Determination of Precipitating Events in the Suicide of Psychiatric Patients

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Data from therapists who were treating patients when they killed themselves were used to provide information about precipitating events that was missing from accounts obtained from suicide victims' relatives and friends. Among 26 patient suicides studied, the therapists identified a precipitating event in 25 cases; in 19 of these, supporting evidence linked the identified event to the suicide. A schema was developed that identifies nine types of evidence provided by therapists in determining that an event precipitated the suicide. Use of the schema is likely to improve accurate identification of events that precipitate patient suicides, and distinguish them from unrelated coterminous events or suicide risk factors.

Both clinicians and researchers have long been interested in understanding the role of distressing life events as precipitants to suicidal behavior. Relying essentially on *ex post facto* accounts of others to identify such events, studies have given little attention to obtaining and evaluating specific evidence that the event did indeed contribute to the person's suicide.

Several studies have reported that both suicide attempters and suicide victims more commonly experience distressing life events in the period preceding the act than do control subjects (Barraclough & Hughes, 1987; Beautrais, Joyce, & Mulder, 1997; Heikkinen, Aro, & Lönnqvist, 1994; Paykel, Prusoff, & Myers, 1975). These events have been categorized by whether they were interpersonal, work related, financial, legal, or medical (Beautrais et al., 1997; Heikkinen, Isometsa, Aro, Sarna, & Lönnqvist, 1995; Rich, Warsradt, Nemiroff, Fowler, & Young, 1991).

In the case of completed suicides, efforts to understand what precipitated the act have relied on the accounts of relatives and friends, a procedure fraught with inherent methodological difficulties (Beautrais et al., 1997; Heikkinen et al., 1995, 1997; Rich et al., 1991). Studies have shown that such informants frequently do not know what was going on in the individual's life (Heikkinen, Aro, & Lönnqvist, 1992; Velting et al., 1998). Even when survivors are aware of recent occurrences in the suicide victim's life, they may be unable to assess accurately how instrumental any particular event was in the suicide. In seeking to give meaning to the suicide, there is a tendency to assume that any potentially distressing occurrence in the victim's recent life was in fact a precipitant.

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Psychiatrists and psychologists who were treating patients when they took their lives may have more accurate information on the importance of recent events, as well as the evidence to support the linkage between a specific event and the suicide. Yet most clinicians treat few such patients in an entire career, and what they learn from them has remained uncollected and anecdotal. The Suicide Data Bank of the American Foundation for Suicide Prevention was designed to collect information from therapists who have experienced the suicide of a patient in treatment. This report on the first 26 patients in this ongoing project examines the events therapists described as precipitating the suicide, and the evidence they provided that linked the event to the suicide.

METHODS

Procedures for recruiting participant therapists, their backgrounds, the clinical and demographic characteristics of the patient sample, and data collection procedures have been described in detail elsewhere (Hendin, Maltsberger, Lipschitz, Haas, & Kyle, 2001; Hendin, Maltsberger, Lipschitz, Haas, & Wynecoop, 2000). In brief, 21 participants were psychiatrists, 4 were psychologists, and 1 was a psychiatric social worker. Each therapist completed semistructured questionnaires on the demographic, clinical, and psychodynamic features of the patient, and the therapist's own reactions to the suicide. They also prepared a 15-page narrative description of the case, disguising the case so as to prevent identification of the patients, their relatives, and others with whom they were involved.

Among the 26 patients, affective disorders were predominant: 16 had major depressive disorder, 4 were diagnosed with bipolar disorder, and 4 had schizoaffective disorder. Nine patients had additional Axis I diagnoses related to substance abuse. A total of 15 Axis II diagnoses of personality disorder were given to 14 patients.

Included in the psychodynamic questionnaire were specific items that asked whether any particular event had precipitated the suicide. For purposes of this project, an event was defined as precipitating if it was experienced within a few months of the suicide, and there was evidence that it played a role in triggering the suicide. Therapists identifying such an event were asked to describe the event and to note the specific evidence that linked it to the patient's suicide.

