Suicide in the Psychiatric Hospital

Alexander Gralnick, MD
High Point Hospital

ABSTRACT: Society's attitudes toward and treatment of the suicider are examined. The emotional and clinical impact suicide has on everyone, and its consequences to the hospital are detailed. Our unfortunate emphasis on "prevention" as against treating the disease process which causes the death is stressed. Also stressed is the psychiatrist's misplaced role in contrast to that of other physicians involved in a patient's death. Only in psychiatry does it seem that the role assigned the physician is that he prevent a specific patient's death as much as that he treat the patient's underlying fatal disease.

Hendin reported the following not too long ago: that there had been an increase in suicide of some two hundred and fifty to three hundred percent among 15 to 24 years of age; that though white males over 50 made up ten percent of the population they composed 30 percent of those who suicided; that several hundred thousand attempts at suicide were made annually, and that about 10% of those ultimately killed themselves within ten years.[1] Society's attitudes toward those who suicide include an array from the humane to the most intolerable and inhumane.[2,3] The continued rising incidence of suicide, however, particularly among the young, now makes this subject a matter of special importance.

Death is uncommonly acceptable and mainly an unwelcome visitor. When it is by suicide, death is a horrible and devastating event for all those associated with the one who kills himself. No other death has more of a wrenching effect on family, friends and caretakers than does this self-killing. No other death can more arouse the passions, the feelings of anger toward the self, the deceased, and his caretakers; and more stir feelings of despair, guilt, and self-condemnation than

Received March 30, 1993; For Revision April 4, 1993; Accepted April 22, 1993.
An address at the 44th Annual Meeting of the Association of Psychiatric Services for Children, New Orleans, Louisiana, March, 1993.
Address correspondence to Alexander Gralnick, Psychiatrist-In-Chief, High Point Hospital, 1104 King Street, Port Chester, New York 10573.

can death by suicide. No other death can be so threatening to the structure and fiber of the family. And no other death can be as destructive to the life of a psychiatric hospital, its patients and professionals as can a suicide.

Why should this be so?

In my career I have had close experience with numbers of unsuccessful attempts at suicide, and with some seven successful attempts—if here you can speak of "success." I think this is a greater experience with suicide than that which befalls most psychiatrists. It is not a great number, fortunately, and it is not a fact about which I would boast. But it has grown out of a long hospital experience treating very sick patients for extended periods of time. The last six of these suicides occurred in the hospital I founded some forty years ago, and of which I have been the chief psychiatrist. In some respects then, this paper is a personal report of observations of myself and of others around me at such times, and of the consequences of suicide to which I have been exposed.

It will be evident that I write with a degree of emotion which largely stems from this experience. I have seen some suiciders with my own eyes immediately after the fact. For instance, a patient who suicided by strangling herself while in a restraint in bed at Central Islip State Hospital; also, a woman who had hung herself; and a young man exsanguinated after having slashed his throat; three others with whom I had less direct contact: one whose hanging was interrupted in the hospital, but who died in the nearby general hospital; a young woman out on a visit who jumped to her death from her father's office; a woman who drowned herself while on a routine daily walk on the hospital grounds, and then hearing her husband, when he first heard the news in my office, say "God Damn her". All of these events were traumatic, each in its own way, each for its own reason and individual tragedy and each for the sense of failure it engendered and the apprehension about threatening consequences it promoted, to wit, unwelcome publicity and malpractice suits. Each haunted you for what you believed you might or must have over-looked. Each goaded you to ask yourself "Where did I fail?"

The hospital psychiatrist falls victim to certain occurrences which are not ordinarily the lot of other physicians. The same, for instance, does not befall the internist who treats a serious illness unsuccessfully, nor the surgeon who loses a dangerously-ill patient under the knife. The one is not in immediate danger of legal action should the patient who has had a coronary die in the hospital, nor is the surgeon

whose patient dies after a lobectomy for lung cancer. Neither has to promptly notify the police who then come to investigate the death, as tho some crime had been committed. Neither must notify the Coroner who then does an autopsy to find "The cause of death". The Office of Mental Health which licenses the hospital must also be notified. It may elect to investigate the hospital and thus find ways of preventing a similar event, or to seek fault.

