Suicide prevention in hospitals

Robert E. Litman and Norman L. Farberow

Zusammenfassung

Das Grundprinzip der Selbstmordprophylaxe beruht auf den Begriffen der Krise, der Ambivalenz, der sozialen Beziehungen und der Beachtung des sozialen Verhaltens. Die Arbeit beschreibt, wie diese Begriffe für die Selbstmordprophylaxe in Spitälern Verwendung finden können.

In den allgemeinen medizinisch-chirurgischen Spitälern besteht ein wichtiges Problem darin, vorübergehend deprimierte oder verwirrte Patienten daran zu hindern, daß sie irgendwo hinunterfallen. Es wird empfohlen, ein spezielles Selbstmordprophylaxe-Komitee einzusetzen, welches Kurse für das Personal organisiert, Selbstmordfälle untersucht, Verbesserungen in der Anlage von Spitälern vorsieht sowie die Kommunikation zwischen dem Pflegepersonal und den Ärzten fördert.

Besondere Hinweise auf Selbstmord bei chronischen und Psychiatrie-Patienten werden aufgezeigt, sowie die Maßnahmen zur psychologischen Unterstützung und Rehabilitation derartiger Patienten.

Besondere Bedeutung wird der notwendigen Nachpflege von Selbstmordpatienten zugemessen. Selbstmordprophylaxe-Zentren und Spitäler können hier auf wirksame Weise zusammenarbeiten.

Summary

The rationale for suicide prevention is based upon the concepts of crisis, ambivalence, communication, and action response. This paper describes how these concepts can be applied to suicide prevention in hospitals. For general medical-surgical hospitals, an essential problem is to prevent patients who are temporarily depressed or confused from falling from a height. A special suicide prevention committee which sponsors educational programs for the staff, reviews cases of suicide, considers improvements in the hospital design, and facilitates communication between nursing staff and physicians is recommended. Special clues to suicide in chronic patients and in psychiatric patients are described, together with measures for the psychological support and rehabilitation of such patients. Emphasis is placed on the need for follow-up and after care programs for discharged suicidal patients. Suicide prevention centers and community hospitals can cooperate effectively.

Because we tend to think of hospitals as preserving, prolonging, and enhancing life, the suicide of a patient in a hospital comes as a special shock. The suicide is not only a tragedy for the family but is felt as a blow to the physicians, nursing staff, and hospital administration. Often, there are accusations of negligence, and consequent legal complications. In this article, we will report on studies of

suicides in hospitals and the circumstances under which such suicides are most likely to occur. We will consider various special problems associated with suicide in general medical-surgical hospitals, convalescent nursing-hospitals, and psychiatric hospitals, and we will offer some recommendations for suicide prevention in each of these settings. Finally, we will discuss the contributions hospitals can make toward preventing suicide beyond their walls.

The Rationale of Suicide Prevention

Can suicide be prevented? Case histories and clinical observations by reliable authorities in many different countries inform us that individual cases of suicide certainly can be prevented. On the other hand, programs of organized community suicide prevention efforts are in their infancy and are much more difficult to evaluate. Perhaps hospitals are a logical place in which to initiate and evaluate a systematic suicide prevention program.

A rationale for suicide prevention is based upon the following considerations: 1. Crisis: For most patients, the suicidal state is limited in time duration. If suicidal people survive for a period of time, they usually readjust and are non-suicidal. This is especially true of patients in general medical-surgical hospitals; 2. Ambivalence: In the great majority of cases, the self-destructive individual is struggling within himself. He has conflicting feelings about death and dying; often he is mixed up and confused. A suicidal action may constitute not only an effort to escape pain, atone for guilt, force a revenge, or make a cry for help but it may, in addition, denote a desire to be rescued, reedemed and reborn. We should remember that it is almost impossible for the human mind to comprehend the finality and totality of death; 3. Communication: The suicidal individual retains the human tendency to communicate what is on his mind. He gives clues to suicide in the form of verbal comments, action communications, or syndromatic signs; 4. Action response: These clues to suicide can be the basis for special protective actions by persons in the hospital environment. Suicide generally occurs in a context of separation from other people, accompanied by aloneness, alienation, and withdrawal from human relationships. One of the most effective suicide prevention measures is to initiate and foster contact between the patient and other persons, giving him the feeling that others are interested and care what happens to him.

