# Risk Management With Suicidal Patients

Alan L. Berman
*American Association of Suicidology*

The patient who is at-risk for suicide is complex and is difficult to evaluate and treat effectively. Should suicidal behavior occur, the clinician faces the potential wrath of bereaved survivors and their externalized blame exercised through a malpractice suit. The clinician's duty of care to a patient is to act affirmatively to protect a patient from violent acts against self. A finding of malpractice is established if the court finds that this duty was breached, through an act of omission or commission relative to the standard of care, and that this breach was proximately related to the patient's suicidal behavior. This article discusses the standard of care and factors that determine liability in a suicide death of a patient. An extensive list of recommendations for competent caregiving for the at-risk patient and risk management guidelines are then presented. © 2005 Wiley Periodicals, Inc. J Clin Psychol: In Session 62: 171–184, 2006.

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The at-risk-for-suicide patient is complex and often has dual diagnoses, acute painful symptoms, and considerable ambivalence about wanting to live. As noted repeatedly in other articles in this issue, the clinical task is to evaluate and treat these patients effectively, in a context of the patient's suicidogenic cognitions, nonrational decision making, and potential for impulsive and self-harmful behavior, over which the clinician often has insufficient control. Moreover, given the patient's history and dynamics, aligning with the at-risk patient often is difficult, and the patient may have a history of noncompliance. Added to these is the ever present guillotine of a patient's suicide during the clinician's watch and the anticipated consequence of bereaved and angry family members' seeking to hold the clinician responsible, by means of a malpractice suit, for their loved one's suicidal behavior.

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Correspondence concerning this article should be addressed to: Alan L. Berman, Ph.D., 5221 Wisconsin Ave., NW, Washington, DC 20015; e-mail: berman@suicidology.org.

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Once and because a doctor-patient relationship exists, clinicians owe a *duty of care* to their patient. This legal concept carries with it responsibilities to act affirmatively to protect a patient from violent acts against self. The scope of this duty may vary from setting to setting, and with the nature of the therapeutic relationship. However, courts have established clear expectations of the psychotherapist. Foremost among these is the duty to attempt reasonably to prevent the suicide of the patient.

Negligence (malpractice) is established if the court finds that this duty was breached, through an act of omission or commission relative to the *standard of care* (discussed later). This breach must be shown to be proximately related to the patient's suicidal behavior. Thus, there are four elements of proof necessary to establish negligence, summarized by a 4D mnemonic: there was a dereliction (breach) of a duty (to care) that directly (proximately causes) damages (a compensable injury) (Rachlin, 1984, p. 303).

In this article I describe the primary factors that define the standard of care and thus determine potential liability in the case of a suicidal death. I then present practice guidelines and recommendations to frame competent caregiving to the at-risk patient and to minimize the clinician's risk of being sued in the event of a patient's suicide.

The *standard of care* is a legal concept, defined by statutes that vary across jurisdictions. The standard of care is established by the judgments of experts who, after a retrospective review of clinical records and available testimony, attest to whether the care provided was *reasonable and prudent*, that is, not deviating from that customarily employed in similar circumstances by professionals of similar training, experience, and skill (Simon, 2004). Expert witnesses are clinical practitioners, hired by opposing attorneys. Thus, it is important to recognize that in any malpractice action there will be experts for both plaintiff and defense expressing opinions about the defendant clinician's practice as meeting or failing to meet the standard of care. Irrespective of the defendant clinician's steadfast belief that he or she practiced reasonably and prudently, clinicians must understand that once a complaint is filed with the court and testimony is provided, there will always be experts speaking in support of the plaintiff's claims that the clinician was negligent. Thus, it is imperative that the clinician understand well how to lessen the risk of facing a malpractice action (in the best of circumstances) or of losing a malpractice case in court (in the worst case-scenario).

## Determining Liability in Suicidal Death

Two factors primarily determine liability in a suicidal death: *forseeability* and *reasonable care*. Forseeability connotes the ability to predict a suicide, but that is not what it truly means. Rather, forseeability speaks to the reasonable evaluation of the potential for a suicidal act on the basis of an assessment of risk. In a malpractice action, experts will evaluate retrospectively whether a death or disability was foreseeable on the basis of evidence that was available before the act and a reasonable interpretation of that evidence. Failure to assess risk (collect evidence and judge its impact) clearly is a breach in the standard of care. Because suicidal behavior cannot be reliably predicted, an assessment of risk should be made and documented for *all* patients. At a minimum, assessing risk involves attending to the possibility of suicidal behavior through a series of linked questions about suicidal thoughts, plans, intent, and actions, in addition to questions regarding known risk (and protective) factors. On the basis of clinical observations, the patient's responses, and the clinician's understanding of what heightens suicidal risk the clinician makes an educated judgment of near-term risk for suicidal behavior and documents that judgment.

