# ***HANDOUTS***

# *Suicide Assessment & Management*

***Standard of Care Strategies***

Presented by

**M. David Rudd, Ph.D., ABPP**
Professor & Chair, Dept. of Psychology
Texas Tech University

## AGENDA

**9:00 Understanding Suicidality and the Standard of Care**
- Standards of care
- What we know about suicide risk assessment, intervention and treatment

10:20 Break (coffee and tea)

10:35 **A Model for Suicide Risk Assessment**
- An empirically informed approach to risk assessment
- Understanding subjective and objective intent
- Differentiating acute and chronic risk

12:00 p.m. Lunch (on your own)

**1:15 Intervention and Management**
- Reconsidering no-suicide contracts and informed consent
- The Commitment to Treatment Agreement
- The crisis response plan
- Critical issues in initial management and treatment

2:30 Break (coffee, tea, soda, snack)

2:45 **The Essentials of Documentation**
- The good, the bad and the ugly
- Essential elements of a good risk assessment entry
- Open and closed markers of risk
- Standard forms

**4:15** Adjournment (pick up CE certificates)

Sponsored by
***J&K Seminars, LLC***
1861 Wickersham Lane
Lancaster, PA 17603-2327
(800) 801-5415
jk@jkseminars.com
www.jkseminars.com

**M. David Rudd, Ph.D., ABPP**
Professor & Chair Psychology Department
Texas Tech University
MS42051
Lubbock TX 79409-2051
806-742-3711 ext 224
David.rudd@TTU.edu

# Suicide Assessment and Management

***July 16, 2007***

***M. David Rudd, Ph.D., ABPP***

**Texas Tech University**

"Well, this is just going from bad to worse."

# The Realities of Practitioner Vulnerability

- *Do Implants Trigger Suicide?*
  - *Swedish researchers found that surgically enhanced women are nearly three times more likely to commit suicide. They also reported a strong link between psychiatric disorders and the desire for cosmetic surgery.*
- (Time Magazine, March 2003)

INSIDE HIGHER ED
insidehighered.com NEWS

- **May 24, 2006**
- **Knox Found Negligent in Student's Death**
- Eight years after a mentally ill man beat a fellow student to death in a dimly lit stairwell on the Knox College campus, an Illinois jury has found the college negligent and ordered it to pay $1.05 million to the family of the murdered student.

Psychiatric Times

- ***The Verdict Against Myron Liptzin-Who Sets the Standard of Care?***
- *by Alan A. Stone, M.D.*
- *Psychiatric Times* April 1999 Vol. XVI Issue 4
- Myron Liptzin, M.D., is a respected psychiatrist who specialized in the treatment of university students. Liptzin retired last year as chief of psychiatry of student health at the University of North Carolina at Chapel Hill, where he had earned a reputation as a skillful clinician who was particularly adept at crisis intervention. If Liptzin had hoped to go on to a less hectic and stressful life, his expectations were shattered when he found himself accused of negligence in one of the most unusual cases of psychiatric malpractice of this century. A former patient went on a rampage-killing two people-and then blamed Liptzin. The verdict against the psychiatrist was front-page news, and CBS's "60 Minutes" went to North Carolina to do a story that aired mid-November 1998. Like a bolt out of the blue, Liptzin had gotten his 15 minutes of unwanted fame.
- The suit against Liptzin has a startling ironic aspect in that the $500,000 malpractice verdict against him was awarded not to the families of the shooting victims, but to his former patient, who carried out the killings. A jury in an earlier capital murder trial found the patient not guilty by reason of insanity.

PSYCHIATRIC news

- ***Psychiatric News*** **January 19, 2001**
  **Volume 36 Number 2**
- **Court Orders Reversal In Liptzin Negligence Case**
- **Years after psychiatrists were shocked by a huge damage award levied against a colleague in a widely publicized negligence case, an appeals court rules that the verdict was wrong and must be reversed.** Justice was certainly delayed for psychiatrist Myron Liptzin, M.D.—for nearly three years, in fact. But thanks to a ruling from a North Carolina appeals court, victory is finally his to savor.

- **MIT responds, denies liability in Shin case**
- Kenneth D. Campbell, News Office
  March 13, 2002
- Lawyers filed answers Friday and Monday to the complaint in the $27 million lawsuit against MIT filed by the parents of Elizabeth Shin, the sophomore who died in April 2000 as a result of burns she suffered in a fire in her Random Hall room.
- The MIT answer filed Friday categorically denies "that any MIT Mental Health Service professionals [failed] to provide Ms. Shin with appropriate care" and denies "that her death was proximately caused by any failure on the part of MIT or anyone affiliated with MIT."

boston.com
The Boston Globe

- **11 years, 11 suicides**
  **Critics say spate of MIT jumping deaths show a ‘contagion’**

  By PATRICK HEALY
- **Students at the Massachusetts Institute of Technology have been far more likely to kill themselves over the past decade compared to those at 11 other universities with elite science and engineering programs — 38 percent more often than the next school, Harvard, and four times more than campuses with the lowest rate — a Globe study has found.**

- *The boy cried for help but was all but ignored. He missed two weeks of school before his death, yet that apparently wasn't viewed as a serious sign of risk. He soiled himself but that wasn't construed as a sign of poor mental health or emotional distress…Any parent understands that it's simplistic to believe that Judith Scruggs alone is responsible for her child's taking the desperate step of hanging himself in a closet…Many missed the obvious signs of his distress*
- Hartford Courant, October 2003

- June 26, 2006
- **Suicide of a Chancellor**
- In the last 18 months, as issues of women in science have received unprecedented attention, Denise D. Denton has been front and center. Any gathering of such scholars would indeed have included Denton, who was then dean of engineering (one of her many "first woman" accomplishments) at the University of Washington and was about to become chancellor of the University of California at Santa Cruz. Denton's career — highly successful in many regards, but challenged of late — came to an end Saturday morning when she leapt to her death from the roof of a San Francisco high rise. Denton had been on medical leave for 10 days, missing the commencement ceremonies at Santa Cruz, but she had been expected to be back on the campus today. *The San Francisco Chronicle* reported that Denton's mother told police that she was "very depressed" about her professional and personal life.

Chronicle / John Storey

On the bridge, Baldwin counted to ten and stayed frozen. He counted to ten again, then vaulted over. "I still see my hands coming off the railing," he said. As he crossed the chord in flight, Baldwin recalls, "I instantly realized that everything in my life that I'd thought was unfixable was totally fixable—except for having just jumped."

Tad Friend. Jumpers. The New Yorker (2003)

## Understanding the Challenge of the Suicidal Patient…………….

- *Robert, a 21 year old African-American male……….died of a gunshot wound to the head.*

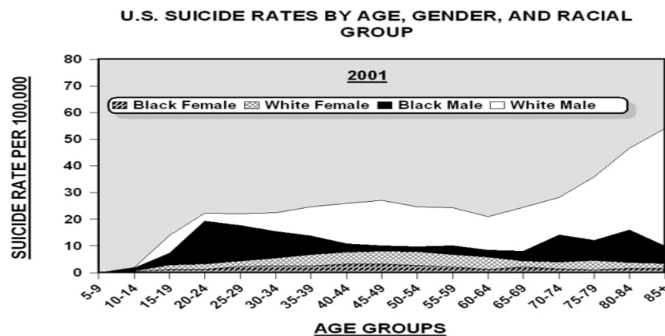
- *Well, I've come down to the fact that the people I care about, depend on, and have supported in their time of need, don't give a crap about me. Thoughts of murder and suicide constantly go through my head. What I'm I to do? I don't trust anyone. I'm not going to expose myself again to the backstabbing, two-faced reality that is friendship. I want to blow my brains out plain and simple. I'm not taking it anymore.*

## The Challenge of the Suicidal Patient…..

- Brad, a 20 year old Caucasian male……died of a gunshot wound to the head.

