

Paradoxical Patient Reactions to Psychiatric Life Support: Clinical and Ethical Considerations

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The authors describe cases illustrating two types of high-risk and especially difficult suicidal psychiatric inpatients. In the first case, a suicidal patient reacted to psychiatric life support measures (maximum observation) with increasingly life-threatening acting out, necessitating a difficult, seemingly paradoxical staff decision to withdraw life support. In the second, a patient felt to be improving killed herself when life support was withdrawn. The authors argue that there are clinical limits to psychiatric life support and an appropriate goal of psychiatric treatment is to maximize the chances for patient survival, rather than to attempt to guarantee such survival.

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The two clinical situations we present in this article are not new to clinicians; indeed, they are all too familiar. These two clinical challenges consume much inpatient staff time and energy in the form of deliberation and concern. In one case, this deliberation was prospective: How should we proceed with a suicidal patient who reacted negatively to our efforts to keep her alive? The other involved a retrospective evaluation of what was done for a suicidal patient who seemed to be improving but then precipitously committed suicide.

We present these cases because we feel there is an important clinical reality that tends to be overlooked and/or denied and may be unintegrated in the thinking of clinicians and of society at large. It is that there is a limit to the powers of our current clinical art and sci-

ence to keep psychiatric patients alive and sometimes our efforts to foster patient improvement entail taking potentially life-threatening risks. Taking such risks is inherent in good care, given the limits of our current therapeutic capacity.

Few clinical situations are as difficult and frightening to psychiatrists as the care of the seriously suicidal patient who fails to respond to treatment. Some patients remain overtly suicidal despite great efforts to provide treatment and life support. In fact, at times our attempts to guarantee survival by the use of life support systems—such as constant observation—may exacerbate psychopathology or deprive the patient of an opportunity to achieve a reasonable level of autonomy.

By “psychiatric life support” we mean procedures that keep psychiatric patients alive but are not directed at ameliorating psychopathology. While medical life support usually entails complex modern technologies, psychiatric life support involves one-to-one monitoring of suicidal patients and the interventions required to restrain patients from harming themselves, such as physical restraint or sedation. Psychopharmacology, psychotherapy, and other psychosocial interventions are also used in this effort and are usually aimed at modifying the course of a disorder, in contrast to life support, which is intended to keep a patient alive until the course of illness is modified. There are patients, however, whose underlying disorders are refractory to the treatment interventions currently known to us. We may observe these patients for long periods of time, get to know them as well as we can, and apply successive therapeutic regimens as intensively as possible, and the patient may still remain suicidal (1-4).

The cases of two patients follow. For the first, extended life support seemed to inhibit recovery. In the second, additional life support might have prevented a suicide.

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CASE REPORTS

Case 1: The Treatment-Refractory Suicidal Patient

Ms. A, an unmarried 29-year-old woman, had been given diagnoses of dysthymic disorder and mixed personality disorder. This was her fifth psychiatric hospitalization for depression and suicidality, which had followed the breakup of her relationship with a boyfriend. Ms. A's hospital care included multiple drug treatments for her depression (including phenelzine, lithium, L-triiodothyronine, trazodone, lorazepam, alprazolam, and various combinations of these agents) and intensive psychotherapy, with little improvement. She required 3½ months of almost continuous observation because of her increasingly life-threatening acting out. Multiple consultations were sought regarding both drug treatment and her milieu treatment with maximum observation. A senior consultant felt that the maximum observation had become countertherapeutic, causing Ms. A to regress in the hospital, and that the somatic and psychotherapeutic modalities were providing her little benefit, as she continued to be actively suicidal.

Since the life support was felt to be harming rather than helping, it was decided to gradually reduce the observation. Ms. A and her family were carefully apprised of the reasons for this course of action and the significant risks involved. As this treatment plan proceeded, Ms. A was observed to be "re-organizing" herself, functioning in a less dependent manner, and exhibiting less sadomasochistic acting out. During this period she superficially cut her wrists and hinted at a plan to hang herself, but the staff felt that these were more attention-seeking gestures than truly suicidal endeavors. Mobilization proceeded and Ms. A was eventually able to be discharged to an outpatient therapist with whom she had a close working alliance.

