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Chapter Nineteen

Suicidality and Self-Harm

Assessing risk of suicide is one of the most important yet terrifying tasks that a beginning clinician can do. It is also professionally risky in terms of practitioner emotional distress and risk for malpractice suits (Packman, Pennuto, Bongar, & Orthwein, 2004). Suicide is the most frequent crisis seen by mental health practitioners (McAdams & Foster, 2000), and almost half the persons who commit suicide are under the care of a mental health practitioner (Institute of Medicine, 2002). Suicide is the 11th most common cause of death in the United States (National Institute of Mental Health, 2004).

Often, beginning therapists work with high-risk populations, such as those in community mental health centers, but suicidal ideation can occur in any population. Thus, you must be prepared to assess and cope with suicidality from your very first day of clinical work.

In this chapter, I focus on performing a thorough suicide risk assessment with adult outpatients. Additional considerations are pertinent to inpatients and emergency settings, and if you are working in those settings, relevant literature should be reviewed (e.g., Simon, 2004). The following steps in assessing, treating, and documenting suicidality are discussed:

- Establish rapport (see chapter 18)
- Assess
  - Screen for suicide risk
  - Current suicidal ideation
  - Past suicide attempts
  - Current and past self-harm
  - Current mental illness and distress
  - Poor judgment, poor self-control, impulsivity, and unpredictability
  - Precipitant and chronic stressors

- Demographic and historical factors
- Protective factors
- Other sources of information
- Assess level of risk
- Determine motivation for treatment

- Plan and implement
  - Determine appropriate intervention level
  - Make a suicide prevention plan and secure client's verbal agreement
  - Implement precautions for outpatients
  - Reduce risk factors and enhance protective factors
  - Hospitalize, if necessary
- Reduce self-harm and suicidal gestures
- Document

ASSESS: SCREEN FOR SUICIDE RISK

Tony Sanchez, a mental health trainee, is working in a walk-in intake clinic. He is assigned a new client, Phil Thomas, to interview. Phil has never been to the clinic before, and there is no chart for Tony to review. Phil is a 66-year-old White male who is accompanied by his 64-year-old sister, Susie. Tony speaks with both of them first. Susie says that she has been worried about Phil's mental health since he lost his wife to lung cancer 3 months ago. Lately, she says, Phil has not been taking care of himself, and when she comes by, he has been sitting alone in the dark, with the television on, but doesn't appear to be actually watching it. Tony asks Susie to step outside and wait, then assesses Phil for depressive symptoms. He then screens Phil for suicide risk: "Are you having any thoughts about hurting yourself?" Phil tells him that he sometimes thinks of blowing his head off with his shotgun. Tony asks Phil how long he has had these thoughts. Phil says that he has been thinking of hurting himself ever since his wife's funeral. Tony asks whether Phil has ever had thoughts of hurting himself before his wife died. Phil denies it. Tony asks whether any family members of Phil's have committed suicide. Phil says that his paternal grandfather committed suicide many decades ago. Tony asks Phil whether he has been feeling hopeless. Phil answers, "Yes."

Fred Takahashi is a mental health trainee who has been assigned a new client, Crystal Hughes, a 27-year-old White female. At their first session, Fred notices that Crystal has five parallel superficial scratches on her left forearm and asks her about them. Crystal says that she loves her girlfriend and does not want to leave her, but she is certain that the girlfriend has not been sexually faithful because she snooped last week and found suspicious messages on her e-mail and cell phone. The girlfriend denied this when she accused her last night, and they argued. After their fight, Crystal felt intense distress and anxiety. Fred asks Crystal whether she has been thinking of killing herself. She says that last night, she was thinking of slashing her wrists but ended up cutting herself instead. She locked herself in the bathroom, took out a razor blade, and scratched her arm until it bled. When Fred asks Crystal whether she has been feeling hopeless, she says that she is feeling hopeless and wants to die. Fred asks her if she has any relatives who have committed suicide, and she denies this.

Often, beginning therapists are afraid to ask clients about suicidal thoughts. They fear that asking about suicidal thoughts might implant suicidal ideas in the client's head. However, there is no scientific evidence that this is the case (Moline, Williams, & Austin, 1998). In fact, if you do not ask about suicidality, you may miss an opportunity to intervene to prevent a suicide, and you may put your professional career at risk.