If suicide is truly a cause of death why are there aroused the reactions and emotions to which I have alluded? If we really accept that it is a cause of death, why is its occurrence accompanied by such dire consequences? With no other deaths are they of such an acute and profound nature. If we mean what we say, namely, that suicide is a most common cause of death among young people, why are we so filled with anger and guilt when it happens? Why are we so condemnatory of those who have been responsible for treating the patient—especially if the patient has been in a hospital? Why do we mourn the victim of the act in that special way? Why do we speak of "the survivors?" Why do we not merely speak of the suicidal patient as having suffered a critical and fatal illness from which he unfortunately died?

Do we think that the act is somehow within the person's control, and that that therefore justifies our condemnation of him? Or do we actually believe that the one who is treating the disease-process is responsible for not having prevented the death? May we really think that disease is not involved; that suicide is a matter of "will" and therefore truly preventable? And that therefore, when we place a severely depressed person in the hospital, his doctors are responsible not so much for treating a sick patient as for preventing his death—that "treatment" is synonymous somehow with preventing death. And if that be so why should the person be placed in a hospital? The function of the hospital, and its doctors, is to treat an illness, not to prevent death. Of course, the aim of preventing or delaying death is desirable and laudable, but should not be an expected inevitability of the treatment of a serious and fatal illness. It is for these reasons that I once titled a paper "Is Suicide A Cause of Death?"[4]

We are dealing with more than a clinical subject. Social attitudes towards life and death, and particularly suicide, are involved; our most precious human values related to life, and its taking, are involved; the law and governmental and police authorities are involved; our beliefs about the most intimate aspects of interhuman relationships and the responsibilities we bear in them, one for the other, have

a bearing; the deeper responsibilities blood - kin feel for each other, and doctors and other caretakers feel toward the patient, are also vitally important. They warrant our closest attention. Each of us must not only have an understanding of these matters, but come to some conclusion about them. With such conviction we will have some chance of dealing dispassionately with the subject of suicide, and of responding adequately to its occurrence.

In our culture life has a great and special value. This value has economic components insofar as the individual may contribute to his family's and community's survival. It has social value in that the person may support the human aspects and moral integrity of his fellow-beings and contribute to their emotional life and growth. Mainly, however, life has an almost Holy quality because it is considered God-given. Having been given by God, it can only be taken by Him. Since life's origin was determined by God, so must be its termination. The suicider, therefore, flies in the face of God and His Law. The act of suicide is blasphemous and sacrilegious. It is an evil deed and in that respect frightening insofar as it can bring down God's retribution. In this respect, suicide is a sinful act. How can a person dare destroy this most precious and Holy trust?

There was a time in the middle ages when it was believed that on death one went to Heaven. When at some period suicide had become uncomfortably common it became thought that such thinking tended to promote suicide. Religious and social leaders then turned their wrath against those who suicided. Religious burial in consecrated ground was denied them. Stakes might be driven through their hearts and their bodies otherwise mutilated. Heaven, of course, was denied them, as was burial.

In recent times we have become more enlightened. One now has the right to "die with dignity"—to determine the time of death by writing a will that denies physicians the right to use heroic measures to prolong one's life. Is this now a type of accepted suicide? We have Hemlock societies which promote the greater acceptance of suicide. A physician has invented an apparatus to permit people to easily and voluntarily kill themselves. It is probable that economic factors are also promoting these newer attitudes toward life and death, and suicide.