Occasionally, the ethical-philosophical question is raised – "Why should we make a special effort to prevent a person from committing suicide if that is what he wants?" We should note that this question has special pertinence with regard to patients in nursing-convalescent hospitals where all too often groups of aged, chronically ill, socially-rejected persons are concentrated to await death. Generally, however, the most perceptive answer to the question –

"Why help them?" is to point out that the suicidal person has mixed feelings and not only wants to destroy his present image and situation but also wants to be rescued and rehabilitated into some different image and situation. We believe that suicide prevention is the established social policy of the community. Moreover, from a strictly legal point of view, the courts have increasingly tended to delineate suicide prevention as one of the responsibilities for the welfare of patients which hospitals must accept.

Some indication of the frequency of suicides in hospitals is given by the experience of Los Angeles County for the years 1963 and 1964. In those two years, there were a total of 2284 suicides, of which 44 occurred in hospitals: Twenty suicides occurred in nursing-convalescent units, twelve suicides in general medical-surgical wards, and twelve were in psychiatric hospitals or psychiatric wards. Reviewing the cases revealed that the problems of suicide prevention are somewhat different in each of these types of hospitals.

General Medical-Surgical Hospitals: During a two year period in Los Angeles, twelve patients on general medical-surgical wards committed suicide. When one considers that the average census of patients in general medical-surgical wards in Los Angeles County is over 20,000, one concludes that twelve suicides in two years represent a suicide rate not greatly above the rate for persons outside hospitals. The average 400 bed community medical-surgical hospital might expect no more than one suicide every five years. The occurrence of suicide with appreciably greater frequency than this should arouse self-criticism and self-scrutiny in a hospital administration. After any suicide in a hospital, there should be an investigation and a report to determine the causes and make recommendations for future prevention of a similar event.

Of the twelve suicides, eleven were men. The median age was 67 years, the median stay in the hospital from admission to suicide was three days. Ten of these patients fell from a height to their deaths. (See Table 1.) Most of the self-destructive acts were impulsive in that they had been planned for only a few minutes to a few hours. The patients had been hospitalized for a variety of physical illnesses. All of them were temporarily depressed or confused.

Cases 1. and 2. had been hospitalized several times previously and were both obviously depressed when they were re-hospitalized. Both of these men were physicians. Because of their profession, the hospital staff did not view the depression as a danger signal. Case 2. brought an overdose of sleeping pills into the hospital with him concealed in his toilet kit. The other death by ingestion, Case 5., was a man with Delirium Tremens who suddenly snatched a bottle of Oil of Wintergreen from a shelf and drank it. Case 3., a 65 year old man, was admitted to the third floor of a community hospital for treatment of acute bronchitis. After three days of treatment with anti-biotics, his fever had disappeared, but he became confused and unreasonable. He demanded his immediate discharge on the grounds that something terrible was happening to

his family, and he had to go home to take care of them. He was given more sedation. He insisted upon lying with his head at the foot of the bed. The charge nurse became alarmed and left the room to obtain restraining devices which could be used to hold the patient in bed. While she was gone he jumped out of the window. Case 12. showed a similar confusion. A 50-year old man became confused four days after gall bladder surgery and pulled his catheter out. He wandered around the ward explaining that he was looking for a basketball. He was given sedatives. He demanded a change in his room which was granted. While an attendant went back to his original room to get his clothes, the patient went out through the window. Case 10. was one of typical depression. He was a man who lived alone and had withdrawn from his friends and relatives. He was admitted to the hospital because of chest pains. That night he was sleepless, and he talked to the other patient in his room, expressing loneliness and hopelessness. After breakfast, he said goodbye to his neighbor and dove head first through a window. Only one of the twelve patients planned his suicide over a period of time and left a note. That was Case 11. who was also

Table 1 Suicides in Medical-Surgical units (Los Angeles 1963/64)