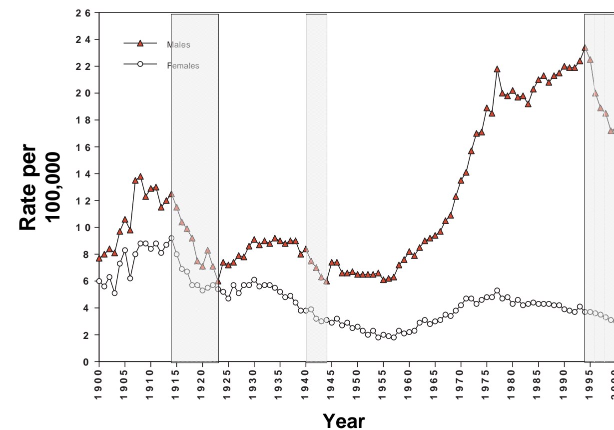
- *I don't want to be a burden on my parents anymore. My life has always been full of depression. I've never lived up to my potential. I've decided to end all of this pain. I am at peace. Goodbye.*

## What Every Clinician Needs to Know About Suicide: Rates, Risk Factors and OR's




## FLUCTUATIONS IN 20TH-CENTURY YOUTH SUICIDE RATES

— UNITED STATES, AGES 15–24 —




Anderson 2002, CDC Wonder 2002, USDHEW 1956, Vital Statistics U.S. 1954–1978

C.E12

# The FDA Warning for Children and Adolescents……………………

**Suicidality in Children and Adolescents**

**Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with Major Depressive Disorder (MDD) and other psychiatric disorders. Anyone considering the use of [Insert established name] or any other antidepressant in a child or adolescent must balance this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. [Insert established name] is not approved for use in pediatric patients. (See Warnings and Precautions: Pediatric Use)** [This sentence would be revised to reflect if a drug were approved for a pediatric indication(s). Such as, [Insert established name] is not approved for use in pediatric patients except for patients with [Insert approved pediatric indication(s)]. (See Warnings and Precautions: Pediatric Use)]

**Pooled analyses of short-term (4 to 16 weeks) placebo-controlled trials of 9 antidepressant drugs (SSRIs and others) in children and adolescents with major depressive disorder (MDD), obsessive compulsive disorder (OCD), or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal thinking or behavior (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events in patients receiving antidepressants was 4%, twice the placebo risk of 2%. No suicides occurred in these trials.**

OPEN LETTER ON ANTIDEPRESSANTS

As advocates for people living with depression and other mental illnesses, we strongly urge the FDA to carefully consider the potential impact of the agency's public statements on the risks and benefits of antidepressants. Access to effective treatments for depression is pivotal in improving the lives of the 19 million Americans that face this devastating illness each year.

Depression can be a debilitating and even fatal illness; yet, despite the wide availability of effective treatments, fewer than half of Americans with depression seek help. This is despite a deep science base that shows treatment works and that medication is often a critical tool in treating depression. In fact, untreated depression carries far greater risk than any potential risk of adverse effects of medication.

It is important to draw lessons from previous pediatric warnings and ensuing media coverage that created barriers to care and unnecessarily scared families away from treatment. The best way to protect the public health is to increase awareness about mental illnesses and treatment options, encourage proper monitoring of patients in treatment and communicate balanced information that helps patients and their families cope and properly treat these terrible illnesses.

Our non-profit national mental health advocacy and medical professional organizations represent consumers, physicians, researchers and the top experts in the field of mental health and neuroscience. For more information about mental illness and treatment, we recommend that you talk to your health care provider or visit our organization websites.

American Academy of Child and Adolescent Psychiatry • www.aacap.org
American Association for Geriatric Psychiatry • www.aagponline.org
American College of Neuropsychopharmacology • www.acnp.org
American Association of Suicidology • www.suicidology.org
American Foundation for Suicide Prevention • www.afsp.org
American Psychiatric Association • www.psych.org
American Psychotherapy Association • www.americanpsychotherapy.com
Children and Adults with Attention Deficit/Hyperactivity Disorder • www.chadd.org
Families for Depression Awareness • www.familyaware.org
Kristin Brooks Hope Center • www.hopeline.com
Mental Health America • www.mentalhealthamerica.net
National Alliance on Mental Illness • www.nami.org
Suicide Awareness Voices of Education • www.save.org
Suicide Prevention Action Network • www.spanusa.org
The Jason Foundation, Inc • www.jasonfoundation.com

# Problems and Implications

- Problems
  - No suicides across studies
  - Small number of adverse events
    - 176 (clinical arm) versus 88 (placebo arm)
  - Diagnostic questions (i.e. bipolar illness)
  - Brief duration of follow-up
- Possible Implications?
  - Reduced use of medications
  - Generalization of concerns to treatment in general

- **Clinical Worsening and Suicide Risk:** Patients and their families should be encouraged to be alert to the emergence of anxiety, agitation, panic attacks, insomnia, irritability, hostility, impulsivity, akathisia, hypomania, mania, other unusual changes in behavior, worsening of depression, and suicidal ideation, especially early during antidepressant treatment and when the dose is adjusted up or down. Families and caregivers of patients should be advised to observe for the emergence of such symptoms on a day-to-day basis, since changes may be abrupt. Such symptoms should be reported to the patient's physician, especially if they are severe, abrupt in onset, or were not part of the patient's presenting symptoms. Symptoms such as these may be associated with an increased risk for suicidal thinking and behavior and indicate a need for very close monitoring and possibly changes in the medication.

## The Ugly

The suicide rate climbed 18 percent from 2003 to 2004 for Americans under age 20, from 1,737 deaths to 1,985. Most suicides occurred in older teens, according to the data — the most current to date from the federal Centers for Disease Control and Prevention.

- Lineberry et al. (2007). Impact of the FDA Black Box Warning on Physician Prescribing and Practice Patterns: Opening Pandora's Box, Mayo Clinic Proceedings, 82 (4), 516-522.
  - 70% of Generalists change in practice
    - Less likely to prescribe (9%)
    - Referral to mental health (17%)
  - 68% of Other Specialists change in practice
    - Less likely to prescribe (20%)
    - Referral to mental health (23%)

## SUICIDE RISKS IN SPECIFIC DISORDERS

| Condition | RR | %/y | %-Lifetime |
|---|---|---|---|
| Prior suicide attempt | 38.4 | 0.549 | 27.5 |
| Eating disorders | 23.1 | | |
| Bipolar disorder | 21.7 | 0.310 | 15.5 |
| Major depression | 20.4 | 0.292 | 14.6 |
| Mixed drug abuse | 19.2 | 0.275 | 14.7 |
| Dysthymia | 12.1 | 0.173 | 8.6 |
| Obsessive-compulsive | 11.5 | 0.143 | 8.2 |
| Panic disorder | 10.0 | 0.160 | 7.2 |
| Schizophrenia | 8.45 | 0.121 | 6.0 |
| Personality disorders | 7.08 | 0.101 | 5.1 |
| Alcohol abuse | 5.86 | 0.084 | 4.2 |
| Cancer | 1.80 | 0.026 | 1.3 |
| General population | 1.00 | 0.014 | 0.72 |

Adapted from A.P.A. Guidelines, part A, p. 16

## Risk Factors for Suicide (OR's): The Question of Risk Resolution?

Qin et al, 2003; Cheng et al, 2000, Shaffer et al, 2000

- Discharge from psychiatric hospitalization
  - Last week 278 x
  - Last month 133 x
  - Last year 34-61 x
- Prior attempt (adol) 22.5 x
- Substance abuse (adol) 7 x
- Firearm in home 5 x
- Chronic renal failure – dialysis 14.5 x
- On disability/unemployed 2-6 x

## Risk Factors

- **Family History: Odds Ratios**

| | OR |
|---|---|
| Depression: | 11 x |
| Substance Abuse | 10 x |
| Sexual Abuse (if intercourse) | 5 x |
| Suicide attempt | 5 x |
| Family discord | 2.5-5 x |
| Psychiatric admission | 2.2 x |

## What is "The Standard of Care"???

- That degree of care which a reasonably prudent person or professional should exercise in same or similar circumstances (Black, 1979, p. 1260
- The duty of therapists to exercise adequate care and skill in diagnosing suicidality is well established (see Meier v. Ross General Hospital, 1968).
- When the risk of self-injurious behavior is identified an additional duty to take adequate precautions arises (Abille v. United States, 1980; Pisel v. Stamford Hospital, 1980).
- When psychotherapists fail to meet these responsibilities, they may be held responsible for injuries that result (Meyer, Landis, & Hays, 1988, p. 38).