Every time you meet a new client, it is wise to do a suicide assessment (Moline et al., 1998). Your client may have been prescreened for you by your supervisor and/or the clinic, but life circumstances can change quickly, so you also should assess for suicidality. Determining an accurate diagnosis of mental illness (if one is present) and asking the following four screening questions should be an adequate screening for suicidality:

> "Are you having any thoughts about hurting yourself? [If yes] Tell me about that."
> "Has that ever been a problem for you?"
> "Have you been feeling hopeless?"
> "Have you had any family members who have committed suicide?"

Most clients will answer no to all these questions, and you are done in just a couple minutes. Simon (2004) suggests that if the answer to any of these questions is positive, a thorough suicide risk assessment should be done. The rest of this chapter describes the procedure for doing a suicide risk assessment.

If the client hesitates when you've asked about suicide, then answers no, remark on that: "Are you sure? I noticed that you were hesitant." In addition, if the client has significant depressive symptomatology, further probing about suicidality may be indicated, even if denied (Jacobs & Brewer, 2006). Note that studies have found that many clients who have suicidal ideation will deny it when asked, so if the client has other significant risk factors, you may want to talk to family members or significant others and/or ask again when there is a stronger therapeutic alliance.

Note that assessing for suicide risk is an ongoing process with many clients. Suicide risk varies from minute to minute, hour to hour, and day to

day because suicidal behaviors are impulsive and transient (Simon, 2006). Clients with a recent suicidal crisis should have their suicidal ideation reevaluated every time they are seen until they are stable and the suicidal ideation is consistently over. Clients with chronic suicidal ideation may need to be assessed at every session as long as the suicidal ideation lasts.

ASSESS: CURRENT SUICIDAL IDEATION

Tony asks Phil more questions about his current suicidal ideation: "Phil, tell me some more about your thoughts about hurting yourself." Phil says, "I think about taking out my rifle, putting it in my mouth, and pulling the trigger." Tony ascertains that there is a gun in the house, along with ammunition, and that it is kept in a locked cabinet in the basement. Tony asks Phil, "Do you think you would ever actually pull the trigger?" Phil says that he doesn't know. Tony asks Phil how often he thinks about hurting himself. Phil says that he thinks about it off and on every day.

Fred asks Crystal more about her suicidal ideation. Crystal says that she has been thinking about taking all her Prozac, but at other times she thinks about slitting her wrists. She says that it would serve her girlfriend right to come in and find her bleeding to death in the tub. Fred asks her whether she thinks she would act on these thoughts. Crystal says that she thinks she might. Fred asks how often she is thinking about killing herself. Crystal says that she has had these thoughts off and on for years but that she has been thinking about this more since she found the messages last week.

The presence of current suicidal ideation is the most important predictor of suicide risk. Here are some of the questions you could ask to assess suicidal ideation (informed by Jacobs & Brewer, 2006):

"When did the suicidal ideas start? Are the thoughts every day? How often throughout the day? When was the last suicidal thought. Today? Yesterday? Last week?"
"Have you made a specific plan to hurt yourself?"
"Do you think you would ever act on those thoughts? Why or why not?"
"Are these passing thoughts, or are you serious about them?"
"Do you have any ideas about how you might kill yourself?"
"How often have these thoughts occurred?"
"What is the closest you've come to hurting yourself?"
"Have you ever started to hurt yourself but stopped before doing anything?"
"How would you hurt yourself?"
"Do you have any guns or weapons available to you?"
"Have you made any preparations to hurt yourself?"
"If you begin to have thoughts about hurting yourself again, what would you do?"

You do not need to ask every one of these questions to every client—these are just to give you an idea what you may need to ask to get the full picture. Once you have this information, you need to consider the likelihood that the client will act on the ideation (this discussion is informed by Joiner, Walker, Rudd, & Jobes, 1999). The most important predictors of acting on suicidal ideation are having a plan and having the intent to act on it. In assessing the plan, consider the following:

- Presence of a specific plan
- The client has the means and the opportunity to enact this plan (e.g., a gun is readily available)
- The client has been preparing to enact this plan (e.g., the client wants to overdose and has stockpiled medications)

In assessing intent, consider the following:

- Whether the client has determination and courage to follow through on suicide attempt
- Whether the client feels competent to kill self
- Whether suicidal ideas have been persistent and intense

Clients who have suicidal thoughts but neither a suicidal plan nor suicidal intent have *passive suicidal ideation*. They will talk about their suicidal ideation in this way:

"I wish I were dead."
"Everyone would be better off if I were gone."
"I wish I had never been born."
"I don't care about my life anymore."

