35 Years of Working With Suicidal Patients: Lessons Learned

DONALD MEICHENBAUM
University of Waterloo, Ontario and
Melissa Institute of Violence Prevention and
Treatment of Victims of Violence, Miami, Florida

Abstract

Following a personal description of several patients who have committed suicide in my clinical practice and consultation, I summarize the literature on risk assessment for suicide. The form adopted is a set of specific questions that a knowledgeable clinical supervisor might use to help a clinical team examine their clinical decision-making and determine practical guidelines in caring for a suicidal patient. The factors covered include suicidal risk assessment, presence of comorbid and protective factors, immediate emergency interventions on both an outpatient and inpatient basis, and possible short-term and long-term interventions. The training and practical clinical implications of following these guidelines are considered. The checklist, in the form of probing questions, is *not* intended to foster an adversarial process, but rather to provide a framework in evaluating the assessment and care of suicidal individuals.

My professional journey began as a graduate student in clinical psychology at a Veteran's Administration hospital. H. B. was a 45-year-old Caucasian male who was diagnosed as schizophrenic and who had a history of parental neglect, as well as combat-related stress experiences. He was one of my first clinical patients and I had worked with him for several months. While under my care, he killed himself.

Over the course of the next 35 years of clinical work, I have been involved with three other psychiatric patients who have died by suicide. Another suicidal patient was being seen by a clinical graduate student whom I was supervising. He was her first patient and he killed himself over the Christmas holidays.

In fact, patient suicide is *not* that unusual in the life of clinicians. As Bongar (2002) has observed, one in six psychology interns and one in three psychiatric residents experience the suicide of a patient at some point during their training. Moreover, with clinical experience the incidence of patient suicide does *not* greatly diminish. A practicing clinical psychologist will average five suicidal patients per month. One in two psychiatrists and one in six clinical psychologists will experience a patient's suicide in their professional careers (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989).

Two other recent clinical consultations are the occasion for the present reflections. I was asked to consult to a Canadian treatment team called the Society of Northern Renewal headed by Dr. William Foote. They were addressing the high suicide rate of Inuit people in the territory of Nunavut. As noted in Dr. Foote's government report (private communication), the Inuit people are twice as likely to commit suicide than other native populations and four times as likely to engage in self-destructive behaviours. A variety of factors, including economic dislocation and deprivation, social isolation, disruption of traditional cultural patterns, and demoralizing social problems (substandard living, overcrowding) and substance abuse contribute to such self-injurious behaviors (Meichenbaum, in press). On top of this array of stressors in the early 1980s in three Inuit communities, a subgroup of 85 male Inuit youth were sexually abused by a self-confessed male pedophile school teacher over a period of six years. One of the consequences of this victimization experience is the very high rate of suicide among the Inuit, especially among the cohort of abused young men. For instance, the suicide rate among Inuit females is 32 per 100,000, 119 per 100,000 for Inuit males, and for the cohort of abused young men ages 19 to 29, the suicide rate is 200 per 100,000 (Foote, 2004, private communication).

These suicidal numbers stand in stark contrast to the base rate of suicide of only 12 per 100,000 in the general population. The suicide rate rises to 60 per 100,000 in a psychiatric population (Bongar, 2002).

My last consultation where a patient committed suicide was at a psychiatric facility where an adolescent patient was hospitalized on Friday evening by his parents for substance abuse and erratic behaviors. On Monday when his parents came to visit, the youth was

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dead, having hung himself. When I met with the hospital staff afterwards, they were concerned that somehow they had been negligent. Somehow they had missed the warning signs, failed to take proper precautions. Moreover, administrative concerns about legal liability also arose.

This recent dialogue with the hospital staff triggered for me a flood of memories and accompanying anxiety that come with the territory of working with a clinical population. Consider that one-third of the general (nonclinical) population have suicidal thoughts at some point in their lives. Given this high base rate of suicidal ideation in the North American population, how shall clinical staff respond when a potentially suicidal patient arrives at the clinic? The hospital staff asked me to summarize the empirical literature on risk assessment for suicide, as well as glean from my 35 years of clinical experience, a set of practice guidelines that they can use with future potentially suicidal patients, as well as in their postmortem analysis of the death of this youth. The clinical staff wanted to make sure that they had left no stone unturned clinically speaking and that no broader system issues were involved. The practice guidelines that I put together are offered in the form of a checklist of probing, but supportive, questions that can be used to improve the quality of care. The remainder of this article is the list of questions that reflect my best judgment about preventative efforts clinicians should follow when working with suicidal patients. These are *not* the only questions or guideposts, but rather they reflect a set of practice guidelines that I now use in my clinical decision-making and in my consultations to psychiatric facilities. They also represent the guidelines that we follow at the Miami-based Melissa Institute for Violence Prevention and Treatment of Victims of Violence, where I am the Research Director. *(Please see www.melissainstitute.org)*.