Following submission of all written materials, several therapists at a time were scheduled to participate in a daylong workshop with the project investigators. Specific attention was given to discussing the events the therapists identified as having precipitated the suicides, and evaluating the evidence linking the suicides to the events. In a few cases, to be discussed later, the evidence or lack of evidence led the therapist and the group to change the original designation of the precipitating event. Utilizing the workshop discussion, three project raters (Hendin, Haas, and Maltsberger) independently re-reviewed all case materials, and were unanimous in confirming the precipitating event.

RESULTS

No Precipitating Event

In 25 of the 26 cases, the therapist identified a precipitating event to the suicide. In the one case where the therapist indicated there was no precipitating event, there was no evidence that there had been one. In four other cases, there was also no evidence to support the presence of a precipitating event. In these four patients, the therapist listed a potentially stressful event occurring shortly before the patient's suicide. No evidence was found, however, that the events were linked to the suicides. In one patient, the therapist treating a young man suffering from major depressive disorder and panic disorder identified as the precipitating event the change of a member of his inpatient treatment team shortly before his suicide. Yet such changes were not infrequent during his 14-month hospitalization, and the patient was not close

to this staff member. The patient committed suicide by ingesting treatment medications that he had been collecting for some time. His suicide note, addressing his unrelieved anguish, did not suggest that the change in his treatment team, or any other precipitating event, had motivated his suicide.

In two other cases, the therapist listed stressful events that were common occurrences in these patients' lives. One 23-year-old woman with a major depressive disorder and alcohol abuse reported a fight with her boyfriend in her last session, a week before the suicide. But such fights with this boyfriend and previous boyfriends were often discussed in her therapy, and only the fact that her suicide took place a week later led the therapist to list the fight as a precipitating event.

Similarly, a 44-year-old woman with major depressive disorder and somatization disorder spent much of her time importuning doctors to administer medical treatments for difficulties that were psychiatric in nature. The therapy session before her suicide had included one more complaint about her physicians, leading the therapist to list the perceived rejection as the precipitating event even though there was no evidence it had led to her suicide.

In the last case, a 22-year-old woman with schizoaffective disorder had been having increasingly frequent hallucinations, aggravated by substance abuse, worsening of her depression, and akathisia resulting from her medication. In her last session, which took place the day of her suicide, she complained of these symptoms but also reported a minor car accident. Her car was parked with the engine running; by not keeping her foot tightly on the brake, she allowed the car to slide into the rear of the vehicle in front of hers. Although the therapist listed the accident as the precipitating event to the patient's suicide, he added that the relevance of this event was uncertain. Her mentioning the incident was perhaps a way of expressing that she felt her life was slipping out of control.

In all five cases in which no precipitating event could be linked to the suicide, deterioration in the patient's emotional condition appeared to be a more significant factor than any external occurrence. The affective state for each of these patients seemed to have become intolerable and there was urgency in their need for relief from their anguish.

In the remaining 21 cases, the evidence indicated that there was a precipitating event. Most of the events identified could be usefully distinguished by whether they had been instigated by the patient or were essentially beyond the patient's control.

Patient Instigates the Precipitating Event

In seven cases, the precipitating event was itself precipitated by the behavior of the patient, related to his or her underlying disorder. A veteran with posttraumatic stress disorder and major depressive disorder drank heavily and behaved abusively toward his wife. In his final therapy session, he attributed his suicidal feelings to his wife's leaving him, but his behavior was responsible for her doing so.

In two other patients with uncontrolled bipolar disorder, a minister striving to become a psychoanalyst and a female attorney, erratic behavior destroyed their careers. Worsening feelings of despair and humiliation related to their career failures were evident in therapy and identified as triggering their suicides.

Two patients literally structured the events precipitating their suicides. An attractive 58-year-old woman with major depressive disorder and body dysmorphic disorder had seven plastic surgeries within 15 years in a single-minded quest to restore her youthful beauty. She described herself in therapy as "maimed" by her most recent nose surgery. She insisted to her therapist and her adult children that she would live only if given reparative surgery in the 2 months remaining before the family's annual holiday gathering. Although still healing from her last procedure so that surgery was contraindicated, she demanded a consultation with a prominent surgeon and killed herself immediately after he refused to operate.

