well, yes," the patient replies hesitantly in answer to the question "Do you have thoughts of ending your life?" This "yes" triggers a network of questions and concerns in the mind of the psychiatrist who must now evaluate the patient's degree of suicidality, judging how close it is to a threshold of life-threatening behavior.

The prediction and treatment of suicidal behavior are serious challenges to our clinical abilities. It was in this arena of realistic concern that the "no-suicide" or, as it is sometimes called, the "no-harm contract" (NHC) was born. How are such contracts being used today? Are they a guarantee or insurance against fatal outcomes or do they primarily provide guidance and comfort for the treating psychiatrist?

Drye et al.¹ were among the first to write about this idea in 1973, describing what they called the no-suicide decision (which in later writings has usually been referred to as the no-suicide contract). To arrive at such a decision, they asked suicidal patients a series of questions about their suicidal thoughts and self-destructive fantasies. They then asked patients to consider the statement "No matter what happens, I will not kill myself accidentally or on purpose at any time." The patients' emotional and cognitive responses to this statement were carefully evaluated. If the patients could not fully agree with the statement, they were asked if there were modifications they could accept (e.g., substituting 1 hour, 2 weeks, etc., for the phrase "at any time"). The authors used the patient's responses to make decisions about the degree of risk and necessary interventions. They were enthusiastic about the use of this technique as a means of continuously monitoring the seriousness of a patient's suicide risk. In their follow-up of over 600 patients, it was their experience that this approach increased patient safety. However, in a careful reading of their paper, one sees that they are not presenting this as a contract in which a guarantee is made by the patient, but instead are using the questioning as a process to insure careful methodical exploration of the patient's thoughts and feelings, and the answers to monitor the patient's sense of self-control. It is a useful way to think systematically about important areas, safeguarding the therapist from any tendency to shy away from asking difficult questions.

However, what started out as a suggested means to guide the psychiatrist in evaluating suicidality appears today to have been incorporated into the everyday management of many patients. In a recent survey of 142 clinicians (120 psychiatrists and 22 psychologists) who attended a course on suicide by the faculty of the Harvard Medical School of Psychiatry, over 70% reported that they had seen suicide prevention contracts in use.² Such contracts were recommended and in regular use in the facilities where they worked—yet over 60% also said they had not received any formal training in this subject. This report is consistent with the review by Stanford et al.³ who wrote that "by the 1980's the concept of the NHC, or the no-suicide contract, seemed to have become firmly established in the literature with minimal empirical base" (p. 345).

**Suicide: What Do We Know about Risk Factors?**

The truth is that we know a great deal about suicide risk factors but unhappily are unable to translate this knowledge into accurate prediction. Pokorny's prospective study of a cohort of 4600 psychiatric inpatients is but one report that demonstrates this.⁴ Patients were examined and rated on a wide range of instruments and measures, but the results yielded too many false positives and no sure way of identifying those who would commit suicide.

In terms of risk factors, we do know that there is an increased risk of suicide among those with chronic recurrent affective disorder, schizophrenia, alcoholism, previous suicide attempts, psychiatric illness, or physical illness, as well as among those who live alone, are widowed, unmarried, and unemployed. Startlingly, in Roy's study of 90 psychiatric patient suicides,⁵ of the 75 outpatient suicides, 58% of the patients had seen a psychiatrist within the previous week!

Many studies of suicide risk factors have been done. Some findings from the considerable literature that has grown up around this subject include the following:

- Patients with schizophrenia who are in the active state of their illness or have depressive symptoms are at increased risk of suicide.⁶

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• There is a significant clustering of suicide among patients who have been recently discharged from a psychiatric facility. In a study by Godacre et al., the risk during the first 28 days was found to be 2.13% times greater for men and 1.34% higher for women than in the population at large. Suicide rates during the first 28 days were 7.1 and 3 times higher, respectively, than in the remaining 48 weeks of the year. This is obviously a particularly dangerous period.7

• In patients with borderline personality disorder, suicide mortality is reported to be as high as 10% in extended follow-up.8

• In Finland, a psychological autopsy review of a random sample of 229 patients who committed suicide over a 12-month period found that all suicide victims with a personality disorder also received at least one Axis I diagnosis. In 95%, this included a depressive syndrome, a psychoactive substance use disorder, or both. Individuals with cluster B personality disorders were more likely than comparison subjects to have psychoactive substance use disorders (79% versus 40%) and previous nonfatal suicide attempts (70% versus 37%) and were less likely to have Axis III physical disorders (29% versus 50%). In summary, suicide victims with personality disorders were almost always found to have had current depressive syndromes, psychoactive substance use disorders, or both.9

Unfortunately, the very illnesses with which we deal in psychiatry often blur the patient's ability to collaborate accurately in making a decision about their plans, impulses, and motivations regarding suicide. Consequently, the psychiatrist is forever trying to balance responses that are appropriately protective against those that are overprotective; to sort out if the threat is primarily driven by an attempt to change something in the environment or represents a true and very dangerous wish to die; and to manage the many countertransference reactions that are inevitably aroused by the threat or danger of suicide.