The intent of this comprehensive list of probing questions is *not* to overwhelm the clinician, but rather to provide a set of reminders that can guide clinical decision-making, especially when clinicians are working under highly stressful and anxiety-engendering circumstances of trying to help suicidal patients. In fact, various surveys indicate that suicidal patients constitute the single most stressful aspect of most psychotherapists' work (Deustch, 1984). Marsha Linehan (1999) has captured this level of stress when she observed:

> Therapy with suicidal patients is similar to *walking a tightrope* stretched over the Grand Canyon. Bending one direction, the therapist must act to keep the patient alive in the present. Bending in the other direction, the therapist must be careful not to respond in a manner that increases the likelihood of future suicide. Complicating all of this are the fears almost all therapists have of falling off the tightrope with the patient and of being held responsible for a patient's death if a misstep is taken and balance is lost. (Linehan, 1999, p. 115)

The following list of probing questions (see Appendix) that I put together for the hospital staff represents my assimilation of the research of multiple suicidologists, including Aaron Beck, Bruce Bongar, Tom Ellis, David Jobes, Thomas Joiner, Phil Kleespies, Anton Leenaars, Marsha Linehan, J. Maltsberger, R. Maris, M. David Rudd, Ed Shneidman and their colleagues. (See Berk, Henriques, Warman, Brown, & Beck, 2004; Bongar, 1992, 2002; Bongar, Maris, Berman, & Litman, 1992, 1993; Clark, 1998; Ellis, 1990; Fremouw, dePerczel, & Ellis, 1990; Friedman, 1989, Hawton et al., 1998a, b; Jobes, 2000; Joiner, Walker, Rudd, & Jobes, 1998; Kleespies & Dettmer, 2000; Kleespies, Deloppo, Gallagher, & Niles, 1998, 1999; Leenaars, 2004; Linehan, 1997, 1999; Maltsberger 1986; Maltsberger & Buie, 1989; Maris, 1981; O'Carrroll et al., 1996; Ramsay, 1987; Range & Knott, 1997; Rudd, 2000; Rudd & Joiner, 1998a, b; Rudd et al., 1996, 2001; Shneidman, 1993, 1996; Silverman, Berman, Bongar, Litman, & Maris, 1994; Spirito, Boergers, & Donaldson, 2000; Weishaar & Beck, 1990). Also see the American Psychiatric Association Practice Guidelines for Assessing and Treating suicide *(http://www.psych.org/cme/apacme/index/cfm)* and the Guidelines for Clinicians offered by Aeschi Working Group on Suicide *(http://www.aeschiconference. unibe.ch/)*.

Imagine that a patient of yours committed suicide and you were going to reflect on your clinical efforts. How many of the following questions could you answer? Or, if you are not a clinician, imagine that a family member or a friend of yours has expressed suicidal thoughts and you refer him/her to a clinician. You want to ensure that your loved one will receive "state-of-the-art" care. How many of the following practice guidelines inherent in the series of questions will the clinician follow? In short, after 35 years of clinical experience, this is the list of guidelines I use when seeing a suicidal patient. Obviously, I cannot keep all of these comprehensive steps in mind when seeing a suicidal patient, but after a session with the patient or right before a future session, a quick review of the questions in the Appendix provides me with a set of reminders of the steps I need to consider.

The Appendix provides a set of practice guidelines for assessing and intervening with suicidal patients. This list can assist in clinical decision-making and in

improving patient care. It is a checklist that I aspire to keep in mind when working with suicidal patients. When considering this list of practice guidelines, it is important for clinicians to heed the warnings offered by Ellis (2004), Hendin (1995) and Jobes (2000). They each cautioned clinicians to be attentive to their own attitudes toward the suicidal patient and to their own fears about possible legal liability. If clinicians use suicide management techniques such as threat of involuntary hospitalization that reflect a controlling posture, then such efforts may inadvertently result in the suicidal patient relinquishing the responsibility for staying alive to others and thus compromise the therapeutic alliance and treatment efficacy.

In considering the practice guidelines enumerated in the Appendix, there are several additional caveats to keep in mind. First, the list of questions and accompanying guidelines do not address all of the issues that might arise in the assessment and treatment of suicidal patients, but they do reflect the cumulative wisdom I have developed over 35 years of clinical experience. Research based on empirical prediction models have consistently failed to reliably predict suicide in any individual case. Such algorithmic equations have resulted in high false-positive and false-negative rates (Pokorny, 1993; Rudd et al., 1996). As Kleespies and Dettmer (2000) have reported in an estimated 60% to 70% of suicide completers they have no known history of prior attempts and they commit suicide on their first attempt.

While there are still limitations to the science of suicidology, there is an urgent need to ensure that our new clinical students have a working knowledge of assessment and treatment guidelines. In fact, a survey of clinical graduate programs in North America by Bongar and Harmatz (1991) indicated that only 40% of graduate programs in clinical psychology offer any formal training in the assessment and interventions with suicidal individuals. Perhaps, the rate of such clinical training has gone up since the Bongar and Harmatz initial survey. Hopefully, the present reflective article will be a catalyst for such additional training, given the widespread occurrence of suicide in the patients we see.

