some patients, like one young woman who made four suicide attempts over the past 10 years, may appear chronically suicidal, they were not suicidal all the time. There were often several years between their attempts, and knowledge of when they were in crisis was important. Such patients appear to be particularly vulnerable when being pressed to make a transition to outpatient status (Fawcett, Clark, & Busch, 1993; Kleespies, Marshall, Pokrajac, & Amodio, 1994).

Several different explanations have been given for the observation that the mood of some depressed patients appear to be better in the days before their suicide—an observation made about several of these patients. The vegetative symptoms of depression have been said to improve in response to medication before affective symptoms such as desperation can resolve, providing the patient with the energy to commit suicide (Himmelhoch, 1987). The improvement also

has been seen as reflecting the calm of patients who know that their suicidal death will soon end their anguish (Hendin & Klerman, 1993). Patients in this study suggest two other explanations. In some cases the improvement was a deception insuring that the therapist took no action to prevent the suicide. In other cases recovery from depression led to expectations of work and independent living that generated intolerable anxiety. Suicide in these cases seemed triggered by the expectations that recovery produced, not by recovery from depression *per se*.

Limitations

We initiated the Suicide Data Bank project with the goal of utilizing a relatively untapped source of information—therapists treating patients at the time of their suicide—to gain greater understanding of the psychology and behavior of patients who commit suicide. Rather than beginning with an *a priori* set of hypotheses, our approach was broadly exploratory, based essentially on our clinical sense that patient suicides occur within a dynamic set of relationships and forces that come together to create what we describe here as a suicide crisis. Our primary aim in looking at these first 26 cases has been to identify common patterns among both such patients and their therapists, which might assist the development of more effective strategies for treating those at high risk of suicide. While we believe that this approach has yielded a valuable perspective, it is subject to a number of methodological limitations that may restrict the ability to generalize the observations offered in this paper.

The therapists who have participated in the project to date were, of necessity, volunteers, and thus, we cannot estimate how representative they are of the population of therapists who have experienced the suicide of a patient. They cut across a wide range of professional experience, therapeutic orientations, and personal styles of interaction. Although our clinical experience supervising and consulting in patient suicide cases does

not lead us to believe that these therapists are different from other therapists with the same experience, it is possible that therapists not volunteering their cases may be more troubled about their treatment of their patients than those willing to have their cases reviewed. The requirements and procedures of this study also may have served to select a group of more highly involved and motivated therapists. On the other hand, it is also possible that participating therapists may be more than ordinarily disturbed about the death of their patients. Our earlier analysis of the reactions of the therapists to the deaths of their patients (Hendin, Lipschitz, Maltsberger, Pollinger, Haas & Wynecoop, 2000) suggests that both of these possibilities were represented among our participating therapists.

Our initial concern as to whether therapists could be frank in discussing cases they regard as treatment failures, did not turn out to be a problem. The therapists who participated were generally eager to reveal all they could about their cases in the hope of learning from the experience, and welcomed the opportunity to present their cases to others with comparable experiences. Virtually all felt their participation was to some degree therapeutic as well as educational.

Persons who kill themselves while in psychotherapy are also not representative of all who commit suicide. Studies show, however, that there are basic clinical similarities between patients and nonpatients with psychiatric problems (Hendin, Gaylin, & Carr, 1965; Leaf, Livingston, Tischler, Weissman, Holzer, & Myers, 1985), with attitudes toward utilization of psychiatric services rather than psychopathology often determining whether those in need of help seek treatment (Leaf, Bruce, Tischler, & Holzer, 1987). The 26 patients whose cases we have analyzed in this project have had more suicide attempts in their past history than have suicides in general. Indeed, suicide attempts were often responsible for initiating their treatment. Comprehensive data do not currently exist on the demographic and clinical characteristics of patients who kill themselves in treat-

ment. It would not be surprising, however, if there were more prior suicide attempts in the histories of such individuals than in the general population of people who commit suicide, many of whom have never had psychiatric treatment and kill themselves on their first attempt.

We are currently undertaking a survey of psychiatrists in the United States to ascertain whether or not their experience confirms this observation. Parenthetically, we have been led by our current project to suspect that a suicide attempt by a patient in treatment is a more serious warning of an impending suicide than in a patient not in treatment, since the attempt may be an indication that the patient does not feel he or she is getting enough help. Indeed, in some of the cases presented here, suicide attempts and actual suicides appeared to be partly directed against the therapist.

Even if the findings here described are applicable only to those who seek treatment, the implications are important since a considerable proportion of suicidal patients do seek treatment and clinicians are in a position to help these individuals. Our work to date suggests the need for additional studies to be conducted to provide reliable empirical testing of our observations related to such suicides. In this regard, it might seem desirable

to compare patients who commit suicide while in treatment with a matched control group of patients who did not kill themselves while treated by the same therapists. While seemingly sound from a methodological perspective, such a study design would be difficult to implement. It would also need to incorporate recognition of the fact that even comparable patients of the same therapist do not have the same relationship with the therapist, and that such dynamics are essential to understanding why one patient commits suicide and another does not.

Perhaps a sounder and more feasible approach would be a prospective study involving a control group of depressed patients who do not kill themselves, against whom the experiences of those who do could be compared. In such a design, it would be possible to elicit patients' descriptions of their affective experiences, and compare them with therapists' evaluations.

We believe that the therapists participating in this study have provided information that has been missing from retrospective studies of suicide. We hope that a central finding of our work, that certain intense affective states together with other crisis markers can help therapists recognize the presence of a suicide crisis, will stimulate further study.

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