The Aftermath of Suicide on the Psychiatric Inpatient Unit

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Abstract: *Suicide in the hospital setting results in a complex array of reactions by the staff, the institution, the remaining patients, the family of the patient, and the outpatient caregivers. In the aftermath of a suicide survivors pass through four predictable and parallel stages: shock, recoil, posttrauma, and recovery. Specific approaches to these stages are addressed. The management of the shock phase requires carefully orchestrated crisis-intervention strategies, containment, and risk management. The numbness and disbelief of this period gives way to the reactions of the recoil phase, which include guilt, shame, anger, depression, self-doubt, and a search for meaning. Group meetings, outreach to the family, the suicide review conference, and, in particular, informal peer contact, are key aspects of recovery in this stage. Family survivors require specialized interventions that take into account the stigmatization that commonly accompanies suicide. In addition, as one fourth to one third of hospital suicides result in lawsuits, specialized approaches to assessment and documentation are indicated. In the posttraumatic phase more general issues of professional efficacy are addressed. The resolution of this phase is enhanced by an open dialogue focusing on the limitations of assessment and treatment of the suicidal patient. Final recovery for staff includes a posture of anticipation appropriate to the clinical setting.*

> Suicide is the final common pathway of diverse circumstances, of an interdependent network rather than an isolated cause, a knot of circumstances tightening around a single time and place . . . [1]

The suicide of a hospitalized patient is a catastrophic event for an inpatient unit. The survivors include not only the family of the deceased, but also fellow patients, the therapist, the staff, and the institution in its many forms and traditions. This article will focus on the aftermath of a suicide, that is, what to expect and how to respond to suicide once it has occurred. Although I specifically address suicide on the inpatient unit, these observations and management approaches are pertinent to other institutional settings, including general hospital wards, outpatient clinics, day treatment centers, and residential facilities.

Demographics

Suicides may occur in spite of aggressive clinical intervention. Suicides occur on inpatient units at a rate of 5–30 times that of the general population. This amounts to as many as 370 suicides per 100,000 patients. This is in comparison to an overall suicide rate of 10–12 per 100,000 in the general population. Individuals most at risk are younger (less than 35 years of age accounting for 38% of suicides) and those with functional psychoses and affective disorders. In comparison, those patients aged 65 and older make up only 4% of inpatient suicides at a rate approximately one twelfth that of the younger group [2,3]. Suicides may occur in those patients who have clearly been designated at risk. One early study found that 50% of suicides occurred in the isolation of a seclusion room [4].

Inpatient suicides may also occur without warning. Most inpatients who suicide are *not* on special precautions, and about half were last judged by the responsible psychiatrist as clinically improved [5]. Currently, most suicides in the hospital occur by hanging in the bathroom or bedroom area. Yet, approximately one half of all suicides of inpatients

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occur outside of the hospital. This group is divided equally between those who have eloped, and those who are on authorized privilege status [2,6]. The first month of admission has been described as the time of greatest risk, with a gradual decrease as the length of hospital stay increases [2,5].

Although there is considerable morbidity and mortality associated with mental illness, death is a relatively uncommon phenomenon on most psychiatric inpatient units. This is in contrast with medical or surgical staff in which treating the dying patient is an essential part of care. In this respect, "mastery by repetition" may occur with an eventual familiarity with the process. On the inpatient psychiatric unit, staff are continually faced with *the prospect* of death in the suicidal patient, but rarely with death itself. In this setting, "the repetitive threat of an event without its actual experience is more likely to produce anxiety about it than mastery" [7]. This absence of patient deaths may, in fact, create a false sense of mastery and the illusion that all suicides may be prevented. It is for this reason that the *anticipation* of the eventuality of suicide is vital. Without a climate of anticipation, when suicide does occur, it is a severely traumatic event in the life of a unit.