Finally, on a personal note, a colleague's spouse had attempted suicide. My colleague asked me what advice I had that she could pass along to the clinical treatment team for her husband. I gave her a copy of the Appendix. Hopefully, these practice guidelines will help save a life.

I am indebted to Dr. Tom Ellis for his helpful comments on this paper. Direct correspondence about this paper to dmeich@watarts.uwaterloo.ca

Résumé

Après avoir livré une description personnelle de plusieurs patients morts par suicide, rencontrés dans le cadre de ma pratique clinique et en consultation, je résume la documentation qui porte sur l'évaluation du risque de suicide. La forme d'évaluation adoptée consiste en une série de questions précises qu'un surveillant clinique expérimenté peut poser pour aider une équipe clinique à examiner la prise de décisions cliniques appropriée et à définir les lignes directrices à adopter pour prodiguer des soins à un patient suicidaire. Les facteurs qui sont abordés comprennent l'évaluation du risque de suicide, la présence de facteurs de comorbidité et de protection, les interventions d'urgence immédiates pratiquées auprès des malades externes et des malades hospitalisés et les interventions possibles à court et à moyen terme. Par la suite, nous examinons l'impact que pourrait avoir l'application de ces lignes directrices sur la formation et la pratique cliniques. La liste de contrôle, composée de questions exploratrices, *n'est pas* conçue pour favoriser un processus accusatoire; elle vient plutôt fournir un cadre de travail pour faciliter l'évaluation et les soins à prodiguer aux patients suicidaires.

References

Baumeister, R. F. (1990). Suicide as escape from self. *Psychological Review, 97*, 90-113.

Berk, M. S., Henriques, G. R., Warman, D. M., Brown, G. K., & Beck, A. T. (2004). A cognitive therapy intervention for suicide attempters: An overview of the treatment and case examples. *Cognitive and Behavioral Practice, 11*, 265-277.

Bongar, B. (1992). Guidelines for risk management in the care of the suicidal patient. In B. Bongar (Ed.), *Suicide: Guidelines for assessment, management, and treatment.* (pp. 268-282). New York: Oxford University Press.

Bongar, B. (2002). *The suicidal patient: Clinical and legal standards of care* (2nd ed.). Washington, DC: American Psychological Association.

Bongar, B., & Harmatz, M. (1991). Clinical psychology graduate education in the study of suicide: Availability, resources and importance. *Suicide and Life-Threatening Behavior, 21*, 231-244.

Bongar, B., Maris, R. W., Berman, A. L., & Litman, R. (1992). Outpatient standards of care and the suicidal patient. *Suicide and Life-Threatening Behavior, 22*, 453-478.

Bongar, B., Maris, R. W., Berman, A. L., Litman, R., & Silverman, M. (1993). Inpatient standards of care and the suicidal patients. Part I. *Suicide and Life-Threatening Behavior, 23*, 245-256.

Chemtob, C. M., Bauer, G. B., Hamada, R. S., Pelowski., S.

R., & Muraoka, M. Y. (1989). Patient suicide: Occupational hazard for psychologists and psychiatrists. *Professional Psychology: Research and Practice, 20*, 294-300.

Chiles, J. A., & Strosahl, K. D. (1995). *The suicidal patient: Principles of assessment, treatment and case management.* Washington, DC: American Psychiatric Press.

Clark, D. C. (1998). The evaluation and management of the suicidal patients. In P. Kleespies (Ed.), *Emergencies in mental health practice* (pp. 75-94). New York: Guilford Press.

Clum, G. A., & Lerner, M. (1990). A problem-solving approach to treating individuals at risk for suicide, In D. Lester (Ed.), *Current concepts of suicide.* Philadelphia, PA: Charles Press.

Deutsch, C. J. (1984). Self-reported sources of stress among psychotherapists. *Professional Psychology, 15*, 833-845.

Ellis, T. E. (1990). Strategies for helping suicidal clients, Part I: Crisis management. In W. F. Fremouw, M. dePerczel, & T. E. Ellis (Eds.), *Suicide risk: Assessment and response guidelines* (pp. 98-129). New York: Allyn & Bacon.

Ellis, T. E. (2004). Collaboration and self-help orientation in therapy with suicidal clients. *Journal of Contemporary Psychotherapy, 34*, 41-57.

Ellis, T. E. (in press). *Cognition and suicide: Theory, research and practice.* Washington, DC: American Psychological Association.

Ellis, T. E., & Newman, C. F. (1996). *Choosing to live: How to defeat suicide through cognitive therapy.* Oakland, CA: New Harbinger Publications.

Freeman, A., & Reneicke, M. A. (1993). *Cognitive therapy of suicidal behavior: A manual for treatment.* New York: Springer.

Fremouw, W. J., dePerczel, M., & Ellis, T. (1990). *Suicide risk: Assessment and response guidelines.* New York: Pergamon Press.