A clinician will not be held liable for incorrect judgment (unless it is based on an egregious minimization or disregard of presented evidence). The fact that a suicide has occurred (thus not been prevented) implies that clinical judgments were incorrect but is not prima facie evidence of a breach in the standard of care. The rule of thumb here is that judgments should be reasonably made, should be based on the data observed, and the data observed should be reasonably sought. Moreover, an often used defense to a legal complaint is that a suicide simply was not foreseeable. For example, consider the following case:

A 35-year-old man being seen weekly in outpatient psychotherapy for treatment of chronic depression was asked about current suicide ideation at every session. Although he had reported fleeting thoughts of suicide over time, he had denied any current ideation for the past 12 sessions. In addition, over the course of these months, his psychotherapist documented observations and subjective statements from the patient that he was functioning better, that his mood had improved, and so on. Five days after his last session this patient completed suicide by hanging. It was later learned that he had been abusing cocaine (and was found to be cocaine intoxicated at autopsy) and that his long-term partner had threatened to leave him on the morning of his death. Neither his substance use nor the precipitating event for his suicide had been communicated to his therapist by either the patient or others.

Contemporaneous documentation (the recording of observations and judgments) is the sine qua non of risk management strategies. Failure to keep proper and contemporaneous records is a violation of customary procedure and ethical standards. More importantly, the lack of careful documentation severely undermines the clinician's defense against a malpractice complaint, as there can be no corroborating evidence of practices asserted to be reasonable. As noted by Simon (2004, p. 21), "Some courts have held that what was not recorded was not done: document, document, document." A lack of proper documentation, unto itself, is not a proximate cause of a patient's suicide, but it makes defending oneself in a malpractice action considerably more difficult. To be sure, clinical notes written after the fact of a patient's suicide will be framed by plaintiff's counsel as purely self-serving.

Consider the following case example:

Upon the suicide of his adolescent patient, Dr. Jones was sued for malpractice by his patient's parents. When his records were subpoenaed and examined, it was noted that Dr. Jones had held and billed for a total of 13 sessions with their son. Yet, he produced contemporaneous clinical notes for only six of these. In deposition, he stated that he had a very busy practice, often did not have time to write notes at the time of seeing his patients, and tended to reconstruct his observations at the end of the week. "Sometimes," he offered, "I overlook a particular session or two." Now, he testified that he "could well reconstruct from memory what transpired in these sessions."

As an additional cautionary note, Health Insurance Portability and Accountability Act (HIPAA) legislation requires clinicians to be particularly sensitive to and cautious about regulated distinctions between clinical (medical) records or progress notes and psychotherapy process notes.

The second factor determining liability is that of *reasonable care*. Reasonable care connotes that the clinician employed a logic model, a systematic and relational approach, in defining a strategy for treatment and that the designed strategy was not egregiously deviant from what the average clinician of similar training would do with a similar patient. Treatment plans follow upon and are consistent with the patient's diagnoses and assessed suicide risk and include appropriate precautions as dictated by that assessed risk. When a clinical depression, for example, increases suicide risk, the treatment plan should include

consideration of therapeutic and pharmacologic interventions specific to the treatment of depression. Should a patient be judged to be at high and acute risk, precautions against that patient's self-harming must be considered and attempted. A high-risk patient should not be sent home to an isolating environment where no one is available to monitor, observe, and report. Nor should a high-risk patient be prescribed medications in sufficient quantity to kill him- or herself. When a patient displays noncompliance with the treatment plan, this noncompliance should be documented in the patient's clinical chart and alternative interventions should then be considered, developed, and instituted. When calculated risks are taken for hoped-for therapeutic gain, rationales for these risks need to be documented, such that the therapist's judgment and decision making can be readily understood in retrospect.

