June 1992

The Risk of Hospitalizing Suicidal Patients: A Personal Retrospective

Leora Bar-Levav, M.D.

Bar-Levav Educational Association, Southfield, Michigan

Follow this and additional works at: <https://jdc.jefferson.edu/jeffjpsychiatry>

Part of the [Psychiatry Commons](#)

[Let us know how access to this document benefits you](#)

Recommended Citation

Bar-Levav, M.D., Leora (1992) "The Risk of Hospitalizing Suicidal Patients: A Personal Retrospective," *Jefferson Journal of Psychiatry*. Vol. 10 : Iss. 2 , Article 9.

DOI: <https://doi.org/10.29046/JJP.010.2.007>

Available at: <https://jdc.jefferson.edu/jeffjpsychiatry/vol10/iss2/9>

This Article is brought to you for free and open access by the Jefferson Digital Commons. The Jefferson Digital Commons is a service of Thomas Jefferson University's [Center for Teaching and Learning \(CTL\)](#). The Commons is a showcase for Jefferson books and journals, peer-reviewed scholarly publications, unique historical collections from the University archives, and teaching tools. The Jefferson Digital Commons allows researchers and interested readers anywhere in the world to learn about and keep up to date with Jefferson scholarship. This article has been accepted for inclusion in Jefferson Journal of Psychiatry by an authorized administrator of the Jefferson Digital Commons. For more information, please contact: JeffersonDigitalCommons@jefferson.edu.

The Risk of Hospitalizing Suicidal Patients: A Personal Retrospective

Leora Bar-Levav, M.D.

Abstract

Many statistically significant risk factors for suicide have been identified. Unfortunately, no study can identify the patient who will, in fact, kill himself. Maintaining a low threshold for hospitalization of potentially suicidal patients generally lowers their short-term risk. Hospitalization, however, like every medical intervention, carries attendant side effects. The dynamic implications of hospitalization for suicidal patients are considered in this paper along with recommendations to lessen the deleterious effects of such an intervention.

When I first began evaluating and hospitalizing potentially suicidal patients in the early months of my psychiatric internship, I was hardly in a position to question the wisdom of the system in which I worked. I understood simply that the lives of patients I barely knew were being placed in my hands and that the weight of that responsibility, for which I felt so ill-prepared, taxed my fledgling professional confidence. Frightened and inexperienced, I clung to the guidelines set out for me by my books and supervisors. I assessed demographic and diagnostic risk factors by religiously noting patients' age and sex and inquiring about previous suicide attempts and concomitant drug or alcohol abuse. I checked for evidence of dementia or delirium and employed a DSM-III-R checklist of symptoms in search of major affective and psychotic disorders.

In the emergency room, I made use of my department's unwritten hospitalization paradigm: 1) Listen first to a patient's verbalized intent. Any declared intent to harm oneself provides sufficient cause for psychiatric hospitalization, if necessary, involuntarily. 2) Look next at a patient's behavior. The suggestion of "imminent danger to self or others" also is sufficient cause for psychiatric hospitalization, even against a patient's will. 3) And "When in doubt" about a patient's potential danger "admit or commit" him. Although predicting suicidal behavior reliably is impossible, the responsibility then, as now, was increasingly delegated to the psychiatric profession by a vague legal code and a precedent of lost malpractice cases. I was keen not to begin my psychiatric career with blood on my hands, so when the "imminence of one's danger to oneself or others" was unclear, I simply applied the third directive and hospitalized patients anyway. This sometimes required creative reasoning on commitment forms since patients occasionally did not share my wish to err on the side of caution.

It was this rationale I used in admitting an adolescent who ingested four

antibiotic tablets claiming she "wanted to die" after arguing with her mother, and in admitting a man who insisted he would drink himself to death because he could no longer deal with his family. I ultimately decided to commit another man who threatened to jump off a bridge, though he changed his mind when his estranged, and then concerned, lover showed up in the emergency room to take him home.

The real suicidal risk of these patients seemed low to me when I compared them to the PCP intoxicated or schizophrenic patients whose command hallucinations had historically brought them very near death. Beyond my inclination to adhere to the safety of my department's directives, however, admitting these patients also made good sense to me. Without being fully aware of it, I recognized that most patients in the emergency room remained preoccupied with the incidents precipitating their harmful behavior, ignoring the real threat to their lives. The powerful force of their fear, rage, and hurt blurred their appreciation of the danger into which they placed themselves. I hoped that my insistence that they be hospitalized might alert them to that danger. After all, if I, as their doctor, considered their threats and actions as dangerous, so too might they. At the very least, I reasoned, they would recognize their behavior was serious since they consequently "required" hospitalization.