The Aftermath of Inpatient Suicide

In the aftermath of an inpatient suicide the staff is presented with two principal challenges: 1) Following an inpatient suicide the acute needs of the patients who remain on the unit must be addressed. This includes the containment of any further self-destructive behavior, and the prevention of a suicide epidemic. 2) The second task, closely related to the first, is the enhancement and support of a process of mourning and recovery. The success of this process may be the difference between the staff's experience of this event as a crisis on one hand, or as a trauma on the other. In the event of crisis, there is potential for growth, maturation, and newly acquired ability. In the event of trauma, a permanent scar may result, with lasting impairment or disability.

In the event of suicide, the inpatient unit passes through a predictable series of characteristic stages. These are *shock, recoil, posttrauma,* and *recovery* [8,9].

Shock—Resuscitation (Key: Containment)

The first few hours after the suicide on an inpatient unit represent a critical period for the survivors of the suicide, who include family, patients, and staff. At the point of impact, there is an initial response of shock, disbelief, confusion, and disorientation. For some, this is immediately accompanied by emotional flooding and panic. It is vital at this time that the unit leadership provide clear information, direction, and support [10]. The emphasis at this stage is on *containment.*

Staff Meeting. Immediately following the suicide, an initial staff meeting is called to inform the entire staff and to develop an appropriate strategy with assignment of tasks. Attention is directed at the patients who remain, and the containment of any potentially dangerous behavior. In addition to closing the ward to all admissions, passes for time off of the unit are suspended. Patients who may present particular risk are targeted for specialized interventions or precautions. Arranging for additional staff may be necessary, and present staff are instructed to cancel appointments or obligations off of the unit. Tasks are assigned with checks to ascertain that they have been accomplished.

Inform and Document—Risk Management. The family of the patient is contacted by the attending psychiatrist, with plans made to meet with the family as soon as possible. It is clearly recommended that the news of the death be delivered in person. In addition, the hospital administrator, outpatient therapist, and departmental head are contacted. An appropriate administrator is designated to deal with further outside interactions, i.e., coroner, media, hospital administration, etc. This supports the treatment team in the important work of making the appropriate arrangements with the family and completing the chart. Finally, as part of "risk-management," the hospital attorney should be notified of the event and details of the suicide.

Patient–Staff Meeting. The mandatory emergency community meeting should be called within hours of the suicide. It is an opportunity to use the context of a brief group session, to accomplish multiple goals. In this meeting the leader has an opportunity to introduce the shock of this event in a controlled fashion, assess the response, and to conduct a brief, crisis-oriented group therapy.

Following informing the patients of the basic details of the suicide, *Shock* is frequently experienced with initial expressions of disbelief, or "numbness." *Primitive guilt* may be expressed, particularly by the more psychotic patients in the community. In what might be considered an

identification with an imagined aggressor, these patients explicitly claim responsibility for the suicide. Some patients may have had knowledge of the plan in advance or personal knowledge of the extent of suicidal ideation. Psychotic patients with poor boundaries may have magical or delusional beliefs that they have directly caused the death. *Fear* is also a commonly expressed affect. This may be a fear based on an identification with the victim in which patients may believe that they are no longer capable of preventing their own dangerous or impulsive behavior. This is related to fears that the unit is unsafe, or that suicide may be contagious. Finally, *Anger* or *Blame* may be expressed. This may be anger directed towards staff, the patient's therapist, or the victim. Frequently, the leader of the meeting may bear the brunt of direct verbal attacks, including charges of incompetence and full responsibility for the death.

The emphasis of this meeting is to contain. Patients may express the fear that they are unable to control themselves, or that staff is incapable of ensuring safety on the unit. It is incumbent upon the leader of the meeting, and the staff in general, to clearly communicate a command of the situation and a readiness to respond to any further dangerous behavior. Questions should be responded to directly, openly, and calmly. Validating the emotional responses of those present will assist in dealing with the shock of the event. In this respect, it may be helpful for staff to articulate the varieties of emotions, fantasies, and fears that suicide evokes, and demonstrate the capacity to tolerate them. Patients will further be reassured when staff make clear that they will decisively move to contain any further self-destructive or impulsive behavior.