*Bongar, B., Berman, A. L., Maris, R. W., Silverman, M. M., Harris, E. A., & Packman, W. L. (eds.). Risk Management with Suicidal Patients. New York: Guilford Press.*

## Three Pillars of Malpractice Liability

(Jobes & Berman, 1993)

- Foreseeability
  - Assessment and documentation of risk
- Treatment Planning
  - Documentation of plan based on determined risk
- Follow-up/Follow Through
- Documentation of executing and following the plan

## Forseeability

**Risk assessment was conducted**

**Risk assessment was thorough**

**Possible use of assessment instruments**

**Possible use of psychological testing**

**Make overall clinical judgment of suicide risk**

**Seek consultation and adequately document assessment information**

## Treatment Planning

Use overall risk to inform and shape treatment plan

Identify both short and long term treatment goals

Consider full range of treatments—what will be used and why

Consider various safety contingencies

Routinely revise and up-date treatment plan

Overhaul treatment plan when necessary

Seek consultation and adequately document treatment information

## Follow-up and Follow-Through

Make sure treatments are being implemented

Coordinate care with others as needed

Always insure clinical coverage when unavailable

Carefully make referrals and follow-up (issues of clinical abandonment)

Seek consultation and adequately document follow-up/follow-through

## Core Competencies and Practice Guidelines

- American Psychiatric Association
- Assessment and Management of Suicide Risk (AAS and SPRC)

## Skill Sets, Competence, and the Standard of Care: Attitudes and Approach

- Awareness of emotional reactions, attitudes, and beliefs related to suicide
- Tolerate and regulate one's emotional reactions to suicide
- Clarity of beliefs related to suicide and end of life
- Understand the impact of these factors in the clinical scenario

- A Clinical Example: Establishing a Therapeutic Alliance

- What behaviors did the clinician use to help form an alliance?
- What is the clinician's attitude toward the client?
- What are the indicators an alliance is forming?
- What does the clinician do to reassure the client?

## Theory, Treatment, and Individual Differences?

- Why do people kill themselves?
- Is it ever acceptable to suicide?
- Can suicide be prevented?
- Do people that access care want to die?
- What are your individual responsibilities?

## Therapist Variables

- Answers depend on:
  - Personal experience with suicidality
  - Attitudes, beliefs, religiosity re: suicide, life
  - Professional experience with suicidality

## What Are Common Emotional Reactions?

- Fear/Anxiety Spectrum:
  - Related to beliefs that
    - Suicidal behavior will occur
    - Will be held responsible
    - Detailed discussion will encourage suicidality
- Anger Spectrum:
  - Related to beliefs that
    - Helpless, hopeless
    - Must control

## Clinician's Emotional Reaction Can….

- Trigger suicidal behavior
- Encourage suicidal ideation and behavior to be kept secret
- Limit growth and development
- Damage alliance
- Result in client's withdrawal and isolation

## Attitudes and Approach (continued)

- Reconcile the difference between the clinical goal to prevent suicide and the client's goal to eliminate psychological pain
- Know and communicate the "rules" regarding confidentiality and the medico-legal aspects to adults, children and adolescents
- Demonstrate desirable attitudes
  - Understanding of psychological pain, instrumental aspects of behavior, loss of self-respect
  - Nonjudgmental perspective
  - Authentic concern
  - Doing "whatever it takes"
  - Accepting the real possibility of death

## Attitudes and Approach (continued)

- Maintain collaborative, non-adversarial stance
  - Listen
  - Communicate clearly
  - Encourage honest reporting
  - Safe environment
  - Empathetic
- Consult with and refer to other clinicians
- Realistic assessment of one's ability and time to assess and care for suicidal patients

## The Importance of Informed Consent

- Provides a foundation to relationship
  - Honest, caring, blunt
- Articulates responsibilities
  - Patient and clinician
- Reduces fearfulness of patient
  - Consequences and boundaries are clear
- Raises the issue of death as "risk"

---

- A Clinical Example: Understanding Suicidality

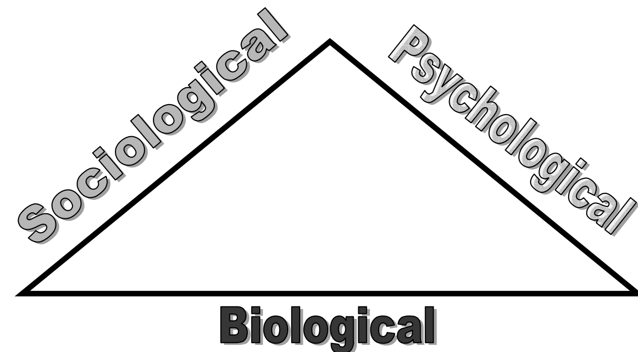
---

## A Conceptual Model for Treatment and Management

- Skill Set: Understand suicide
  - Basic definitions and terms
  - Phenomenology of suicide
  - A biopsychosocial perspective
    - Assessing each domain
    - Consider each in formulating risk
    - Integrate each into treatment
    - Consider each in management decisions
    - Document each in record

---

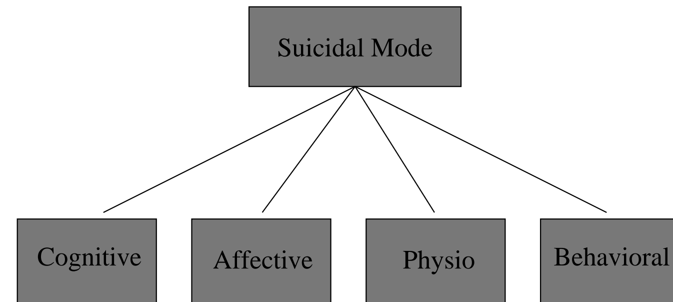
## Understanding the Suicidal Mind



# Beck's Theory of Modes and Modifications for the *Suicidal Mode*

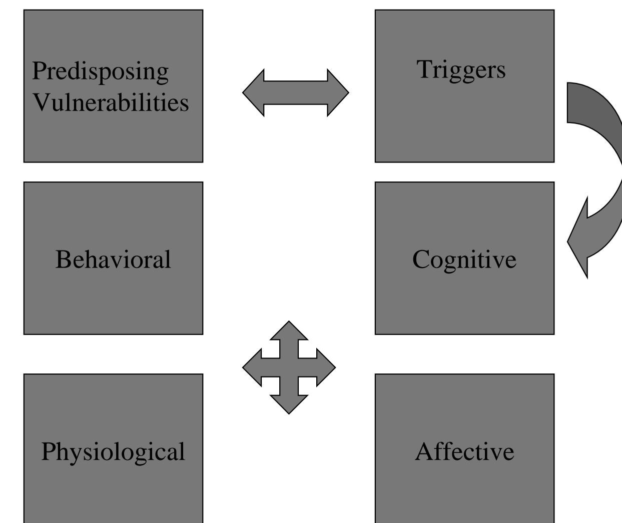
- *Mode: Specific suborganizations within the personality organization that incorporate the relevant components of the basic systems of personality: cognitive (information processing), affective, behavioral, and motivational* (Beck, 1999; p. 4).

# Modal Components




# Modal Components

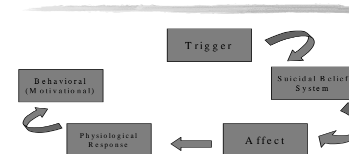
- Cognitive: all aspects of information processing, critical component is the *suicidal belief system*
- Affective: produces emotional, affective experience
- Motivational/Behavioral: allows for automatic activation or deactivation of the individual for response
- Physiological: comprised of physiological symptoms comprising the mode



# Synchronous Activation

- *As I stood holding onto the rail I began to think about climbing over the rail and just jumping. I looked down below and thought about how far it was. I knew if I did jump, it would kill me for sure. It is hard to describe exactly what I felt at this time, but I shuddered all over. There was just this overwhelming pressure from within telling me if I just climbed up and jumped, all of this would be over in a matter of seconds. I had never felt like this before. I knew that I had to get back into the room and off that balcony. I realized as I tried to move away from the rail, that I had great difficulty doing so. It was as if I couldn't move----I just kept looking at the ground and thinking "just do it". I finally made myself go inside the room, close the sliding glass door, and lock it. I sat on the edge of the bed, scared and shaking, knowing that those feelings of self-destruction were still close and fresh.*

# Making it Easy to Understand:
## A Linear Application of the Active Suicidal Mode




# Understanding Suicide-Specific Hopelessness

- Four identifiable themes:
  - Unlovability
    - *I don't' deserve to live*
  - Helplessness
    - *I can't fix my problems*
  - Poor distress tolerance
    - *I can't stand feeling this way*
  - Perceived burdensomeness
    - *Everyone would be better off if I were dead*

# Monitoring Treatment Outcome: IAW with Risk Assessment Approach

- Direct Markers
  - Suicide
  - Suicide Attempts
- Indirect Markers
  - Suicidal Thoughts
    - Frequency, intensity, duration
  - Associated Symptomatology
    - Depression
    - Anxiety
    - Hopelessness
  - Skill development
    - Acquisition
    - Application
    - Refinement

An Empirically Informed Approach to Assessment

***Prediction is hard, especially when you're talking about the future.***

Yogi Berra

# Questions about Suicide Assessment

1. How should clinicians use knowledge of suicide risk factors in their assessment of patients at risk?
2. Which diagnoses, risk factors and symptoms should most concern clinicians?
3. Under what circumstances, if any, should a clinician ask a patient to sign a no-suicide contract?
4. Is psychotherapy always recommended for patients at risk for suicidal behavior?