*Abandonment*, a breach of a caregiver's duty to protect the patient, may be found if the therapist did not act reasonably to have planned precautions carried out with *dependability*. Reasonable care requires that if deemed necessary and planned/ordered, follow through would occur. Thus, for example, the therapist who orders a suicide watch for a patient in an inpatient unit will be held responsible if the suicide watch was not carried out by the nursing staff responsible for it. Inpatient treatment teams have been found liable for not reasonably assuming continuity of care at discharge of a patient admitted for suicidal behavior. Consider the following case example:

A 58-year-old man was admitted to an inpatient psychiatric unit from the hospital emergency department after a self-inflicted stab wound to the abdomen was medically treated. At intake he described little insight into the impulsive self-harming behavior but did admit to binge drinking after he had a fight with his wife over family finances. No attempt was made during his hospitalization either to see his wife or to recommend marital counseling. Moreover, when he was discharged after reporting no suicidal thoughts for 2 days, it was recommended to him that he get individual outpatient psychotherapy, but no attempt was made to establish for or with him an appointment with any outpatient clinician. He killed himself 2 days after discharge.

## Practice Guidelines

Experts who testify regarding standard of care (and claimed breaches thereof) are best informed by published practice guidelines, codes of ethics, professional literature and authoritative sources, an institution's own policies and procedures, and legal precedent. Practice guidelines, in themselves, do not define standards of care; rather, they describe what may be considered reasonable and prudent behaviors. With regard to patients at risk for suicide, practice guidelines (cf. American Academy of Child and Adolescent Psychiatry, 2001; American Psychiatric Association, 2003) establish parameters for the clinician to attend to the at-risk patient in risk assessment and treatment planning reasonably.

### *Risk Assessment*

The prudent clinician knows well that suicidal behavior cannot be reliably predicted. However, the standard of care requires the clinician to assess adequately for the potential for suicidal behavior. It, then, is expected that every patient would be considered to be potentially at risk until an assessment of such a potential can be made. The clinician should systematically evaluate the patient's presenting symptoms and complaints, both distal and proximal current suicide risk factors (cf. Maris, Berman, & Silverman, 2000), and the presence of coping skills and factors that protect against suicide risk. Further, the

clinician should gather information regarding the patient's family history, conduct a mental status exam, and consider any value-added information offered by psychological testing. Inherent in this assessment is consideration of the patient's medical and psychological histories, inclusive of prior suicidal and/or self-harm behaviors; treatments and treatment compliance; and family history of mental disorders and psychiatric hospitalization. When relevant and possible, particularly when the patient is a minor, collateral family interviews should be conducted to augment information supplied by the patient. Contact with family members also mobilizes their support and communication of relevant and potentially important information during the course of treatment

With these data, differential and multiaxial diagnoses should be established, in accordance with the criteria of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition. With all the foregoing information, a reasoned judgment of current risk for future suicidal behavior may be made (and documented). Asking about the presence of suicidal thoughts and plans, and, if present, the patient's motivation, intent, and the lethality of any plan being considered is essential. It is important to note that most patients who go on to suicide denied having suicidal thoughts when seen in their last psychotherapy session (Busch et al., 2003; Isometsa et al., 1995). Thus, a patient who denies suicidal thinking when other signs of acute risk are in evidence (e.g., hopelessness, increased substance use) and the patient's mental status suggests poor control (e.g., psychotic thinking, agitation) should be probed further to discern what can be identified.

The assessment of suicide risk establishes a basis for the judgment about the degree of acute risk (imminent, high, moderate, low) and identifies treatable risk factors and protective factors that may be strengthened. As such, suicide risk assessment allows for treatment planning.

### *Treatment Planning*

Treatment must focus on reducing the acute risk for suicide and the underlying predisposition to be suicidal. Treatment planning needs to be based on the evaluation of current suicidality and suicide risk. At its ideal, treatment attempts to reduce those factors that elevate risk and increase the strength of those factors that protect against suicide; the treatment plan should demonstrate and document a focus toward preventing suicidal behaviors. A risk-benefit analysis of the need and value of medication (and a referral for consultation regarding it) for the mental disorder, especially when there is research evidence of potential benefit either in combination with psychotherapy or as a stand-alone treatment, should be documented (Pampallona, Bollini, Tibaldi, Kupelnick, & Munizza, 2004). The need to protect the patient from his or her own impulses should motivate consideration of short-term inpatient care (including the need for close observation and monitoring) or alternative possibilities for close observation. I recommend that consideration of least restrictive treatment settings and maximization of the therapeutic alliance with an at-risk patient should be reflected in the clinical record. Consultations with objective colleagues and records of previous treatments, when obtainable, may be highly informative with regard to undisclosed history, patient compliance with recommended interventions, and alternative intervention strategies.

Suicide prevention contracts do little to prevent suicide and may actually mitigate against the vigilance necessary for effective risk management. More will be said of these later in this article.