Crisis Intervention Planning/Containment. The response of patients in the meeting may provide invaluable clues in the assessment of those who are most at risk. The patient who is unable to tolerate the meeting and who abruptly leaves should be closely observed. In addition, at-risk patients are those who are currently suicidal, those who have made prior suicide attempts, and those who are depressed [11]. Those patients already struggling with suicidal feelings may experience an upsurge of feelings of hopelessness on the death of a peer or friend by suicide [12]. This is compounded for the psychotic patient with impaired reality testing who either believes that he has directly "caused" the suicide or does not fully realize that death constitutes an end to life [13]. Those patients who have formed pathologic identifications with the deceased patient are also at risk. This includes those who have been especially close to the patient during the hospitalization and those who have shared similar psychiatric histories [14]. For these patients, one-to-one "specials," closely monitored seclusion, or transfer to a more secure setting may be indicated.

Recoil—Rehabilitation (Key: Process)

For staff, the initial sensation of numbness and disbelief is inevitably followed by a wave of reactions that in many ways mirror those of the patients. Shock often gives way to profound feelings feelings of *guilt*. This may be accompanied by fears of being held fully responsible or "blamed," as well as feelings of *shame* and despair. *Anger* may follow, or may occur in the place of self-recrimination. This anger may be at the patient or at the family (including insinuations that "They drove the patient to it"), or towards fellow staff, supervisors, or administrators. Standing philosophies of treatment, procedures, policies, and leadership may also bear the brunt of this pervasive wish to find a focus of causality and blame.

Finally, *depression, self-doubt,* and *a search for meaning* may result. This may be manifest by a sense of futility and hopelessness in the face of taking care of other suicidal patients. These patients may seem indistinguishable from the patient who has suicided. Clinical judgment may no longer seem reliable and patients may be either placed on suicide restrictions prematurely, or impulsively discharged. For several months the identified clinician, or the unit as a whole, may experience impaired judgment or lack of self-confidence. This may result in staff feeling literally paralyzed and unable to make the simplest of decisions. During this time consultation is made readily available for determination of timeouts and discharges.

Outpatient therapists who have experienced the suicide of their patients report profound feelings of isolation and loneliness. At its best, the inpatient setting may provide a context of shared responsibility and mutual support [15]. Yet the immediately public character of this personally traumatic event may also be intrusive. Inpatient psychiatrists have described feeling the pressure to immediately prepare a rational explanatory statement, in a "superficial ritual" to make sense out of the suicide. These psychiatrists felt betrayed by "stereotyped responses and formulations" by others. In addition

there was a painful awareness of implicit "silent accusations" of colleagues [16]. For the clinician in training, this may be even further exacerbated by the "fish-bowl" effect of training programs in which clinical work is open to multiple sources of scrutiny. This is especially significant in that as many as one third of psychiatric residents will experience a suicide during their training [17].

Meetings, Conferences, Peer-Groups, and Supervision. During the phase of recoil, the emphasis is on *processing* the event. Team meetings, staff process meetings and ward conferences may assist in a collective "working through" of the feelings of anger, guilt, fear, and depression that inevitably follow suicide. Yet the act of processing must once again be counterbalanced by containment. During this phase the staff is supported in the verbalization of painful feelings, while limits are placed on destructive or divisive self-expressions. Scapegoating, critical or blaming accusations, excessive self-blame, emotional withdrawal, or denial should be contained and addressed [10]. At the same time, the more personalized settings of supervision, peer groups, or peer contact may be especially helpful.

Informal peer contact has been cited by staff as the most valuable support in the early attempts to cope. The capacity to utilize peer support in the first few days following a ward suicide has been associated with more favorable staff outcome [10]. A leaderless group of outpatient therapists who had each lost a patient to suicide has been described. In meeting regularly for 1 year they report significant success in "working through" the losses. The injury to an imagined "omnipotence" and loss of self-esteem is often accompanied by shame, guilt, feelings of vulnerability, and self-doubt. Above all, these therapists report a profound sense of isolation with the loss and feelings of *loneliness*. The peer group may answer some of the needs for "support, understanding and absolution" and ultimately assist in mastering the traumatic event [18].

