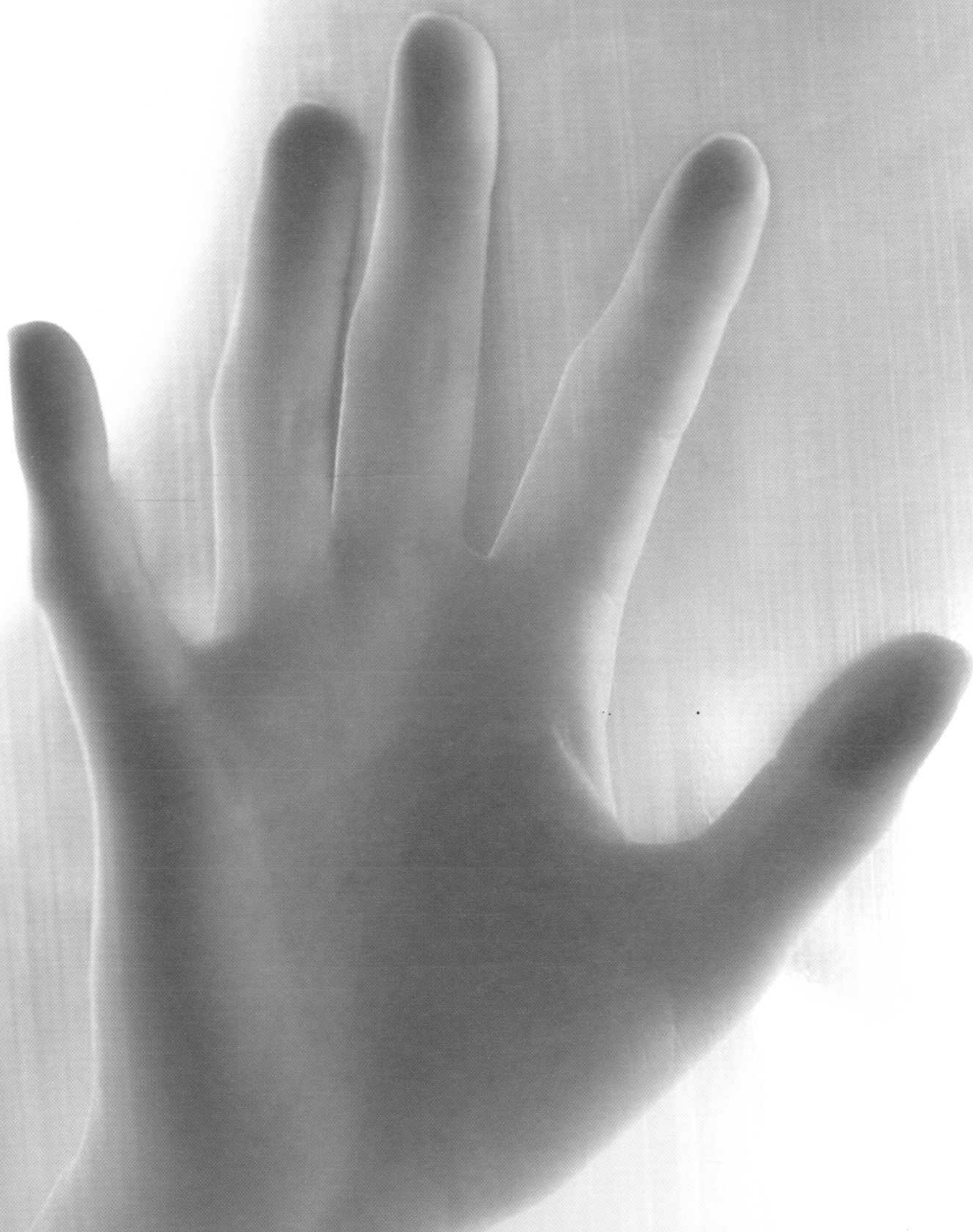
Risk Management with the Suicidal Patient



by Bruce Bongar, PhD and Ronald Stolberg, PhD

Suicidal behavior is the most frequently encountered mental health emergency and is considered one of the most stressful aspects of clinical work (Bongar, 2002). The National Institute of Mental Health (2009) classifies suicide as a major, preventable public health problem. Recent research shows us that up to two-thirds of those who commit suicide have had contact with a health-care professional in the month before their death (Kutcher & Chelil, 2007). In addition, as suicide is one of the few fatal consequences of psychiatric illness (Packman, Marlitt, Bongar, & Pennuto, 2004) our responsibilities seem clear and profound: Ask directly about suicidal ideation and act affirmatively.