The second such patient, a 44-year-old artist with bipolar disorder, told his psychiatrist that he would kill himself unless he succeeded in opening an art gallery within the next 6 months. For financial as well as other reasons, this was not likely to happen; when it did not he hanged himself.

For two women the suicide was precipitated by events stemming from their rejecting men with whom they had been romantically involved. A 27-year-old woman with schizoaffective disorder sustained a live-in relationship for 3 years despite increasing symptoms of dependency, anxiety, rage, and paranoia. The couple entered therapy together but soon after the patient broke off their relationship. Her psychotic symptoms increased and she was hospitalized following a serious suicide attempt, but shortly thereafter eloped and killed herself.

The second such patient was a 63-year-old woman with a major depressive disorder and narcissistic personality disorder. Twice divorced, she was totally preoccupied in therapy with finding a male partner and increasingly hopeless and anxious over her single state. For several months she had a relationship with an eligible man, but treated him disparagingly and used him only as an escort to social functions. She became distressed, however, when he began losing interest. The link between her sudden suicide and this relationship was confirmed when the therapist learned by chance that the man had left a phone message for the patient only hours before her suicide, saying he had become involved with someone else and would not be escorting her to an upcoming dance.

Precipitating Event is External

In ten cases, the precipitating event was to varying degrees external, rather than instigated by the patient. In two cases the event involved the probable or actual death of a loved one, which could not have been anticipated or prevented by the patient.

A 34-year-old noncommissioned military officer developed a major depressive disorder and became suicidal after his infant son was diagnosed with leukemia. He saw the illness as a failure in his role as the protector of his family. On entering therapy he revealed that his immediate reaction to the diagnosis had been to suggest to his wife that they kill themselves and their two children by immolation in the family car. His continuing symptoms of irritability and dysphoria interfered with his job performance and led to increasingly serious conflicts with his supervisor. Faced with the probable loss of his son and his military career, he saw his life falling apart and ended it by shooting himself in the family garage.

The second case was a 17-year-old boy with adjustment disorder and dysthymia, whose idealized 19-year-old brother hanged himself in jail after being arrested for drug possession. The patient began wearing the brother's clothes, and in therapy related dreams of reunion with him. His delinquent behavior and substance abuse worsened. After making self-destructive gestures, he was admitted to a hospital; within a few days he too hanged himself.

For two female patients, the suicides were linked to rejection and disparaging treatment by men with whom they had been involved. A woman in her late thirties with two small children sought therapy to cope with the symptoms of a major depressive disorder which included increasing feelings of anxiety. She was unhappily married to an unfaithful husband from a wealthy, domineering family. After the couple separated, the patient became desperate and enraged at her husband's vindictive withholding of money, his threats to take the children from her, and his flagrant affairs. Her fear of independence was exacerbated by her lawyer's advice not to work or date before receiving a divorce settlement. Feeling she was losing control of her life, she consumed rat poison and hanged herself in a cheap motel near her husband's office.

Another young woman of 27 suffered since early adolescence with recurrent major depressive disorder with psychotic features and bulimia. A humiliating public rejection by her inpatient boyfriend, which occurred at the same time as the birth of her therapist's child, and her upcoming transfer to outpatient status, triggered a serious suicide attempt. Although the hospital staff intervened

to prevent her death, her next attempt shortly thereafter was fatal.

In the last six cases included in this category, the events precipitating the suicide were directly related to their treatment. In two such cases, the decision to move a reluctant institutionalized patient to an outpatient status for which he did not feel ready was the precipitating event. The mother of a 39-year-old man with bipolar disorder convinced his therapist to move the patient out of his group home to foster his independence. The patient responded by confiding to other patients a plan to drown himself with the help of ropes and cinderblocks, showing them materials he had acquired. Although the therapist was informed and confiscated the materials, he proceeded with the discharge plan, interpreting the patient's behavior as resistance to change. A dream the patient reported in his last session linked his death to the feeling of being swallowed by his mother—represented as a large fish—after being swept into its mouth by the therapist. Several days later the patient used weights to drown himself.