Friedman, R. S. (1989). Hospital treatment of the suicidal patients. In D. G. Jacobs & H. N. Brown (Eds.), *Suicide: Understanding and responding* (pp. 379-402). Madison, CT: International University Press.

Haw, C., Hawton, K., Houston, K., & Townsend, E. (2001). Psychiatric and personality disorders in deliberate self-harm patients. *British Journal of Psychiatry, 178*, 48-54.

Hawton, K., Townsend, E., Arensman, E., Gunnell, D., Hazell, P., House, A., van Heeringen, K. (1998a). Deliberate self-harm: The efficacy of psychosocial and pharmacological treatment. *Cochrane Review.* Oxford: Cochrane Library.

Hawton, K., Arensman, E., Townsend, E., Bremner, P., Feldman, E., Goldney, R., et al., (1998b). Deliberate self-harm: Systematic review of efficacy of psychological and pharmacological treatment in preventing repetition. *British Medical Journal, 317*, 441-447.

Hawton, K., & VanHeeringen, K. (Eds.). (2000). *International handbook of suicide and attempted suicide.* Chichester, UK: Wiley ands Sons.

Hendin, H. (1995). *Suicide in America: New and expanded edition.* New York: Norton.

Jacobs, D. G. (Ed.). (2000). *The Harvard Medical School Guide to Suicide Assessment and Intervention.* New York: Wiley.

Jobes, D. A. (2000). Collaborating to prevent suicide: A clinical research perspective. *Suicide and Life-Threatening Behavior, 30*, 8-17.

Joiner, T. E., Rudd, M. D., & Rajab, M. H. (1997). The Modified Scale for Suicidal Ideation: Factors of suicidality and their variable to clinical and diagnostic variables. *Journal of Abnormal Psychology, 106*, 260-265.

Joiner, T. E., Walker, R. L., Rudd, M. D., & Jobes, D. A. (1999). Scientizing and routinizing the assessment of suicidality in out-patient practice. *Professional Psychology: Research and Practice, 30*, 447-453.

Kleespies, P. M., Deleppo, J. D., Gallagher, P., & Niles, B. (1999). Managing suicidal emergencies: Recommendations for the practitioner. *Professional Psychology: Research and Practice, 30*, 454-463.

Kleespies, P. M., Deleppo, J. D., Mori, D. L., & Niles, B. L. (1998). The emergency interview. In P. Kleespies (Ed.), *Emergencies in mental health practice: Evaluation and management.* New York: Guilford Press.

Kleespies, P. M., & Dettmer, E. L. (2000). An evidence-based approach to evaluating and managing suicidal emergencies. *Journal of Clinical Psychology, 56*, 1109-1130.

Leenaars, A. (2004). *Psychotherapy with suicidal patients.* Chichester, UK: John Wiley and Sons.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* New York: Guilford.

Linehan, M. M. (1997). Behavioral treatment of suicidal behaviors. In D. M. Stoff & J. J. Mann (Eds.), *Behavioral treatment of suicidal behaviors: Neurobiology of suicide.* New York: Annals of New Academy of Suicide.

Linehan, M. M. (1999). Standard protocol for assessing and treating suicidal behaviors for patients in treatment. In D. G. Jacobs (Ed.), *The Harvard Medical School guide to suicide assessment and intervention* (pp. 146-187). San Francisco, CA: Jossey-Bass Publishers.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allman, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060-1064.

Maltsberger, J. T. (1986). *Suicide risk: The formulation of clinical judgment.* New York: New York University Press.

Maltsberger, J. T., & Buie, D. H. (1989). Common errors in the management of suicidal patients. In D. Jacobs & H. N. Brown (Eds.), *Suicide: Understanding responding.*