It was not long, however, before I recognized how misguided my assumptions were. As the months passed, I was surprised to find very few patients seemed truly alarmed. Some were angered by the inconvenience and stigma associated with hospitalization, but voluntarily admitted themselves under threat of commitment. Others, particularly adolescents, mouthed concern about their behavior with a frivolity that belied their genuineness. Some "used" their suicidal ideation and gestures to further entrench themselves in a victim's role, narcissistically claiming that their need for hospitalization confirmed their need to be treated delicately.

In the end it was the patients' behavior that spoke most plainly. Within a matter of months some patients returned to the hospital with similar presentations as before. Other patients returned only after longer periods had elapsed. As a trend, it seemed suicidal gestures were replaced by threats, while actual attempts became more serious. Something seemed to have gone wrong, though I could not then identify what it was.

I speculated at first, that the problem was a function of patients' illnesses. After all, it was clear that these patients were emotionally quite sick. The power of their intense emotional involvement with some other person, as each patient's story reflected, had evoked early fears, primitive rage and deep hurt. Though not diagnostically psychotic, the suicidal gestures represented circumscribed areas of psychotic thinking and living. Like a set of prisms, intense feelings had distorted these patients' ability to view their situations objectively. Their ability to test reality and to inhibit action in the presence of intense feelings was both underdeveloped and underemployed. Yet, having been briefly separated from confusing relationships and from pathologic environments through hospitalization, patients' feelings diminished in intensity. Generally, as the highest level of their anxiety dissipated, so too did their suicidal ideation. Though most had essentially returned to their "premorbid

functioning" within the first two to three days, the majority of these non-psychotic, potentially suicidal patients remained in the hospital for several weeks.

As before, I reasoned that this made good clinical sense. Quick to deny the seriousness of their behavior, some patients initially argued against needing to remain in the hospital. They had "simply made a mistake," they "were sorry" and "it wouldn't happen again." But their suicidal act often did not really frighten them. What they said seemed to be for the benefit of others, rather than representing a troubling dialogue with themselves. Given that, I believed it was not yet safe to discharge them. Having admitted themselves voluntarily, however, they were also free to leave. So in an attempt to protect myself and the remainder of the "treatment team" from any litigation if such patients were subsequently to harm themselves, I was taught to obtain written acknowledgements that they left against medical advice. As in the emergency room, the legal responsibility for patients' lives ironically remained far more in my hands than in their own. Ironical, because I believed that the purpose of continued hospitalization was to help patients recognize the danger into which they had placed themselves and begin to accept realistic responsibility for their actions. And yet the process of hospitalization itself did not seem to be facilitating this recognition and acceptance of responsibility.

Gradually, I began examining the shortcomings of inpatient treatment of such patients. Increasingly, I began to doubt my own rationale for dissuading patients from leaving the hospital. Several days of hospitalization, I told them, was insufficient to address their real life situations and their relationships with significant others. Certainly without intending it, I erroneously reinforced a notion that their emotional difficulties were caused by processes basically outside of themselves.

I then reconsidered the effects of the hospital setting itself. Hospitalization displaced the burden of responsibility for protecting patients from their own actions onto the treating physician, in this case me, the rest of the staff, as well as the structured setting itself. I started to see that a hospital stay beyond several days for some character disordered patients was not only wasteful but actually deleterious. After a prolonged stay in a setting that posed little challenge to the health of patients for monitoring and for containing *themselves*, some actually became less able to handle their real life situations than they were shortly after their admission. Because of such emotional regression, the sickest among these patients typically required readmission soon after discharge. For other patients, the effects of hospitalization were more insidious. The uncharacteristic high level of attention and concern often shown by family, friends and staff following suicidal gestures and attempts frequently reinforced patients' images of themselves as sick and fragile. Contrary to the obvious intent, for many patients the process of hospitalization added value to dangerous behavior. In fact, I came to recognize with embarrassment that my cautious practice of freely admitting and keeping patients in the hospital too often served to protect me in the short run, at the long term expense of my patients' welfare.

Were it possible to accurately identify the patients likely to ultimately kill themselves without hospitalization these problems would be minimized. Numerous studies have, in fact, been conducted with the goal of differentiating suicide attempt-

ers from suicide completers. Retrospective studies, which utilize the vital statistics of populations are more common. They typically employ a case control design in which all those who suicided during a given period are matched to a representative sample of controls who did not suicide. Without the opportunity to interview the proband these studies are limited by their need to perform "psychological autopsies" (1). This technique attempts to reconstruct the events immediately prior to death by relying on information principally obtained from relatives, friends, physicians, coroners, medical records, diaries, and other personal notes. The possibility for considerable bias from this method is acknowledged even by those who employ it. Some studies focus on differences between the groups in the number of "adverse life events" (2), others on psychiatric patients' diagnoses (3), social factors (4), methods used (5), and the degree of hopelessness voiced by patients (6), among other features. Much information is gathered by these efforts that again identify patients at higher risk. They do not, however, provide answers to the critical question of how high is suicidal risk nor how long such risk is likely to last.