Two last points about treatment planning. First, treatment planning, based on the clinician's assessment of suicide risk, must occur at the beginning of treatment. Revisions,

based on the patient's changed level of functioning and risk, should be made to that initial plan whenever relevant. Second, treatment plans should not be driven by managed care parameters. The clinician's first duty is to the patient, not to the patient's insurance or managed care company. When managed care case managers refuse further coverage for clinical care, a vigorous argument in advocacy of a recommended treatment plan often will be successful. When it is not, the decision to abandon an advocated treatment plan because of a third-party decision is rarely in the best interest of either the patient or the clinician.

## Providing Treatment

Once targeted goals are established through an assessment of a patient's suicidality and vulnerabilities, the treatment plan outlines the strategies to be employed to achieve these goals. The prudent clinician now must implement treatment in accordance with the treatment plan. Central to the implementation is attention to building an empathic, supportive, and, ideally, collaborative therapeutic alliance, with particular reference to the patient's (and the patient's family's) cooperation with recommended treatments.

A number of other considerations will guide the implementation of planned treatments. It is important to establish a collaborative alliance with the patient by providing information about diagnoses and alternative treatments specific to these, with the goal of gaining the patient's adherence to treatments of choice. With the patient's consent, which should be aggressively sought, it is good management to communicate with the patient's support system about assessments and associated treatment recommendations and reasonable expectations for treatment progress. Assuming outpatient care, I highly recommend educating family members or parents regarding the need to monitor their loved one/child and to communicate observations of change or concern. In doing so, it is important that the clinician evaluate the parental or other caregiver system's ability to fulfill essential observational, limit-setting, and supportive functions and make recommendations and referrals when indicated to empower family members/parents to fulfill these functions. It is equally important to educate family members/parents about safeguarding the home, particularly with regard to removing accessible firearms. Referring the patient for physical examination including appropriate lab tests to rule out organic causes for presenting symptoms further demonstrates clinical attention to accurate diagnosis and a best possible understanding of what each patient contributes to the therapeutic task.

When indicated by diagnosis, psychopharmacologic interventions may need to be considered, leading to a referral for appropriate consultations. When these referrals lead to collateral treatments, the standard of care would require evidence (documentation helps greatly here) of collaboration and communication, for example, between the psychologist and the psychiatrist. Significant treatment observations need to be shared and treatment decisions coordinated by collateral caregivers. When medications are prescribed by a physician, the nonmedical clinician has a responsibility to report observed or patient-communicated side effects and adverse reactions to the prescribing physician, in addition to observed changes in mental status after initiation of drug treatment. Conversely, it is the physician's responsibility to communicate to the nonmedical clinician any changes in dosage or medications prescribed during the course of treatment. In this regard, it behooves the nonmedical clinician to be knowledgeable about prescribed medications and, in particular, about medications that have published evidence of efficacy in reducing observed suicidal behaviors (cf. Meltzer, 1999; Tondo, Jamison, & Baldessarini, 1997). Given recent federal warnings about the potential for selective serotonin reuptake inhibitors to exacerbate suicidality in youth, caution must be exercised in

monitoring these drugs when used by children and adolescents. In the case of a malpractice action against a prescribing physician that alleges negligent prescribing, the collaborating psychologist is at risk of being deemed equally negligent when such negligent actions should have been known to the psychologist.

Clinicians who treat at-risk patients have a responsibility to maintain reasonable accessibility to the patient and his or her family. Reasonableness in this regard is open to interpretation and expert opinion (one plaintiff's expert asserted that the standard of care required clinicians to be accessible 24/7, thus to carry a beeper—an assertion that speaks to optimal, not reasonable, care), but, at a minimum, should include instructions as to what the patient and/or family/guardians should do if one is not immediately accessible (unavailable, on vacation, or otherwise unreachable) in an emergency.

Inherent in providing reasonable care to at-risk patients is the need for clinicians to manage (monitor and respond to) countertransferential reactions (cf. Maltsberger & Buie, 1974), behave within professional ethical standards (see later discussion), and seek consultation or refer the patient if no improvement is evident.

I would also iterate that ongoing assessment of suicide risk is an inherent part of treatment. Documenting the patient's current assessed suicide risk is particularly important at times of discharge or termination from treatment, at management transitions (e.g., therapist vacations and staff rotations in hospitals), and at times of significant shifts in environmental stressors. (For a more detailed consideration of inpatient risk management, the reader should consult Bongar, 2002, and Bongar et al., 1998.)