Madison, CT: International University Press.
Maris, R. W. (1981). *Pathways to suicide: A survey of self-destructive behaviors*. Baltimore, MA: John Hopkins University Press.
Meichenbaum, D. (1994). *Treating adults with PTSD*. Clearwater, FL: Institute Press.
Meichenbaum, D. (2002). *Treatment of individuals with anger-control problems and aggressive behaviors: A clinical handbook*. Clearwater, FL: Institute Press.
Meichenbaum D. (in press). Trauma and suicide: A constructive narrative perspective. In T. Ellis (Ed.), *Cognition and suicide: Theory, research and practice*. Washington, DC: American Psychological Association.
Michel, K., Maltsberger, J. T., Jobes, D. A., Leenaars, A. A., Orbach, I., Stadler, R., et al. (2002). Discovering the truth in attempted suicide. *American Journal of Psychotherapy, 56*, 424-437.
Michel, K., & Valach, L. (1997). Suicide as goal-directed behavior. *Archives of Suicide Research, 3*, 213-221.
Moller, H. J. (1990). Evaluation of aftercare strategies. In G. Ferrari, M. Bellini & P. Crepet (Eds.), *Suicidal behavior and risk factors* (pp. 39-44). Bologna: Monduzzi Editore.
O'Carroll, P., Berman, A., Maris, R., Moscicki, E., Tanney, B., & Silverman, M. (1996). Beyond the Tower of Babel: A nomenclature for suicidology. *Suicide and Life-Threatening Behavior, 26*, 237-259.
Pokorny, A. D. (1993). Prediction of suicide in psychiatric patients. In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit (Eds.), *Assessment and prediction of suicide*. New York: Guilford.
Ramsay, R. F. (1987). A *suicide prevention training program: Trainer's handbook*. (3rd ed.). Calgary, AB: Ramsay, Tanney, Tierney & Long.
Range, L. M., & Knott, E. C. (1997). Twenty suicide assessment instruments: Evaluation and recommendations. *Death Studies, 21*, 25-28.
Reilly, C. E. (1998). Cognitive therapy for the suicidal patient: A case study. *Perspectives in Psychiatric Care, 34*, 26-31.
Rudd, M. D. (1998). An integrative conceptual and organization approach to treating suicidality. *Psychotherapy, 335*, 346-360.
Rudd, M. D. (2000). Integrating science into practice of clinical suicidology. In R. W. Maris, S. S. Connetto, J. L. McIntosh, & M. M. Silverman (Eds.), *Review of suicidology*, 2000 (pp. 47-83). New York: Guilford Press.
Rudd, M. D., & Joiner, T. E. (1998a). The assessment management and treatment of suicidality: Towards clinically informed and balanced standards of care. *Clinical Psychology: Science and Practice, 5*, 135-150.
Rudd, M. D., & Joiner, T. E. (1998b). An integrative conceptual framework for assessing and treating suicidal behavior in adolescents. *Journal of Adolescence, 21*, 489-498.
Rudd, M. D., Joiner, T. E., & Rajab, M. H. (2001). *Treating suicidal behavior: An effective, time-limited approach*. New York: Guilford Press.
Rudd, M. D., Rajab, M. H., Orman, D. T., Studman, D. A., Joiner, T., & Dixon, W. (1996). Effectiveness of an outpatient intervention targeting suicidal young adults: Preliminary results. *Journal of Consulting and Clinical Psychology, 64*, 179-190.
Salkovskis, P., Atha, C., & Storer, D. (1990) Cognitive-behavioral problem-solving in the treatment of patients who repeatedly attempt suicide: A controlled trial. *British Journal of Psychiatry, 157*, 871-876.
Schneidman, E. S. (1993). *Suicide a psychoache: A clinical approach to self-destructive behavior*. Northwale, NJ: Jason Aronson.
Schneidman, E. S. (1996). *The suicidal mind*. New York: Oxford University Press.
Silverman, M., Berman, A., Bongar, B., Litman, R. E., & Maris, R. (1994). Inpatient standards of care and the suicidal patient. Part II. *Suicide and Life-Threatening Behavior, 24*, 152-169.
Spirito, A., Boergers, J., & Donaldson, D. (2000). Adolescent suicide attempters: Post-attempt course and implications for treatment. *Clinical Psychology and Psychotherapy, 7*, 161-173.
Townsend, E., Hawton, K., Altman, D. G., & Arensman, E. (2001). The efficacy of problem-solving treatment after deliberate self-harm: Meta-analysis of randomized controlled trials with respect to depression, helplessness and improvements in problems. *Psychological Medicine, 31*, 979-988.
Weishaar, M., & Beck, A. T. (1990). Cognitive approaches to understanding and treating suicidal behavior. In S. Blumenthal & D. Kupfer (Eds.), *Suicide over the life cycle*. Washington, DC: American Psychiatric Press.
Werth, J. L. (1996). *Rational suicide? Implications for mental health professionals*. Washington, DC: Taylor and Francis.

Appendix

Evaluation of Suicidal Patients: Risk Assessment and Practice Guidelines

What are you doing to establish a therapeutic alliance with the suicidal patient?

- Before we examine how you are assessing ongoing risk, let me (the supportive clinical supervisor) ask some questions about how you (the clinician) are going about establishing a *therapeutic relationship* with your patient so he/she feels comfortable sharing his/her "story" and accompanying suicidal feelings, thoughts, and behaviours.
- Specifically, how are you connecting with your patient so you can understand the current and lifetime circumstances that led to the present suicidal behaviours?
- How are you going about establishing a supportive, collaborative, nonjudgmental therapeutic relationship?
- Have you asked your patient to tell his/her "story" of what happened that led up to the present suicidal behaviours? In what ways have you become a "fellow traveler" in understanding the developmental pathways, the inner experiences of pain and shame, and the goal-directed behaviours behind the present suicidal urges and acts? (See Maris, 1981; Michel & Valach, 1997).
- How are you *sharing decision-making responsibility* with the patient in order to foster a collaborative relationship? What are you doing to help nurture a collaborative "team" approach so you both work on an agreed-upon treatment plan, and both feel responsible for progress?
- How are you nurturing a collaborative "we" effort right from the outset of your contact? I ask these questions because the research evidence highlights the critical importance of a therapeutic alliance in the assessment and treatment process of suicidal patients. (See Chiles & Strosahl, 1995; Ellis, 2004; Hawton et al., 1998b).
- How are you monitoring the quality of this therapeutic relationship with the patient? Are you using any specific probes, Patient Therapy Alliance Scales, monitoring and recording patient active involvement?