The identification of suicide risk remains among the most important, complex and difficult tasks performed by clinicians (Bongar, 2002). A quarter million nonfatal suicide attempts in the United States are estimated to occur each year, 15% of those who attempt suicide will eventually take their lives, and one-third of those who complete suicide have nonfatal attempts in their past (Yufit & Lester, 2005). According to the most recently published statistics, suicide is the eleventh leading cause of death in the U.S., accounting for 33,300 deaths (National Institute of Mental Health, 2009). Or another way to look at the severity, the overall rate was 10.9 suicide deaths per 100,000 people in 2005 (Heron, Hoyert, Xu, Scott, & Tejada-Vera, 2008). Essentially, this number remains unchanged for the past decade. Thus, clinicians are faced with extraordinary decisions about what to do when a patient reports suicidal ideation or when assessment data lead to the same conclusion (Wingate, Joiner, Walker, Rudd, & Jobes, 2004). Unfortunately, many suicidal individuals do not voluntarily report thoughts of suicide or self-harm to their health care providers (Stolberg & Bongar, 2009; Glassmire, Stolberg, Greene, & Bongar, 2002; Johnson, Lall, Bongar, & Nordlund, 1999).

The purpose of this article is to provide specific information on working with the suicidal patient. Thus, we detail the clinical and legal knowledge base and subsequently recommend practical guidelines for the assessment and management of the suicidal patient, based on an optimal rather than minimal set of recommendations. Key elements in high-quality clinical practice and risk management include consultation, durable documentation, assessment of personal and professional competency, and involvement of the family and interpersonal matrix. However, efforts toward the detection of elevated risk and the taking of affirmative precautions based on detected risk must rest on a foundation of highly- individualized, systematic, and integrative care within the context of a sound therapeutic alliance (Bongar et al., 1989).

Risk Factors

Understanding base rates enables a skilled clinician to understand when the risk is increased and plan accordingly. For instance, approximately 80% of all suicides are committed by males (Gold, 2006). Females attempt suicide considerably more often than males, yet men are three times more likely to die from their attempt (Bennett, Bricklin, Harris, Knapp, Vandecreek, & Younggren, 2006). The highest rates of suicide for women occur among Caucasian females in the 40 to 44 age range (Gold, 2006). For women, pregnancy has often been thought of as a protective factor against suicide, but more recently postpartum depression and postpartum psychosis have posed significant risks to the mother and the infant (Kutcher & Chehil, 2007).

In terms of evaluating a patient's predisposition towards suicidal behavior, look at a myriad of factors. A good starting point is determining if there is a history of psychiatric diagnoses, suicide attempts, abuse, or family violence (Bennett et al., 2006). Base rates suggest other risk factors. Those at a higher risk of suicide are often European American, single, including widowed and divorced, males, or the members of a sexual minority including gay, lesbian, bisexual, and transgender (GLBT) individuals (Horton, 2006). There is a bimodal age distribution with increased risk seen with adolescents and young adults, namely 15-19 year-olds, (Ash, 2006) for whom suicide is the third leading cause of death, as well as with the elderly, specifically Caucasian men over the age of 65.

With regard to diagnosis, most clinicians are aware of the increased risk of suicide for patients who suffer from major depression and affective disorders, but Kessler, Berglund, Borges, Nock, and Wang (2005) found that a variety of psychiatric diagnoses increase the risk of patient suicide: patients with generalized anxiety disorder, obsessive-compulsive disorder, and substance abuse disorders have rates of completed suicide similar to depressed patients (Bennett et al., 2006).

Kutcher and Chehil (2007) have identified five psychiatric disorders with the greatest increase in suicide risk: mood disorders (accounting for 50% of all completed suicides), psychotic disorders, anxiety disorders, alcohol and other substance use disorders, and personality disorders. Bennett et al., (2006) addressed patients diagnosed with Cluster B personality disorders such as borderline personality disorder (BPD). They describe these patients as often having chronic thoughts of suicide and heightened levels of self-mutilation, ges-

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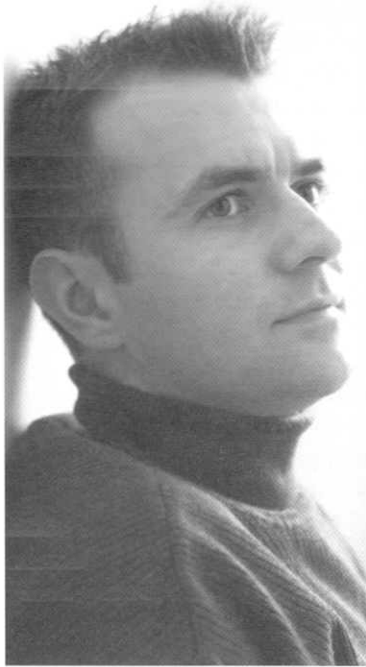
tures and attempts. Gunderson and Ridolfi (2002) estimated that suicide threats and gestures occur repeatedly in 90% of patients with BPD.