One may consider the subject of suicide from one of several vantage points. In any event one's views will be limited by his own experience, biases and interests. Certainly the view of the relative will differ from that of the treating psychiatrist, as his will differ from that of

the mental health officer, as his will differ from that of the legal authorities, and so on down the line. I address the subject as the Chief Medical Officer most responsible for the welfare of seriously and chronically-ill patients, most of them adolescents and young adults who have been treated unsuccessfully in one or more previous hospitalizations. Many of them have been suicidal and all carry a dark prognosis for life. They come to the hospital almost as a last resort to be rescued from the illness which has been relentlessly destroying them.

Together with others I am dedicated to helping discover the origins of mental illness, particularly Schizophrenia, and to finding more successful ways of treating those who require hospitalization. I am devoted particularly to that type of hospital-social-system which will be therapeutic by its very own nature and thereby assist the sickest of patients. The ultimate psychiatric hospital should be a rational social-system whose therapeutic modalities are multiple but which itself, as a totality, is the therapeutic vehicle. We should not speak of psychiatric treatment given in the therapeutic-community hospital, but of this hospital itself as the psychiatric mode of treatment. It is in such a hospital that the patient dedicated to his own death should find reason yet to live.

Suicides in a psychiatric hospital are traumatic events. In large institutions they mainly affect the unit in which the suicide occurs. In the small hospital which houses all its patients in one building a suicide is especially traumatic to one and all. Everyone will have known the patient intimately, especially if he has been in the hospital any length of time. Our most recent suicide by a young Schizophrenic patient was of this nature, and turned out to have the most devastating effect on all of us. We generally treat only 40 patients and are housed in one building in which the major activities occur.

The immediate stated reaction of the father of the patient was that he would sue the hospital. For an extended period of time the mother kept calling the Office of Mental Health and The New York State Commission on Quality of Care, apparently to complain. There then followed a series of unannounced visits of representatives of these agencies to inquire about the death, to inspect the hospital building and to talk to different members of the staff, both professional and non-professional. Before long, on behalf of the family came a letter from an attorney asking for a complete copy of the record. From what we could gather from the official visitors the mother seemed to be calling insistently and persistently, and that they had no alternative

since nothing seemed to calm her anger or soften her complaints. One could only fear that she would just as soon see us destroyed as anything. These visits continued for some four to five months. Almost three years after the event reverberations continue.

There were some additional suicides which occurred in other nearby hospitals. Ultimately I believe all the hospitals in the area were inspected and an official memorandum sent instructing all of us to remove any and all "hazards" which could be used in suicides. The overwhelming emphasis was on those objects which could assist the patient to hang himself. All pipes were to be concealed, including sprinkler heads; all hooks and shower curtain rods were to be made "breakway"; towel racks and closet clothes hangers were to be made "breakway"; all projecting objects were to be removed; and so on down the line. It appeared that the Office of Mental Health was bent on minimizing, if not eliminating suicides from its psychiatric institutions. It were as though suicide was conceived as some act that could be prevented by merely taking these steps. Not dissimilar from the thinking that suicide would be minimized, if not prevented entirely, by establishing suicide prevention clinics and "hot lines". Yet suicides are undoubtedly on the up-swing.

The patient himself was more understanding and forgiving. In suicide notes which were kind, warm and gentle in nature, he explained his reasons. He praised and thanked his doctor and the hospital for their help and devotion to him. He pleaded with his parents not to blame themselves and not to sue the hospital. He saw no alternative and was resigned to his fate. He was convinced that he was hopelessly sick! As best as one could reconstruct his last moments he must have very planfully studied the way he was being observed and have deliberately plotted to accomplish his own death by misleading everyone. Even patients close to him did not seem to know what he was contemplating. Some expressed anger at him for what they considered his deception, even of them.

Much as I cared for the patient and much as I appreciated the depth of his illness and suffering; much as I could place myself in his shoes and see the "logic" of his act, considering his convictions about the chronicity and hopelessness of his illness; much as I knew that many psychiatrists were just as pessimistic about the prognosis for Schizophrenia as was this young and callow youth; much as I wanted him to live; much as I wanted the professional satisfaction, and yes, the victory of conquering his malignant illness, I could be and was angry at him at times when discussing the event with the staff.