This case illustrates that our usual hospital treatment modalities may exacerbate rather than ameliorate a patient's condition, creating an environment that induces clinical regression and the potential for further life-threatening behavior. The multiple expert consultations requested reflect the extreme danger that the staff perceived for this patient. Ultimately the staff recognized that their best treatment efforts had been ineffective and that providing a risk-free environment was antitherapeutic. They then attempted to fashion a treatment that might help to promote the patient's well-being by enhancing her autonomy and responsibility, rather than providing total protection from risk. The treatment team also appreciated that the risks of this decision must be shared with the patient and her family.

As the staff's adoption of Ms. A's ego functions was cautiously reversed and monitoring was withdrawn, she made a series of suicidal gestures that, fortunately but not predictably, were of minimal seriousness. The treatment strategy was successful in this instance. Ms. A had a good therapeutic alliance with an outpatient psychiatric psychotherapist, which helped sustain her during this process, and she was eventually able to be discharged. We emphasize, however, that the patient might have killed herself, and that other patients in sim-

ilar circumstances have done so and will do so in the future.

In the following case vignette, the patient appeared to be doing better than Ms. A but killed herself when life support was tapered.

Case 2: The Suicidal Patient Who Seems to be Improving

Ms. B, a young unmarried woman, had been admitted for psychiatric hospitalization because of acute psychosis and suicidal ideation. Her adolescence had been marked by multiple symptoms, including sexual promiscuity, religiosity, rebellion against her parents, substance abuse (marijuana and some cocaine), and bulimia. She had also exhibited bizarre behaviors, such as stating that she could communicate with tiny creatures, having odd decorations in her room, and treating pet animals sadistically. Ms. B's one prior psychiatric hospitalization had been related to her eating disorder; she believed her "stomach was connected to the center of the earth." Before her current hospitalization she had been paranoid and said she was being manipulated by the television and radio. The bizarre nature and chronicity of her symptoms and a prior poor response to lithium led to the diagnosis of schizophrenia.

After her workup, Ms. B was treated with neuroleptics, psychotherapy, and various milieu therapeutic modalities. Given the protracted nature of her illness, after due consideration the staff believed that Ms. B's best chance for both survival and achievement of the maximum level of adaptation of which she was capable would be best served by long-term hospitalization.

Ms. B's initial hospital course was unremarkable. Although she was psychotic (i.e., had ideas of reference, thought others were speaking her thoughts, and exhibited paranoia) and suicidal, Ms. B was able to come to the staff when feeling suicidal, was reassured by their attention, and responded well to restriction to the unit's central lounge.

On hospital day 13, Ms. B came in contact with an elderly depressed male patient, which seemed to upset her greatly. Afterward she precipitously and surreptitiously eloped with a strong intent to obtain razor blades and to swallow them and kill herself. She was found and brought back to the hospital by her mother. After her return, she continued to be psychotic and suicidal. Her neuroleptic dose was increased. The elopement was felt by the staff to signal a significant change; Ms. B could no longer be counted on to come to the staff for help when feeling acutely suicidal. From day 13 on, therefore, she was placed on round-the-clock observation.

With the increased neuroleptic dose, Ms. B's paranoid ideation diminished. Her active suicidal ideation persisted, however, and the maximum observation was continued. ECT was considered but postponed in the belief that it might interfere with efforts to facilitate Ms. B's transfer for long-term care. Indeed, with the higher dose of neuroleptic her mood began to brighten. She rejoined activities and was much less suicidal.

After 22 days of round-the-clock observation her status was downgraded, and her monitoring was decreased to checks every 15 minutes during the day and constant observation at night. For 12 days, at this level of monitoring, Ms. B was able to participate in some activities and was more communicative with the staff, in whom she could now confide her periodic passive suicidal ideation.

On hospital day 47, after 34 days of total or partial observation, it was felt that maximum observation could be discontinued. Three days later Ms. B continued to appear to be doing well. After a pleasant telephone call with her mother and a conversation with a staff nurse, neither of whom detected any special difficulty, with no evident precipitant Ms. B went into a bathroom stall, put a plastic bag over her head, and asphyxiated herself. She was found a short time later and was given cardiopulmonary resuscitation but was eventually found to be brain dead.

A follow-up mortality and morbidity conference was held, as is the hospital's usual procedure after a death. It was uniformly thought that Ms. B's diagnosis and treatment had been appropriate. Her diagnosis (schizophrenia) and demoralization were seen as high-risk factors in the case. However, Ms. B had seemed to be doing better at the time of her suicide and during the days before it, after maximum observation had been withdrawn.

