Use of Case Vignettes in Suicide Risk Assessment

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ABSTRACT: Thirty-three brief case histories of suicidal patients were given to 19 experienced crisis workers for 7-point ratings of short- and long-term suicide risk. The ratings revealed considerable variability, raising questions about the reliability of such global assessments of suicidality. The most consistently rated cases were selected to operationally define "mild," "moderate," and "high" risk. Thus, each level was "anchored" by several vignettes. It was hoped that these anchor points would lead to more uniform future ratings among crisis workers.

The correlation between short- and long-term risk ranged from near zero for some vignettes to as high as .82 (median = .46), demonstrating the need to rate both separately. Long-term risk was more difficult to rate, as demonstrated by a larger number of cases judged to be unrateable because of "insufficient information" (94 vs. 53 rater-case combinations).

When the anchor vignettes were provided as a guide to the same sample of crisis workers, their ratings of suicide risk, as expected, showed significantly improved consistency.

The impetus for the current study came from various sources but mainly from a dissatisfaction with the day-by-day clinical utility of most suicide potential rating scales. The clinical usefulness of various empirically derived scales has been questioned by several suicidologists (Brown & Sheran, 1972; Litman, Farberow, Wold, & Brown, 1974; MacKinnon & Farberow, 1976; Motto, 1985).

Many of these rating scales are based on a prediction rather than an assessment model; that is, the current suicide risk is derived by inference from the probability of a future event, such as a suicide attempt or a completed suicide. And yet it is well established that short-term prediction of individual suicidal behaviors is nearly impossible to achieve by the existing instruments (Pokorny, 1983). This is especially true if these prediction instruments are general-purpose in kind—that
is, supposed to be universally applicable to many different populations and settings. Some writers have correctly pointed out that rating scales, in order to be maximally useful, should be situation- and setting-specific (Brown & Sharan, 1972; Litman et al., 1974; Motto, 1985). The use of an actual suicidal event as a criterion of antecedent suicide risk is flawed, despite the easy measurability of such events. Besides the ubiquitous base-rate problem, we are faced with the fact that very high-risk individuals sometimes miraculously survive suicide attempts and low-risk persons end up committing suicide because of ignorance, poor judgment, or miscalculation. Also, those who eventually attempt or commit suicide may do so many years later in a state of mind and under circumstances that may have little relationship to the situation at the time suicide risk was assessed. Furthermore, prediction is made difficult because the clinician working in a suicide prevention center typically has inadequate knowledge and control over such variables as precipitating events, opportunity to commit suicide, availability of the chosen method, and effectiveness of intervening treatment.

In addition, our ability to make assessments is hampered by a lack of knowledge about how to assign proper weight to the known risk factors. It is indeed curious to see risk factors of vastly different clinical importance side by side within the same rating scale (typically empirically constructed), without this difference being formally recognized by some form of weighting system. Such items as sex, age, and season of the year are given the same weight as presence of mental disorder and being unconscious from a suicide attempt (Cohen, Motto, & Seiden, 1966; Tuckman & Youngman, 1968).

One notable exception is represented by the Suicide Risk Assessment Scale developed by Motto (1985). The various response categories receive scores ranging from 0 to 100, in recognition of the differential contribution to suicide risk by the various items. This scale also does not presume to be predictive of future suicidal behavior. To quote the author, “The use of a scale has never been intended to predict suicide, but simply to supplement clinical judgment at the time an evaluation is done.”