EVALUATING SUICIDAL IDEATION, INTENT, AND PLANS

When a clinician suspects that a patient is considering suicide the emphasis is on the specific patient who has aroused concern, and not merely on base rates. Regardless of the diagnosis, gender, or age, the first step in evaluating a potentially suicidal patient is essentially identical - namely, a thorough evaluation of the patient's suicidal ideation, suicidal intent, and whether the patient has an identified suicide plan.



Suicidal ideation refers to how much the individual is thinking about suicide as an option for psychological distress. These thoughts may be concrete, but can also be expressed in the form of a longing or fantasy - taking on a ruminative or preoccupied tone. Here the clinician can directly query the patient, "Have you been thinking about harming or damaging yourself in any way?" Certainly, any reasonable form of the question will do, but the question must be asked. "The greater the magnitude and persistence of the suicidal thoughts the higher the risk level for eventual suicide" (Kutcher & Chehil, 2007, pg. 13).

Suicidal intent refers to the patient's commitment to die. It is a subjective measure of how certain they are that suicide will make things better for them. It is also a subjective analysis by the clinician about how seriously to take such threats. Here, the clinician looks at both process and content of the communication. Does the patient express a sense of purpose and relief, or does the patient exhibit a waxing and waning of their psychological pain - unsure of what to do next?

Once ideation and intent have been considered, the clinician then asks whether the patient has a suicidal plan. The more detailed and specific the plan, the greater the risk of patient suicide (Kutcher & Chehil, 2007). Here, it is important to pay particular attention to the lethality of the plan, the accessibility of the method, and any actions taken by the patient to prepare for the event (Bongar, 2002). The patient who expresses a desire to use a firearm or other deadly weapon is obviously conveying crucial information as to the lethality of the potential method. Affirmative and immediate precautions must be addressed in the safety plan, and clinicians must query each patient as to access to firearms, and any other highly lethal means - directly confronting such heightened risk factors. Even for patients who do not have immediate and ready access to a gun, it is a red flag if a patient indicates consideration of a high lethality method, and such risks must be dealt with in a timely and sensitive manner.

RISK MANAGEMENT

For health care professionals, few events in their professional lives are as devastating as the death of a patient by suicide. Unfortunately, it is now common for lawsuits to be brought against clinicians after a patient attempts or commits suicide (Conner, 1994). However, lawsuits against psychologists, while highly traumatic experiences, remain relatively rare occurrences as compared to other health care specialties (Bongar, 2002). The fear of being sued probably has more widespread and deleterious effects on clinicians than do actual lawsuits. While there are no specific guidelines that can completely guarantee a psychologist will remain immune from losing a patient to suicide or being sued, there are ways to reduce overall risk when assessing or treating a suicidal patient (Hoge & Applebaum, 1989; Bongar, 2002).

Ignorance of the law can make the legal profession and the courts seem menacing to the average practitioner. However, a clinically useful understanding of the law may actually enhance clinicians' enjoyment of their practice activities by, in Simon's words, "making the law a working partner" (1988, p. xv). In the current climate of increased malpractice actions against health care professionals, we consider it naive for the practicing psychologist not to consider appropriate clinical and legal management issues when treating these high-risk populations. Indeed, Simon (1988, 1992) argued that it would be not merely naive, but foolhardy to ignore risk management procedures in the course of treating such patients. Here, the keys are to know when to apply risk management practices and to make certain that patients are helped by such practices (Simon, 1988, 1992). Psychologists should attempt to "incorporate legal issues into their management of patients - turning the law to clinical account for the benefit of the patients" (Simon, 1988, xv; 1992).

The best overall risk management strategy remains a sensitive and caring therapeutic alliance within the context of the best possible clinical care. Harris (1990) noted that psychologists who wish to incorporate high-quality risk management activities as part of their professional practice activities must be completely familiar with the

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American Psychological Association's ethical standards and combine this understanding with specific laws and regulations that govern psychological practice in their state. Effective risk management includes the additional requirement of obtaining essential clinical assessment and management information on specific at-risk populations, understanding the relationship between the law and health care practitioners, knowing the rules and limitations regarding confidentiality and informed consent, understanding how courts determine malpractice, and learning how professional liability insurance policies work. Finally, we believe, as do Harris (1990) and Bennett et al., (2006) that two critical components of effective risk management are documentation and consultation.

