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# Suicidal Blackmail:

## Ethical and Risk Management Issues in Contemporary Clinical Care

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Sheila, an attractive 24-year-old physical therapist, had an extensive history of sexual, physical, and psychological abuse and a remarkably complex set of psychological issues. She originally presented for psychotherapy with a long history of bulimia, severe depressive episodes, various acting out behaviors, and poly-substance use and abuse. Sheila also had a significant history of suicidal thoughts and attempt behaviors. For Sheila, suicide had become a constant companion; the idea of not "having" suicide as a focal option for coping with her pain seemed simply unthinkable. In other words, the prospect of suicide became an organizing focus of Sheila's psychological world—it *comforted* her. Although suicide played a central role in Sheila's life, she willingly sought mental health care and to that end I had worked with her for four years in on-going psychotherapy. In the course of this treatment, Sheila had made three suicide attempts by medication overdoses and made a harrowing near-attempt off her 17$^{th}$ story apartment balcony (her boyfriend barely grabbed her at the last moment as she went over the railing). She required hospitalization on three separate occasions and frankly her situation had deteriorated significantly over the course of our work together.

At the four year mark, Sheila again needed a psychiatric hospitalization for a fourth time following her fourth medication overdose on her anti-depressants. At this

point in her life, Sheila had now become psychiatrically disabled and she received a modest level of support from disability insurance. Her boyfriend, with whom she lived for two years, had become completely fed-up and seemed poised to end their relationship; her larger nuclear family had all but abandoned her. The situation appeared bleak and Sheila's eventual suicide seemed only a matter of time.

As her outpatient psychotherapist, I felt at my wits end. I cared deeply for Sheila and I felt committed to her care but had also become overwhelmed and at a loss for what to do next. We had tried every psychotherapy approach I could imagine. Sheila had undergone many trials on various medications—anti-depressants, mood stabilizers, and anti-anxiety drugs, yielding minimal results. She tried group therapy, herbs, and acupuncture; her psychiatrist considered electroconvulsive therapy as the only other option not tried, but that prospect frightened her. Thus, we had pursued multiple tried-and-true conventional approaches and various and alternative and holistic approaches. But the situation remained desperate. In truth, we both felt desperate and scared.

As I reflect back on this case now, our treatment had gone off the rails. My work with Sheila had turned into a therapeutic free fall; I felt constantly in a reactive mode and in a continuous state of anxiety and worry. By our fourth year, I found myself on the phone with Sheila almost daily, helping her get through sometimes hour-to-hour crises that she somehow managed to barely survive every day. Worst of all, I felt as though I were a prisoner within this case. While I cared for Sheila, I also resented her. I felt blackmailed by her constant verbal threats of suicide, her obsessive suicidal thinking, and her repeated suicidal behaviors. On the one hand, I felt like I had to do everything I could to insure that she would not take her life (which had come to mean over functioning and

burning myself out). On the other hand, I believed that if I backed off in any way, Sheila would undoubtedly take her own life.

As a career suicidologist, the prospect of a suicide outcome remained utterly and entirely unacceptable to me. At the time, I deemed that a patient suicide would: (a) completely undermine my credibility in the field, (b) render my research and professional publications bankrupt, (c) ultimately "out me" as an incompetent imposter-clinician, and (d) somehow *define* me as a professional and a person. Beyond this uncharacteristic self-doubt and castigation, I can now see that I had become personally at risk. This complex case had moved to the verge of consuming me and all that I most care for in life—my professional self, my marriage, even my sanity. Fortunately, supportive colleagues, key clinical consultants, and a remarkably patient and supportive wife all offered variations of the same theme: this cannot go on, you must make a radical change in this patient's care; to continue to work with this troubled patient in this fashion is simply not acceptable. Indeed, one particularly treasured friend and colleague looked me in the eye and said, "…to knowingly continue as you are would be unprofessional—without some sort of major therapeutic change, continuing in this way would be *unethical."*