Even if such rating scales are used by suicide prevention centers and generate a cumulative score representing a certain level of suicide risk, the typical clinician will, in most instances, utilize additional data outside the content of the rating scale. This leads to a subjective global suicide risk assessment based on all available information. As a matter of fact, a question has been raised regarding the relative utility of assessments based on rating scales as compared to clinical/global/subjective judgments, or integrated assessments based on both (Motto, 1977). According to Litman et al. (1974), “the scales should supplement but not replace the clinical judgment of people with experience in any particular setting.” To the extent that clinical judgment is unavoidable, and perhaps even desirable, there is a certain danger that suicide potential rating scales may be misapplied if they fall into the wrong hands. It is seductive for individuals without mental health training to have available to them easily scorable scales that can be applied in a rather mechanical fashion. Unless such scales are applied in a strictly initial screening function, such nonclinical use could lead to faulty treatment plans and dispositions. (The assumption made here is that the risk ratings make a real difference—that “mild-risk” clients, for instance, may get outpatient counseling while “high-risk” clients may be involuntarily admitted to a locked psychiatric ward.) Again, the need for subjective judgment made by an experienced clinician is recognized by Motto (1985): His Suicide Risk Assessment Scale is to be administered by a clinician; the scale “is intended as a supplement to, not a substitute for, clinical judgment”; and “when the scale is not consistent with clinical judgment, clinical judgment should be given precedence.”

Table 1 illustrates an attempt by one of us (Z. T. S.) to match various levels of suicide risk, as exemplified by rationally constructed case vignettes, with proposed intervention strategies. The purpose of this table is to emphasize the dimensional nature of suicidality and the feasibility of attaching appropriate clinical dispositions to the various risk levels. The popularity of this table led, in part, to the current study.

Although the table is useful to illustrate a point, it has several shortcomings. One is that the vignettes do not represent real people. Another is that one can obviously arrive at the same level of risk through very different “packages” of risk factors. Also, various interventions may not be possible in certain settings (e.g., tracing phone calls, legal holds, seclusion, etc.). Finally, depending on the base rates of significantly suicidal individuals in a given clinic or center, there may be substantial disagreement as to what constitutes “mild” as opposed to “moderate” suicide risk. (This, by the way, demonstrates even further the relative nature of such ratings.)

Because of these limitations, clinical judgments of suicide risk tend to be rather unreliable. It has been found in previous studies that significant disagreements exist over ratings between judges and for the same judges over time (e.g., Wittemore, 1968). The current study was an attempt to use actual case histories instead of individual risk factors to anchor suicide risk ratings. The intent was to guide scorers and to make scores more comparable from rating to rating. Such anchoring points would also serve as a sort of dictionary, translating the “language” of one agency or crisis worker to that of another. Thus, the
The operational meaning of “moderate” risk would be explicated by the corresponding vignettes.

Method

The cases used in the study were not selected randomly, but were deliberately chosen to represent a continuum of suicide risk from low to high, with 11 cases in each category (the selection was random within each category). The groupings were made on the basis of earlier global/subjective judgments made by experienced crisis workers. Thus, the sample obviously does not represent the reality of a crisis center population because the proportions of each risk category were chosen to be equal, when, in fact, low-suicide-risk patients are much more numerous than high-risk patients.

Thirty-three charts containing a recent global suicide risk rating were selected from a crisis intervention center's active files. One of us (Z. T. S.) then summarized the record, attempting to include most of the data relevant to the assessment of suicide risk. Since the information was gathered as part of crisis intervention visits, it was often rather scant, and the content varied from case to case.

The case summaries were then given to 19 crisis workers for 7-point short-term and long-term suicide risk ratings. The staff were given the following instructions:

As you may have guessed, our risk ratings are quite variable, with only moderate correlation between ratings of individual staff members. The following is an attempt to anchor down risk ratings in order to achieve a greater uniformity in our suicide assessment. These vignettes are extracts from patient case histories. The data represent information that was felt to be relevant, at the time of contact, for arriving at a global risk assessment. The vignettes vary in length, comprehensiveness, and content covered; this reflects not only my selection, but also the particular content elicited from the patient by our staff. The vignettes represent all levels of suicide risk from low to high. You are asked to indicate your personal rating for each of the vignettes on a 7-point scale. Try to use the entire range of ratings instead of bunching them up in the middle. It may be helpful to read through all the vignettes first and then go back to the individual ratings. If you feel the information provided is not sufficient for a rating, please indicate so. Please do not consult with your colleagues regarding your ratings, as this would confound the results.