Guthiel (1990) claimed that documentation and consultation are *the twin pillars* of liability prevention (p. 338). Good documentation provides a durable contemporaneous record, not only of what happened, but the exercise of the health care professional's judgment, the risk-benefit analysis, and the patient's ability to participate in planning treatment. Consultation provides a *biopsy* of the standard of care, capturing in a practical way the reasoning of the *average and reasonable practitioner*, that mythical being who represents the reference standard for the determination of the standard of care and any alleged deviations (p. 338).

Packman and Harris (1998) suggested eight guidelines for clinicians working with suicidal patients.

1. Be familiar with the current literature regarding risk factors, epidemiology, and management of the suicidal patient. It is equally important for clinicians to be knowledgeable of the law of the jurisdiction and with current developments in the field.

2. Take a complete patient history that includes indicators of suicide risk based upon diagnostic criteria and known risk factors for suicide. Throughout treatment when risk is elevated the clinician should ask specific, forensically significant questions about suicidal feelings and thoughts and depression.

3. Obtain releases to consult with past therapists and secure the patient's medical and mental health records.

4. Use the DSM diagnostic criteria to accurately diagnose patients and guide treatment.

5. Recognize limitations (e.g. time restraints and appointment availability), understand technical proficiencies (training, education, and experience) and be aware of emotional tolerance levels when working with suicidal patients.

6. Good record keeping is paramount. The model risk-benefit progress note should include the following: (a) an assessment of suicide risk; (b) the information alerting the clinician to that risk; (c) which high-risk factors were present in that situation and in the patient's background; (d) what low-risk factors were present; (e) what information, namely the patient's history and the clinician's professional judgment, led to actions taken and rejected (p. 168).

7. Routinely seek consultations from professional colleagues who have expertise in treating suicidal patients.

8. Consult with legal counsel to determine if the insurance carrier needs to be notified of a serious suicide attempt or completed suicide.

In the *Psychologist's Legal Handbook*, Stromberg et al. (1988) point out that practitioners are most likely to be found liable in the case of suicidal inpatients. The underlying assumption in such cases is that hospital-based practitioners have greater observational capabilities and control over their patients. In matters of outpatient suicide, a malpractice suit is often based on the family members' contention that the outpatient psychotherapist provided inadequate diagnosis and treatment. Specifically, the psychologist is likely to be held liable if "similarly situated practitioners would have provided more care or would have controlled the patient better" (p. 467).

A crucial premise here is that clinicians have a duty to take steps to prevent suicide if they can reasonably anticipate the danger. "Therefore, the key issues in determining liability are whether the psychotherapist should have predicted that the patient was likely to attempt suicidal behavior, and (assuming there was an identifiable risk) whether the therapist did enough to protect the patient" (Stromberg, 1989, p. 467).

In this regard, Pope (1986) stressed the importance of staying within one's area of competence and of knowing one's personal limits, observing, "that working with suicidal patients can be a demanding, draining, crisis-filled activity. It is literally life or death work" (p. 19). In addition to obtaining adequate training, psychologists must become familiar with the legal standards involving rights to treatment and to refuse treatment, as well as the rules regarding confidentiality and involuntary hospitalization. A standard of care involves a screening for suicide risk during the initial contact and ongoing alertness to this possibility throughout treatment. There should be frequent consultation and ready access to facilities needed to implement appropriate affirmative precautions (e.g., emergency teams, hospitals, crisis intervention centers, day treatment).

The courts have been sympathetic to the difficulties clinicians have in predicting suicides and rarely have imposed liability in the absence

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of prior observable acts or verbal threats by the patient. For example, in the case of *Bogust v. Iverson*, a college guidance counselor was held not liable when a student committed suicide six weeks after sessions with the counselor ended. The student had not talked about suicide nor had exhibited behavior that would have prompted the counselor to initiate procedures for civil commitment (Stromberg et al., 1988).

The general legal standard for patient care clearly includes a thorough understanding of the procedures for assessing elevated risk and specific clinical management techniques for the suicidal patient (Bongar et al., 1989; Gutheil, 1992). Health care professionals have been held liable when they have not taken adequate precautions to manage patients. The courts will not necessarily defer to a psychologist's decisional process when they find that "due to a totally unreasonable professional judgment, he or she underestimated the need for special care, or failed to take the usual precautions" (Stromberg et al.,1988. p. 468).