These clients, unless they have other significant suicidal risk factors (as discussed in the rest of this chapter), are considered to be either not at risk (Joiner et al., 1999) or at low risk of suicide. However, even if the suicidal ideation is passive, you should continue to perform and document a full suicide risk assessment (Simon, 2004).

Clients with a suicide plan and/or suicidal intent have *active suicidal ideation*. Even if the suicidal ideation has been fleeting and brief, consider the client to be at risk if there are suicide plans (Joiner et al., 1999). If clients have active suicidal ideation, they will talk about suicidal ideation like this:

"Whenever I go over that bridge, I think that if I was really brave, I would crash off with the car into the water."

"I've got a gun, and I often think I should kill myself."
"Sometimes I think of hanging myself off the rafters in the garage. No one would find me until I were dead."
"I think about taking an overdose of my pills, but I know that my children would be devastated."
"If I had the guts, I'd kill myself."
"If I killed myself, then my boyfriend would understand how he hurt me."

In conclusion, here are some initial determinations about levels of suicide risk that you could make from assessing current suicidal ideation:

- The client has passive suicidal ideation but no other significant risk factors (as described in the rest of the chapter). Risk level: none to low.
- The client has passive suicidal ideation and has other risk factors of significance. Risk level: low to high, depending on what the other risk factors are.
- The client has active suicidal ideation. Risk level: moderate to high on the basis of this risk factor alone. Note that as the interview progresses, the client may become interested in following through with the treatment plan and that intent may lessen, decreasing risk.

ASSESS: PAST SUICIDE ATTEMPTS

When asked by Tony, Phil denies any history of past suicidal ideation, behavior, or self-harm prior to his wife's death.

When asked, Crystal says that she has been hospitalized twice in the past after making suicide attempts. She points out very faint scars on her wrists that Fred had not noticed before and said that she cut her wrists when she was 16 years old after being rejected by a boyfriend. She said that the second hospitalization was last year and that she had taken a half bottle of Xanax but then got scared and called 911.

Past suicide attempts are the second most important predictor of current suicide risk after the presence of active suicidal ideation. Persons who have made past suicide attempts are at a much higher risk than any other group for completed suicide. Past attempters have risk of completed suicide that is 38 times (in an aggregate of many studies; E. C. Harris & Barraclough, 1997) to over 100 times (in a review of international studies; Owens, Horrocks, & House, 2002) greater than the general population. Persons who have attempted suicide at least twice, known as *multiple attempters*, are the group at greatest risk of future suicide and suicide attempts (Joiner et al., 1999). Thus, past suicide attempts must be thoroughly evaluated, and clients with past attempts, especially those with more than one attempt, must be very carefully monitored and treated. *Note that past suicidal ideation, without any history of suicidal behavior, is so common that it is a poor predictor of risk*, although it can still be informative to assess.

To assess past suicide attempts, ask the following:

"Have you had any thoughts of hurting yourself in the past?"
"Have you ever done anything to hurt yourself in the past?"

If the client appears to be confused or you suspect forgetfulness or minimizing, ask further specific questions, such as "Have you ever been hospitalized for an emotional problem?" or "What was going on when you went to the hospital?"

When the client reveals a past episode of suicide attempts, gather as much information about that episode as possible:

"How old were you?" (or "When was that?")
"What was going on with you at the time?"
"Were you using drugs or alcohol then?"
"How did you hurt yourself? What happened then?"
"Did you get any help? Did you go to the hospital?"
Then ask the client, "Other than that, were there any other times in the past when you felt like hurting yourself?"

Keep asking this question and then asking about the specific episodes until the client denies that there are any other previous episodes of suicidal thoughts or behavior.