The raters were very experienced mental health professionals and a few mental health workers. Of the total of 19, 11 had 10 or more years of experience at the crisis intervention center; 5 had 2 years or less of experience at the center, but all of them had considerable previous experience in psychiatric settings.
During the second stage of this study, 2 years after the initial ratings, 15 of the vignettes that were not selected as anchoring points were resubmitted to the same staff members for a second short-term risk rating, this time with the help of the anchor vignettes as a guide.

Results

Table 2 provides a summary of the suicide risk ratings obtained on the 33 case history vignettes. Most of the 19 staff members were able to complete short- and long-term suicide risk ratings on all but two or three of the vignettes. Long-term risk was found to be slightly more difficult to rate: Of 627 long-term rater—case combinations, 94 were judged unratable because of “insufficient information,” as compared with 53 rater—case combinations for short-term risk. Of the 33 vignettes, 1 proved to be essentially unratable.

Means and standard deviations were computed for both the short- and long-term suicide risk ratings obtained from the 19 staff members on 32 of the 33 case vignettes. The average mean risk rating (across vignettes) was 4.5 for short-term risk and 4.3 for long-term risk—both, as one would expect from the manner of vignette selection, “moderate” on the 7-point scale. Similarly (by design), some vignettes had an average rating in the 2’s (low risk), and others in the 6’s (high risk).

The short- and long-term risk ratings on a vignette were always positively correlated across raters, with the average Pearson coefficient being .44, but 13 of the 32 computed correlation coefficients did not achieve statistical significance at the p = .05 level (i.e., an r greater than .38).

For each of the 19 raters, the short- and long-term risk ratings were positively correlated across the 32 vignettes; the smallest Pearson coefficient was .11, the largest was .80, and the pooled estimate (using all rater data) was .55.

Although Table 2 displays mean risk ratings that obviously differ significantly among the vignettes, the variation in ratings within a given vignette was also large. Typically, a short-term risk rating (for a given vignette) had a standard deviation (due to rater “error”) of about 1.2 points, and the long-term risk ratings had a standard deviation of about 1.3 points. There were even instances when one staff member rated a vignette 1 (minimum risk) while another staff member gave the same vignette a 7 (maximum risk). When viewed in comparison to the designed variation across vignettes, this within-vignette rating error represents a substantial level of unreliability. An intraclass correlation (or reliability coefficient) for the short-term risk ratings was found to be .49, and for long-term risk ratings a mere .22. Neither reliability would be considered very satisfactory for clinical purposes.

It is clear from inspection of the data that some staff members tended to rate, on the whole, significantly higher or lower than others. This suggests the possibility that a more reliable rating could be achieved by normalizing the ratings for each rater separately, then proceeding as before with rater-normalized scores. Such a procedure would be
difficult to apply in practice, but it might point the way for the development of more reliable measures. Unfortunately, applying this methodology resulted in no significant improvement in reliability.

On the basis of the average rating and standard deviation for each vignette, the following vignettes were selected as most representative of three suicide risk scale points (see Appendix for the actual vignettes1):

- **Low:** Vignettes 1, 4, 11, 14, 26
- **Moderate:** Vignettes 17, 20, 27, 31, 33
- **High:** Vignettes 2, 3, 7, 13, 19

The following results are worth noting:

1. There was considerable and disconcerting variability among staff ratings.
2. The variability, as measured by the standard deviation, was comparable between short-term and long-term ratings.
3. The range of ratings for long-term risk was slightly more “compressed” than for short-term risk ratings. The raters may have felt less sure about the long-term risk ratings, and although the variability of the ratings remained high, the average ratings tended to bunch closer to the middle.
4. The standard deviation for the ratings of short-term high risk was considerably smaller than the standard deviations for ratings of short-term mild and moderate risk. This suggests that there was much better agreement among raters for high-risk cases.
5. Not only did certain crisis workers tend to rate consistently high or low across vignettes, but they also differed considerably on the spread of their ratings. For short-term risk, the mean ratings ranged from 3.25 to 5.61 (standard deviations from 1.00 to 2.16); for long-term risk, the range of means was 1.81 to 5.86 (standard deviations from 0.98 to 1.69).
6. Staff members also differed significantly in their willingness to rate the case histories. Some found all vignettes rateable, whereas others rejected as many as 10! Again, long-term risk was apparently harder to rate, as judged by the higher mean number of rejections (5.1 vs. 2.8 for short-term risk). There were some common elements in the content of vignettes rejected by most raters: The crisis center staff was unable to complete a comprehensive evaluation at the time of the index crisis visit because the patient was intoxicated, uncooperative, incoherent, or otherwise difficult to interview.