On one occasion I applied a rather harsh word to describe what I thought of him. I found myself saying that as good as he seemed to be, and as sick as he seemed to be, he nevertheless had deceived all of us. He had actually plotted his death as would some felon bent on committing a heinous crime; he had been bent on an act that he believed would be beneficial for him with little thought for the consequences that would befall all of us, including his family. He had even thought that his family might sue us. In that respect there was a selfishness to the act, if not a dishonesty and sinister character attached to it.

Of course, in thinking as I did I was employing my own value system in judgment. But what was so bad about that? I was accustomed to using values in the treatment of all patients. Why not then with the one who contemplates killing himself? Those of us remaining were to be judged, and were being judged by the values of others. If there was nothing wrong then in applying my values might there be a helpful clue in using them? Might it help us to minimize the occurrence of suicide?

Is it possible that we lose our critical acumen and objectivity with the depressed and hopeless-feeling patient? Do we thus suffer a counter-transference in forgetting that he is potentially a murderer who is nefariously plotting a killing? Are we thinking solely of him to the exclusion of ourselves when he is thinking only of himself without regard for the consequences to us? Who, after all, will be left in the lurch?

In such instances would we be doing the patient harm if we thought of ourselves in addition to the patient? Would we be harming the patient by having this additional reason for guarding him? I think not! Could not this way of thinking lead us to a therapeutic ploy, namely, of placing some onus on the patient's shoulders for the welfare of those others who would suffer from his act? And if we taught this to our psychiatrists, and especially our nursing personnel, might they not watch the patient a bit more carefully? Now they would have to be more mindful of themselves because they had a stake in the action, and thus an additional good reason for protecting the patient against himself.

The patient was seen by a staff psychiatrist the very morning of the night he hung himself. On being questioned he denied suicidal intention. On the contrary, he stated that he had things "under control". In retrospect we can only imagine what he really meant by "under control". The psychiatrist, nevertheless, put the patient on a five minute check to be doubly sure. That very psychiatrist happened to be in the

hospital that fatal night and was called to resuscitate the patient after he had been cut down. To this very day the physician plagues himself for not disregarding the patient's "reassurance" and for not having put him on one-to-one nursing attention rather than the "five minute check". When I myself reported the suicide to a member of our Board of Governors I began to sob. I had become fond of the patient, and he had become a challenge to me. This had not happened to me on any previous similar occasion. At other times I had been angry, upset, chagrined, condemnatory of myself and others, and worried about consequences. This time there was frustration, a deep sense of defeat, and sorrow over this self-inflicted and fruitless death of a young man.

On several occasions I had emphasized to the patient's therapist that I strongly believed him to be suicidal. After the event I asked this psychiatrist if he had truly believed me. He knew me well and had worked with me for 25 years. Yet he forthrighly declared that he himself had not believed the patient to be really suicidal.

How then are we to proceed and plan? None of us of course, knows the real answers! However, there is much we need rethink! First, and perhaps foremost, we must consider that in the main suicide is the fatal end-result of a serious mental disease-process. As such it cannot be "prevented" any more than can death associated with other grave illnesses. This will become more evident as suicide may be related to brain impairment and genetic factors. The disease may yet be found largely, if not entirely of physical origin, tho I think social factors will always be important components. We may then have to conclude, and declare, that suicide cannot be "prevented." Major emphases, methods and efforts of ours will have to be modified. We will accept that suicide cannot be prevented but that it can be minimized as can death from other disease processes. We must see that lowering the incidence of suicide will depend only on our discovering the origins of the disease causing the death and better ways of curing its pathology. We must shift from our primary emphasis on "prevention" to other considerations. Szasz dealt with this aspect of the subject in 1986.[5]