In the other case, a 26-year-old man was treated in a private hospital for 4 years for schizoaffective disorder and panic disorder. He became one of the first patients treated with clozapine and responded well. His anxiety, however, was exacerbated by his impending discharge, which he otherwise seemed to accept. While on pass, he threw himself in front of a train. In retrospect, the therapist thought that the patient was overly compliant about his discharge to please the therapist and his overburdened family.

Similar therapeutic pressure was a precipitating factor in the suicide of a 21-year-old man with major depression and alcohol abuse, who recently had been discharged from an inpatient program. During the workshop, the therapist expressed concern that the patient's symptoms—drinking and self-mutilation—had worsened in response to strong pressure from the therapist to get a job and continue his education. In retrospect, the therapist felt this pressure was premature, too intense, and was likely to have precipitated the suicide.

Another case involved a 22-year-old male inpatient who was treated for major depressive disorder and bulimia for 10 months. His treatment team decided he had become too attached to his nursing coordinator and terminated the relationship. The patient's despair over her loss was evident in notes he wrote in his daily journal. Shortly before the patient hanged himself, his therapist saw that he had carved the nurse's initials into his wrist.

A fifth case involved a 23-year-old woman with major depressive disorder, borderline personality disorder, and narcissistic personality disorder. In response to the therapist's threat to hospitalize her, the patient concealed her depression and suicidal ideation. Her taped note found after her death revealed the intense desperation, hopelessness, and rage that had resulted from what she perceived as a betrayal by the therapist.

The final such patient was a 32-year-old woman with schizoaffective disorder, who had formed an intense attachment to one of her two co-therapists. She was devastated when this therapist had to discontinue treatment because she was relocating. Her condition deteriorated and she became suicidal; in both her sessions and her suicide note, she expressed hope for reunion with this therapist.

Unclassified

In four cases, evidence of a precipitating event was not sufficient to determine to what degree the event was precipitated by the patient or by external factors. A 41-year-old man with major depressive disorder and avoidant personality disorder had worked for 12 years as a machine operator. He was profoundly lonely, unable to form any meaningful relationship at work or socially, and troubled by sexual confusion he found difficult to discuss. In treatment he complained of being abusively teased at work, but would not elaborate. In his last session, he was agitated and angry, alluding to a distressing incident that had just occurred at work. Refusing to discuss it, he stated he was finished with work and with therapy, and was "getting out now." He left the session abruptly and killed himself

the next day. Without knowing what had transpired at work, it was not possible to determine the degree to which his behavior had played a role.

In the other three cases in this group, the precipitating event involved an argument (with a boyfriend, a work supervisor, a father) where it could not be determined whether the patient or the other party instigated what transpired.

DISCUSSION

Identifying a precipitating event does not mean that the patient would be alive, had it not occurred. All these patients, with the exception of the noncommissioned officer, were already in treatment when the event precipitating their suicide occurred. Most were significantly depressed and had a history of suicide attempts, and thus were vulnerable to suicide regardless of any precipitating event. Such vulnerability makes it essential to consider evidence that links the suicide to the precipitating event listed by the therapist.

Most therapists were able to provide clear evidence that an event they identified precipitated the patient's suicide. As we have described, however, in four cases in which a precipitating event was listed, there was no link between the event and the suicide other than temporal proximity. Although therapists had been asked to provide evidence for any precipitating event identified, we did not caution them that temporal proximity was not sufficient to establish an event as precipitating the suicide. Nor did we provide a detailed list of evidence they might consider.

Reviewing the kinds of evidence that were used in this study to link patient to a precipitating event has led us to develop the following schema of questions. We believe that asking therapists to use this schema will improve their accuracy in identifying precipitating events, and reduce the number of cases in which precipitating events are listed without adequate evidence.