# Questions about Suicide Assessment

5. Is it ever acceptable to defer or avoid hospitalizing a suicidal patient?
6. Should we expect antidepressants or mood stabilizers to lower suicide risk?
7. What are the most important elements to document in a suicide risk assessment?

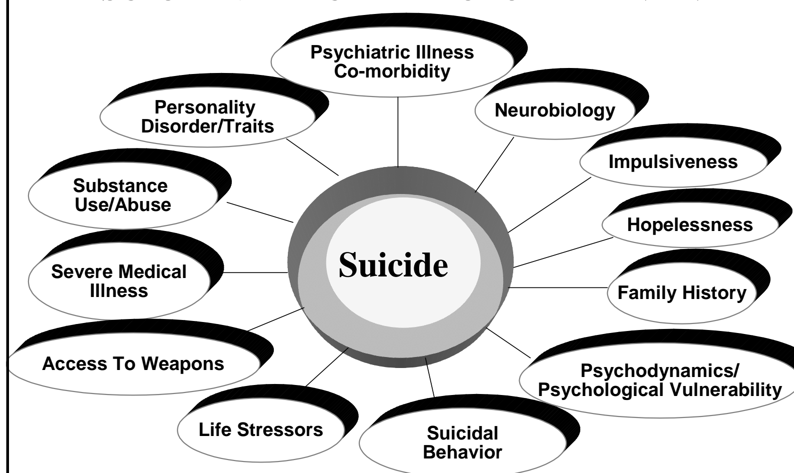
## SUICIDE PREDICTION vs. SUICIDE ASSESSMENT

- **<u>Suicide Prediction</u> refers to the foretelling of whether suicide will or will not occur at some future time, based on the presence or absence of a specific number of defined factors, within definable limits of statistical probability**
- **<u>Suicide (risk) Assessment</u> refers to the establishment of a clinical judgment of risk in the very near future, based on the weighing of a very large mass of available clinical detail. Risk assessment carried out in a systematic, disciplined way is more than a guess or intuition – it is a reasoned, inductive process, and a necessary exercise in estimating probability over short periods.**

## COMPONENTS OF SUICIDE ASSESSMENT

- **Appreciate the complexity of suicide / multiple contributing factors**
- **Conduct a thorough psychiatric examination, identifying risk factors and protective factors and distinguishing risk factors which can be modified from those which cannot**
- **Ask directly about suicide; The Specific Suicide Inquiry**
- **Determine level of suicide risk: low, moderate, high**
- **Determine treatment setting and plan**
- **Document assessments**

## SUICIDE: A MULTI-FACTORIAL EVENT




## Areas to Evaluate in Suicide Assessment

| | |
|---|---|
| Psychiatric Illnesses | **Comorbidity,** Affective Disorders, Alcohol / Substance Abuse, Schizophrenia, Cluster B Personality disorders. |
| History | Prior suicide attempts, aborted attempts or self harm; Medical diagnoses, Family history of suicide / attempts / mental illness |
| Individual strengths / vulnerabilities | Coping skills; personality traits; past responses to stress; capacity for reality testing; tolerance of psychological pain |
| Psychosocial situation | Acute and chronic stressors; changes in status; quality of support; religious beliefs |
| Suicidality and Symptoms | Past and present suicidal ideation, plans, behaviors, intent; methods; hopelessness, anhedonia, anxiety symptoms; reasons for living; associated substance use; homicidal ideation |

**Adapted from APA guidelines, part A, p. 4**

## Definitional Issues

Differentiated on three features:

- Intent (i.e., subjective versus objective)
- Evidence of self-infliction
- Outcome (i.e., injury, no injury, death)

## Advantages

- Remove pejorative language: gestures
- Improve consistency of documentation
- Improve communication between clinicians
- Improve accuracy of risk assessments
- Improve clinical decision making
- Improve treatment outcomes

## Intent Subjective vs. Objective

- Subjective: *stated intent*
- Objective markers of intent: lethal method, preparation (letter writing, financial records, giving away possessions), prior attempts with serious injury, efforts to prevent discovery/rescue, help seeking behavior after an attempt

## Example of Objective Markers of Intent

- 28 y/o African-American male hung himself in the closet (highly lethal method), waited till his wife and child left, prepared a financial and insurance packet, made no effort to seek help, was only discovered because his wife *forgot something at the house* and returned

# Terminology

- Suicide attempt with injuries
  - non-fatal injury, intent, extent of injuries
- Suicide attempt without injuries
  - potentially self-injurious behavior, intent
- Instrumental suicide related behavior **or Self-Harm Behavior**
  - potentially self-injurious behavior, motivation other than death, with/without injuries
- Suicide Threat
  - interpersonal action, verbal or nonverbal, stopping short of a directly self-harmful act

# Terminology and the Clinical Scenario: Working with Chronic Individuals

- Instrumental suicide related behavior (not recommended for use in school district)
  - potentially self-injurious behavior, motivation other than death, with/without injuries
- Sara, 21 year old Hispanic female…….
- *Thoughts of wanting to be dead flew through my head. I felt like cutting myself, looking for places it wouldn't show and wouldn't drain on my clothes. I though about taking my pills to excess. It wouldn't have killed me but probably would have numbed me and I really want that right now………*

# Skill Sets: Collecting Assessment Information

- Obtain accurate information
  - Integrate risk assessment for suicide within the context of a clinical interview in multiple settings, knowing that all clients are potentially at risk for suicide and that the risk for suicide must be ruled out in each case.
    - Obtain records and information from collateral sources
    - Continue to collect assessment data, including asking the client about his/her urge to quit treatment, at critical times
      - Precipitating events, transitions, increased stress, mental status changes, immediately following an attempt or hospitalization, when treatment setting changes, and the end of a crisis intervention incident.

# Content vs. Process

- Content: questions, risk variables
- Process: interpersonal factors determine emotional response, disclosure, can be conceptualized as intervention

## Risk Assessment: Process

- Interpersonal variables important:
  - to engage, listen
  - direct, unambiguous language
  - eye contact
  - specific questions
  - repetitive questions (method, plan)
  - collaborative decision making
  - role of hierarchical questioning
  - acknowledge resistance

## Monitoring Process

- Initial Phase: historical focus, what's already happened
- Assessment Phase: current status
- Action (Intervention) Phase: future plans
- Phase changes occur during and across sessions

## Risk Categories: Static

- Predisposition to Suicidality
  - prior suicidality, attempts, ideation
  - frequency, context, perceived lethality, outcome, stated intent, rescue opportunity, preparatory behaviors (psychological/practical), help seeking behaviors
    - Risk/Rescue issues
      - Method, timing, place, arranging sequence of events
  - psychiatric hx, diagnosis, treatment hx, response, compliance
  - abuse hx, sexual, physical, emotional

---

- Primary Distinctions:
  - Multiple attempters vs. single attempters or ideators
  - Psychotic vs. non-psychotic
  - Presence vs. absence of substance abuse

## Risk Categories: Aggravating

- Precipitant/Stressors
  - Interpersonal loss or conflict
  - Economic or legal problems
  - Consider in the context of individual vulnerability, strengths, and support system
- Symptoms (essentially Axis I picture)
  - Emphasis on depression and anxiety (79% of inpatient suicides reported severe anxiety/agitation), command hallucinations
  - type, breadth, severity, duration
  - associated cognitive disruption, mental status impairment
- Hopelessness
  - severity, duration, source(s)

## AFFECTIVE DISORDERS AND SUICIDE

**High-Risk Profile:**

- **Suicide occurs early in the course of illness**
- **Psychic anxiety or panic symptoms**
- **Moderate alcohol abuse**
- **First episode of suicidality**
- **Hospitalized for affective disorder secondary to suicidality**

- **Risk for men is four times as high as for women except in bipolar disorder where women are equally at risk**

## SCHIZOPHRENIA AND SUICIDE

**High-Risk Profile:**

- **Previous suicide attempt(s)**
- **Significant depressive symptoms - hopelessness**
- **Male gender**
- **First decade of illness – (however, rate remains elevated throughout lifetime)**
- **Poor premorbid functioning**
- **Current substance abuse**
- **Poor current work and social functioning**
- **Recent hospital discharge**