The latter is particularly relevant when the patient has major personality problems. Here the suicidal behavior may have become a way of life, not just a response to depression or a psychotic thought process. In this instance, the therapist is more vulnerable to losing sight of the fact that it is still the patient's emotional disorder that is eliciting the suicidal thoughts and actions. At the moment of impulsivity, patients are usually not as much in control of their behavior as inexperienced psychiatrists might believe. In contrast, when a patient is suffering from schizophrenia or a major affective disorder, it is easier to see that it is the disease that is the enemy; it is the disease process that attacks our competence and strips away our desired ability to heal. Unfortunately, if a patient does commit suicide, we can never be certain that we "did everything we could." It is inevitable that, in retrospect and with the clarity of hindsight, we will always wonder if something else might have been tried that would have prevented the tragedy. There are no test tube or animal studies or radiologic findings to use for basic reassurance. This part of our work, where life and death decisions must be made, will always carry with it the possibility that we may fail; there are some patients whom we will be unable to deter from this tragic life event. We can only look to our own clinical experience and that of others, familiarize ourselves with what is known about suicide, recognize how our reactions may blur our judgment, make the necessary internal corrections, and do the best we can.

The Problem for Clinicians

Our therapeutic alarm systems are therefore well armed about the risk of suicide and are constantly set off by patients with serious problems in self-regulation, but we are unable to predict with certainty what will happen to each individual patient. No wonder we wish that a no-suicide contract worked!

There is a shift in medicine today away from the paternalistic medical model of the past towards a paradigm of informed consent and medical information being shared prudently with patients. Unfortunately, the very illnesses

How Best to Deal with the Suicidal Patient

As with all patients, you need to make a careful evaluation of the psychiatric illness, psychodynamic issues, the patient's strengths and weaknesses, psychosocial stresses, and available resources. Getting to know the patient and working towards developing a therapeutic alliance are of paramount importance. This work is done in small steps, day by day, with no quick answers. In today's healthcare world, often dominated as it is by those who manage finances rather than patient care, healthcare managers need to hear this message. This is a place where the battle must be fought hard. Hoping that a "hot line" or
a "contract" can stand alone against the forces of the disease is tilting at windmills. Patients will die. We can look to others and must do so to provide assistance with modalities such as support groups, day care, and vocational rehabilitation, but the basic responsibility falls on the shoulders of the treating psychiatrist and cannot be relegated elsewhere. This responsibility can be a very heavy load. You need to confer with a colleague or consult with an expert.

Early in my career, I treated an intensely and chronically suicidal patient suffering from borderline personality disorder. Every mishap in her life evoked intense suicidal feelings which were sometimes, but not always, acted upon. In the early phase of treatment, the dangerousness of this impulsive behavior necessitated frequent hospitalizations and occasional emergency calls to the police. I had the good fortune of having readily available consultation with Robert Litman, M.D., the Chief Psychiatrist at the Suicide Prevention Center. He saw her in consultation with me, and even met with her regularly during an unavoidable prolonged absence of mine. With him "by my psychological side," I titrated the intensity of my interventions and gradually felt free to place increasing responsibility in the hands of the patient. There was a point during this transition when the patient seemed to feel an increasing need to stop progress and try and "grab me and hold on tight." To increase the stakes, she even had her young son telephone and tell me how suicidal his mother was! What to do at that moment? Was this a rebellion that was in her control or an uncontrolled regression?

Bob and I talked and made the decision that this was a crucial point in her treatment and I must continue with my current response of letting her decide whether she could manage her feelings or needed to be hospitalized. "But what if . . . ?" I asked.

"Well," said Bob, "we will never know for certain." The essence of his statement was that, in our clinical judgment, it seemed to be in the patient's best interest at that time to promote her emotional growth and independence and let her decide! Needless to say, it would be much easier on the therapist to call the police or The Emergency Response Team. This patient did survive and continued to progress towards emotional growth, eventually achieving aspects of autonomy and independence and becoming able to deal with her terrible sense of aloneness. To this day, I vividly remember my sleepless nights and hope that my decisions on such issues will always prove to have such positive results!

The Answer to the Question

I now return to my original question of "who benefits from no-suicide contracts?" When such contracts are used as one of the measurements in evaluating a patient, they can certainly be of help. They organize important and relevant information and help the clinician overcome any resistance to or inexperience in discussing the full spectrum of suicidal thoughts and behavior. The use of such contracts can demonstrate to patients that you are sincerely concerned and interested in their welfare and that you take what they say quite seriously. As described by Drye et al., this is not a one-time process but rather part of an ongoing dialogue with the patient. However, those who manage the economics of medical treatment should not think for one minute that caring for a suicidal patient consists of simply having the patient sign a no-suicide contract or referring him or her to a case manager or a suicide hotline and being done with it! On the contrary, these patients need ongoing, consistent, therapeutic work with skilled clinicians.

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