## Case Example

To illustrate, consider the following case, which presents a fact summary, "failures" or breaches in the standard of care as alleged by plaintiff's experts, and the defense expert's responsive opinions.

A 29-year-old female entered outpatient psychotherapy with a psychologist on referral from her psychiatrist. She presented a significant long-term history of depression with passive suicide ideation, without plan or intent. She stated she had harbored a "wish to die" since the age of 7. She had a history of one low-lethality overdose of over-the-counter drugs in early adolescence after a fight with her mother—she purposely vomited up the pills. Her retrospective characterization was "I survived; I failed." The first year after college she slashed her wrists, again after a fight with her mother. She bandaged her wounds and told no one for 2 days, then informed her mother and was hospitalized for 10 days. She reported, "It didn't help." Family history was significant for mood disorder (mother) and posttraumatic stress disorder (father), both diagnoses made after their divorce when the patient was 11. Her father died when she was 15.

The patient complained of feeling unconnected to friends, isolated, and ashamed of her depression ("It's a character flaw, a weakness"). She had symptoms of hypersomnia, anergia, and anhedonia. She stated that her medications (Wellbutrin 75 mg, Diazapam 5 mg) were not helping. She reported that past trials of other antidepressants (Prozac, Zoloft, and others) had not helped. She denied current suicide ideation ("It's not an option anymore"). Her mental status evaluation noted she had flat affect and moderate anxiety; her judgment was described as "intact." Her only significant and positive attachment was to her job, which she liked. She had worked for the same employer for the past 5 years. She was diagnosed as having Dysthymia with Recurrent Major Depressive Episodes. She was further assessed, on the basis of her history, as being at high risk for a suicide attempt, but at low risk for a completion.

Her psychologist authored a treatment plan targeting her depression with cognitive-behavior therapy and psychoeducation. He also planned a collaborative and coordinated relationship with her psychiatrist to maintain her compliance with his pharmacological treatment.

The patient was seen in weekly outpatient psychotherapy over the next 5 months, during which some moderate improvements were noted. She was compliant with her medications, was functional at work, and had increased her involvement in activities and exercise. Her Global Assessment of Functioning (GAF) increased from 55 at intake to 70 over these months.

In the sixth month of treatment the patient called for an emergency appointment. She stated that she felt that her medications were no longer effective and her symptoms had worsened. She reported that 2 days earlier, she had overdosed on her prescribed medications, induced vomiting, then called and stayed with a female friend. Her friend insisted that she call her psychologist.

The psychologist scheduled an appointment that day, called her managed care company to preauthorize a possible hospitalization and increased frequency of outpatient visits, and contacted her psychiatrist to report her phone call. When she appeared in interview, the overdose incident was discussed in detail. She described that she was feeling badly and overwhelmed, that she wanted to medicate the pain, and that she was not thinking about suicide at the time. She reported now feeling more stable. Her mental status at interview appeared to confirm her words. Both hospitalization and electroconvulsive therapy were discussed and considered, but rejected by the patient ("If it's that bad, then life, indeed, would not be worth living"). Alternatively, she agreed to daily contact by phone and a follow-up therapy session in 2 days.

A phone call to her that night reinforced her psychologist's belief that her condition had stabilized. On the next day she reported that she felt considerably better, that her medications appeared to be working, and that she was back at work. She cancelled her appointment on the next day, stating that she was doing much better and wanted to return to her weekly schedule of visits. She did agree to continue daily telephone check-ups. Two days later, her psychologist was informed that she had completed suicide by overdosing on her prescribed medications.

The patient's family initiated litigation, alleging malpractice by the psychologist. The plaintiff's expert asserted that the psychologist

- Failed to assess risk for suicide at the time of her last session
- Failed to conduct or have occur a psychological evaluation
- Failed to secure prior treatment records
- Failed to treat adequately and to manage her suicidal crisis appropriately
- Failed to hospitalize her, voluntarily or involuntarily, when needed 6 days before her suicide, thus
- Failed to protect his patient from known danger to self, and, therefore
- Failed to possess an adequate degree of skill and training to assess and treat suicidal patients adequately

The expert for the defense countered these allegations as follows:

> The patient's suicide was not foreseeable. The psychologist responded to her reported attempt, 6 days before her death, with expediency and concern. This "attempt" was clearly of low lethality, required no medical intervention and had no reported complications. It was reported by the patient as lacking in suicide intent. This statement is reinforced by the fact that she

self-induced vomiting, then immediately called and stayed with a friend. The records attest to these observations, thus that an evaluation of her risk occurred. Had the friend not insisted, it is not known that she even would have reported it to her psychologist. This, then, speaks to her history of inconsistent compliance with previous treatments and raises a question of her therapeutic alliance. The psychologist responded to this incident by immediately seeing his patient, making preparations for contingent hospitalization, and talking with her psychiatrist. When seen, her mental status was improved, she appeared to have stabilized, and she refused hospitalization. She did not meet criteria for involuntary hospitalization. As a voluntary outpatient, she had control over this decision and over her compliance with the treatment plan that had now been put in place. The psychologist respected her autonomy and the principle of least restrictive care in his decision not to push for voluntary hospitalization. That she cancelled a planned next session and killed herself was then beyond his control.

Further, the psychologist's initial evaluation of her risk for suicide led to an appropriate treatment plan specific to her presenting diagnoses and in the context of a chronic history of suicidality. The standard of care required that the psychologist work collaboratively with his patient's psychiatrist to manage her care and this was done. The need for psychological testing is an elective decision and is not required as a standard of care.

Lastly, the patient's last hospitalization occurred some 8 years before her initial evaluation with this hospitalization. As no suicidal behavior occurred in the interim, that he did not seek or secure those hospital records is inconsequential. Had they been secured, there is no evidence that he would have altered his treatment plan or prevented her suicide, thus this "failure" is not a proximate cause of her suicide.

## Attitudes and Approaches

Clinicians *must*—in fact, are legally *expected* to—have an affirmative stance toward intervention with a patient at risk for suicide. A patient in therapy, thus, has entered a therapeutic relationship defined, in part, by the therapist's value system, that preventing suicide is in the best interests of that individual.

Suicide is a consequence of a complex system of interacting forces, ranging from psychopathology to irrational cognitions, from disturbed family systems to biological dysfunction. As such, defending the typical suicidal act as one of autonomous choice is difficult. An empathic understanding of the suicidal patient demands that those conditions that make the patient suicidal be treated and that treatment can be reasonably expected to decrease that patient's suicidality.

Thus, the important clinical and ethical questions are those related to kinds of treatments that will best accomplish decreased suicidality. To be sure, the best intervention is not always coercive prevention or even hospitalization (Jobes, 2000; Linehan, 1993). The clinical goal is to reduce risk for suicide at an acceptable cost. The myopia of the suicidal patient demands whatever cost is necessary to establish time and treatment to help create a truly autonomous individual.

Embedded in this process are a number of therapeutic versus antitherapeutic approaches to working with patients at risk for suicidal behaviors. Clinicians should be aware of potential countertransference reactions that may negatively influence at-risk patients. For example, feelings of anger aroused by a noncompliant or difficult-to-treat patient can lead to overreactions to or even abandonment of the patient. Negative feelings can "leak" through a therapist's tone or body language and lead patients to withhold information regarding increased risk or to deny suicide ideation because they fear a punitive response. Therapists who become hopeless in response to a patient's lack of improvement or expressed hopelessness may lose an empathic understanding of their patient and collude in the patient's belief that change for the better will never occur.

Risk management suggests that psychotherapists need to tolerate and regulate their emotional reactions to at-risk patients. Seeking consultation with colleagues or supportive therapy, if necessary, is a good risk management strategy when a clinician is aware of negative countertransferential feelings.

Some clinicians maintain unfounded beliefs and pejorative cognitions about suicidal patients that negatively influence the quality of their care. For example, not all low-lethality suicidal behaviors are meant to manipulate another person. Even if accurate, defining a behavior as manipulative impels distancing rather than greater understanding that the patient lacks necessary skills to gain a sense of control in nonmanipulative ways. Some clinicians believe that hospitalization is necessary for all at-risk patients when they express suicidal ideation; often that is simply not true. The benefits and psychological costs of hospitalization should be seriously weighed whenever it is considered a treatment option, and the rationale for a decision to or not to hospitalize a patient should be documented.

Although widely used, "no-suicide contracts" have not been shown to prevent suicides. In contrast, overreliance on such a contract may lead a clinician to decrease vigilance at a time when it should be heightened. No-suicide contracts have some use to probe the patient's controls and ability to form and keep a contract, but they are not recommended for new patients, in emergency settings, or with psychotic or impulsive patients. They should only be used within an established therapeutic alliance.