## ALCOHOL / SUBSTANCE ABUSE AND SUICIDE

- **Suicide occurs later in the course of the illness with communications of suicidal intent lasting several years**
- **In completed suicides, men have higher rates of alcohol abuse, women have higher rates of drug abuse**
- **Increased number of substances used, rather than the type of substance appears to be important**
- **Most have comorbid psychiatric disorders, females have Borderline Personality Disorder**

**High Risk Profile:**

- **Recent or impending interpersonal loss**
- **Comorbid depression**

## PERSONALITY DISORDERS AND SUICIDE

**Borderline Personality Disorder**

- **Lifetime rate of suicide - 8.5%**
- **With alcohol problems -19%**
- **With alcohol problems and major affective disorder -38% (Stone 1993).**
- **A comorbid condition in over 30% of the suicides.**
- **Nearly 75% of patients with borderline personality disorder have made at least one suicide attempt in their lives.**

**Antisocial Personality disorder**

- **Suicide associated with narcissistic injury / impulsivity.**

## Skill Set: Eliciting Suicidal Ideation

- Comfort in asking about suicide
- Elicit past, present, and current suicidal thoughts, behaviors, plans, intent
- Sequence and word questions in effective manner
  - First attempt, past several years, past several months, current episode
    - Undermines resistance, reduces anxiety, develops trust, improves accuracy of report, differentiates suicidal and instrumental beahviors
- Address client fears about “what will happen” if suicidal thoughts are acknowledged

- Nature of Suicidal Thinking
  - Ideation: frequency, intensity/severity, duration, specificity (plans), availability/accessibility, active behaviors (preparation, rehearsal), intent (subj. vs. obj.), perceived lethality, degree of ambivalence, deterrents (family, religion, positive treatment relationship, support system)
  - Severity of psychological distress pain
    - Distress tolerance

- Clinical Example and Role Play: The Suicide-Specific Inquiry

- Impulsivity/Self-Control
  - objective vs. subjective
  - duration, severity, source

## Risk Categories: Protective

- Protective Factors
  - Markers of the emergence of hopefulness
  - Social support, available and accessible
    - previous crises
  - Coping/problem-solving skills
    - previous crisis management
  - Religious beliefs
  - Life satisfaction
  - Good reality testing
  - Pregnancy
  - Good therapeutic relationship
  - Treatment compliance hx critical
    - investment/commitment to treatment

## Fluid Vulnerability Theory and Understanding Suicide Risk Assessment

- Fundamental Assumptions:
  - Baseline risk varies from individual to individual
  - Baseline risk is determined by *static* factors
  - Baseline risk is higher for multiple attempters (2 or more attempts)
    - more severe, enduring crises w/ precipitant
    - more frequent, severe, enduring crises w/o precipitant
    - more frequent instrumental behaviors/acts

- Risk is elevated by *aggravating* factors
- Severity of risk is dependent on baseline level and severity of aggravating factors

- Risk is elevated by aggravating factors for limited periods of time
  - hours, days, weeks
- Risk resolves when *aggravating* factors effectively targeted
- Risk returns to baseline level only
- Modifying baseline risk requires long-term treatment not just symptom resolution (Axis I)

➢ Risk is reduced by protective factors

➢ Multiple attempters have fewer available protective factors (support, interpersonal resources, coping/problem-solving skills, cognitive, treatment hx)

# Specific High Risk Subgroups:

## Multiple Suicide Attempters

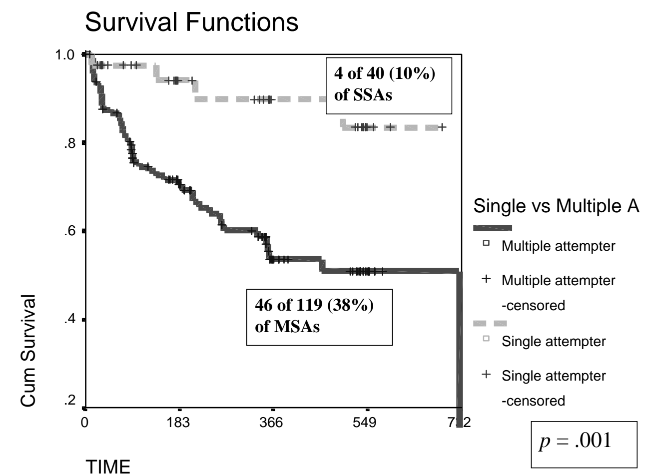
## Multiple Suicide Attempters (MSAs) v. Single Suicide Attempters (SSAs)

➢ Appear to be a different diagnostic group. Higher levels on virtually all measures of psychopathology (depression, hopelessness, global functioning, substance use, borderline pathology, unemployment, etc.)

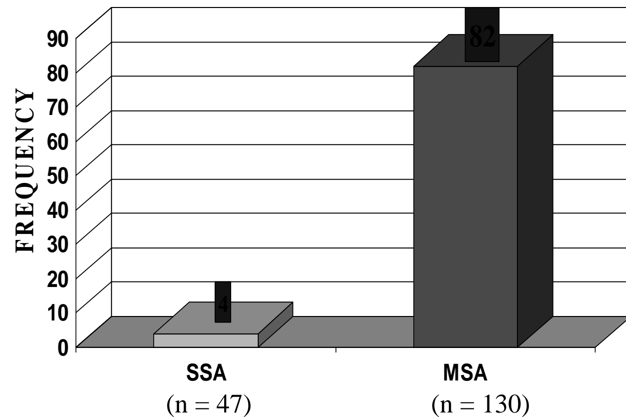
➢ Easily assessed

➢ Much greater risk for subsequent suicide attempt

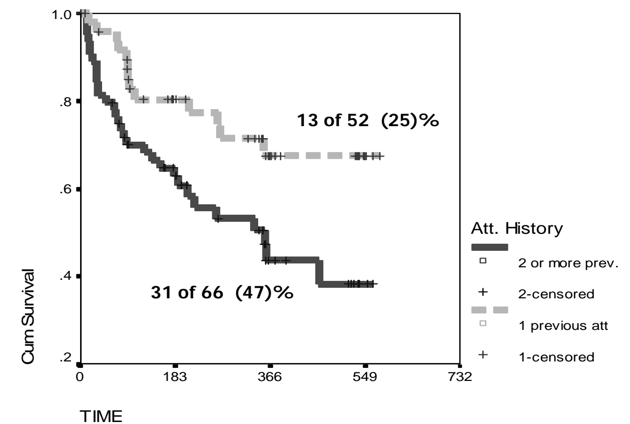
**Survival Curves for Days until First Suicide Attempt by Attempter Status (Single v. Multiple)**



## Total Number of Subsequent Suicide Attempts by Single v. Multiple Attempters



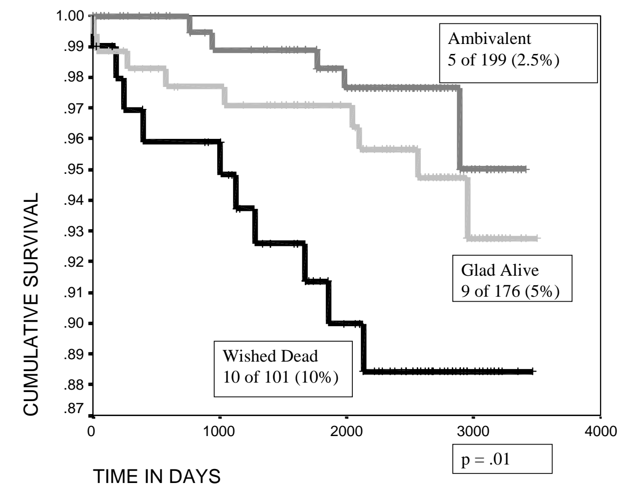

## Survival Curves for Days until Subsequent Suicide Attempt for Patients with 1 previous versus 2 or more previous suicide attempts




## Suicide Attempters' Reaction to Their Attempt as a Predictor of Eventual Suicide

- Suicide attempters have varied reactions to their suicide attempt after it happens.
- We hypothesized and found that those who wished they had died following the attempt would be more likely to eventually kill themselves
- Easily assessed variable that should be documented and considered when evaluating for risk of suicide.
- Revision of article reporting these findings is under review at *JCCP.*

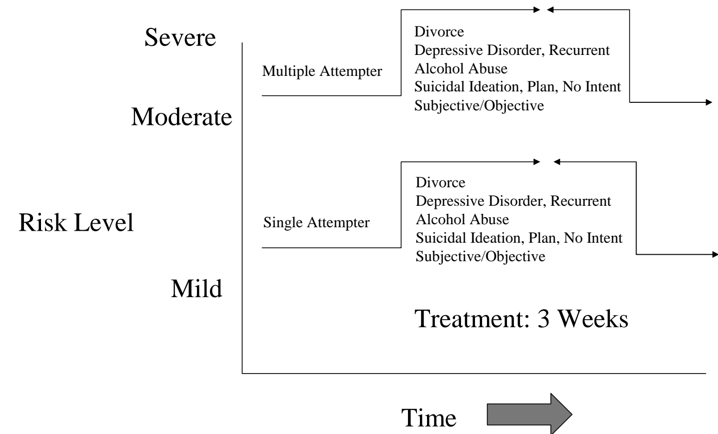
## Survival Curves for Days until Suicide by Reaction to Attempt (Glad Alive, Ambivalent, Wish Dead).