The Rituals of Death/Outreach. Involvement in formal rituals of death have been described by some staff as a vital step in the eventual recovery process. The sending of flowers or a card, or the attendance at the wake or funeral are both important for staff, but also are part of a vital outreach to the family survivors [10]. The clinician at the funeral or wake 1) gives families an opportunity to talk about their experiences surrounding the death; 2) allows the physician to support, reassure, and help families with their feelings of guilt; 3) adds credibility to the sense of worth of the deceased; and 4) assists the clinician in resolving the loss through participation in the mourning ritual [19]. A review of medical–surgical (nonpsychiatric) practices at the time of death has found that less than 10% of physicians reported sending a card or flowers or attending the wake or funeral. Only 6% contacted the family or scheduled an appointment with the family *after* the funeral [20]. To this date, the author has found no studies that have documented mental health clinician practices at the time of patient death secondary to suicide.

In addition to this involvement by staff in the family's formal rituals of mourning, it is suggested that a formal recognition of the death occur for the fellow inpatients of the deceased. A memorial service in the hospital for patients and staff is recommended within 2 weeks of the suicide. This service is helpful in providing some preliminary closure to the death and facilitates the mourning process [3].

The Suicide Review Conference. The suicide review conference may be an important component in bringing a sense of closure to this stage. At its inception, this conference was designated by Shneidman as the *psychologic autopsy*. This systematic review of suicide focused specifically on a determination of the cause of death in equivocal situations.

> The main function of the psychological autopsy is to clarify an equivocal death and to arrive at the "correct" or accurate mode of that death. In essence the psychological autopsy is nothing less than a thorough retrospective investigation of the *intention* of the dead—where the information is obtained by interviewing individuals who knew the decedent's actions, behavior, and character well enough to report on them. [21]

Schneidman has suggested a specific approach to this examination, as adapted in Table 1.

A formal psychologic autopsy may be necessary when an "equivocal suicide" has occurred and the cause of death must be determined for medicolegal purposes. In this context, the *autopsy* follows the function of the pathologist–scientist; it is a *dissection*, that is, it attempts to reveal the underlying pathology and circumstances of the death. Yet often death may occur by suicide and there is no question of the cause of death. Nonetheless, a suicide review conference should always follow. In

Table 1. Outline For The Psychological Autopsy[a]

1. IDENTIFYING INFORMATION (name, age, address, marital status, religious practices, occupation, etc).
2. DETAILS OF DEATH (cause, method, and other pertinent details)
3. BRIEF OUTLINE OF HISTORY (medical illnesses and treatment, psychiatric illness and treatment, prior suicide attempts).
4. DEATH HISTORY OF VICTIM'S FAMILY (suicides, fatal illnesses, ages at death, etc.)
5. DESCRIPTION OF PERSONALITY AND LIFE STYLE OF THE VICTIM
6. TYPICAL PATTERNS OF REACTION TO STRESSORS
7. RECENT STRESSORS OR KEY LIFE CHANGES
8. ROLE OF ALCOHOL OR DRUGS (in overall life style, in death of victim)
9. INTERPERSONAL RELATIONSHIPS (marriage, family, social, with physicians)
10. EXPRESSED IDEATION OR FANTASIES (dreams, thoughts, premonitions, or fears of victim relating to death, accident, or suicide)
11. CHANGES IN VICTIM PRIOR TO DEATH (observed changes in habits, hobbies, eating, sexual patterns, and other life routines)
12. ADAPTATION, STRENGTHS ("will to live": successes, plans, long-range goals, etc.)
13. ASSESSMENT OF INTENTION (role of victim in his own demise)
14. RATING OF LETHALITY
15. REACTION OF INFORMANTS AND SURVIVORS OF VICTIM'S DEATH
16. COMMENTS, SPECIAL FEATURES ETC.