You should always review any mental health records that are immediately available regarding past suicidality. If ongoing treatment is anticipated, send releases to get records from past treatment facilities for any client with any level of suicide risk (Packman, Pennuto et al., 2004). If the family is available, consider getting a written or oral (crisis situation) agreement from the client to talk to them (and document that agreement in the chart), then ask them for their perspectives on the client's past suicidal behavior (Simon, 1988).

The clients who tell you about past suicidal ideation, attempts, and self-harm will fall into several (possibly overlapping) categories:

- More than one previous suicide attempt with intent to die
- One suicide attempt with intent to die
- Past suicidal gesture(s) without intent to die (e.g., scratches wrist with razor just before boyfriend is due home because she is angry at him)
- Self-harm behavior without intent to die (e.g., superficially scratches self with knife on leg or gives self an ugly homemade tattoo on arm with ink from a pen)
- Past suicidal ideation but no attempts or self-harm
- No previous history of suicide attempts, self-harm, or ideation

These groups are listed from most to least risk of suicide (Joiner et al., 1999; Nock & Kessler, 2006). Again, be very cautious with any client who has more than one previous suicide attempt; these clients should be considered to be at moderate to high risk if additional significant suicidal risk factors are present (Joiner et al., 1999). The risk level of the other groups is significantly lower and must be assessed in the context of other risk factors that are present. Note, however, that a suicidal gesture can be fatal, even if not intended to be, and thus past suicidal gestures should be considered to be indicative of significantly higher risk.

ASSESS: CURRENT AND PAST SELF-HARM

Crystal reports that after she cut herself yesterday, she felt relief and could "float above my problems." She said that she didn't feel any pain at all from the scratches. Fred asks her if she has hurt herself before. "Many times," Crystal replies.

"Have you ever done anything to hurt yourself?" will usually elicit self-harm behavior as well as suicidal behavior. However, initially the client may deny this but volunteer it later, or you may see suspicious injuries and ask about them, as Fred did earlier in the chapter.

It is not always possible to know whether a client meant a past episode of self-harm to be fatal. However, whenever possible, ascertain whether the self-injurious behavior was meant as an actual suicide attempt: "Did you actually mean to kill yourself?"

There is a lack of definitional clarity regarding self-harm and suicide; however, Nock and Kessler (2006) argue that a distinction can and should be made between genuine suicide attempts and suicidal gestures in which there is not any intent to die but rather a cry for help. Self-harm is a sign of acute distress. Current and past self-harm is often seen in multiple suicide attempters. Additionally, self-harm is associated with other risk factors for suicidal behavior: substance abuse (Nock & Kessler, 2006), antisocial personality disorder (Nock & Kessler, 2006), borderline personality disorder (Linehan et al., 2006), comorbidity (three or more diagnoses; Nock & Kessler, 2006), and histories of childhood sexual abuse (Gratz, 2003). Note that self-harm is more common in women (McAndrew & Warne, 2005).

Self-inflicted injuries are often burns or scratches on the skin; they are often on the arms but may also be on the legs, abdomen, or other areas of the body. Clients may wear clothing that covers the area when in public. Self-harm can also include self-poisoning by overdosing on medications, alcohol, or street drugs.

If the client admits to injuring self, ask where the injuries are. If there are cuts or other injuries in an area that you can observe, without the client inappropriately disrobing, you might ask if you can see them. Even if you are not a physician, it is likely that you will be able to see whether the cuts are superficial or whether it would be wise to have a medical evaluation. If your have any doubt whether the client significantly damaged self, a physician or nurse should be consulted. If the self-inflicted injury is in a more private location, such as the inner thigh, you should get a nurse, psychiatrist, or another physician to examine the injuries. If none of these health professionals is on-site, you may need to obtain a release of information to talk to the client's physician.

ASSESS: CURRENT MENTAL ILLNESS AND DISTRESS

Tony assesses Phil for symptoms of depression. Phil has poor appetite and has lost 15 pounds in the past 2 months. He is not sleeping well. He is feeling either numb or depressed most of the time and cries uncontrollably when thinking about how much he misses his wife. He feels guilty that he did not appreciate her enough when she was alive. Tony screens Phil for bipolar disorder, post-traumatic stress disorder (PTSD), and psychotic symptoms, but these are denied.