## Informed Consent

Patients have the right to informed consent. They should be informed by the clinician at the beginning of the therapy relationship that the clinician will break confidentiality if he or she believes the patient's life is at stake and do everything necessary to protect the patient from self-harm or death. When there are risks to any planned intervention, these, too, should be disclosed to and discussed with the patient. The following case offers a brief look at an instance when informed consent issues were mishandled by the treating clinician.

The patient, a professional woman in her late 30s who had a long history of borderline personality disorder, alcohol abuse, and depression with suicide ideation, extracted from her psychotherapist a promise that she would never be hospitalized, as the patient made clear hospitalization would surely give her reason to kill herself. The clinician treated her patient within this agreement for more than 4 years. When, on the eve of the clinician's planned trip overseas, the patient called the clinician in the early morning hours and in slurred words spoke of wanting to die, then abruptly hung up the phone, the clinician called the rescue squad to intervene and take her patient to the hospital. At the hospital, the patient, more sober now, denied suicide ideation and was coherent in her presentation. She was discharged, went by her therapist's office in the early hours, left an angry note about being "betrayed" by the clinician she had so long trusted, and went home and killed herself.

## Why Are Caregivers Sued for Malpractice?

Bereaved survivors of suicide are traumatized victims of their loved one's suicide. Many have discovered their loved one's body; still others have witnessed their loved one's suicide. Yet many more have lived through their loved one's *psychache* and lament about a troubled life, despair, hopelessness, and anger in the months and years preceding the suicide. Those who were in treatment at the time of their suicide, perhaps 25%–35% of

those who take their own life, may well have expressed negative feelings about their caregiver, as a result of inadequate relief and/or their narcissistic injuries that resulted from inadequate parenting. Patients who have comorbid diagnoses of a mood and borderline personality disorder, for example, are well known to express rage toward the "bad therapist" as a consequence of "splitting" (the therapist can instantly morph from a good object, all-loving and idealized, to a bad object, worthy of abject scorn for incompetence and stupidity).

Survivors, as well, may have had ambivalent attachments to their loved one. Surely, for many survivors, a seriously mood-disordered loved one can induce a sense of helplessness and consequent guilt. Borderline patients tax all relationships, not just those with caregivers. When the suicide occurs, there are anger and an implicit, if not explicit, feeling of blameworthiness for (1) failure to make the decedent value life sufficiently to remain alive (an act of omission) or (2) anything that might be seen in retrospect as a stimulus for the decedent to take his or her life (an act of commission). In this context, it is understandable that a surviving family member might readily direct anger and blame toward clinicians who were expected to intervene and prevent a suicide. Indeed, a survey of families who had survived the suicide of a loved one in treatment found that a majority had considered contacting an attorney and 25% actually did (Peterson, Luoma, & Dunne, 2002).

For psychotherapists, a patient's suicide is a traumatizing event. It raises doubts and provokes questions of one's competency and induces feelings of helplessness, loss, shame, and often anger and guilt. For an estimated one-third of these therapists their level of distress is described as severe (Hendin et al., 2004). Moreover, psychotherapists often fear being humiliated in some public way among their colleagues or among referral sources. In some, ideally rare, cases negative reactions from the therapist's institution feed their distress (Hendin et al., 2004). The most feared sequela of a patient's suicide, however, is the possibility that bereaved survivors will institute a lawsuit alleging malpractice.

In the Middle Ages, the suicide, him- or herself, was punished for a self-murder. Property was forfeited to the crown, the hands of the perpetrator were cut off, and burial in consecrated ground was disallowed (Berman, 1993). Modern social thought now shows compassionate concern for survivors and a greater understanding that the decedent's suicide was consequent to mental disorder. Consequently, responsibility for a suicide has shifted from the perpetrator-decedent to those in custodial caretaking roles. Clinicians have the responsibility to protect their patients from self-harmful and suicidal behavior. This responsibility makes psychotherapists and other treatment providers ripe targets for the externalization of survivors' rage.

Once a surviving family member seeks consultation with a personal injury attorney, the possibility of a lawsuit's being initiated is great. It is unknown what proportion of suicides result in a malpractice complaint. More than two decades ago, Litman (1982) estimated that one in three suicides by patients in inpatient care results in a lawsuit and that about 1 in 10 of these reaches the courtroom. Whereas in years past the great majority of malpractice claims were lodged against inpatient practitioners and institutions, forensic experts have noted a shift over the past 20 years toward a dramatic increase in suits against outpatient practitioners (Bongar et al., 1998; Jobes & Berman, 1993). No therapist is immune to the potential of legal action when there are both a wounded family member and a plaintiff's attorney who, independently or through a potential expert, discerns breaches in the standard of care. Simply put, this is what good plaintiff's attorneys do to make a living.