[a] Adapted from Shneidman, The Psychological Autopsy, Suicide and Life-Threatening Behavior, Vol 11(4), Winter 1981.

the event of an inpatient suicide this function is considerably broadened to accommodate a specific role in the recovery of the unit. In this sense, rather than dissection, the ultimate goal is a *resynthesis* [22] of the separate parts of this event and a reconstitution of the functioning components of the ward. This necessitates an extension of the pathologist–clinician model to include the clinician–preventative medicine model. In this respect, although the outline shown is a useful guide, the suicide conference should be adapted to assist the staff in understanding the suicide and to help in overcoming feelings of helplessness or incapacitating guilt.

The suicide review conference has been found to be especially unhelpful, and even harmful, if performed immediately following the suicide [23]. In the early stages of the aftermath those most affected by the loss are in a vulnerable state in which normal coping mechanisms are flooded. A formal suicide review should be performed after there has been time for a reestablishment of equilibrium, with the resolution of initial phases of *shock* and *recoil*. This will vary depending on the staff dynamics and may require a period of at least several weeks.

A consultant from outside of the ward or hospital is called in to chair the review. Reviews of suicides that are done with the intent to assign guilt may result in scapegoating and may be especially destructive and demoralizing. On the other hand, reviews that fail to address actual errors in judgment or contain key oversights may be experienced as "whitewashing," and will leave staff feeling isolated and unsupported in their feelings of responsibility and guilt. In this context it is useful to clarify that a clinician's mismanaging a case can only increase the probability of suicide, *never cause it* [24]. In helping the staff review the suicide, this exercise can assist in placing the death in a more realistic perspective, thereby lessening the overwhelming feelings of guilt. In addition, the review may focus attention on specific problems which the unit has in the care of the suicidal patient which may be addressed by future changes in procedure or structure.

Posttraumatic Phase—Renewal (Key: Anticipation)

During this period there is a progressive diminishment of feelings of depression and demoralization. This may be accompanied by an attempt to explain or find meaning. In this stage, the challenge is to begin to move away from a posture of processing the loss, towards a position of being able to work again with suicidal patients. This requires achieving a capacity to tolerate what it means to *anticipate* the possibility of future losses to suicide.

The Search for Meaning. This attempt to find meaning in the event may result in an insoluble dilemma, which can be summarized as the conflict between the extremes of therapeutic nihilism and therapeutic efficacy [25]. The notion that suicide is unavoidable and ultimately unpreventable results in removing the spectre of self-blame, and yet results in a sense of impotence and a therapeutic nihilism. In this context, it appears that the tools of the clinician are flawed and unreliable and that

there may be nothing to prevent suicide in other patients. If, on the other hand, all suicides are seen as the result of diagnostic or empathic failures, then a clear "error" may be defined and "blame" assigned. This may result in an overwhelming burden of responsibility and sense of guilt [25]. The conflict between these extremes may result in a generalized sense of self-doubt and demoralization.

For the unit, clarification of this dilemma lies in meetings and case discussions in which there is a review of the limits of assessment and treatment of the suicidal patient. In particular, this is reflected in a recognition that the efficacy of assessment and intervention varies, depending on the patient's psychopathology. For staff, this acknowledges that *some* patients *are* able to utilize the structure, support, and treatment modalities of an inpatient unit in the midst of a suicidal crisis. These patients may possess a degree of relatedness that allows the clinician to develop a working therapeutic alliance. In this context, adequate monitoring of suicidality may be possible, and a collaborative treatment occurs. On the other hand, an empathic approach is limited for those patients who are severely schizoid, psychotic, or isolated in their decision to suicide. For example, the intention to "join" a loved one who is deceased, or the wish to "escape" a tormented life, may outweigh any direct attempt by the clinician to establish a relationship that allows for a direct clinical assessment of suicidality. Here, Buie has suggested the clinician may be easily mislead [26]. For the staff unit, recognizing and accepting the limitations of empathy and clinical assessment is an important step in resuming the work of caring for the suicidal patient.