Fred assesses Crystal for mental illness. She had a history of bulimia in high school but denied any problems with that in recent years. She has many symptoms of major depression. When asked about manic symptoms, she describes an episode in the past that might have been hypomanic, but Fred is not sure. Clearly, Crystal is in great distress.

After active suicidal ideation and past suicidal behavior, the presence of certain mental illnesses is the third-strongest predictor of suicide. All other factors are less significant predictors in research studies than these three. Almost all mental illnesses have been associated with increased mortality from suicide (E. C. Harris & Barraclough, 1997; Institute of Medicine, 2002).

E. C. Harris and Barraclough (1997) reviewed the research and derived combined risks of suicide for a number of mental illnesses (based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders* [3rd ed., revised]; *DSM-III-R*) by aggregating numbers across studies. These numbers indicate the degree of increased risk compared to the general population. Here are the findings of this study:

- Eating disorders, 23 times (23 times the rate of suicide in the general population)
- Major depression, 20 times

- Bipolar I disorder, 15 times (since the diagnostic criteria of the studies that were aggregated were based on *DSM-III-R*, bipolar II was not included)
- Dysthymia, 12 times
- Obsessive-compulsive disorder, 10 times (the authors suspect that number should be higher)
- Panic disorder, 10 times
- Schizophrenia, 8.5 times
- Brief reactive psychosis, 15 times
- Personality disorders, 7 times
- Adjustment disorder, 14 times

Note that E. C. Harris and Barraclough (1997) did not include PTSD in this study, and comparable rates are unavailable. However, it is known that PTSD does increase risk of suicide (Hudenko, n.d.).

A review of risk factors in depression (Institute of Medicine, 2002) indicated that certain depressive symptoms are more predictive of suicide: suicidal ideation, hopelessness, guilt, loss of interest in usual activities, low self-esteem, cognitive distortions, and few perceived reasons for living. Hopelessness, especially, may be a particularly significant risk factor for suicide (Packman, Marlitt, Bongar, & Pennuto, 2004).

Emotional distress is likely to be an important factor mediating the relationship between a diagnosis of mental illness and suicidality. Thus, in addition to noting the client's diagnosis, carefully attend to the client's distress about current symptoms. In particular, such factors as comorbidity of diagnoses and symptom severity can increase suicide risk (Simon, 2004). The reality of having a mental illness is often highly distressing for high-functioning clients; this may put them at greater suicide risk (Simon, 2004). The combination of severe depression along with anxiety and/or panic attacks can be especially distressing and predictive of suicide risk (Simon, 2004). Since clients are discharged so quickly from inpatient units, they are rarely completely stable. The week after discharge is an especially high-risk period for suicide, and the 3 months after discharge continue to be high-risk time for suicide (Appleby et al., 1999).

ASSESS: POOR JUDGMENT, POOR SELF-CONTROL, IMPULSIVITY, AND UNPREDICTABILITY

Tony assesses Phil for substance abuse. Phil admits that he has often been drinking a six-pack of beer every day, sometimes followed by hard liquor. Phil says that the alcohol dulls the pain of his loss. At this point, Phil admits that

when he is very drunk, he will sometimes take out the shotgun and cradle it on his lap, thinking of killing himself. However, he states that lately his sister Susie has been bringing him to her Alcoholics Anonymous (AA) meetings with her, as Susie is a recovering alcoholic herself. He stated that he has been trying to cut down on the alcohol, and that he had 2 days last week when he did not drink.

Crystal admits that she occasionally uses cocaine and marijuana. She said that she was drunk when she made the two previous suicide attempts. She stated that she drinks alcohol on the weekend when out with friends. When screened for psychotic symptoms, Crystal says that she sometimes hears a voice telling her to kill herself.

Client characteristics that are indicative of greater impulsivity or less self-control are generally linked to greater suicidality (Joiner et al., 1999). Those who are incarcerated and those with antisocial personality disorder are at increased risk (Verona, Sachs-Ericsson, & Joiner, 2004). Clients with a history of poor follow-through in treatment are at greater risk (Joiner et al., 1999). Certain symptoms may also contribute to lack of self-control; the client may not be getting much sleep or may have reduced concentration. Clients with a history of head trauma are at greater risk of suicide (Krakowski & Czobor, 2004).