Case No.	Sex	Age	Method	Hosp. days	Time	Diagnosis and Condition
1	M	68	Fall	1	8 a.m.	Pre-op bladder surgery-depressed
2	M	70	Ingest.	2	3 p.m.	Cerebral thrombosis-depressed
3	M	65	Fall	3	8 p.m.	Acute bronchitis-confused
4	M	44	Fall	3	5.30 p.m.	Acute hepatitis-confused
5	M	68	Ingest.	10	11 a.m.	Alcoholic psychosis-confused
6	M	66	Fall	2	12.30 p.m.	Acute alcoholism-depressed
7	M	81	Fall	8	8.15 p.m.	Cerebral thrombosis-depressed
8	F	27	Fall	6	2 p.m.	"Diagnostic studies"-panic
9	M	73	Fall	4	10.15 p.m.	Emphysema-depressed
10	M	41	Fall	1	9 a.m.	Chest pain-depressed
11	M	76	Fall	300	3.20 p.m.	Arterio-sclerosis-depressed
12	M	50	Fall	4	4.15 p.m.	Post-operative gall bladder-confused

Median Age: 67 years
Median Hospital stay: 3 days
Median Time of day: 3.20 p.m.

11 males
1 female

10 falls
2 ingestion

the only patient who had been in a hospital for a considerable period of time. In this respect, Case 11. resembled the typical patient of a nursing-convalescent hospital.

Apparently, one essential problem of suicide prevention in general medical-surgical wards is to prevent patients who are temporarily depressed or confused from falling from the third floor or above. Simple safety devices, which would limit the opening of windows, or modern safety screens on doors and windows, would, we believe, prevent about 200 deaths by falls yearly. Screening devices for exposed stairwells are also recommended. Some attention should be paid to the frequent complaint of nurses that they have difficulty in communicating with the physicians in charge of cases. For example, nurses would note that a patient was confused and demanding to go home or threatening suicide or testing the strength of the screens. The physicians, however, were not responding to the implications of the nurses' observations but would merely order routine sedation for the patient. Hospitals might adopt a special signal-flag for nurses to place on charts of patients who might be suicidal. If doctors are not available, ward nurses should be able to communicate through the head nurse to obtain consultation. The consultant should recommend some clear, direct action.

It has been suggested that with elderly patients, some article from home be brought with them to the hospital to remind them of their usual identity and help prevent personal disorientation. This is a device that is used frequently with children. It has also been suggested that lights be left on at night. In this small series of twelve cases, suicide at night was not particularly noticeable. Neither was suicide during the changes of shifts of nurses and attendants noteworthy.

None of the twelve patients was in the hospital because of a suicide attempt. We conclude that suicide on general medical-surgical wards is rare. However, it must be added that suicide immediately after discharge from general medical-surgical hospitals is common. One of these twelve cases illustrates this dramatically: Case 6. was a 66 year old man who was admitted to a general medical-surgical hospital for acute alcoholism with mild delirium tremens. He responded well to supportive treatment, and his doctor discharged him two days later at 1.00 p.m. The patient complained that he was all alone in the world, and he said that he had no place to go. His pleas for sympathy were ignored. He then jumped from the third floor fire escape of the hospital to his death in the alley below. The reaction of the doctor and the hospital staff was anger, and a temporary rule was initiated prohibiting the admission of acute alcoholics. However, the relevant medical issue concerns to what extent the hospital should hold itself responsible for the after-care of discharged patients. In the same time period, in which there were only 12 suicides in general medical-surgical hospitals, there were over 150 persons who committed suicide within two

months after discharge from such hospitals. We believe that it is a fair question for the medical staff and administrators of medical-surgical hospitals to consider whether they are doing justice to their patients from the standpoint of follow-up and after-care.