1. Did the patient make statements in therapy linking suicidal feelings or behavior to an event that had occurred?
2. Did the patient make statements in therapy threatening suicide if an event were to occur (or not occur)?
3. Did the patient make a suicide attempt or suicidal gestures following an event?
4. Did the patient disclose a suicide plan following an event?
5. Did the patient recount dreams in therapy that contained images of death linked to an event?
6. Did the patient's written or recorded words (journals, letters, suicide notes or tapes) link suicidal feelings or behavior to an event?
7. Did the patient make a previous suicide attempt following a similar event, when the meaning of the attempt had been discussed in therapy?
8. Did the patient's affective state, behavior, and/or symptoms worsen following an event?
9. Did other person(s) provide information about an event affecting the patient's psychological state immediately prior to the suicide?

In most of the patient cases in this study, more than one type of evidence was found that pointed to the precipitating event. As summarized in Table 1, certain types of evidence were, overall, found to be particularly useful in determining that an event precipitated a patient's suicide. In 19 of the 21 cases in which the suicide was linked to an event, the linkage was made, at least in part, through the therapist's observation of a worsening of the patient's affective state, behavior, and/or symptoms following the event. In almost all these cases, this observation was buttressed by the patient's preoccupation in therapy with the event and related concerns. Nine patients made direct statements to the therapist linking their suicidal feelings or behavior to the event, seven after the event had occurred and two when it was anticipated.

The importance of an event as a precipitant to the patient's suicide was shown

TABLE 1
Evidence Determining a Precipitating Event in 21 Cases of Patient Suicide

Type of Evidence	Number of Cases
1. Patient's statements in the therapy linking suicidal feelings or behavior to an event that had occurred.	7
2. Patient's statements in the therapy threatening suicide if an event were to occur (or not occur).	2
3. Patient's suicide attempt or suicidal gestures following an event.	4
4 Patient's disclosure of a suicide plan to the therapist following an event.	2
5. Patient's recounting of dreams in the therapy that contained images of death linked to an event.	2
6. Patient's written or recorded words (journals, letters, suicide notes or tapes) linking suicidal feelings or behavior to an event.	3
7. Previous suicide attempt following similar event(s), when the meaning of the attempt had been discussed in therapy.	3
8. Therapist's observation of worsening of patient's affective state, behavior, and/or symptoms following an event, usually with patient's preoccupation with the event and related concerns in therapy.	19
9. Information obtained by therapist from person(s) knowledgeable about an event affecting the patient's psychological state immediately prior to the suicide.	5

through suicidal behavior (4 cases) or disclosure of a suicide plan (2 cases) immediately following the event. For two such patients, a previous suicide attempt following a similar event provided an additional link, and in two others dreams recounted in therapy were confirmatory. The patient's written or recorded words provided key evidence linking the suicide to a precipitating event in three cases. Finally, other persons provided information to the therapist that helped link the suicide to a precipitating event in five cases.

In 19 of the 21 cases where there was evidence of a precipitating event, the workshop participants agreed with the event listed by the therapist. In the two cases where they did not, the therapists' own actions were the precipitants to the patients' suicides. Both therapists' workshop presentations indicated their awareness of the role their actions had played.

The first case involved the patient whose behavior, dreams, and suicide plan made clear that his suicide had been precipitated by pressure from his therapist and his mother to leave a group home and become independent. In the workshop, the therapist expressed concern that his compliance with the mother's wishes was central to what happened. Yet on the questionnaire he had listed as the precipitating event the return to this country of the patient's brother who had been living abroad. Although the patient disliked his brother, they would be living in different cities, with no greater contact now than before. The change in residence that appeared to be troubling the patient was his own.

The other case involved the 21-year-old patient whose therapist observed in the workshop that excessive pressure he had put on the patient to get a job and continue his education appeared to precipitate the suicide. On the questionnaire he indicated that the patient's lack of improvement at his two year anniversary in treatment might have been the precipitating event although there was no evidence to support this. Like the therapist in the previous case, on the questionnaire he was reluctant to indicate his own role, but he clearly wished to discuss it.

In previous work we have described a *suicide crisis* as a time limited period during which a patient is at imminent risk for suicide, as distinguished from *suicide risk*, which

encompasses long-term factors that make certain patients more vulnerable (Hendin et al., 2001). Precipitating events play a role in the development of such a crisis.