Unethical? The word stung me like slap in the face. At first I felt ashamed and embarrassed in the eyes of my colleague and friend; he had obviously seen that I had somehow "let" this complex case get out of control. But as we consulted further, he gently pointed out that I had actually done nothing "wrong." He noted that the case had evolved—and unraveled—incrementally over years with both of us (clinician and patient) doing everything we knew to do—the best we could—earnestly and in good faith. He further pointed out that I had always behaved appropriately with her and true in my

therapeutic intent; my only "failing" involved perhaps caring too much and trying too hard. He said: "…at the end of the day, her life needs to matter more to *her* than it does to *you*…right now that is not the case." In turn, he pointed out that my patient—whom he had seen in group treatment—was unusually and deeply disturbed. Then he said the unspeakable: "…perhaps she is simply beyond your, or anyone's, therapeutic reach; all you can do, is all you can do." Reflecting on this point, I knew that he was 100% correct.

Armed with his support and insightful feedback, I began a new process of picking myself up and dusting myself off, with new clinical resolve and determination. With my patient recently transferred from the inpatient psychiatric unit to a substance abuse residential treatment setting for six weeks, I felt poised to either chart a whole new course in our work together, or discontinue therapy with her. Thus I told her the first week in the residential center that I planned to "clear the deck" and completely "reboot" our treatment plan during her stay in the residential program. After much consideration, and additional professional consultations, I wrote an extensive 12-page evaluation report describing our work together and what we had learned. Moreover, I explained that I would present a completely new treatment plan for her to consider at the end of this evaluation process. At this crucial juncture, she would then have the following options: (a) embracing the new finite treatment plan that we could extend in the event of therapeutic progress, (b) accepting a referral to another clinician for a different course of care, or (c) taking a break from treatment altogether. Whereas I had been previously reluctant to take such a firm position, fearing it would provoke her suicide, I now plainly saw the need to render my best possible clinical judgment and recommendations for prospective care, which she could ultimately take or leave.

Naturally, Sheila responded warily—even fearfully—to my new clarity, firmness, and resolve. Frankly, the initial weeks of this new effort became quite rocky; she felt quite confused, even betrayed, by this approach. But she did find my thorough evaluation report both accurate and remarkably helpful. I believe that Sheila eventually understood that my therapeutic change of course was motivated by concern for her best interests. The previous treatment plan had become a bust. In turn, Sheila began to see and appreciate that it would in fact be "…unethical to knowingly continue in a treatment plan that is plainly not working."

The busted treatment plan? For four years we had largely focused directly on her painful memories of past trauma, working-through feelings of betrayal, vulnerability, and terror. Without delving into the contentious debate that plagues discussions of clinical treatments for victims of trauma, let me simply say that for Sheila "abreactive" therapy, working-through her trauma history and memories of abuse proved utterly iatrogenic (although for the record, I have many times seen this exact kind of work help other trauma victims). Plainly, we know that profound individual differences exist in how people cope and what works for whom; we intuitively know that one size treatment can not fit all. In Sheila's case, a highly structured treatment plan that focused on "therapeutic" repression, avoidance, and containment of traumatic material proved extraordinarily helpful. We also developed a singular and intense focus on behavioral functioning and concrete goals. While this approach would not work with every trauma victim, it helped Sheila to stabilize and then improve.

At the start of our fifth year together, we turned an imperceptible therapeutic corner and never looked back. Six months later, Sheila had gone off disability and begun

working part time, still later that year she returned to her old job and functioned remarkably well. At the six year mark, we began a gradual process of mutually terminating our work together. After termination, Sheila relocated and soon met and then married a loving and supportive man. Today, some twelve years since we finished our work, Sheila has become an award-winning health professional, working in large urban hospital. She is happily married and has been sober for 14 years. Finally, and most critically from my view of these things, she feels extremely grateful to be *alive*.