Convalescent-nursing Hospitals: Unlike general medical-surgical hospitals, which emphasize rapid discharge, convalescent-nursing hospitals represent in general the end of the road. For suicide, the median age is 76 years, and the median hospital stay is measured in years. The primary diagnoses are tuberculosis, diabetes, cardiac disorders, and other chronic, serious diseases such as arteriosclerosis, multiple sclerosis, and cancer. Nurses and other patients noted severe depressions in most of these suicidal patients, the majority of whom communicated something about their suicidal intentions. A majority left notes. These patients seldom jumped from heights, possibly because nursing homes tend to be one story structures. They committed suicide by the ingestion of pills that they had saved up or smuggled in, or by cutting themselves. Although for the most part they gave ample warning about what they were going to do, they were not closely supervised. Apparently, many professional caretakers still ignorantly believe in the myth that people who talk about suicide won't do it. Some informants, in discussing these cases, raised the philosophical-ethical problem of why there should be any sanction against suicide in patients who were in their eighth decade of life, ill with incurable diseases, suffering from loneliness and abandonment, debility, and conscious of being unwanted and a drain on the resources of the family. In these patients the suicidal tendency did not take the form of a crisis. Many of them had made previous suicide attempts and were chronically suicidal.

It should be noted, however, that only a small minority of the patients in convalescent-nursing homes actually do commit suicide, although nearly all share, to some extent, the pattern of chronic illness, isolation, and a downhill course. The patients who committed suicide seemed to have been characterized by a special inability to adjust to their environment. While most patients made a reasonably satisfactory adjustment to the hospital, these patients constantly complained and made efforts to change things, often arousing some impatience and antagonism in the hospital staff. We do not know if it is feasible to change the whole approach of convalescent-nursing hospitals to their patients in order to inspire in them more of a feeling of belonging and of usefulness and meaning to their lives, but we recommend that in individual cases special efforts be made to make changes in the treatment plan when a given patient has made a suicide attempt or has expressed fairly constant dissatisfaction together with suicidal threats or ideas. As a minimum, we recommend a psychiatric consultation for such patients. At least then the suicide of such a patient should not come as a surprise, and the staff of the unit would not be left with a feeling of guilt over something therapeutic possibly being left undone.

Suicide in Psychiatric Hospitals: Patients who commit suicide in psychiatric hospitals are much younger with the median age of 44. Hanging is the most frequent method used. The length of time of hospitalization varies from one day to several years, with a median period of two to three weeks. Many of these patients had made previous suicide attempts. Even with psychiatric patients, suicide occurred relatively rarely within the walls of psychiatric hospitals – only twelve in two years in Los Angeles County. During the same period, there were three times as many suicides of psychiatric patients who were being carried as patients of hospitals but were out of the hospital on trial visits at home or had run away.

The most serious crises, associated with the highest suicide potentialities, occur just before admission and immediately after discharge from psychiatric hospitals. In a recent analysis of suicides in Los Angeles, we observed that 15% of the people who committed suicide had received but not followed a recommendation for psychiatric hospitalization within a few weeks before their deaths. Seven per cent of the suicides had been recently discharged from psychiatric units.

Why do people fail to accept a recommendation for psychiatric hospitalization which might save their lives? We find that there are still great resistances to psychiatric hospitalization, even though facilities are more readily available, therapy is more flexible, and often liberal insurance plans bear much of the cost. The patients and their families argue that hospitalization is inconvenient. For men, it means loss of earnings. They fear that the psychiatric label will make them unemployable. Women fear the separation from family and children. Generally, however, the symbolic attributes of hospitalization far outweigh the reality factors. People express shame and resentment about being categorized as psychiatric cases. Often they feel that by going to the hospital they are taking upon themselves a responsibility for what should be acknowledged as a family problem. Often the resistance to hospitalization is more of a family resistance than an individual resistance, and it can best be handled by family conferences in an attempt to obtain the cooperation of a number of the people who are concerned.

Another important barrier to appropriate psychiatric hospitalization stems from attitudes about hostility and rejection directed toward suicidal persons by physicians and their assistants. Doctors sometimes tease or belittle these patients and refuse to take them seriously. Sometimes a physician and his psychiatric consultant hesitate about hospitalization for someone in the community who is a leading financial, political, professional or social figure whose image might be damaged by publicity about psychiatric illness. The outcome of such hesitation may be suicide. It is appropiate to consider sending such a notable person away to another community for hospital treatment.