Although suicidal individuals have been found to experience an increased number of untoward life events prior to the suicide (Heikkinen et al., 1992), in all but one of our cases one such event was sufficient to trigger the suicide crisis. The exception was the young woman where three events—a humiliating rejection by her boyfriend, the birth of her therapist's child, and her anticipated shift to outpatient status—coincided to precipitate the suicide. Rather than constituting three distinct events, these precipitants appeared to have had a singular significance for the patient in their overwhelming reinforcement of her lifelong sense of abandonment. This differs from an accumulation of disparate stressful life events, which would be more accurately considered a risk factor for suicide in depressed individuals rather than a precipitating event in a suicide crisis.

It is worth noting that in several of these patient cases, an initial event triggered suicidal behavior which, in turn, led to subsequent events that aggravated the situation. In such cases, we considered it important to consider which occurrence within this chain of events could most accurately be considered the precipitant to the suicide. The military officer who became enraged and suicidally depressed after his son was diagnosed with leukemia, for example, had an argument with a superior officer that further threatened his service career just before killing himself. Since there was clear evidence in the patient's statements in therapy that the son's illness was the basic trigger for the suicide, this rather than the argument, we believe, was best considered to be the precipitating event.

On the other hand, unlike this serviceman, most of these patients were depressed before the occurrence of any precipitating event, and their affective state clearly shaped their response to the precipitating event. Although it is admittedly somewhat arbitrary, it seems more helpful to treat depression as a risk factor making the patient more vulnerable to events.

In a significant number of cases, 5 of the 26 in this study, there was no evidence of a precipitating event (although in four cases, as discussed earlier, an event was originally listed by the therapist). Of equal clinical importance is the recognition that in a number of cases, seven in this study, the precipitating event was itself precipitated by the patient. It is also noteworthy that in six of the ten cases where the precipitating event was predominantly external, actions by the therapist or treatment team—pressure to change, a threat to hospitalize, or simply the need to discontinue treatment because one was relocating—were the precipitant.

Limitations

Persons who kill themselves while in psychotherapy are not representative of all who commit suicide. In the most obvious respect, distressing events directly related to the treatment itself can precipitate the suicide, as was seen with six patients in our study. For the other patients, however, the nature of precipitating events was similar to those reported for nonpatient suicides, commonly involving interpersonal loss or work conflicts.

The participant therapists in this project are of necessity volunteers, and thus we cannot estimate how typical they are of the population of therapists who have experienced a patient's suicide. Those whose cases are reported here had a wide range of professional experience, therapeutic orientations, and personal styles. It is possible, however, that therapists not volunteering their cases may be more troubled about the treatment they provided than those willing to have their cases reviewed. The requirements and procedures of this study may also have served to select a group of more highly involved and motivated therapists. On the other hand, it is also possible that participating therapists may be more than ordinarily disturbed about the suicide of their patients. Our earlier analysis of the reactions of our participating therapists suggests that both possibilities were represented (Hendin et al., 2000).

In these first 26 cases, an open-ended

questionnaire item was used to ask therapists for the evidence that linked a precipitating event to the patient's suicide. The accuracy of therapists' responses likely would be enhanced by structuring the instrument to include the nine specific subquestions contained in the schema presented in this article. This change has been incorporated into the questionnaire being used for new project participants.

CONCLUSION

We initiated the Suicide Data Bank project to explore a relatively untapped source of information—therapists treating patients at the time of their suicide—to gain greater understanding of the psychology and behavior of patients who commit suicide. Our aim in this aspect of the project was to obtain a better understanding of the linkage between precipitating events and suicide, by using specific types of evidence we felt would be uniquely available to therapists.

The therapists who participated were generally eager to reveal all they could in the hope of learning from the experience, and welcomed the opportunity to present their cases to others with comparable experiences. Virtually all felt their participation was to some degree therapeutic as well as educational. These therapists provided information about the events precipitating suicide that has been missing from studies relying on significant others to identify distressing events in the victim's recent life history.

In our continuing work, use of the schema presented in this article is likely to improve therapists' accurate identification of events that precipitate patient suicides, and help to distinguish them from unrelated coterminous events or suicide risk factors.

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