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1 Because of space limitations, only the short-term risk vignettes are listed here and reproduced in the Appendix. The long-term risk vignettes can be obtained upon request.

7. Somewhat predictably, the sex differential, in terms of suicide risk, came through very clearly in the final selection of vignettes. Although 15 of the original 33 vignettes involved females, all short-term low-risk patients were female, all but one of the short-term high-risk patients were male, and the short-term moderate-risk category occupied a middle position in respect to the male–female ratio.

8. Of the original 19 raters, 17 were available to perform a second, benchmarked, short-term risk rating on 15 sample vignettes. On the first, nonbenchmark occasion, these staff members produced an average rating for the same 15 sample vignettes of 4.53; on the second, benchmarked occasion, the same raters gave an average rating of 4.24. A standard deviation of ratings across vignettes may be taken to represent desirable variability of risk. The first rating yielded an average value for these standard deviations of 1.44, while the second rating yielded an average of 1.41—a very minor decrease. Thus, as intended, the benchmarking procedure did not change the overall level or range of the risk ratings in any significant way.

With respect to interrater agreement, the initial, nonbenchmark vignette ratings had an average (across vignettes) of standard deviations (across raters) of 1.36; the benchmarked ratings yielded an average standard deviation (across the same raters) of 1.05. Applying a t-test to the mean change in standard deviation across the 15 sample vignettes, gave a $t = -3.50$, $p < .01$ with 14 degrees of freedom. Thus, using anchor vignettes as a guide did improve interrater agreement modestly but significantly.

**Discussion**

Global judgments about suicide potential are made every day in hundreds of crisis intervention and suicide prevention centers, whether they are made with the help of additional, more objective measures or not. These assessments have significant consequences for the persons being judged. However, quite experienced and (for the most part) professionally educated and trained crisis workers do not show much agreement in their ratings, except for short-term high suicide risk. It is perhaps somewhat reassuring that at least for this high-risk group, these judgments show more uniformity (and, we may hope, lead to appropriate clinical decisions). The meaning and implications of lower-risk ratings and long-term risk ratings are less certain.

This approach and the study in general have obvious shortcomings. One of the main problems with using individual case histories is that it is rather cumbersome. The crisis worker has to read the case histories, somehow integrate them, and establish some similarity among common
elements in the vignettes and characteristics of the case to be judged. Rating scales that emphasize commonalities to begin with avoid this extra step and, at the very least, are more convenient to use. On the other hand, individual case histories may contain more idiosyncratic pieces of information and combinations of factors, which in some instances may improve the ratings.

Ideally, each crisis program should derive its own anchored vignettes for best fit with the target population of clients it serves. The setting specificity, of course, is a problem for all measuring instruments, including rating scales that use more general risk factors.

Other methodological shortcomings of the study include the following: The numbers of case histories and raters were rather small; the case histories were summarized by one individual using subjective judgment in the selection of relevant clinical material; the standard deviations for the finally chosen anchor vignettes were still substantial; it is unknown which aspects of the case histories determined the ratings (this is being examined in a subsequent study); the case summaries were quite brief, and the kind of clues one may observe in face-to-face situations were not available to the raters; the average age of the selected patients was quite low, and therefore did not adequately cover older individuals. (on the other hand, the age range represented in this sample is probably an accurate reflection of the type of persons who tend to contact crisis intervention and suicide prevention centers); and, finally, the issue of validity was not addressed (considering the already discussed obstacles to short-term individual prediction of suicidal behavior, it is perhaps unfortunate that most studies addressing validity of various rating scales have emphasized predictive validity).