# Risk Quotient

Risk = $\frac{\text{Static Factors + Aggravating Factors}}{\text{Protective Factors}}$

# Graphic Example




# Practical Implications

- Risk: high risk can be enduring, resistant to short-term interventions
- Treatment: short-term, long-term targets
- Liability: limited predictability, control
- Patient responsibility: significant for crisis management, treatment

# Risk Classification

- Acute Risk (1 or fewer previous attempts)
  - Mild
  - Moderate
  - Severe (objective markers of intent, none stated)
  - Extreme (objective and subjective intent)
- Chronic Risk (2 or more previous attempts)
  - with/without acute exacerbation

## Skill Set: Formulation of Risk

- Make a clinical judgment of the likelihood that a patient will attempt or suicide in the short and long-term
  - Integrate and prioritize information
  - Apply research
  - Engage in critical thinking
  - Assess patient's motivation to minimize risk
  - Assess patient's motivation to exaggerate risk

- Provide patient and significant other with a summary of assessment findings and implications for care, next steps
- Write the rationale for clinical judgment in the chart

## Small Group Exercise
## The Case of JoAnn

- Suicide Risk Section
  - Acute Risk?
    - Static Factors
    - Aggravating Factors
      - Precipitant, stressors
      - Symptoms
      - Hopelessness
      - Suicidal Thinking
      - Impulsivity
      - Protective Factors
  - Chronic Risk?

## Risk and Response

- Severe, Extreme
  - immediate psychiatric evaluation
  - accompanied and monitored
- Moderate
  - increase frequency, duration of sessions
  - periodic consideration of need for hospitalization
  - involvement of family

- Reevaluation of treatment goals
- 24-hour availability of ER services
- frequent reevaluation of suicide risk
- consideration of medication for symptom relief/stabilization
- Use of telephone monitoring
- consultation
- frequent input from family members

## Suicide Assessment Measures Problems

Little predictive validity

Limited settings for development, application: psychiatric patients, college students, few used in ER's, primary care settings

Most target children, adolescents, young adults, few for elderly, none address potential differences with minority populations

## Suicide Assessment Measures Problems

Potential differences between self-report and clinician-rated scales---recommend use of both

Clinician's rate risk as more extreme in comparison to self-report

Issue of liability in primary care settings---availability of immediate intervention

## WHEN TO DOCUMENT SUICIDE RISK ASSESSMENTS

- **At first psychiatric assessment or admission.**
- **With occurrence of any suicidal behavior or ideation.**
- **Whenever there is any noteworthy clinical change.**
- **For inpatients:**
  - **Before increasing privileges/giving passes**
  - **Before discharge**
- **The issue of firearms:**
  - **If present - document instructions**
  - **If absent - document as pertinent negative**

## WHAT TO DOCUMENT IN A SUICIDE ASSESSMENT

- **Document:**
  - **The risk level**
  - **The basis for the risk level**
  - **The treatment plan for reducing the risk**

**Example:**

**This 62 y.o., recently separated man is experiencing his first episode of major depressive disorder. In spite of his denial of current suicidal ideation, he is at moderate to high risk for suicide, because of his serious suicide attempt and his continued anxiety and hopelessness. The plan is to hospitalize with suicide precautions and medications, consider ECT w/u. Reassess tomorrow.**

## Documentation continued

- The patient's actual statements (quotes if possible) regarding the increase or alleviation of suicidal thoughts
- The content of discussions about risk and safety
- Any contemporaneous information provided by concerned family members
- Any attempts to obtain prior treatment records
- All increases in treatment intensity or frequency
- Any special precautions taken, or arrangements made
- Any attempts to have the patient voluntarily admit himself or herself to a hospital
- All reasons why hospitalization was rejected as an alternative
- Evening, weekend, and emergency arrangements that were made

(Baerger, 2001)

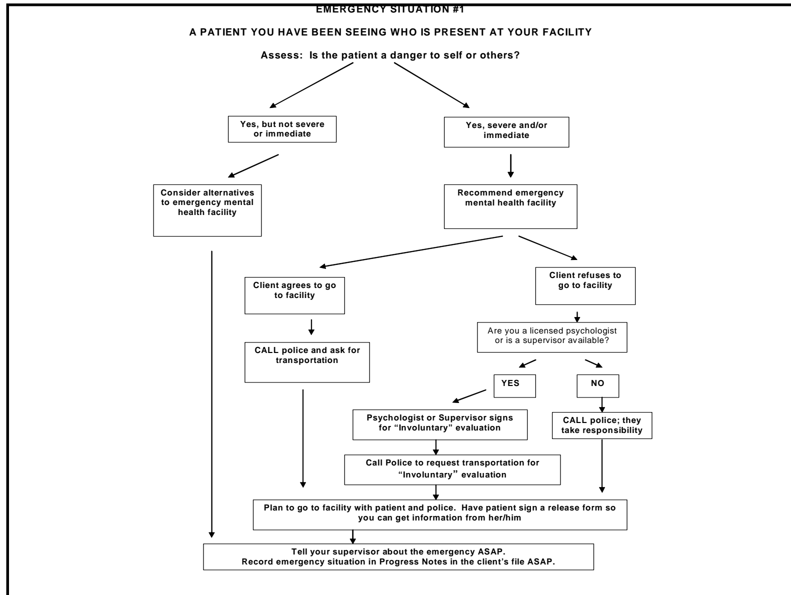
## WHEN A SUICIDE OCCURS

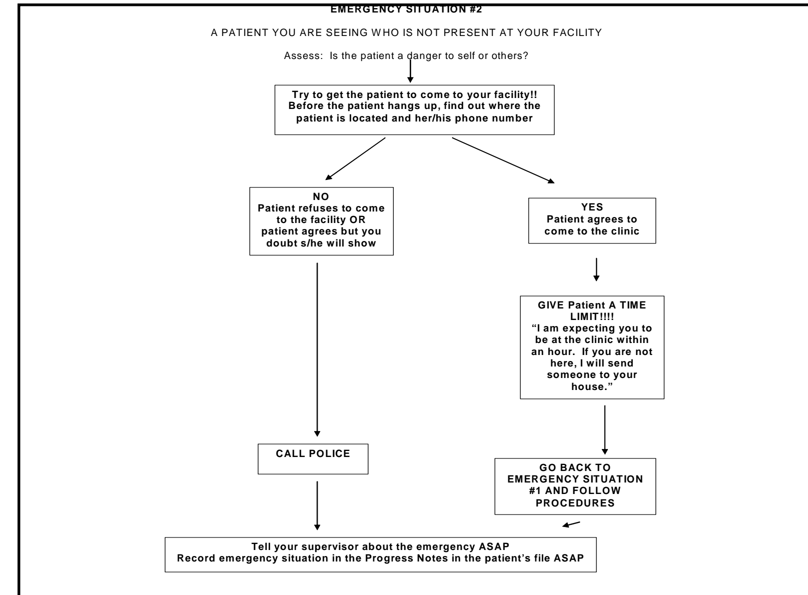
**Despite best efforts at suicide assessment and treatment, suicides can and do occur in clinical practice**

**Approximately, 12,000-14,000 suicides per year occur while in treatment.**

**To facilitate the aftercare process:**

## Consider the Utility of Flow Charts…………………….
.




# Working with Challenging Suicidal Clients

# Some Management Issues and Strategies

## *The Problem and Controversy of No-Suicide* Contracts

- Have limited value and meaning
- No empirical support
- Pose a potential liability
- More a reflection of clinician anxiety and lack of control
- Not actually a therapeutic intervention
- Hidden messages
  - blame, control, *open* communication

## The Importance of Language

Do We Mean What We Say and Say What We Mean?