Other general principles include family involvement for support and improved compliance; diagnosis and treatment of any co-morbid medical and psychiatric condition; the provision of hope, particularly to new-onset patients; the restriction of the availability of lethal agents; and assessment of the indications for psychiatric hospitalization (Brent et al., 1988).

The treatment of depression in an outpatient setting gives an excellent example of the kind of specific technical proficiency needed in a suicidal crisis. Ideally, those clinicians who undertake the treatment of severely depressed patients should have broad spectrum training, including an understanding of the limitations and benefits of the various psychosocial and organic therapies and have ready access to appropriate inpatient facilities.

Technical proficiency also means that the psychologist who sees a suicidal patient in an outpatient setting must learn to distinguish carefully between acute suicidal states related to DSM-IV-TR Axis I clinical syndromes and to chronic suicidal behavior as part of an Axis II personality disorder. Therefore, an initial task is the evaluation a priori of the strengths and limitations of his/her training, education, and experience in the treatment of specific patient populations in specific clinical settings. Remember that patient suicide is regularly ranked as the most stressful of all clinical endeavors. Thus, psychologists must make the difficult and highly personal decision to conduct their own self-study of personal and professional competence to treat suicidal patients before the fact.

Documentation and Consultation

In a well-known article, Gutheil (1980) suggested that the prudent health care practitioner use paranoia as a motivating force to make psychiatric records effective for forensic purposes, utilization review, and treatment planning. Gutheil's key principles are "If it isn't written down, it didn't happen," and "What you see is what you've got." Clinicians should write their notes as if a lawyer were sitting on their shoulders, reviewing every word.

In the legal field, malpractice is referred to as a tort or a civil wrong. This type of civil wrong can result when a health care professional is found to be negligent from either a sin of omission that is, not doing something that should have been done, as opposed to an intentional tort or a sin of commission, doing something that should not have been done (Gutheil, 1999; Simon, 1992). In theory, honest error is separable from negligence, but in practice, juries often confound the distinction. There is no infallible protection against this fact of forensic life (Gutheil, 1980).

Although it is essential to understand the purposes and context of defensive record-keeping, the psychologist should never lose sight of the most important purpose of clinical records and the rationale that underlies the keeping of such meticulous high-quality records, namely, that documentation is an organizing framework for focusing the psychologist's attention on making sound clinical judgments (Bongar, 2002). The APA Committee on Professional Practice and Standards (2007) adopted guidelines for record keeping which take into account this purpose as well as the reality that the records may be needed for financial or legal purposes. This ethos of meticulousness is of particular importance in clinical situations that are suffused with uncertainty (Gutheil, 1990). Suicidal situations have in common the taking of clinically-based calculated risks, trial and error empiricism, and thinking out loud for the record.

Not hospitalizing the patient is often clinically wise but, after a given patient commits suicide, even the soundest decision may appear dubious in hindsight. And, we must recall, it is with hindsight that the evidence at the trial is presented. It is unfortunate that juries often have difficulty seeing that for a treatment to be 80 percent effective, two people out of ten must succumb to dismal failure - and one of the two (or their next of kin) may be the plaintiff - without any aspersion being cast on the treatment itself . . . There is no absolute defense against this problem, but "thinking out loud for the record" stacks the deck heavily in favor of error in judgment rather than negligence (Gutheil, 1990, p. 482).

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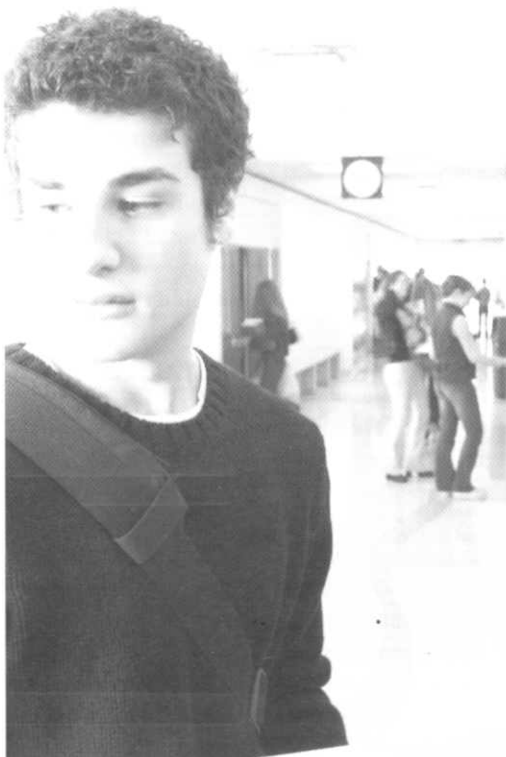
For example, in the case of not hospitalizing a suicidal outpatient, such informed record-keeping would include the dangers that the patient might be exposed to, and the "careful articulation of the pros and cons, including known risks and disadvantages and the reasons for overriding them . . . specific dates, and names are included, showing that the treating professional did not operate alone and unchecked in making this difficult but commonly encountered situation" (Gutheil, 1980, p. 482).