Although most staff resolve the crisis of confidence following suicide and are able to reinvest in the work, absenteeism and reports of illness may commonly occur. This failure to resolve the loss may even take the form of pathological grief reactions and disability. There are, for example, reports of psychiatrists attempting or completing suicide shortly following losing patients to suicide [24]. In addition, some clinicians have described pathologic identifications with the patient who has committed suicide and have assumed symptoms related to the suicide [25].

Review of Ward Dynamics/Policy/Structure and The Suicide Epidemic. In returning to the care of the patients who remain, an assessment of the ward policies, structure, and, in some cases, staff dynamics, may be indicated. This is especially the case if a series or an epidemic of suicides has occurred. Studies of suicide epidemics on inpatient units have suggested that staff dynamics and structural conflicts *may* act as contributing factors. This is especially the case in the context of staff conflict, staff demoralization, or marked disagreement among the leadership over treatment goals or philosophies. Poor communication among different disciplines and lack of clear documentation of clinical status and treatment plans have also been noted [16,27]. In addition, rapid changes in leadership accompanied by dramatic changes in the basic traditions, rules, and values of the ward may also act as contributing factors [28].

In these instances, an assessment of ward procedures, policies, and staff dynamics may be useful. Rather than focusing on processing staff feelings or debates of treatment philosophy, it is recommended that the staff "return to the basics" of patient care. These include 1) institution of procedures to assure thorough patient evaluations, 2) setting of reasonable short-term goals, 3) systems for recognizing, communicating and correcting errors, and 4) attention to the practical issues and needs of the patients [27]. It is cautioned that a reactionary response to suicide may exacerbate current feelings of demoralization. Dramatic changes in policy and procedure with significantly increased restrictions and controls may further staff feelings of helplessness and undermine clinical confidence [29].

In addition to the above measures, an assessment of the physical structure and design of the inpatient unit may be warranted. This includes a review of environmental safeguards or "suicide-proofing" of the unit [30,31].

Return to a Long-Term Focus. The long-range effects of patient suicide consists of a working-through process that may take months and even years. Repressed feelings of grief may be reawakened in the context of other losses, or anniversaries.

Special Considerations

The Family—Postvention. Although most uncomplicated grief reactions resolve in 4–6 weeks, the spouse or family of the suicide victim has an especially difficult task at hand. Shneidman has described the the complex nature of mourning loss by suicide. "The person who commits suicide puts

his psychological skeleton in the survivor's emotional closet—he sentences the survivor to deal with many negative feelings, and more, to become obsessed with thoughts regarding he own actual or possible role in having precipitated the suicidal act or having failed to abort it" [32].

The family survivor of suicide is frequently avoided by those who would normally offer support. In this way loss by suicide is dramatically different from loss by natural causes. Interactions with agencies or the authorities are often described as the most traumatizing of all interactions. These include inquiries by police, insurance representatives, and the refusal of some clergy to conduct usual burial services or bury on church grounds. Blame may also be explicitly or implicitly placed on the spouse for "driving him to it" or failing to prevent it. The avoidance by those who would normally offer support such as neighbors, friends, and relatives is in marked contrast to the support and assistance usually offered the bereaved [33]. This experience of stigmitization reinforces the sense of shame and guilt already present and results in many families moving out of their community within 6 months of the suicide [34].

For those family members who have suffered loss by suicide incomplete or pathologic grief reactions are common and disabling outcomes [33, 35]. As part of this response, prolonged or delayed grief may occur, only to surface at the anniversary of the death or at the time of another loss [36,37]. Masked or major depression is common. Distorted grief reactions may also occur. As many as 25% of family suicide survivors develop psychosomatic illnesses such as migraines, asthma, colitis, ulcers, or hypertension, and the majority experience exacerbations of prior medical illness [34]. Because of the high risk of developing psychologic or physical sequelae, outreach to the family, or postvention is especially important.

The work of postvention with the families may be considered to occur in three discrete stages [22]. These mirror those described for the stages of resolution for the inpatient unit:

1. *Psychologic Resuscitation:* A supportive visit to the home within the first 24 hours to assist with the initial shock phase of the grief.
2. *Psychologic Rehabilitation:* In the following 2 months, weekly sessions to explore guilt, distortions, and the sense of loss, and to facilitate the mourning process.
3. *Psychologic Renewal:* Substitution of new object relations and establishment of new contacts. This should be followed by a contact on the anniversary of the death.