## Discussion

### *Key Ethical Issue*

As a trainer of mental health professionals, I know first hand that many clinicians have harrowing cases, cases like Sheila's. Relevant to this particular saga, I can further attest that many professionals feel similarly "blackmailed" by patient's suicidal thoughts, verbal threats, possible attempts, and related behaviors. The anxiety of clinical work with suicidal patients is palpable. One can easily come to feel utterly responsible for another's life, with all the accompanying convoluted clinical, moral, legal, and personal implications. The sheer weight of this life vs. death sense of responsibility can insidiously distort a clinician's judgment which can then lead to enmeshment and clinical over-involvement where the clinician feels compelled to do too much. Alternatively, the weight of responsibility can also lead to abject clinical paralysis.

Ethical issues related to the prospect of clinical abandonment also lurk in this discussion. Truthfully, many clinicians understandably fear and frankly resent patients with suicide risk behaviors. They naturally want to rid themselves of the worries, hassles, and anxieties incumbent on psychotherapists when caring for a patient standing

on the ledge of suicide. The temptation to rid oneself of the burdensome suicidal patient can lead to acting out in the clinician, perhaps most commonly manifest in clinician-imposed hospitalizations that may prove fruitless and even unhelpful to the situation at hand. While I believe that certain hospitalizations can save lives, I also believe that some hospitalizations have more to do with the clinician's desire for riddance (or what they perceive is legally protective) than purely clinical motives.

Beyond these perhaps provocative musings, I would further contend that suicidal risk in a patient can potentially adversely affect other ethically relevant practices related to the central ethical consideration: professional *competency*. In my view, ethical and competent care of a suicidal patient involves a number of critical clinical activities including thorough informed consent, competent clinical assessment, competent (ideally, evidence-based) clinical treatments, and appropriate risk management.

Having said this, I do fear that in general practice many clinicians often fail in these areas when working with suicidal patients. For example, clinicians too often fail to provide sufficient informed consent as to what they can do, and more critically, cannot do, when helping a high risk suicidal person and his or her family. In turn, I fear that the thorough and comprehensive assessments that suicidal states require remain rare because clinicians may fear a deeper level of inquiry. I further worry that many clinicians succumb to temptation and rely too much on inpatient hospitalizations which often prove too brief, to help. In lieu of an inpatient admission, too many clinicians I encounter still rely on utterly inadequate "no suicide" or "no harm" contracts which neither protect the patient nor the practitioner should malpractice litigation occur. I regret that too many clinicians do not use empirically supported interventions that emphasize coping and the

development of new skill sets—particularly in a suicidal crisis. Finally, I find that too many clinicians do not use sufficient risk management techniques; they often fail to embrace the use of consultations with key colleagues and fail to carefully document assessment material and a suicide-specific treatment plan within a well-maintained medical record.

I recognize that the preceding discussion reflects a rather bleak view of how clinicians in general practice commonly work with suicidal patients; I say it with no sense of superiority or relish. I do not mean to preach. But let us be plain: working with suicidal patients is scary; it is inherently challenging work, both professionally and personally. Just to clarify, my rather harsh views and genuine concerns and fears about our field in relation to suicide risk are based on four main sources: my clinical experiences, my research of twenty five years in clinical suicidology, my experiences of training mental health professionals in clinical suicidology, and my work as a plaintiff and defense expert in malpractice tort litigation cases of wrongful death. Based on these varied perspectives, I have come to a rather stark and unpleasant conclusion—we have a major professional *and ethical* crisis in relation to the standard clinical care of suicidal people within the United States. It is my unvarnished view that significant changes are needed in routine clinical mental health practice if we have any genuine ambitions of meaningfully impacting this leading cause of premature death.

*Work Setting*

I believe that the vast majority of suicidal patients can be appropriately and safely treated on an outpatient basis. There will always be a need for inpatient care and I am an ardent proponent of such care for a certain sub-set of high risk suicidal patients. But the

reality these days is that inpatient care is severely limited by insurance constraints and inpatient psychiatric stays are now remarkably short. Nevertheless, I hope that in coming years we may see new models of care and coverage, particularly in light of the recent passage of mental parity within the United States Congress.