At the same time, it is always advisable to maintain well-documented records of consultation with other professionals (Bennett et al, 2006; Bongar, 1991; Packman & Harris, 1998). Such records are vital to providing quality patient care and for providing evidence of meeting legally acceptable clinical standards (Appelbaum & Gutheil, 1991; Simon, 1992). In fact, the written record is necessary in order for the consultation to be legally recognized and unquestioned (Appelbaum & Gutheil, 1991).



The need for accurate documentation is a sine qua non of demonstrating professional competence (Packman & Harris, 1998; VandeCreek & Knapp, 1989). Detailed records showing accurate documentation of assessment, treatment, and consultative procedures help the psychologist prove adequate care was provided. Similarly, the lack of documentation can fatally cripple the defendant's case, even if the therapist had acted in a conscientious and professionally sound manner: "the almost complete lack of records left a legitimate issue as to the fact and so the settlement against the hospital and psychiatrist was made" (Perr, 1985, p. 217). The settlement in that case was for $500,000. (VandeCreek & Knapp, 1989, p. 30). In the case of *Abille v. United States* (1980), the court implied that if good notes had been kept, documenting the rationale for the change of an inpatient's status from suicidal to a lower level of precaution, the psychiatrist may not have been found liable. "In the absence of notes, a breach of duty and failure to follow professional standards had occurred" (Fremouw, de Perczel, & Ellis, 1990, p 8).

The power of documentation in retrospectively evaluating the quality of assessment and treatment is underscored by the observation that "clinicians who make bad decisions but whose reasoning has been articulated clearly and whose justification for the intervention is well documented often come out better than clinicians who have made reasonable decisions but whose poor documentation leaves them vulnerable" (Gutheil, 1984, p. 3). A good clinical record should be explicit about treatment decisions such as whether to hospitalize the patient, as well as those concerning therapeutic impasses, pass/discharge and other privileges, any uncertainty about diagnosis, and evaluation of psychosocial supports. In addition, VandeCreek and Knapp (1989) note that the clinician should carefully document any decisions to reduce the frequency of observations of suicidal patients. Each significant decision point should include a risk-benefit analysis that indicates actions considered, the reasons that led to an action, and the reasons for rejection. The record must indicate specifically whether consultation and supervision were employed and include a written record of the consultant's recommendations. Also, Gutheil (1980) pointed out that "malpractice suits, it must be obvious, have been won or lost on matters of timing . . . For this reason alone, as well as for the clinical need to reconstruct events with accuracy, the use of time notations (as well as dates) is a useful habit to develop" (p. 482).

For example, in a situation where the psychologist has duty to protect a patient, the optimal clinical record shows that the psychologist considered hospitalizing the patient and that the clinical decision making process was based on this particular patient's history and the current clinical situation, leading the psychologist to take certain actions and reject others. The record also would indicate explicitly the use of informed consent and the participation of the competent patient, and, when appropriate, their significant others in formulating the management and treatment plan. If the patient or the family is acting in a manner that goes against the psychologist's professional judgment, a detailed accounting of actions taken is included.

In patient suicides that lead to litigation, attention is often focused on the last evaluation performed by the clinician and/or staff before the patient's suicide (Gutheil, 1984). For this reason, the risk of suicide should be noted regularly for each patient (Simon, 1992). The notes should include the re-evaluation of risk of suicide at each significant turn in the treatment or at any junction when important treatment decisions are made (Simon, 1992). Gutheil (1980) noted that the questions raised after a patient's suicide center on whether the clinician adequately evaluated and documented decision making once an elevated risk was detected.

However, clinicians who attempt to alter the clinical record after the fact are making a fatal mistake. Tampering or inserting new material after the fact can insure that the psychologist will lose the case regardless of the reasonableness of the treatment decisions made by the clinician (Monahan, 1993).

As certainly must be clear by now, one of the most critical risk management activities for psychologists is the routine practice of keeping meticulous and timely chart notes of their assessment and treatment activities. As a rule in malpractice litigation, if a psychologist failed to record an action in the patient's records, there is a good chance the jury will assume that the psychologists failed to carry out the assessment or treatment effectively or completely, regardless of how convincing the psychologist is on the stand. Again, in any forensically-charged or uncertain situation, one's records should include a complete and highly detailed report of what actually happened and the reasons for one's actions.