A suicidal crisis may complicate office psychotherapy for many reasons. It may be due to an extraneous factor in the patient's life, such as the death of a loved one, or to some problem brought out in the therapy such as the need to separate from a parent, or it may involve some issue with the therapist – for example, his undesired vacation – or some subtle transference-countertransference tension which cannot be resolved. Often a crisis is signaled by a break in communication, by missed appointments and silence. In these situations, the hospital offers not only a sanctuary and refuge, but also a setting for continuing the therapy. Certain patients have a capacity for entering into a deeply-regressive, symbiotic relationship with the persons who are meaningful in their lives, including their therapists. The effort to work through this kind of involvement frequently produces a deep depression which may alternate with acting out behavior, and this can take the form of repeated suicide threats and suicide attempts. Such patients should often be hospitalized during a crucial part of the therapy. In the hospital they tend to stir up rivalries between members of the staff and exploit any difficulties in communications that exist. One of the advantages of the hospital is the easy availability of shared communication and formal and informal consultations.

Excessive use of sleeping pills is a problem with many suicidal patients. The hospital is the ideal place to control the sleeping pill habit. Often the patient will plead that he should be the special exception to the hospital rule of decreasing medication, and his doctor will agree. At this point, consultation with the rest of the staff will tend to correct what may be an over-protective attitude on the part of the doctor.

Preparations for discharging a patient from a psychiatric hospital should include an evaluation of the suicidal potential. For this, the recorded observations of the nursing staff, who live with the patient around the clock, are invaluable. Certain clues may alert the responsible physicians. For example, some psychiatric patients are extremely over-dependent on the hospital. When the possibility of discharge or home visit is mentioned, these patients become agitated and panicky. They commit suicide on trial visits home if insufficient attention is paid to their anxious states and the type of home environment to which they are being returned. Favorable outcome after psychiatric hospitalization has been closely correlated with efforts to prepare the environment to accept the discharged patient. Often the accepting or rejecting attitudes of the most significant other persons make the difference between life and death.

Of hospital patients who will eventually commit suicide, about half do so within three months after leaving. Depressive patients tend to have at least one recurrence of symptoms after discharge. Since manic-depressives tend by character to have all-or-nothing psychologic reactions, they feel the transient symptom as a total crisis. "The treatment failed. I can't stand another depression now." So thinking, they take suicidal action. The nature of depressive

cycles should be explained to depressive patients, and they should be warned that brief low moods are expected after hospitalization and do not necessarily mean the start of a new depressive period. Patients should be encouraged to call their doctors when mood swings occur. Regular outpatient, follow-up consultations for at least three months after hospitalization are recommended.

United States Veterans' Administration Hospitals: Probably the most extensive study of suicide prevention in hospitals has been reported by Farberow, Shneidman and coworkers, who examined the charts of over 300 patients who committed suicide in veterans' administration hospitals over a period of nine years and compared these charts with the files of persons who did not commit suicide. They recommended that suicide prevention training, like fire prevention training, should be part of the education of every person who works in a hospital of any type. Such training would tend to increase the sensitivity of the physician, nurse, psychologist, social worker, attendant, etc., to both the overt and subtle clues which are often the precursors of suicidal behavior. They would establish a professional climate on each ward and within each hospital that would permit easy communication from patient to aide, from aide to nurse, and from nurse to physician, this making the problem of suicide prevention everyone's problem and everyone's responsibility. They recommend the creation in each hospital of a suicide prevention committee, which would take the responsibility for continuing staff education and, in addition, would investigate every case of suicide that might occur in the hospital. The committee would also make any recommendations for physical changes in the hospital plant which might be indicated.

They suggest that special procedures be established for discharging patients, especially those who at any time during their stay in the hospital aroused a suspicion of suicidal behavior. This would include investigation of the home environment and arrangements for follow-up and after-care, as a minimum. Finally, the possible use of psychological testing to pick up cases of covert suicidal potentiality was suggested. Current studies are investigating a brief paper and pencil test for this purpose.