This case highlights a number of clinical and ethical points. Despite our best clinical efforts we cannot always predict underlying suicidality, especially in our schizophrenic patients (5, 6). When a patient is improving, as Ms. B was, and we are trying to switch the patient to less restrictive long-term treatment, we attempt to transfer self-care functions back to the patient.

Cases such as this one make us wonder if extending monitoring for suicidality beyond the point of apparent clinical improvement would prevent many suicides. Despite the potential merits of such an option, clinicians would generally find this an ill-advised and unacceptable clinical precaution. Unlike the monitoring of patients who have had myocardial infarctions, who may experience life-threatening arrhythmias, psychiatric life support may be an invasive procedure associated with morbidity itself and may delay the patient's reacquisition of self-care capabilities or, as in the first case, stimulate regressive self-destructive acts.

DISCUSSION

We have identified two kinds of suicidal patients who are difficult to manage. The first type seems to worsen with maximum observation and improve when it is terminated and the patient is given increased responsibility for his or her own care. The second type seems to be improving but is at risk for unexpected suicide when maximum observation is withdrawn. Currently there are no means of identifying either type of patient despite careful clinical attention. Careful study and research are needed to diminish the time required to identify the first type of patient and to devise some form of extended observation or monitoring for the second. Despite our best efforts, however, we are faced with and will continue to be faced with a central clinical ethical dilemma. Psychiatric recovery entails the patient's eventually regaining responsibility

for his or her own care. Since this is an important part of the recovery process, some small percentage of patients will at some point present the kind of risk described in case 2.

The question of when life support may ethically be discontinued has preoccupied medicine since technology has been able to sustain physiological functioning in patients who are no longer sentient or whose hopelessness and suffering—and their wish for relief from the pain of life—would lead to a wished-for death in the absence of life support (7). The comparable response in psychiatry is not technologic; rather, it invokes a social procedure—maximum observation—to maintain life in a patient whose psychiatric disorder leads to the determination to die and who does not respond to available treatments. A psychiatric hospital has an obligation to 1) provide a safe haven for the patient, 2) carefully consider all diagnostic possibilities, 3) offer all appropriate treatments, 4) work assiduously at understanding the patient and family to help them overcome any resistance to compliance, 5) alert the patient and family to the risks and limitations, as well as benefits, of any treatment effort, 6) take steps to protect the patient with all available life support measures pending successful treatment, and 7) recognize when a treatment has failed or is contributing further to morbidity.

As psychiatrists, we may find it difficult to accept that a small percentage of our suicidal patients are refractory to the currently available interventions and that acceptance of this risk is a critical part of the care of psychiatric patients. Like their counterparts in oncology and other medical and surgical subspecialties that deal with the severely and terminally ill, some of these patients, despite our best efforts, will die. Our task is to maximize life support for those who will benefit from our treatments while, with the greatest caution, we attempt to identify that small group who cannot benefit from and may be harmed by prolonged psychiatric life support procedures. At some point in the care of the nonpsychotic, chronically suicidal patient, we must examine whether life support measures are contributing to the patient's morbidity and whether their usefulness justifies the drain on the resources available for the care of other patients.

Paradoxically, some patients appear to do worse with maximum observation and respond well to the judicious return of self-care functions (as in case 1), while some who seem to be improving surprise us with impulsive lethal acts (as in case 2). Clearly, both groups deserve additional study and research. Until we better understand the nature of the impulsive, "unpredictable" suicide and since we cannot and should not keep all improving patients under extended maximum observation, we must accept that facilitating patient improvement and autonomy will engender a small but significant unavoidable risk of mortality.

REFERENCES

1. Robins LN, Kulbok PA: Methodological strategies in suicide, in *Psychobiology of Suicidal Behavior*. Edited by Mann JJ, Stanley M. New York, Annals of the New York Academy of Sciences, 1986
2. Linchan MM: Suicidal people: one population or two? *Ibid*
3. Cohen J: Statistical approaches to suicidal risk factor analysis. *Ibid*
4. Pfeffer CR: Suicide prevention: current efficacy and future promise. *Ibid*
5. Johns CA, Stanley M, Stanley B: Suicide in schizophrenia. *Ibid*
6. Salama AA: Depression and suicide in schizophrenic patients. *Suicide Life Threat Behav* 1988; 18:379-384
7. Rachels J: Barney Clark's key. *Hastings Cent Rep* 1983; 13(2): 17-19