What assessment strategies are you using to determine ongoing risk of suicide?

- Having established such a therapeutic relationship with the patient, how are you systematically assessing for the patient's level of suicidality and ongoing risk of suicide?
- More specifically, has the patient evidenced suicidal verbalization, talk of death or dying, mood and behavioural changes? Are you assessing for the severity of the suicidal attempt in terms of intent, motives, precautions to prevent discovery and premeditation?
- What specific assessment measures and interview questions are you using in formulating the level of suicide risk? (See Collaborative Assessment and Management of Suicidality, CAMS, Protocol developed by Jobes, 2000).
- Have you explicitly assessed for:
  - your patient's history of all past suicidal behaviours, including suicidal ideation, plans or threats of such suicidal acts, even if no expressed intent to die, and patient's previous statements not to engage in suicidal behaviour;
  - the degree of symptoms that Joiner and colleagues (Joiner, Rudd, & Rajab, 1997; Joiner, Walker, Rudd, & Jobes, 1999) describe as Resolved Plan and Preparation which include:
    - the intensity and duration of suicidal ideation (more important than the frequency of suicidal ideation);
    - specificity of the suicidal plan;
    - preparation for the suicidal attempt;
    - sense of courage and competence to make an attempt;
    - the likelihood of the patient acting impulsively and his/her sense of confidence and control to delay acting on impulses;
    - access and means to engage in self-injurious behaviours (availability of a weapon in the house, means to overdose).
- Have you conducted a behavioural and cognitive chain analyses of the events that led up to the suicidal act?
- Have you assessed for the patient's Reasons for Living?
- Since over 90% of suicidal patients have an underlying psychiatric and substance abuse disorder, what DSM-IV diagnoses did your patient evidence at the time of your initial contact and over the course of his/her lifetime (i.e., lifetime comorbidity)?
- How often do you conduct re-evaluations of suicide risk? On an ongoing basis, have you assessed the patient's suicidal ideation, intent, and plans, access to lethal means, degree of hopelessness, acute dissociative and psychotic symptoms, drug and alcohol use, and the use of psychiatric medications? How do you choose the re-assessment times?

- Have you assessed for specific maladaptive cognitions and accompanying feelings such as hopelessness, helplessness, unworthiness, unloveability, and an inability to tolerate distress? Have you assessed for the patient's feelings of having been humiliated, estranged, emotionally numb, and the patient's beliefs that such feelings are both irreversible and unendurable?
- Have you assessed for the patient's tendencies to evidence rigid, dichotomous thinking concerning him/herself and others, poor
  problem-solving skills, and his/her view that suicide is a desirable, and the only, solution to his/her problems?
- Have you been able to determine what intra- and interpersonal problems suicide might solve for the patient (e.g., escape from self, avoid stressors and conflict, restore sense of control, hurt others, and the like)?
- Based on your assessment, what risk and protective factors (e.g., family or friends) have you determined to be present in this case? Have you asked the patient to recall times from the past when he/she was able to "tough it out" and cope with suicidal urges and various stressors?

What background factors have been assessed?

- What background and developmental factors have you considered in formulating your appraisal of suicidal risk? Have you found any evidence of a history of physical and/or sexual abuse? How was this determined?
- Have you obtained a family history (use a Genogram) that tracks the incidence and seriousness of depression and suicidality in the patient's family and community?

How have you assessed for comorbidity and determined level of suicidal risk?

- Have you found any evidence of any other comorbid psychiatric or medical disorders that could have increased the risk of suicide? How are you assessing for the presence of major affective disorders; anxiety disorder such as panic attacks, PTSD, schizophrenia, substance abuse, and Borderline Personality Disorder, angry, hostile and irritable behaviours?
- How would you characterize your patient's level of suicidal risk? Is the suicide risk nonexistent, mild, moderate, severe or extreme?
- What is the patient's legal status? What steps have you taken to ensure that the legal guidelines for treating suicidal patients are followed?
- Given that your suicidal patient has been judged to be at high risk as evidenced by his/her multiple suicidal attempts, psychiatric history, and diagnostic comorbidity, and elevated level on the Resolve Plan and Preparation indicators, have you provided intensive follow-up care such as increasing the frequency of your treatment appointments, providing intensive case management, ongoing telephone calls, letter writing to the patient, and /or home visits?
- Have you considered psychiatric hospitalization (including involuntary hospitalization), especially for patients who are judged to be at severe and extreme risk of suicide as evidenced by a history of multiple suicidal attempts and a lifetime history of comorbid disorders? Is hospitalization available and accessible to the patient?

What have you done explicitly to reduce the presence of risk factors?