It was noted that the judges seemed to be more reluctant to assign ratings of high long-term risk than ratings of high short-term risk. Informal interviews with the raters revealed that this reluctance was based upon the assumption that drastic intervention needs to take place in all high-risk cases, short-term or long-term. Thus, although crisis workers know that chronically suicidal individuals require different clinical management, they do not trust public perception (in particular, the perception of relatives and the courts) to appreciate the difference between the treatment of acute and chronic suicidality. This results in the workers' deliberately assigning lower chronic risk ratings than their clinical judgment dictates. Naturally, a better solution in the long run would be to educate the public that someone can be a high chronic suicide risk and yet may not require such interventions as hospitalization each time the person contacts a crisis center.

An interesting refinement would be to correlate case histories directly with clinical dispositions, avoiding intervening judgments of suicide risk. This would be particularly promising, considering the poor reliability of global risk ratings. There are only a limited number of dispositions available to most crisis centers: release, refer, hospitalize, trace the phone call, send police and/or ambulance, place the patient on a legal hold, keep the patient for overnight observation, and so on. This has been done with the 15 case histories not used as anchoring vignettes, but the results are not yet available.

It would also be useful to know which elements within each vignette determined the ratings. The absence of such knowledge, however, is not a critical flaw, since most of our clinical judgments are made in this fashion. Furthermore, the knowledge would do little more than make the case history approach resemble rating scales using general risk factors. Thus, some of the desirable uniqueness would be lost, and the benefit of the more sophisticated methodology typically applied in generating common risk actors would not be obtained. Nevertheless, the same crisis workers who made suicide risk ratings for the current study were also asked to identify the main elements in the case histories that led to their judgments. These findings will be reported at a later time.

In conclusion, it seems that suicide risk ratings of the type used in this study have, indeed, very limited usefulness. Fortunately, for the most serious cases—those requiring immediate emergency response—the agreement among experienced crisis workers seems to be at an acceptable level. Furthermore, the use of anchoring vignettes does, in fact, significantly improve interrater reliability. When asked whether the anchor vignettes influenced their subsequent ratings, the great majority of crisis workers indicated that they were "somewhat" guided by them (a mean score of 5.2 on a scale of 1 to 10, 10 denoting "considerable influence" and 1 "no influence").

The intent here is not to offer a new suicide risk rating scale. It is recognized that whatever rating scales are used, they will always be supplemented by some form of more global/subjective/clinical judgment. To the extent that this is true, we should continue looking for ways to improve the reliability of such judgments. The use of anchoring case histories indicates a possible avenue for some improvement. Advocating the mechanical use of rating scales by inexperienced staff members (based on the notion that these instruments will relieve these workers from making clinical judgments that they are not trained to make) is ill conceived. Lack of experience or competence has seldom restrained people from making judgments; on the other hand, to rely entirely on a score seems foolhardy as a basis for making complex decisions in emergency situations. The bad news is that poorly trained and inexperienced staff members are handicapped in whatever approach they
use. What this study is suggesting is that the best currently available solution is to use the most sophisticated suicide risk rating scales with weighted risk factors, in combination with guided global judgment, both designed for as specific a target population as possible.

APPENDIX
SELECTED REPRESENTATIVE SHORT-TERM RISK VIGNETTES
Low Risk

26-year-old white female phoned her counselor, stated that she “might take pills,” then hung up and kept phone off the hook. Counselor called police, and patient was brought to the Crisis Intervention Center (CIC) on a transportation hold. Patient angry, denies suicidal intent, refused evaluation. Described as “selectively mute.” Diagnostic impression: dependent and/or borderline personality.

17-year-old Native American female, referred from a detoxification center for an evaluation of suicide risk. Patient lacerated her wrist with a piece of glass while intoxicated. Now regrets the attempt and denies being suicidal. Has been depressed for approximately 1 month, but there are no vegetative signs of depression. Self-esteem is impaired, however. Patient recently lost boyfriend and has difficulties coping with it; did not finish school and is unable to provide for herself. There was one previous suicide attempt exactly 1 year ago (cut wrist); this attempt also occurred following the loss of a boyfriend. Patient is dependent on alcohol and marijuana and has had chemical dependency treatment in the past. She also received 1 month of counseling following the previous suicide attempt. Diagnostic impression: atypical depression.