Clinical outreach to the survivors is both the most humane response in the context of trauma and also the best preventative medicine for potential malpractice litigation [38]. Open, direct, and supportive involvement with the family will limit potential distortions and projections.

Legal Issues. Malpractice suits are, nonetheless, a relatively common and often demoralizing outgrowth of an already traumatic experience for staff. As many as one fourth to one third of suicides in the hospital result in lawsuits [39,40]. Suicide currently amounts to 18%–25% of all malpractice suits against psychiatrists [41,42].

The courts have changed standards of liability from earlier custodial models of care to accommodate contemporary "open-door" policies. Traditional, overly restrictive polices have been recognized to potentially inhibit recovery and further engender feelings of helplessness, isolation, and low self-esteem [43,44]. Open-door polices in the psychiatric hospital have evolved that promote less restrictions and encourage patients to assume more responsibility for themselves. The courts have recognized that not all suicidal patients require restrictive settings with constant observation. This is reflected in several decisions, including Dinnerstein vs. U.S., in which it was written:

> Not every potential suicide must be locked in a padded cell. The law and modern psychiatry have now both come to the belated conclusion that an overly restrictive environment can be as destructive as an overly permissive one [43].

In fact, the suicide rate within hospital has actually decreased since more liberal policies have been instituted [45].

The courts have decided malpractice cases on the basis of two related questions [44]:

(1) Could the psychiatrist "reasonably" have been expected to foresee the likelihood of suicide and to have taken the appropriate precautions to prevent it? No successful lawsuits have been won in cases in which cooperative and cheerful appearing patients suddenly and unpredictably engaged in self-destructive behavior. Similarly, liability was not found when a patient without any prior expressed or demonstrated suicidal tendencies suddenly jumped from an unguarded win-

dow. Conversely, liability has been found in cases when treatment plans have clearly overlooked, or neglected clear evidence of suicidal tendencies [43].

(2) Could the psychiatrist "reasonably" have found that the risk of potential suicide outweighed the therapeutic benefits of a less restrictive environment?

Any decision to grant less restrictive privileges should include documentation of:

a. The clinical condition of the patient warranting this decision [47].
b. A brief discussion of the thinking supporting this decision. The risks of less monitoring should be weighed relative to therapeutic benefit to be gained [46,47].
c. Informed consent, i.e., documentation of a discussion of these risks and benefits with the patient [38].
d. In equivocal situations, consultation from a supervisor, senior staff, colleague or consultant should be obtained and documented [38,47].

Recovery—Anticipation

This last stage of the aftermath reaction is marked by a return to the daily routine of caring for patients and the capacity to look forward to future clinical challenges. For the inpatient unit staff this includes an anticipation of the eventuality of suicide. This acknowledgement of the likelihood of suicide in especially high risk patients is an important part of managing the shock of suicide when it occurs. This may include specific "patient at risk meetings" in which particularly suicidal or otherwise extremely ill patients are reviewed. To anticipate that a given patient may commit suicide, or that working at a particular site exposes one to a constant risk of patients committing or attempting suicide, ultimately facilitates the difficult work of caring for these patients.

Summary

In surviving and working through the aftermath of a suicide on an inpatient unit, there is a possibility for growth, as well as a preparedness for the eventuality of its return. As one group of therapists who lost patients to suicide described their recovery from the event:

> We found that as we worked through our mourning, we felt we had been through a rite of passage. While we did not feel immunized against having to reexperience this painful process in the future, we felt we had undergone something which had transformed and matured us and increased our sense of what we could withstand. We became more able to give up magical expectations and fantasies of therapeutic omnipotence . . . we became more willing to accept our own limitations and to forgive ourselves.
> . . . we cannot always prevent patients from committing suicide and therefore prevent therapists from having to undergo the process of mourning a patient who does kill himself [18].

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