- Have you ensured that all easily accessible means of committing suicide such as firearms and drugs are removed? What have you done to convince the patient to remove such lethal items? Have you informed family members (cohabiting individuals) of the existence of lethal items? Have you removed (or have someone remove) the potentially lethal items?
- How have you conveyed your availability to your suicidal patient? Have you scheduled the therapy sessions more frequently? Have you provided the patient with designated times to call in between sessions? Have you called the patient between sessions? When you are away, have you provided the patient with the name and telephone number of the back-up therapist?
- Have you provided the patient with a wallet-size "crisis card" that includes names, telephone numbers of hospital emergency rooms, hotlines, and social supports?
- Have you generated contingency plans with the patient (and significant others) of how to handle emergencies? Have you encouraged the patient to seek services early in a crisis by calling an emergency number or by going to the emergency room?
- While there is some debate about the usefulness of a written and oral "Contract for Safety" with suicidal patients, have you employed such an intervention, as described by Fremouw et al. (1990) and Linehan (1993). If you have not used such a Contract for Safety, what is your rationale for omitting it?
- Have you been able to solicit from the patient a commitment to both refuse to act on suicidal urges and to inform the therapist, other staff members, family or friends before acting?
- Have you engaged the patient in a discussion of the relationship between depressed feelings and thoughts and suicidal behaviours? For example, have you conveyed to the patient: ***"While suicide is an available option and given your view of your situation that is understandable, it is critical that you allow us some time to work on reducing your emotional pain. The depression that you are experiencing has a way of obscuring other possible solutions. Would you be willing to partner with me and hold off on the suicide option in order to allow yourself the time that is needed to address these issues? You are just plain wrong in***

your belief that suicide is the only or the best solution to your problems. I do <u>not</u> want you to make a permanent decision to what may be a temporary problem." (See Ellis, 2004.)

- Have you directly treated the patient's suicidal behaviours (e.g., frequency and duration of suicidal ideation, level of hopelessness, improved the patient's adaptive coping efforts such as emotion-regulation skills, distress and frustration tolerance skills, problem-solving abilities) and the patient's ability to form and sustain supportive relationships?

Have you involved family members and significant others?

- How will you decide if significant others (family members, friends) should be involved in assessment, treatment planning, and interventions? Are there any contra-indications to involve family members such as risk of (re)victimization, level of family members' psychopathology?
- How have you involved the patient's significant others (spouse, parents, caregivers) in the initial assessment, treatment planning, and ongoing risk assessment processes? How have you evaluated the significant other's ability to provide and maintain a safe, supportive environment for the patient? How have you assisted the significant others to develop communication skills with the patient and to address their own needs, stress, and psychopathology, if present?
- Have you helped the patient to establish and mobilize available and accessible social supports? What exactly have you done to accomplish these treatment goals?
- What have you done to communicate assessment and treatment information to the patient's significant others?
- What have you done to alert family members of the patient's suicidal risk? Have you worked out a plan with family members of risk indicators and instituted a suicide watch at home, if indicated? Have you provided a list of preventative interventions/options to help the family members decrease the risk of suicide?
- Have you notified significant others (if appropriate) of the treatment plan and enlisted them as allies in reducing ongoing stressors, and as facilitators of treatment adherence?
- How have you used community resources during the patient's suicidal crises, namely, the police, paramedics, crisis hot line team, the patient's physician, mental health team, and family members?

How have you gone about determining the role of medication?

- How have you gone about assessing *all forms of medication* (prescribed psychotropic, over the counter and other forms of unprescribed medications) that he/she is using? How have you determined what illegal forms of substances the patient is using?
- In consultation with a psychiatrist, what specific psychotropic medications have been prescribed for symptomatic relief? What have you done to ensure that your patient takes the medications as prescribed?
- Given that medication was prescribed, what anticipatory adherence counseling, including a consideration of possible barriers to treatment compliance, have you addressed in treatment?

What specific psychotherapeutic interventions did you provide?

- Let us begin with a question I raised at the outset of this inquiry. Given the critical importance of the *therapeutic relationship* to the assessment and treatment process, what have you done to enhance this relationship and to foster a collaborative working alliance? Have you collaborated with the patient in re-evaluating his/her treatment goals in order to nurture a self-help orientation? (See Ellis, 2004.)
- More specifically, based on your evaluation of the patient's suicidal risk, what specific assessment and treatment decisions and actions have you taken?
- Have you increased the frequency and/or duration of your clinical contacts with the patient?
- Have you conducted frequent assessments of suicide risk and documented these?
- Have you solicited at the outset of treatment in both verbal and written form the patient's informed consent concerning issues of confidentiality and safety?
- In addition, have you considered with the patient the treatment goals and the various treatment options (kind, time, costs, potential benefits) to achieve these goals?
- How have you gone about choosing a specific psychotherapeutic intervention with this patient? In choosing your interventions, where have the promising results on problem-solving therapy with suicidal patients fit in (e.g., Clum & Lerner, 1990; Hawton & VanHeeringen, 2000; Townsend, Hawton, Altman, & Arensman, 2001; Salkovskis, Atha, & Storer, 1990) and cognitive therapy with suicidal patients (Berk et al., 2004; Ellis, 2004; Freeman & Reinecke, 1993; Jacobs, 2000; Linehan, Armstrong, Suarez, Allman, & Heard, 1991; Meichenbaum, 1994, 2002,: Reilly, 1998; Rudd, 1998; Rudd et al., 1996, 2001).
- It has been recommended that the treatment for patients who are experiencing an acute suicidal crisis should consist of relatively short-term psychotherapy, that is, directive and crisis-focused, which emphasizes problem-solving and skills building. How have these recommendations, if at all, influenced your treatment decision-making?
- It has been recommended in the instance of chronic cases of suicidality that relatively long-term psychotherapy, in which relationship issues, interpersonal communication, and self-image issues, should be the focus of your intervention. How have these recommendations, if at all, influenced your treatment decision-making?