A Psychologist's Risk-Benefit Note

A model risk-benefit progress note includes:

1. an assessment of risk, including the patient's background;
2. the information that alerted the clinician to that risk;
3. high risk factors which were present in that situation;
4. low risk factors which were present, such as reasons to live, care of minor child, etc;
5. questions asked and answers given; and
6. how the information, including the psychologist's clinical/evaluative judgments led to the actions taken or rejected.

The analysis documented in the progress note should include the specific pros and cons of each action from a clinical and a legal perspective. State the name and credentials of those formally consulted, what was communicated, the nature of the response, and the actions recommended, and if clear-cut. If the consultant offered alternative recommendations, describe those in detail, together with the rationale for not exercising those alternatives. If the opinions of consultants differ from one's own or from each other, state the sources of difference.

Whenever possible, the risk-benefit note should indicate that the psychologist understood the role of informed consent (Cantor & McDermott, 1994) and the right of the competent patient to participate collaboratively in the decision-making process. Specifically, the chart should describe the psychologist's efforts to involve the competent patient, and any significant others, in an open discussion of the risks and benefits of a particular course of action. If there is any disagreement in this process, it is wise to advise the patient and family immediately that they have the right to obtain a second opinion and facilitate such a consultation. Calls to hospitals and significant others should be contemporaneously recorded. The record should be as timely as possible, but this should not prevent one from including details at a later date when so recognized. This is different from altering or rewriting the record after someone questions the decisions made. As Hoge and Appelbaum (1989) noted, "no single act so destroys the clinician's credibility in court" (p. 620).

Obviously, no practitioner will be able to obtain all the information recommended for every forensically significant situation. But the more information that is contained in the record, the more the record will demonstrate that even though the result may have been extremely unfortunate, the practitioner behaved in a reasonable professional manner, given the information possessed at the time. The extra time and effort required to draft comprehensive records pays high dividends, should the tragedy of a patient suicide occur. Harris (1990) commented it is better to spend the time imagining a lawyer on your shoulder now, than to face a phalanx of plaintiff attorneys in the future without the protection of adequate documentation. Excellent records may even discourage the plaintiff's attorneys from pursuing legal action in the first place, or at least encourage them to avoid costly litigation and to propose settlement for a reasonable amount (Harris, 1990).

Obtaining Previous Medical and Psychotherapy Records

It is a grave error to ignore the written records from a patient's previous treatment (Simon, 1987, 1988, 1992; Bongar, 1991). Especially for patients with a history of suicidal behavior, the psychologist should obtain permission to telephone previous psychotherapists for the full history of suicidal behavior and contact family members, who can help to determine the gravity of past suicide attempts (Simon, 1987, 1988, 1992; Bongar, 2002). In this regard, two important court cases have found clinicians liable for malpractice for failure to obtain prior medical and psychotherapy records (see *Bell v. New York City Health and Hospital Corporation*, 1982; *Psychiatric Institute V. Allen*, 1986). The absence of efforts to obtain previous medical and psychotherapy records is a reliable channel marker for finding other signs of inadequate clinical care.

If a patient refuses to give a clinician permission to get past treatment records, it is an indicator of a high risk situation (e.g., the patient has borderline personality disorder or another Axis II disorder, or is a victim of physical or sexual abuse). Unless there are very good reasons for the patient's refusal, a clinician should consider not treating a patient who is unwilling to give him or her permission to secure past treatment records (Packman and Harris, 1998, p. 167).

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Involving the Patient and Family in Management and Treatment

Research indicates that it may be advisable to warn the support system and significant others of a patient's suicidal potential and increase their involvement in management and treatment (VandeCreek & Knapp, 1989; Bongar, 2002). However, the psychologist must judge whether family interactions would be constructive or if the patient needs protection from such interactions for the time being (Jacobson, 1999). Such involvement, if constructive, can be a strong factor in promoting the patient's recovery (Bongar, 1991, 2001). Observing that suicide is often a highly charged dyadic process, Shneidman (1981c) urged support group involvement in suicide prevention efforts. He also stated that at the very least the psychologist must carefully assess the interpersonal matrix for the role of significant others as either helpers or hinderers in the treatment process. If the patient actually does commit suicide, the therapist has established the communication channels and, ideally, good relations with the family that may facilitate a healthy resolution of ensuing sorrow and grief.