37-year-old white female, self-referred. Stated plan is to drive her car off a bridge. Precipitant seems to be verbal abuse by her boss; after talking to her nightly for hours, he suddenly refused to talk to her. As a result, patients feels

19-year-old female, Native American, referred from the Emergency Room with lacerations on both forearms requiring 26 stitches. Patient calls her suicide attempt a “mistake” and a “gesture.” Denies being depressed and having any
further suicidal impulses ("It's not worth it"). Precipitant: argument with boyfriend (jealousy). Patient cut herself "to hurt him." Patient is cooperative in the interview, and her cousin confirms the patient's story.

16-year-old Native American female, self-referred following an overdose of 12 aspirins. Precipitant: could not tolerate rumors at school that she and another girl are sharing the same boyfriend. Denies being suicidal at this time ("I won't do it again; I learned my lesson"). Reports that she has always had difficulty expressing her feelings. In the interview, is quiet, guarded, and initially quite reluctant to talk. Diagnostic impression: adjustment disorder.

27-year-old Cambodian female called the suicide line after ingesting 20 sleeping pills last night. Following the ingestion, she induced vomiting, slept until morning, and then called CIC. Patient still feels suicidal, refused to give identifying information. Phone call was traced, and police brought the patient to CIC. Patient still feels frustrated and hopeless, but states that the attempt was impulsive. Stress: has been recently fired from her job, broke up with boyfriend, and has chronic painful back injury. Patient was pregnant by her boyfriend and had a recent abortion. He has abused her physically. There is a history of two previous suicide attempts, one at age 18, the other 18 months ago. Currently in treatment in two groups (one of them for sexual assault). Poison Control Center informed CIC that patient is medically safe.

49-year-old white female brought by police on a transportation hold following threats to overdose on aspirin (initially telephoned CIC and was willing to give her address). Patient feels trapped and abused, can't cope at home with her schizophrenic sister. Wants to be in the hospital and continues to feel like killing herself. Husband indicates that the patient has been threatening to shoot him and her daughter but probably has no gun. Recent arrest for disorderly conduct (threatened police with a butcher knife). History of aspirin overdose 3 years ago. In the interview, patient is cooperative; appears depressed, anxious, helpless, and hopeless. Appetite and sleep are down, and so is her self-esteem. Is described as "anhedonic." Alcohol level: .12.

23-year-old white male, self-referred. Patient bought a gun 2 months ago to kill himself and claims to have the gun and four shells in his car (police found the gun but no shells). Patient reports having planned time and place for suicide several times in the past. States that he cannot live any more with his "emotional pain" since his wife left him 3 years ago. This pain has increased during the last week, but the patient cannot pinpoint any precipitant. Patient has a history of chemical dependency, but has been sober for 2 months and currently goes to AA. There is one previous psychiatric admission. During the
marriage, the patient beat his wife severely several times a week. She is currently in another relationship, and there is little likelihood of her returning to the patient. In the interview, patient appears depressed and irritable. Is angry, hostile, and threatening (“You bitch, I hate women”). Reports no sleep or appetite disturbance.

22-year-old black male referred to CIC from the Emergency Room on a transportation hold. He referred himself to the Emergency Room after making fairly deep cuts on his wrists requiring nine stitches. Current stress is recent breakup with his girlfriend and loss of job. Has developed depressive symptoms for the last 2 months, including social withdrawal, insomnia, anhedonia, and decreased appetite. Blames his sister for the breakup with girlfriend. Makes threats to sister (“I will slice up that bitch, she is dead when I get out”). Patient is an alcoholic who just completed court-ordered chemical dependency treatment lasting 3 weeks. He is also on parole for attempted rape. There is a history of previous suicide attempts and assaultive behavior, which led to the patient being jailed. In the interview, patient is vague regarding recent events and history. He denies intent to kill himself but admits to still being quite ambivalent about it. Diagnostic impression: antisocial personality.