*Reflection.*

As I reflect on my work with Sheila, I arrive at a rather blunt and unpleasant truth. Even when a clinician provides stellar assessment and clinical interventions, and even with spectacular consultation and inspired clinical competence, determined suicidal persons can and sometimes will take their life if they are determined to do so. It is of course, *their* life, no matter what we think, wish, or do. This central consideration is obviously not trivial. My core struggle with Sheila was inextricably wrapped up in this consideration. I simply could not accept the prospect of her suicidal death; I could not go there. But my absolute insistence on her living, no matter what, got me (and us) into clinical trouble over time. In hindsight, much of what came to ultimately plague my treatment of Sheila directly followed from my dogmatic, if unconscious, insistence that suicide was an absolute non-option.

Herein lays a reflective paradox at the heart of the matter: *suicide is always an option*. What I have now come to appreciate (at least intellectually) since my work with Sheila, is that even expert professional competence in clinical suicidology will never *guarantee* that I will never lose a patient to suicide. Herein lays another paradox: this realization is simultaneously grim and also quite liberating. As my dear friend and consultant noted: I can do what I can do…but what I can do, is a lot! This pragmatic truth was crucial in my ability to re-engage Sheila in a whole new line of treatment.

Thus the central clinical question is not whether a patient *can* take her life, she most certainly can and do on a daily basis. Rather, the central question is whether the patient *should* take her life while engaged in a mental health treatment designed to save her life. This is not a mere ploy or a play on words, it is central to my thesis. The central clinical question at hand for patients is whether they are willing to seek a clinical treatment that potentially renders suicidal coping obsolete. One can readily argue to the patient that he or she has everything to gain and nothing to lose by engaging in a life-saving treatment over a finite period of time. If the treatment does not work, the patient is free to pursue other "options" for dealing with their pain and suffering.

I fully appreciate that these arguments may seem quite provocative, but I contend that we communicate an empathic respect of the patient's pain and struggle when we take this position properly. From Sheila, I learned to disengage from the power struggle of "whether suicide" to more properly focus on "if not suicide, then what instead and for how long?" To be clear, I am a passionate suicide preventionist, but I am also a student of suffering, human nature, paradox, pragmatism, and the importance of hope in dealing with suicidality. Indeed, there is something quite powerful in offering a potentially life-saving treatment which can be juxtaposed with other possible options which of course includes *not being in treatment.* The unique and skillful interplay of clinical empathy, respect, autonomy, and the presentation alternative prospects for coping can become a compelling recipe for instilling the seeds of hope in a suicidal person. The goal is to raise in the patient the following considerations: Maybe there is a way out of this hell? I guess I can give this treatment to save my life a try; there is no downside to trying this for now because I always have the option of suicide for *later.*

The above observations are just some of the things that Sheila helped me to understand about effective care of suicidal people. In the case of Sheila I visited the limits of my clinical endurance, influence, and ability to care for another person. All these years later, I am so grateful to Sheila for putting up with my earnest—yet largely unhelpful—clinical efforts. The irony that I came to appreciate (and now fully embrace) was that my hard-earned ability to recognize my clinical limits, and contemplate the loss of my patient to suicide, created a crucial turning point in what proved to be a potentially life-saving treatment. Let us thus face the facts: we no longer have the luxury of simply locking a suicidal person up in an inpatient setting until they come to their senses. But here is the final paradox: when a clinician perseveres and finds a way to be forthright, honest, and disengage from the suicidal power struggle with the patient, the prospect for pursuing a truly life-saving course of care can be created and clinically realized.

*Key Ethical Principles and Standards*

Ethical Principles of Psychologists and Code of Conduct (APA, 2002): Standard 2.01 Boundaries of Competence; Standard 2.06 Personal Problems and Conflicts; Standard 3.04 Avoiding Harm; Standard 10.01, Informed Consent to Therapy; Standard 9.02 Use of Assessments; Standard 10.10, Terminating Therapy.

## References and Further Reading

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