- Informed Consent
- Capacity
- Compliance
- Competence
- Commitment
- Contract
- Responsibility

## Simple Acts, Complex Meaning

*What are we saying when we make an agreement with an acutely or chronically suicidal patient?*

*In short……………a lot… about the patient, about treatment and about ourselves!*

## A Few Definitions to Consider

- Informed Consent
  - *Agreement to a therapeutic procedure on the basis of the patient's understanding of its nature and possible risks*

  (Longman Dictionary of Psychiatry and Psychology)

- Capacity
  - *The maximum ability of an individual to function in mental or physical tasks*
- Competence
  - *Being adequately or well qualified, a specific range of skill, knowledge or ability; being legally qualified to perform an act.*

- Compliance
  - *Submission to the wishes or suggestions of others*
- Commitment
  - *An agreement or pledge to do something in the future*

- Collaborate
  - *To work jointly*

- Responsibility
  - *Moral, legal, or mental accountability, reliability or trustworthiness*

- Contract
  - *An explicit agreement…usually in writing that states what the patient and the therapist are to do (patient and therapist obligations)…….*

- No-suicide contract
  - No-harm contracts
  - Safety agreements
  - Suicide prevention contract
  - *Means of gaining a patient's commitment to not act on suicidal or self-destructive urges and to inform clinicians of the status of those urges* (Miller, 1999)
  - *Agreement between the patient and clinician in which the patient agrees not to harm herself and/or seek help when in a suicidal state and she believes she is unable to honor the commitment*

## Problem with the word "contract"

- Medico-legal overtones
- May limit open and honest communication
  - Attempts to free clinician from blame
  - "Binding agreement", bind is to confine, restrain, or restrict
  - Patient's recognize this implicitly

## An Empirical Foundation? A Review of the Literature

- A total of 21 articles identified
  - Frequency of use
  - Opinions (favorable, non-favorable)
    - Patients
    - Clinicians
  - Perceived utility
  - Potential problems, liability concerns

- Three useful empirical studies
  - Drew (2001)
    - Patients with no-suicide contracts more likely to engage in self-harm (retrospective chart review)
  - Kroll (2000)
    - 41% of clinicians using no-suicide contracts had patients die by suicide or make serious attempts while under an agreement
  - Kelly & Knudson (2000)
    - *No empirical evidence supports the effectiveness of no-harm contracts in preventing suicide.*

## General Conclusions from the Literature

- Agreements routinely used
- No empirical evidence of effectiveness
  - Reducing targeted behaviors?
    - Direct and indirect markers of suicidality
  - Increasing use of emergency services?
  - Facilitating improved therapeutic relationship or general treatment outcomes?
- Not theoretically driven or related

## Some Troubling Trends and Questions?

- Evidence of lack of formal training and theoretical models for use with suicidal patients
- Evidence of increasing use with those at higher risk
  - Despite a lack of data on effectiveness
- Evidence of high-rates of attempts/suicides while in use
  - 41% made an attempt, completed suicide

## Areas of Identified Need

- Theoretical models driving use of contracts/agreements with patients
  - When is it used?
  - Why?
  - Updated?
  - Eliminated?
- What are the essential elements of an agreement?
- Differential impact across patient type?

- Outcome data re:
  - Impact on target behaviors
    - Suicidal
    - Use of crisis/emergency services
    - Other treatment targets?
  - Therapeutic alliance
  - Overall treatment process

## The Central Role of Competence

- Fundamental Assumptions
  - There is an inverse relationship between impairment and competence
  - There is an inverse relationship between risk level and competence
  - Risk level and impairment are fluid constructs

- Chronic risk carries some limitations in competence
  - In crisis management
  - Daily living
  - Therapy

## Impaired…..by Definition?

- Brad, a 20 year old Caucasian male……died of a gunshot wound to the head.

- *I don't want to be a burden on my parents anymore. My life has always been full of depression. I've never lived up to my potential. I've decided to end all of this pain. I am at peace. Goodbye.*

- *Robert, a 21 year old African-American male………..died of a gunshot wound to the head.*
  - *Well, I've come down to the fact that the people I care about, depend on, and have supported in their time of need, don't give a crap about me. Thoughts of murder and suicide constantly go through my head. What I'm I to do? I don't trust anyone. I'm not going to expose myself again to the backstabbing, two-faced reality that is friendship. I want to blow my brains out plain and simple. I'm not taking it anymore.*

## When Agreements are *NOT* Appropriate

- High (imminent) risk patients
  - Acute and chronic distinctions
- Severely compromised competence
  - Symptom type and severity
- Lack of commitment
  - Objective and subjective evidence
- Inability or unwillingness to engage in collaborative care

## What's a Commitment to Treatment Agreement

- *An explicit agreement that identifies patient and clinician responsibilities in ongoing care. Such an agreement always includes a crisis response plan and incorporates behaviors consistent with the patient's identified level of competence and unique to his or her presentation.*

## Making Reasonable Agreements

- *Commitment to treatment* statement
  - Individualized
  - Concrete and specific
  - Enhanced individual responsibility
  - Commitment to living
  - Does not imply giving up control or *right to suicide*
- *Crisis response plan*

## Elements of a Good Agreement?

- Defined as a commitment to
  - Living
  - Treatment and care
- Incorporates a crisis management or response plan
- Specifically identifies responsibilities
  - Patient
  - Clinician

- Includes behaviors for which the patient has demonstrated competence
- Is modified routinely
  - At request of patient or clinician
  - When indicated by clinical markers
- Is individualized

## Commitment to Treatment Statement

- *I agree to make a commitment to the treatment process. I understand that this means I have agreed to be actively involved in all aspects of treatment including:*
- *attending sessions (or letting you know when I can't make it)*
- *voicing my opinions, thoughts, and feeling honestly and openly, whether negative or positive*

## CTS (continued)

- *being actively involved **during** sessions*
- *completing homework assignments*
- *experimenting with new behaviors and new ways of doing things*
- *taking medication as prescribed*
- *implementing my crisis response plan.*

## CTS (continued)

- *I also understand that, to a large degree, my progress depends on the amount of energy and effort I make. It it's not working, I'll discuss it with my therapist. In short, I agree to make a **commitment to living***

## Crisis Response Plan (CRP) Components

- Define *crisis*
- Identify trigger(s) and associated thoughts, feelings (suicidal belief system)
- Specific goal is to reduce escalation of suicidal crisis and reduce manifest intent
- Moves from self-management to external intervention
- If not successful, access emergency care and assistance in manner that facilitates skill development

## Crisis Response Plan

- *When thinking about suicide, I agree to do the following:*
- *When I find myself making plans to suicide, I agree to do the following:*
- *1. Use my hope box.*
- *2. Review my treatment journal*
- *4. Do things that help me feel better for about 30 minutes, including taking a bath, listening to music, and going for a walk*
- *5. Repeat all of the above*
- *6. If the thoughts continue,get specific, and I find myself preparing to do something, I call the emergency number XXX-XXXX*
- *7. If I'm still feeling suicidal and don't feel like I can control my behavior, I go to the emergency room*

## Crisis Response Plan Pointers

- Be specific
  - when to use, steps to take, where to go, what numbers to call
- Be concrete
- Ensure safety, remove access, availability
- Make it accessible
  - put on a card, can be carried in a wallet or purse
- Practice, role play
- Periodically review and update
- Use of STR

## Crisis Services and Availability

- Clear crisis management plan
  - integrated into informed consent statement
  - use of crisis cards
- Accessible referral sources
  - clarity of identifying those requiring long-term care
  - out of center referrals following crisis stabilization

- A Role-Play: Discussing Commitment to Treatment

## Countertransference Issues in Suicidality

- Critical influence of attitudes towards suicide
- Consequences:
  - Cognitive (*this is just talk, I don't have time for this, I can't handle this, I'll be held responsible*
  - Affective (*guilt, anxiety, fear, shame)*
  - Behavioral (*withdrawal, avoidance, non-directive*)

## Countertransference Hate

- Transference hate manifested by projection and provocation:
- *You hate me so my hate for you is justified*

## The Problem of Countertransference Hate

- A *normal* reaction
- Monitor and address in consultation, supervision
- Unacknowledged feelings of anger, anxiety, frustration, pose greater threat---- will surface in other ways

## Client Emotional Abuse

- A pattern of hostile, undercontrolled or otherwise emotionally provocative verbal behavior and boundary infringements that are directed at the therapist

## Provocation

- *Something that provokes, arouses, or stimulates*

## Classification of Provocatoins

| | |
|---|---|
| Direct | **Verbal devaluation**: *You really don't know what you're doing; How'd you get a license, I might as well kill myself now* <br> **Direct actions/behaviors**: *tantrums, repeated phone calls, missed appointments, letter writing,* |
| Indirect | **Indirect actions/behaviors**: *silence, refusal to talk, noncompliance, arguing over trivial issues, forgetting things,* |