Prospective studies are seemingly better able to answer these questions. Contrary to popular belief suicide is a relatively rare event, (U.S. averages 12.5/100,000 population) even among high-risk populations. Prospective studies are, therefore, burdened at the outset by the need to follow very large numbers of subjects over long periods of time (7). Furthermore, while prospective studies allow for interviews with prospective suicide victims, at closer look they rarely provide better information than retrospective studies about the events immediately antecedent to death. Suicides simply tend not to follow interviews (8). The reasons for this are at least twofold: first, ethical considerations require that interventions be employed when someone is acutely suicidal and second, prospective victims may inadvertently benefit from the human contact and the interaction with an interviewer, thereby temporarily altering the course of their actions.

Since the ability to predict suicide accurately is poor, in practice patients fitting a higher risk profile as defined by such studies, are generally readily admitted. The dynamic meanings attached to the process of hospitalization are only rarely considered seriously. I, for one, gave little thought to the "side effects" associated with hospitalization and was cautioned about it by my supervisors only in reference to patients fitting the diagnostic category of Borderline Personality Disorder.

Friedman and Adler (9,10) were among the first to document the dangerous regressive influence of hospitalization on borderline patients noting that inpatient management of such patients "often initiated, intensified and perpetuated" their suicidal and disruptive behavior (9). Unfortunately, even this observation is not often understood well and its significance is commonly overlooked. One author, for example, writing about the factors associated with suicide in borderline patients concludes that "Admission did not prove to be a risky situation but the discharge process seemed to be of the utmost importance" (11). This obscures the obvious that only those patients admitted to hospitals must ultimately face discharge.

Every medical intervention has the potential for negative consequences, whether they are intended or not. The consequences of hospitalization begin at the time of

admission if not earlier, when this possibility is considered. Insuring physical safety of the suicidal patient is the primary intended result, but the hopes and expectations of patients to be soothed and solaced are also inevitably rekindled. Powerful yearnings to be cared for perfectly by others rather than oneself, common to all human beings, are naturally stimulated by a setting where one is routinely looked after carefully, fed, spoken to and attended to around the clock. The promise of hospitalization is not unlike the fantasied promise of new relationships and romantic love. Hope that one will "be unconditionally loved, welcomed, and accepted" is raised (12). Relationships often sour and fail when it is clear that such unrealistic expectations cannot be fulfilled by them. Disappointment, hurt and rage commonly follow. In this light it is not surprising, for example, that epidemiologic data on suicide among U.S. Air Force personnel from 1981-1985, ($n = 322$) showed "a powerful consistent association between a dyadic love object relationship in total collapse and completed suicide" (13). Borderline patients, possessing more exquisite sensitivity to separation and rejection coupled with limited exercise of their ability to modulate and contain their feelings and actions, naturally make suicidal gestures and attempts more frequently (14).

In my own experiences, neurotic, psychotic, depressed and alcoholic patients do not basically differ in their dynamic expectations from hospitalization. It all too often promises a respite from the gnawing emotional pain that their symptoms try to bind and thus lessen. The attention and care given to patients in hospitals is often better than any they had known before. It can take years of many repeated admissions until the luster of hospitalization also dulls. For others, the unfulfilled "promise of hospitalization" is as empty as their shattered hopes in broken relationships. It is understandable in this context that many patients suicide shortly after discharge (15,16,17,18).

The goals of short-term hospitalization are generally considered to be "the clarification of diagnosis, the stabilization of biological treatment including medication, and the beginning of psychotherapy," and also taking into account that "a treatment alliance capable of maintaining outpatient treatment must be in place before the patient's discharge" (19). For patients whose suicidality is most obviously an expression of character pathology, the establishment of DSM-III-R diagnoses is more helpful in assuring insurance reimbursement than in prescribing an effective treatment approach. Although medication is occasionally useful to treat symptoms which can interfere with the psychotherapeutic process, they are rarely indicated in these patients for acute stabilization. Given the attendant risk of hospitalization it is probably safe to conclude that the most important function hospitalization can serve beyond immediate stabilization is to establish a psychotherapeutic relationship for follow-up treatment.