- Have you addressed in treatment with the patient the identified stressors that contributed to suicidal risk? Has the patient experienced losses, reversal in status, changes in circumstances or health? How have these issues been addressed?
- Have you reframed the suicide attempt as a failure in problem-solving, and worked with your patient to increase options for dealing with life stressors and interpersonal conflicts?
- Have you helped the patient break what he/she perceives as his/her problems into smaller parts in order to deal with one aspect at a time? How have you helped the patient appreciate that the stressors he/she experiences are potentially solvable problems?
- What have you done over the course of therapy to remove or lessen the impact of ongoing stressors in the patient's life? How have you helped the patient to address the variety of factors that may have contributed to the initial suicidal attempt such as acute conflict with significant others, losses, history of victimization?
- Which of the following targeted-identified skills deficits that contributed to the suicidal behaviour have you targeted for treatment, namely, emotional dysregulation, poor distress tolerance, impulsive behavioural style, anger management, interpersonal communication, cognitive distortions, poor problem-solving, self-image disturbances, and day-day functioning at home and at work? How have you helped the patient address each of these deficits?
- What have you done to help the patient extricate him/herself from such difficult situations? How have you helped the patient to address his/her sense of loneliness, feelings of unworthiness, and unloveability?
- What have you done to help the patient develop a life that is "worth" living? What specific therapeutic steps have you taken to help the patient improve his/her life? As Linehan (1999, p. 166) observed, ***"Therapy must be more than a suicide prevention program. It must be a life improvement program."***
- Have you given the patient anything to read concerning suicidal behaviour? For example, bibliotherapy such as *Choosing to Live* (Ellis & Newman, 1996).
- Given the high rates of nonattendance of suicidal patients at aftercare follow-up, some 50%-60%, what explicitly have you done to increase the likelihood that your patient will indeed show up at your sessions? Have you set up a specific date and time for follow-up appointments; thoroughly explained the reasons for continuing with care; reviewed the likely goals and proposed length of therapy; reviewed with the clients and, where appropriate, the client's family, their expectations and possible misconceptions about therapy; directly addressed any possible resistance and maintained ongoing contact with the patient; actively sought out the patient when he/she became less responsive and did not show up for treatment; and actively engaged the patient and significant others in a verbal agreement to engage in at least six brief therapy sessions and, based on the progress during this time period, to consider extending treatment (see Moller, 1990; Rudd & Joiner, 1998a).
- Have you increased the number of outpatient visits and/or increased the number of telephone contacts?
- How have you evaluated the relative effectiveness of your interventions in reducing the patient's suicidal ideation and self-injurious behaviours (e.g., frequency, intensity, duration, specificity) and accompanying comorbidity and correlates (e.g., attributional style, ruminative behaviour, problem-solving ability)? Have you also assessed for changes in protective factors such as an increase in social supports?
- On an ongoing basis, what patient changes have influenced the assessment and treatment decisions you made?
- If you are referring your patient to others, have you called ahead to verify that the patient could be seen, as advised? Have you followed up to ensure that the patient has in fact attended the sessions and is continuing treatment?
- Have you kept both accurate records and progress notes concerning the patient and have you shared this information and consulted with a colleague?

INPATIENT STATUS

When the suicidal patient has been seen on an inpatient basis, the following questions must be addressed.

- If the suicidal patient is an *inpatient*, are you providing constant surveillance in a secure ward? Have you informed the attending staff members of the patient's suicide risk?
- Have you put the patient on a suicide watch?
- Have you used physical and/or chemical restraints?
- Have you used oral or intravenous medications? How are you monitoring their effectiveness?
- Have you conducted a careful, systematic search of the patient and a careful review of the environment to remove all potential items that could be used in suicidal attempts?
- Have you trained your staff to identify suicide risk factors? Please describe this training and how you provide ongoing evaluation of the staff's skills.
- Do you have a rapid intervention team in your hospital setting to respond to suicidal attempts?
- Do you confer with professional colleagues about the suicidal risk assessment of this patient and document the formal consultation in the patient's record?
- Do you document in your progress notes the level of suicidal risk and attendant decisions and actions you take?