## Invalidating Environments

- Extreme, inappropriate responses
  - dismissed
  - trivialized
  - punished
  - attributed to unacceptable characteristics (e.g., over-reactive, paranoid, manipulative)
  - even normal reactions pathologized

## Therapist's Disruptive Behaviors

- Being late, rescheduling appointments
- Ending appointments early
- Taking phone calls during sessions
- Forgetting critical information
- Not returning phone calls
- Daydreaming, distractibility

## Responding to Provocation

- Step 1: Explore client's feelings
  - Attend to, label, and reflect the client's feelings
  - Illicit additional thoughts or feelings about the current situation, define the context for the provocation
  - Reinforce appropriate expression of negative affect, or if inappropriate, place the problem within the context of treatment

## Responding to Provocation

- Step 2: Help the client understand the patterns of provocative communication
  - Summarize the client's general pattern of expression of negative affect
  - Link to recurrent suicidal crises
  - Identify purpose of negative affect

## Responding to Provocation

- Step 3: Introduce alternative ways to solve interpersonal problems
  - Identify the mechanism for resolving the problem/conflict in the future
  - Develop a specific plan for managing the provocation in the future
  - Don't reinforce maladaptive behavior

## Treatment Resistance

- What's the function of the resistance?
- Does it fit the developmental pattern?
- What is the client afraid of if he/she complies?
- Does the client agree with or misunderstand the interventions?
- Are the client's skills inadequate?
- What situational factors prevent change?

## Treatment Resistance

- Is change inconsistent with the client's self-image?

# Termination

- Clarify expectations, obligations, goals from the beginning, document agreement
- Address financial issue from outset, plan for non-payment
- Provide referrals, assist in transition
- Follow-up on withdrawals if continued care indicated, document

# Follow-up Procedures

- Monitoring of implementation of follow-up plan, compliance-----specific appointments, use of reminder letters/calls, coordination with family

"The doctor's lawyer will see you now."

***Case vignette***. JoAnn is a 46-year-old, twice divorced female with a bachelor's degree and a master's degree in health education and fitness. She is in her third marriage (three years long), and has reported "it's a very good one." She currently works as a part-time personal trainer, spending the rest of her time caring for her two children (ages 12 and 8, one from each of her first two marriages). The children have little contact with their fathers. JoAnn reported that she is seeking help secondary to escalating symptoms of bulimia. Although initially she was hesitant, she reported "maybe two to three" binge-purge episodes each day. Further exploration reveals a long history of bulimic symptoms dating back to her early teens, although she could not be more specific. At the beginning of the disorder, she reported feeling "fat and ugly," but noted, "I don't really know why I do it now…maybe it's just a habit". JoAnn also reported lowered mood, anhedonia, middle and terminal insomnia, some attention and concentration problems, poor energy, and periods characterized by "feeling like I'm stuck and things will never get any better." She added that she feels "incredibly guilty" for her behavior and often thinks she is "worthless." JoAnn reported that a "few times" in her life she has "felt like dying," but only acted upon these impulses a couple of times, apparently overdosing on pills at ages 14, 17 and 18, quickly adding that she "never told anyone about any of it." When questioned about the duration of these symptoms, JoAnn stated that she has "always felt this way." She reported thinking about killing herself "maybe 15 times a day," but added that the thoughts only last a few seconds, and she does not currently plan "on doing anything about it." Joann reported thinking about overdosing, but "doesn't have any pills right now." The primary stressors in her life were reported to be "work, kids, and trying to please my husband." She added that she "really doesn't like conflict," and "will do almost anything to avoid it," especially with people that she is "close to".

JoAnn also reported being a chronic worrier. When asked about though content, she said she worried about "just about everything in my life," noting that the only thing that "helps" is to drink occasionally and "sometimes to smoke a little pot." She was evasive about frequency of substance use when questioned further. JoAnn reported a history of mental health treatment, but could not recall exactly how many professionals she had seen because she would reportedly go "for a few months and quit because it didn't really help." She also reported pharmacological treatment through her primary care physician over the last 10 years, but again noted that she would "start and then quit because of side effects." When asked in more detail about her treatment experiences, JoAnn added that "it didn't work because I'm beyond help…I'm a hopeless case."

She described her current marriage as "better than the other two put together," and admitted that her previous marriages ended due to her infidelity (her current marriage was a result of an affair). Joann reported a "troubled" childhood marked by "some sexual abuse" by her father from the ages of nine to twelve. When questioned about the abuse, she commented that she has "gotten over it," adding that "it really wasn't that big of a deal." JoAnn reported seeing her parents about "twice a year" around holiday events, with little contact in between. She noted that she has always felt like she "disappointed" her parents because they "expected much, much more from me." JoAnn added that she has distant relationships with her siblings and has "no true friends." She spoke in some detail about "trying to please her husband," noting that "it doesn't seem to work." She "feels that way with most people," like she is "a real push over with everyone," particularly men. When asked what she wanted to get from therapy, JoAnn quipped, "stop throwing up and just feel better," adding "maybe somebody can actually figure me out."

---

# Informed Consent with Suicidal Patients

Consistent with available data, any informed consent statement, whether consistent with the example provided below or not, should include several identifiable elements including:

1. For patients who have attempted suicide or who have reported suicidal ideation, risk can endure throughout the treatment process and, for possibly as many as half, can result in a subsequent suicide attempt.
2. Patients who have made multiple suicide attempts are at the greatest risk to continue to experience symptoms, associated dysphoria and make a subsequent suicide attempt.
3. Therapy will involve emotional experiences and related upset. The patient and therapist will work together to help the patient work through difficult emotions, but at times painful issues will be discussed and purposefully targeted in treatment.
4. Therapy will involve experimenting with and learning new skills that will lead to more effective problem solving without using suicidal behaviors.
5. Procedures to follow in a crisis situation will be explicitly described and the patient and therapist will work together to determine things the patient is willing (and capable) to do.
6. One of the primary targets in treatment is the reduction of suicidal behaviors.
7. The failure to pursue treatment for certain disorders carries the risk for a subsequent suicide attempt and, for a smaller percentage, death.
8. A collaborative approach to treatment, compliance with the treatment plan, and effective crisis management are all essential to reducing risks and maximizing treatment outcomes.

**Example Statement**

*If you're presenting with some form of suicidality (i.e. suicidal thinking or a suicide attempt), it's important to recognize the risks inherent in treatment, as well as a decision not to seek treatment. Randomized controlled trials for the treatment of suicidality have found re-attempt rates during treatment as high as 47%, with a number of experimental treatments significantly reducing the rate of subsequent attempts by as much as half. The risk of a suicide attempt during treatment is greatest for those who have made multiple suicide attempts (i.e. two or more). Treatments have also been found effective at preventing repeat suicide attempts, reducing symptoms related to suicidality (e.g. depression, anxiety, and hopelessness), and associated problems (e.g. interpersonal stress, problem-solving ability). One of the risks both in and out of treatment for various disorders (e.g. major depression, bipolar disorder,*

*schizophrenia, anorexia, borderline personality disorder) is death, although this is infrequent and relatively rare. Specific rates vary across diagnoses in outpatient (or inpatient) care. Treatments for all of these problems have been found to be effective. If you would like diagnosis-specific information, please let me know.*

*We will talk more specifically about the issue of suicidal thoughts and behavior in our commitment to treatment agreement. A primary target in treatment will be the reduction of suicidal behaviors. An important element of therapy involves learning new skills that will help you to more effectively manage your emotions, reactions, and relationships with others without suicidal behavior. As you learn these new skills, you should begin to notice improvements in your mood and how you feel you are managing your life.*

*You should be aware that we will talk about some things that will be very painful for you. We will do this when both of us feel that you have acquired the skills to be able to deal with these emotions and we will work together to help you benefit from these experiences.*

*Early in your therapy we will set up a crisis response plan that will include specific steps for you to follow when you begin to feel upset or in crisis. I will expect you to make every effort to carry out these plans and we will any obstacles that come up when you try to use this crisis response plan. This is a very critical part of your treatment and it is less likely that your treatment will be successful if you do not utilize this plan.*

*What is clear is that use of a crisis response plan and a willingness to fully engage in the treatment process will reduce risks and increase the effectiveness of treatment. Given the risk of problems in treatment for those with chronic suicidality, it's important to recognize and understand up front the potential need for family support and involvement in care. This might mean allowing me to contact a family member during a suicidal crisis. It's also critical to recognize the need for an honest and trusting relationship in treatment, one allowing for you to be direct and specific when problems with treatment compliance emerge.*