In a special study of suicide in patients with chronic terminal illnesses, who might be found especially in convalescent hospitals or as repeated re-admissions to general medical and surgical acute units, these authors noted that the psychological status of the patient was most important. Such patients should never be alienated from human contacts, for example, by transfer to a private room to await death. Continued interest by the physician and the staff, and continued communication to the staff about the patient, was emphasized. Every facility of the hospital should be mobilized to carry the patient through his last days. This includes attention to his physical comfort by judicious use of tranquilizing drugs, narcotics, analgesics and sometimes the use of anti-depressive medication. In addition, psychological support is essential, and the use of family,

friends, volunteer workers and the hospital staff for this purpose should never be neglected. "What must be done is to give such a person a reason to live until the moment of death."

In the case of one chronic illness, cancer, they found that the highest risk was associated with older men with cancer of the throat and larynx and younger men with Hodgkins disease or leukemia. It was pointed out that suicide occurred in all stages of disease, including advanced terminal physical conditions. It occurred in cases where there was relatively little pain or discomfort from the illness, as well as those in which there was much. Regardless of age or disease site, a suicidal potential was considered present if all, or most of the following factors were present: a) Emotional stress; b) Severe depression and anxiety; c) Dejection, agitation or over-dependency; d) Low tolerance for pain or discomfort; e) Excessive demanding and complaining behavior with strong need for attention and reassurance; f) Controlling and directing activity (for example, insistent requests for or refusals of treatment and medications); g) Relative alertness in orientation; h) Exhaustion of resources, physical and emotional, including lack of support and attention from family or hospital; i) Prior or present suicide attempts.

These authors observed especially the predictive value of diagnosing the dependent-dissatisfied pre-suicidal chronic patient. This kind of patient makes increased demands for attention and reassurance – wanting to see the doctor, the nurse, the chaplain, asking for unnecessary physical examinations or dental work, requesting sedation, seclusion, therapy of various kinds, etc. In many cases, the patients made excessively self-centered demands for attention that were simply impossible to satisfy. Statements such as "Nothing is being done for me", "Other people don't like me – I should end it all". "There is no place for me anywhere" were further indications of intense dissatisfaction. This demanding, time-consuming attention-getting behavior was often irritating and disturbing to the hospital staff and to other patients as well, and this patient was, on occasion, referred to as the hospital pest.

In handling this type of patient, they suggested that the hospital staff be alerted to the seriousness of such behavior from the standpoint of suicidal potentiality. They suggested instituting new treatments or medications which often give this type of patient temporary relief and improvement; and sympathetic recognition by the hospital staff that the excessively complaining, demanding, depressed behavior of the dissatisfied patient is an expression of desperate, although excessive, need for care and support. Finally, these authors go out of their way to commend the nursing staff, which has the responsibility for the psychological support of patients in the hospitals. Often enough, in reviewing charts of persons who committed suicide, the medical notes were of virtually no help in revealing the character of the patient concerning the reasons for his death, whereas the nurses' notes contained many clues to the patient's personality and special problems.

Suicide Prevention Center

Suicide Prevention covers a wide range of activities and situations. Police officers, clergymen, teachers, lawyers, and landlords are involved, as well as doctors and nurses. In many communities suicide prevention centers have been established to collaborate with all the elements of the community who may become involved in helping potentially suicidal people. An effective working relationship with the hospitals of the community is essential for such a suicide prevention center. Suicide attempts provide the most common example for the need for cooperation between hospitals and suicide prevention centers. Deliberate self-injuries with greater or lesser intention to die are treated in every hospital – a 400 bed community hospital might expect 200 suicide attempt cases a year. These patients seldom make another suicide attempt in the hospital, but they frequently do so immediately after discharge. Therefore, some evaluation of the suicidal potentiality of each such case should be made before discharge. Many suicide attempters might be referred to a suicide prevention service for further evaluation, psychological support, and eventual placement into an appropriate treatment facility.

Address of the authors: Dr. *Robert E. Litman*, M.D., *Norman L. Farberow*, Ph.D., Suicide Prevention Center, 2521 West Pico Boulevard, Los Angeles, California 90006.