19-year-old white male found by roommate in a “sluggish” state following the ingestion of 10 sleeping pills (Sominex) and one bottle of whiskey. Recently has been giving away his possessions and has written a suicide note. After being brought to the Emergency Room, declares that he will do it again. Blood alcohol level: .23. For the last 3 or 4 weeks there has been sleep and appetite disturbance, with a 15-pound weight loss and subjective feelings of depression. Diagnostic impression: adjustment disorder with depressed mood versus major depressive episode. Patient refused hospitalization.

21-year-old male, foreign graduate student, brought to CIC by friends and pastor. After informing his friends that he planned to jump off a bridge, he actually went there and had to be physically restrained from jumping. Had written several suicide notes, one willing his computer to a friend, another to a different friend stating that the patient would be dead by the time his note would be opened. Describes himself as being quite depressed, with low energy, poor sleep and appetite, and persistent suicidal ideation. Precipitants seems to
have been his girlfriend's breaking off their engagement 4 days ago. He has a psychiatric history of several years, but refuses to reveal details about it. Exhibits some grandiosity, paranoid mentation, anger, agitation, and irritability. Appears to be somewhat manic but not depressed. Denies acute plan to commit suicide and is threatening to sue CIC for being detained.

25-year-old white male referred from the Emergency Room following a suicide attempt with gas and strangulation. Patient turned on the gas and tied a towel around his neck until he turned blue and passed out. His roommate was present while he turned on the gas. Emergency Room classifies this medically as a high-lethality suicide attempt. At CIC patient maintains that he will still hang himself, given the opportunity. Precipitant seems to be the patient finding out 1 week ago that his girlfriend was dating his friend. Other stressors include a recent move, financial problems, and being on probation at work for absenteeism. History reveals an overdose at the age of 15, which led to psychiatric hospitalization. Diagnostic impression: adjustment disorder with depression, plus questionable alcohol abuse.

32-year-old white male referred from the Emergency Room. Patient was in the process of overdosing when he was called by a friend, who arranged for the ambulance to bring patient to CIC. The patient took 72 over-the-counter sleeping pills and 10 or 15 aspirin tablets. Patient wrote a long suicide note bequeathing belongings, expressing guilt about not doing well on his job, feeling hopeless about a "hereditary thinking disorder." Feels that no one can help him; suffers from low self-esteem ("I'm a misfit"). Three nights ago, made a suicide attempt with Navane and aspirin but woke up by himself in the morning. Lives by himself. No obvious immediate precipitant, but the patient's mother died 6 months ago. Currently in therapy and also has a psychiatrist.

References


Case Consultation

Cathy

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Case Summary

A white female, Cathy became a client of the Anytown Emergency Services at the age of 36. During the 2 years Cathy interacted with the center, some 250 contacts were recorded. Predominantly phone contacts, sporadic face-to-face appointments, emergency walk-ins, and emergency outreach contacts marked her relationship with the center.

Cathy’s references to her past were limited or vague. Specific information included a history of physical and emotional abuse by her father, who met a violent death while Cathy was a teenager, and a mother who apparently fostered a dependent and guilt-ridden relationship with her daughter. It appeared that Cathy engaged in numerous suicide attempts throughout her adult life and was periodically involved in therapy with numerous therapists. She reported brief psychiatric hospitalizations at various points, along with intermittent prescriptions for either antidepressants or minor tranquilizers.

Cathy’s adult life appeared to be marked by a series of unsuccessful relationships. Although apparently capable of functioning effectively with others both professionally (Cathy was a registered nurse) and personally in the short run, long-term stability appeared elusive for her. The center’s initial contacts with Cathy were in response to an immediate crisis resulting from a relationship problem; however, over the next 2 years the issues of anger, rejection, and trust became common themes. Phone contacts often fell into one of two patterns: (1) long

Editor’s Note: This is the second in a continuing series of case consultations published as a new feature of the journal. Case situations will vary to reflect the breadth of suicidology and the interdisciplinary nature of subscribers’ interests. Readers are encouraged to submit case problems (please limit to 800 words) to the editor: Alan L. Berman, PhD, Washington Psychological Center, Suite 602, 4201 Connecticut Avenue, N.W., Washington, D.C. 20008. Letters of comment and response to these presentations are also encouraged and welcome.