The presence of command hallucinations to commit suicide should be evaluated (Simon, 2004), so ascertain whether clients with psychotic symptoms are having auditory hallucinations telling them to kill themselves. If so, find out if the client feels that the commands can be resisted, if the client wants to resist the command, how often the voices are occurring, and if there is a known voice (client may be more likely to act if the voice seems to be that of a known person).

Alcohol or drug abuse significantly increases the risk of suicide (and other impulsive behaviors as well; all risks from E. C. Harris & Barraclough, 1997):

- Sedative dependence and abuse, 20 times (20 times the rate of suicide in the general population)
- Multiple dependence and drug abuse, 20 times
- Opioid dependence and abuse, 14 times
- Alcohol dependence and abuse, 6 times
- Cannabis heavy use, 4 times

ASSESS: PRECIPITANT AND CHRONIC STRESSORS

Tony asks Phil about his stress. Phil talks about how he has had to learn how to do his own laundry and cooking since his wife died. His wife managed all

the finances as well, and he has been ignoring the bills. Phil has arthritis in both hips, which has been very painful lately. He has been putting off getting the hip replacements that his doctors recommended. He is uncertain if he can afford to keep his current condo, given the loss of his wife's pension and Social Security.

Crystal tells Fred that she has been under a lot of stress. Her younger sister has been staying with her and would otherwise be homeless, but they argue all the time. Crystal is distressed about the recent argument with her girlfriend and fears that they will break up. She hasn't gone to her job for the last 3 days and fears that she will be fired.

Ask the client about recent stressors: "Has anything stressful been going on in your life lately?" Both Phil and Crystal have experienced significant stressors lately that have contributed to emotional instability and suicidal ideation.

A wide variety of stressors have been linked to suicide attempts. These include losing a job, poverty, sickness-related absence from work, and chronic illness or disability (K. L. Knox, Conwell, & Caine, 2004). The presence of shame, possibly associated with important recent losses, can also increase risk of suicide (Simon, 2004). Serious medical problems such as AIDS, seizure disorder, spinal cord injury, brain injury, Huntington's chorea, and multiple sclerosis have been found to increase the risk of suicide two to seven times (E. C. Harris & Barraclough, 1997), so it would be wise to consider any chronic serious medical problem a suicide risk factor. Interpersonal trauma, whether recent (e.g., domestic violence) or remote (e.g., childhood physical or sexual abuse), increases risk of suicidality (Packman, Marlitt et al., 2004). Social isolation increases risk of suicide in general (Packman, Marlitt et al., 2004)—those who are single or live alone are at greater risk of suicide (Institute of Medicine, 2002)—and the loss of a spouse is a particularly salient stressor that can precipitate suicidality (Louma & Pearson, 2002), especially among men under 35 years old.

ASSESS: DEMOGRAPHIC AND HISTORICAL FACTORS

Tony considers Phil's demographic risk factors. Phil is a White male, over the age of 65, and thus is in a very high-risk group. He has recently become a widower, increasing his risk. He also has a family member who committed suicide, which again increases his risk.

A number of demographic factors are associated with suicidality. Men are three to four times more likely to commit suicide then women, although women make three to four times as many attempts (Simon, 2004). Whites and Native Americans are more likely to commit suicide than Asian Americans or African Americans. Historically, older people were at greater risk for suicide, although that may be changing (Packman, Marlitt et al., 2004). However, White males over the age of 65 are at particularly high risk, and White males over 85 are at even greater risk (Simon, 2004). People who live in more rural areas are at increased risk (Singh & Siahpush, 2002). People who are divorced are at greater risk than those who are married (Institute of Medicine, 2002).

Some historical factors that are associated with suicide risk include suicide in a parent, which is estimated to increase risk in the client six times (Brent et al., 2002). Suicide in other family members increases risk of suicide in the client as well (Simon, 2004). Strangely, women who have breast implants have about two to three times the rate of suicide as comparable women in the general population (McLaughlin, Wise, & Lipworth, 2004).