Legal Considerations of Informed Consent and Confidentiality

When psychologists formulate a treatment plan, they face the important task of involving the patient in the treatment process. However, the law of informed consent is often confusing to health care professionals, who tend to see this task as an intrusion by the legal system into the treatment process, and who reduce it "to a meaningless, mechanistic ritual of form signing" (Hoge & Appelbaum, 1989, p. 613). Instead, if the psychologist sees the process of informed consent as an ongoing interactive process opportunity that increases communication and collaboration between the psychotherapist and patient, this particular task "can have a powerful therapeutic influence of its own" (Hoge & Appelbaum, 1989, p. 613; Rozovsky, 1990; Stone, 1990).

The legal and ethical rationale for informed consent is based on the principle that patients should have the right to participate actively in making decisions about their psychological care. Not only are patients likely to cooperate more in treatment they have had an active role in, but the likelihood is greater that the chosen treatment will specifically address the patient's real concerns (Hoge & Appelbaum, 1989). However, (King, 1986; Simon, 1988; Simon 1992) four exceptions to the requirement for informed consent are:

1. Emergencies: immediate treatment is needed to prevent imminent harm;

2. Waiver: the patient knowingly and voluntarily waives the right to be informed;

3. Therapeutic privilege: the psychologist determines that a complete disclosure might have deleterious effects on the patient's well-being; and

4. Incompetence: the patient is unable to give consent.

As psychologists, we might do well to focus our clinical efforts on Shneidman's basic maxim for working with suicidal patients (Shneidman, 1985), a rule that borrows heavily from the "philosophy of crisis intervention—namely, to see our involvement with the suicidal patient not as an attempt to ameliorate the patient's entire personality or to cure all emotional illness, but rather as an attempt to meet the immediate need to keep the person alive" (Bongar et al., 1989, pp. 64-65).

Safety Agreements or No-Suicide Contracts

Patient-therapist contracts and agreements are common therapeutic management strategies. Wekstein (1979) encouraged psychotherapists to establish a contract describing the terms of therapy for all patients. Two terms used with patients at risk for suicide are a No Suicide Contract or a Safety Agreement. To be clear, neither a safety agreement nor a no-suicide contract holds any legal standing or will serve as a significant means of protection in a licensing board complaint or malpractice suit (Bennett, et al., 2006). Schutz (1982) suggested for suicidal patients that clinicians obtain a promise from the patient to control suicidal impulses or call the psychotherapist before attempting suicide. Ayd and Palma (1999) pointed out that no-suicide contracts have limited usefulness as it "erroneously asks seriously ill patients to cooperate with professionals when the patient's illness impairs the capacity to do this" (p. 40).

Simon (1988) pointed out specific limitations with these agreements: (a) many patients state that if self-destructive impulses arise they cannot or will not want to contact their psychotherapist; (b) the contracts have no legal standing; (c) the contract may falsely relieve the psychotherapist's concern and lower vigilance; and (d) such contracts may control the psychotherapists' stress and anxiety in treating these type of patients.

However, when such an agreement is used properly, that is as a clinical, not a legal intervention, it can be effective for evaluating the patient's level of intent and sense of control. Bennett et al. (2006) stated that these agreements are more effective when they:

1. Include as many affirmative statements as possible (Newman, 2005);

2. Are created collaboratively with the patient and are tailored to unique life circumstances;

3. Identify stimulus cues for suicidal thoughts; and

4. Identify responsibilities and available options to follow when suicidal urges become strong (p 165).

CONCLUSION

Suits against health care professionals are traumatic experiences, yet they remain a relatively rare occurrence. The fear of being sued probably has more widespread and deleterious effects on clinicians than do actual lawsuits. There is no specific set of clinical practices that can absolutely guarantee a psychologist immunity from being sued or even from a judgment for the plaintiff. However, there are some sources of reassurance, as well as ways to reduce overall risk when assessing or treating a suicidal patient (Hoge & Appelbaum, 1989).

Pope (1986) noted many years ago that in assessing and treating the suicidal patient "perhaps most importantly communicate that you care" (p. 20). Although individual psychologists may differ in the ways that they demonstrate such caring, they can convey their commitment to doing whatever needs to be done to keep the patient alive - that every effort will be made to help the patient to decrease their pain, hopelessness, and lethality. Hoge and Appelbaum (1989) observed that when a clinician is uncertain of what to do in a particular situation, the best course is "that which is consonant with the patient's therapeutic interests" (p. 619).

AUTHORS

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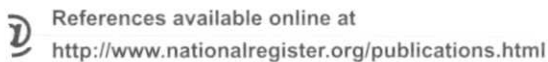

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