As noted earlier, psychologists and psychiatrists have been estimated to have between a one in four and one in two chance of having one or more patients commit suicide during

the course of their professional career. Kleespies, Penk, and Forsyth (1993) estimated that one of every nine psychology interns/trainees suffered a completed suicide of a patient, the majority during the internship year. There is considerable reason for therapists at all levels to be alert to, and protect against, the possibility of such litigation.

## Risk Management Guidelines

On the basis of the foregoing discussion, the following is an extensive, albeit imperfect, list of recommendations that serve both to describe competent caregiving to the at-risk patient and to minimize the risk of being sued for malpractice in the unfortunate, but real, possibility of a patient suicide. As noted earlier, to the extent that the clinician can demonstrate (through documentation) use of reasonable judgment and prudent compliance with standards of care, plaintiff's attorneys will simply see little benefit in pursuing a tough-to-win case. That being said, the following more specific actions and attitudinal positions represent sound risk management advice. These guidelines, when followed, demonstrate more than a minimal concern for the at-risk patient and tend to minimize risk for malpractice actions in the event of patient suicide.

- Maintain a collaborative, nonadversarial relationship with the patient even when confronted with challenging behaviors.
- Respect and validate an understanding that the patient is in pain psychologically and that suicidal thoughts are understandable in the context of the particular circumstances.
- Manage and tolerate one's own emotional responses as a mental health professional.
- Limit the number of significantly at-risk patients in one's practice at any one time.
- Obtain informed consent and inform the patient of HIPAA rights to privacy and confidentiality.
- Secure patient's permission to speak to family members as deemed clinically necessary.
- Provide whatever time and accessibility are necessary to meet reasonable patient needs and circumstances. If you cannot, refer the patient.
- Be current in reading (knowledge skill set) about risk and protective factors for suicide, particularly those specific to the patient's diagnosis.
- Make and document a multiaxial diagnostic assessment.
- Conduct an assessment of suicide risk and repeat that assessment whenever the patient's symptoms or circumstances change.
- Make all assessments and treatment plan decisions via face-to-face consultations.
- Consistently inquire about suicidal thinking and plans. Do not assume that a patient's denial of current suicide ideation reflects a reasonable assessment of that patient's suicide risk.
- Conduct and document mental status evaluations at each session with at-risk patients.
- Make reasonable efforts to secure clinical records or to consult prior clinical caregivers.
- Make a clinical judgment of current risk, particularly with relevance to conditions that might precipitate either planned or impulsive suicidal behavior.
- Evaluate and monitor the quality of the therapeutic alliance.
- Develop a treatment plan consistent with the patient's diagnoses, dynamics, suicide risk, and ability to comply.

- Collaborate with family members as appropriate; keep them informed of suicide risk and treatment plans; involve them in treatment as appropriate.
- Implement a treatment plan with particular relevance to modifiable risk and protective factors and attention to barriers to the patient's compliance. Treat aggressively.
- Do not solely rely on "no-suicide contracts."
- Have in mind criteria for hospitalization and know one's own state statutes for involuntary hospitalization, in case of immediate need.
- Never leave a patient deemed in need of hospitalization alone.
- Do not allow managed care limitations to dictate clinical decision making.
- Communicate with collaborating professionals, particularly those prescribing medications; make sure treatments are coordinated and based on communicated observations
- Limit the availability of potentially lethal amounts and dosages of prescribed medications.
- Monitor and evaluate with the patient the effectiveness of the treatment plan and make necessary or desirable modifications.
- Document risk-benefit rationales for all decisions.
- Safeguard the patient's environment, particularly with regard to easy access to available firearms and toxic agents.
- Inform the patient (and family) of crisis management procedures and steps.
- Provide for continuity of care if therapeutic contact is limited. Discharge plans should ensure continued safety precautions and treatment. Attend to the patient's compliance with the aftercare plan.
- Comply with policies and procedures in any institutional setting; follow all professional codes of ethics.
- Follow up after end of treatment or discharge to ensure that discharge recommendations or follow-up plan has been carried out.
- Obtain paid consultation when confronted with problems in assessment or treatment.
- Unless superseded by court directive or other mandate, understand that confidentiality does not end with a patient's death. Provide only the minimum of information until legally allowed to be more responsive to survivors' specific questions.
- Act respectfully toward family survivors.
- Maintain patient records according to state statutes.

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