ASSESS: PROTECTIVE FACTORS

Tony asks Phil what has kept him alive until now. Phil talks about how much he loves his two grandsons, who live nearby. They used to get together every week and play catch and board games. Phil learned to play their favorite video games, "although I always lose," he says with a smile. He says, "I know what it is like to lose a grandfather to suicide and don't know if I can do that to them. But maybe they'd be better off without me." He says that he has been avoiding his grandsons "because they shouldn't see me like this." Tony tells Phil that he is sure that his grandsons would not be better off without him and that, in fact, if he committed suicide, that would put them at greater risk of suicide later in life. Phil says that he would not want that to happen. Tony suggests that Phil and his grandsons can be a comfort to each other, and Phil agrees that this might be true. Tony asks Phil about his relationship with his sister. They have always been close and raised their children and grandchildren together. Susie has been looking in on Phil and making him eat and go out to AA meetings every day. Phil says that he feels that she has helped keep him alive. Tony asks Phil, "Would you be willing to come for treatment regularly, for your family, if not for yourself?" Phil says that he would.

Fred asks Crystal what has been keeping her alive. She says that she has a close relationship with her younger sister and has been trying to help her out since her sister lost her job last month. Both of their parents have died, and she feels responsible for her sister. She says, "I think about killing myself, then I think about how my little sister would then be all alone."

Each client has unique protective factors. Ask whether client has any reasons to live:

"What has kept you alive so far?"
"What made you decide to come in and talk to me today?"
"Why do you say that you couldn't commit suicide?"

Carefully note what these reasons are. These are probably protective factors. Clients who have more coping skills, greater self-control, greater self-efficacy, and more adaptive coping skills are at less risk (Institute of Medicine, 2002).

Protective factors often involve social and family functioning. Having young dependent children, being pregnant, or having a caring partner can be protective (Institute of Medicine, 2002). Thinking about the pain that suicide would cause to one's close family members can be protective. A close circle of friends or any other supportive group can be protective. Being actively involved in organized religion can be protective (Institute of Medicine, 2002), and some religions have explicit prohibitions against suicide that clients may take very seriously.

Engagement in treatment can be considered a protective factor. Being in a low-risk suicide group (e.g., young African American women) can be considered a protective factor. A sense of efficacy to cope with the crisis can be protective. If the client feels hopeful and has plans for the future or events to look forward to, this can be protective. Even being afraid of the pain of committing suicide can be considered a protective factor (for a longer list of empirically generated reasons for living, see Linehan, Goodstein, Nielsen, & Chiles, 1983).

ASSESS: OTHER SOURCES OF INFORMATION

Tony feels that Phil is not at immediate risk to hurt himself or leave the clinic, as Phil has verbalized his willingness to get help. He asks Phil to wait in the waiting room and asks if it is okay for him to talk to Susie for a few minutes. Phil gives his verbal agreement. Tony then asks Susie some questions. He briefly verifies Phil's report that he has not been suicidal in the past and has never gotten any mental health treatment. Susie says that Phil was not bathing regularly after the funeral until she started stopping by each day. She said that he seems to be recognizing more that he needs to get professional help and stop drinking. However, she worries about him a great deal. He has been refusing to go anywhere with her but to the grocery store and AA meetings until today.

When possible, talking to the client's family and significant others, as Tony does in the previous vignette, will sometimes reveal significant information that the client did not volunteer. Collateral information from the family can be especially useful when no other historical documentation is available, as in the case of Phil.

Whenever you are working with a client, you should be aware of information that is in the client's chart. This is even more important with any potentially suicidal client. You must thoroughly review the chart, document that you did so, and be aware of any relevant information from the chart that is pertinent to the suicide risk assessment. You should also be in regular contact with other mental health professionals at your facility who have regular sessions with the client and be aware of what they have learned regarding the client's suicide risk. Keep up to date with current chart notes from other clinicians as treatment progresses.

If the client was treated in private practice, chart records can sometimes be unavailable or insufficient. In those cases, obtain a signed release, call the practitioner and discuss any suicidal behavior or ideation during the previous episode of treatment, and then document the call thoroughly in the client's current chart. If the client was treated at other facilities, you should obtain copies of those records and review that information as well. Often, phone contact with a prior treating mental health practitioner and/or review of a faxed discharge summary can and should be done in a timely manner (Simon, 2004). Again, document this clinical activity in the chart.