I think we must be more clinical in our evaluation of the suicidal patient. We should not allow our softer side to blind us to his baser side, nor permit the anticipated reactions of family and others to obscure our objectivity. In our sympathy we tend to shield the patient from some responsibilities because he seems already to be so overburdened. This may be an error. Instead we should let him know the full impact his contemplated act would have on those he professes to love

and those responsible for his life. We should be more mindful of ourselves and utilize our values as well as call upon the patient to use his own best values as he contemplates killing himself. In the process he may appreciate that he has a place of importance in the lives of these others. The suicidal patient is self-absorbed and needs to be diverted from this engrossment by consideration for others. How many of us dare ask the patient whether he realizes that he is really contemplating murder, and actually use the word "murder" with him?

We will have to more seriously explore the biologic, physiologic and genetic factors which are related to the conclusion the patient reaches that death is preferable to life. Schizophrenia, for instance, is a disease-process in which suicide occurs with an uncommon regularity and frequency. It at least suggests that suicide is related to a specific mental disorder and possibly a brain-imbalance.

There will have to be more productive studies of the social scene and the teachings of our culture which seems to prompt so many of our young to select death instead of life. Our culture seems to promote a degree and quality of pessimism which prevails over any hope for the future and the many years that lie ahead of the young.

There is much speculation about what cultural factors and teachings influence one to take his life, but nothing which resembles scientific connection. The traumatic occurrences of life are often considered causative of the depression which leads or is thought to lead one to suicide. These include severe financial reversals, extreme disappointments and failures, and the loss of loved ones. Yet we are aware that not all persons who experience such traumas become depressed or commit suicide. There is not necessarily a direct connection.

We variously account for the gap that exists between the specific event and the end-result which occurs in a selected individual. We surmise about constitutional and genetic factors; we believe we have found body and cerebral chemical changes; we search back to the earliest of life's traumatic experiences, and yet we are always at a loss to fully explain the act, much less accept it as we do other deaths.

Summary

I would think that we must look to and into ourselves to understand and question our own views about suicide. Have we emphasized "prevention" too much and given insufficient emphasis to the "fatal

disease" aspect of the subject? Have we perhaps not sufficiently-well educated the public, health officials and legislators, let alone our own professionals? Is our own objectivity about suicide impaired? Have we perhaps become a bit too much the crusader and too little the clinician?

There is a growing recognition of one's "right to die" and of the importance of "dying with dignity". These new emphases are intimately related to the subject of suicide. As they become more widely accepted they are bound to affect society's attitudes toward suicide and thereby our own. Our practices in trying to combat suicide are sure to change as will the reactions of relatives and friends toward the suicider and his caretakers. The laws which relate to suicide are also certain to change.

It appears that another "track" about suicide is appearing on the horizon. I think that certain suicides under agreed-upon conditions will become acceptable, if not actually encouraged. There are current signs to support that belief. Today, society is permitting certain deaths to occur prematurely in certain illnesses. The justification is economic and the shortage of technical equipment. Living wills are playing a part in earlier deaths. We will be faced with judging which self-inflicted deaths are "suicides" in the usual sense of the word and which are "acceptable" self-determined terminations of life. These decisions will not be easy to make, but ultimately not all suicides will be the horrible events they now are. Perhaps suicide will not be so taboo a subject nor so devasting in its effect on everyone. At least we should be watchful and mindful of these arising changes.

References

1. Hendin H: Suicide in America. New York, Norton 1982.
2. Rosen G: History. In S. Perlin (ed.), A Handbook for the Study of Suicide. London, Oxford University Press, 1975.
3. Deutsch A: The Mentally Ill in America, Columbia University Press, 1952.
4. Gralnick A: Is Suicide A Cause Of Death. Am J Soc Psychiat. Vol V, Number 1, Brunner/Mazel, New York 1985.
5. Szasz T: The Case Against Suicide Prevention. Am Psychol pp 806-812, July 1986.