The need for follow-up treatment is central since suicidal gestures, attempts, and threats, in the absence of organic causes, are regarded as symptoms of festering emotional illness. Treating this illness requires much more than providing a temporary safety valve for the expression of feelings that threaten to overwhelm the sense of reality of patients and which sometimes spills over leading to self-destructive acts.

Looking back on my experience now at the end of my residency I understand two factors of treatment to be critical. First, it is necessary to establish during hospitalization a therapeutic relationship that emotionally involves patients intensely enough to rival the relationships that initially triggered their suicidal ideation or act. This therapeutic relationship must be based on a strict non-acting out contract. Thoughtfulness and due consideration, not feelings, must become the basis of behavior. This is in contrast to previous non-therapeutic relationships where feelings usually dictate action. Though major failures of this contract are not to be tolerated, minor ones are common and constitute a bulk of the therapeutic work. Secondly, it is necessary to conduct work in a setting that maximizes the use of patients' health, strengthening their ability to separate their feelings from their thinking and from their actions. Attempting to truly change the impulsive and self-destructive tendencies of suicidal patients requires long-term and intensive work. It is likely to be most effective and efficient in the outpatient setting where each session provides patients an opportunity to regress emotionally, though not behaviorally. The end of each session further requires patients to relegate feelings to a secondary position behind the dictates of reality again assuming the normal realities and responsibilities of adult life (20).

It is probably unrealistic to expect cautious hospitalization practices to change significantly at a time when the teaching of "defensive psychiatry" is considered an integral part of a psychiatric residency. In retrospect, though, it appears that keeping a low threshold for admitting and maintaining patients in the hospital frequently supports patients' pathology.

The trend of insurance carriers to limit mental health coverage to inpatient services can tempt both patients and well-intentioned practitioners to extend hospitalization to the maximum number of allotted days. Were I now to practice in an inpatient setting, I would, on the contrary, attempt to keep the length of such patients' stay to a minimum and focus the majority of my efforts, beginning at the time of admission, towards an effective transfer to outpatient treatment. If these observations are valid, the mental health interests of patients demand that this strategy be followed by others as well.

REFERENCES

1. Shneidman ES: The psychological autopsy. *Suicide and Life-Threatening Behavior* 1981b; 11:325-340
2. Paykel E, Prusoff BA, et al: Suicide attempts and recent life events: a controlled comparison. *Arch Gen Psychiatry* 1975; 32:327-333
3. Roy A: Risk factors for suicide in psychiatric patients. *Arch Gen Psychiatry* 1982; 39:1089-1095
4. Murphy GE, Robins E: Social factors in suicide. *JAMA* 1967; 199:303-308
5. Murphy GE: The physician's responsibility for suicide is an error of commission. *Ann Internal Med* 1975; 82:302-304
6. Beck AT, Kovacs M, Weissman A: Assessment of suicidal intention: The scale for suicide ideation. *J Consult Clin Psychol* 1979b; 217:343-352

7. Pokorny A: Prediction of suicide in psychiatric patients. Report of a prospective study. *Arch Gen Psychiatry* 1983; 40:249-257
8. Murphy GE: The prediction of suicide: why is it so difficult? *Am J Psychotherapy* 1984; 38:341-349
9. Friedman H: Some problems of inpatient management with borderline patients. *Am J Psychiatry* 1969; 126:299-304
10. Adler G: Hospital treatment of borderline patients. *Am J Psychiatry* 1973; 130:32-35
11. Kullgren G: Factors associated with completed suicide in borderline personality disorder. *J Nerv Ment Dis* 1988; 1:40-44
12. Bar-Levav R: A unified theory of general human motivation and behavior, In: *Thinking in the Shadow of Feelings*. New York, Simon and Schuster, pp. 326-330, 1988
13. Rothenberg J, McDowell C: Suicide in United States Air Force Personnel, 1981-1985. *Military Medicine* 1988; 12:645-649
14. Gunderson J: *Borderline personality disorder*. American Psychiatric Press, 1984
15. Pokorny AD: Characteristics of forty-four patients who subsequently committed suicide. *Arch Gen Psychiatry* 1960; 2:314-323
16. Temoche A, Pugh RF, MacMahon B: Suicide rates among current and former mental institution patients. *J Nerv Ment Dis* 1964; 138:124-130
17. Roy A: Suicide in chronic schizophrenia. *Br J Psychiatry* 1982bp; 141:171-177
18. Roy A: Risk factors for suicide in psychiatric patients. *Arch Gen Psychiatry* 1982a; 39:1089-1095
19. Margo GM, Manring JM: The current literature on inpatient psychotherapy. *Hosp Comm Psychiatry* 1989; 40:909-915
20. Bar-Levav R: *Thinking in the Shadow of Feelings*. New York, Simon and Schuster, pp. 231-234, 1988