ASSESS: LEVEL OF RISK

Tony's initial assessment is that Phil is at moderate risk. Phil has significant risk factors, specifically, that he is a recently bereaved older White male. Phil also has a suicide plan; specifically, he been thinking of using a gun, a very lethal method of suicide. Phil has also been drinking, which puts him at greater risk. However, Tony sees that Phil has expressed and demonstrated some willingness for treatment and that he has remaining family members who care about him and have good relationships with him. Phil also has no previous history of suicidal ideation or behavior. Tony suspects that if he can engage Phil in treatment, that will lower his risk quickly, but Tony is willing to revise his risk assessment to high risk if Phil does not readily agree with all his recommendations and the suicide prevention plan.

Fred's initial assessment is that Crystal is at high risk. Crystal has significant risk factors, including two previous suicide attempts, substance use, recent

self-harm, and acute distress. Crystal has two suicide plans that she has been contemplating. Fred thinks that Crystal should be hospitalized.

Each client is a unique individual and has unique risks and protective factors. Thus, no one risk factor can be used in isolation, and a thorough evaluation is needed in every case. Keep in mind that no particular suicide can be predicted with accuracy. Suicide is a *low-base-rate* event (Institute of Medicine, 2002), meaning that it happens so infrequently that accurate prediction is impossible. Literally thousands of research studies have evaluated various aspects of suicidality, yet still, with any single client, it is impossible to accurately predict suicide. We can only ascertain whether the client is at risk and the level of risk.

When comparing the current situation to past suicide attempts, consider the following signs of high risk:

- In the past, the client was involuntarily committed for being a danger to self and others. In this case, you'd be more concerned about the client's ability to follow through appropriately.
- Risk factors have worsened. For example, the client has a new boyfriend who has introduced her to crack cocaine.
- The client's suicidal behaviors have progressively worsened over the years (Yufit, 2005). Again, be very concerned if this is the case; the client is probably high risk.

Here are some signs of lower risk in the case of past suicide attempts:

- Risk factors have improved. For example, the client is now abstinent from alcohol.
- Demographic risk factors have improved. For example, a client might have cut her wrists when she was 16 years old and had a breakup with a boyfriend. You meet the client when she is 32 years old, and she has passive suicidal ideation and a young child. The client's demographic risk factors have changed for the better (she is no longer an adolescent, and she is the mother of a young child), so she is probably at much less risk now than in the past.
- In recent crisis situations, the client has asked for help from professionals, thus refraining from any suicidal behavior.

When we think about Crystal, we see that her risk level is probably about the same as in the past circumstances in which she made suicide attempts (e.g., when using substances or under stress). Therefore, hospitalization is a prudent choice.

Many articles and books talk about the importance of assessing risk level, but few give guidelines for labeling the level of risk for a particular client. However, several references (Jacobs & Brewer, 2006; Joiner et al., 1999; Simon, 1988) are useful in this regard. Although no description can be comprehensive, I have provided some case vignettes and descriptions in appendix 20 to help you learn how to assess and label your clients' risk levels. I recommend that you use these to supplement what you have learned in this chapter so that you understand how to make a risk-level determination.

ASSESS: MOTIVATION FOR TREATMENT

Tony sees that Phil has shown good engagement and motivation for treatment. It is a good sign that he has been willing to follow his sister's recommendations and go to AA as well as come to the clinic today. Tony is concerned, but he also sees positive signs regarding Phil's engagement and motivation for treatment. As the interview progresses, Phil appears relieved and more willing to get help. Phil even smiled when talking earlier about his grandsons.

As you discuss a suicide prevention plan and attempt to work with the client to reduce risk factors and enhance protective factors, you will notice the emotions and responses of the client. Ask yourself these questions:

- Is the affect of the client becoming brighter as the session progresses?
- Does the client readily agree to treatment recommendations?
- Does the client readily agree to the suicide prevention plan?
- Is the client open to your reframing of the situation (e.g., that coming in for evaluation and treatment was wise and courageous)?

All these would indicate that the client is becoming more hopeful as the evaluation session progresses and thus will now be at significantly lower risk. This means that outpatient treatment could be considered for this client if careful consideration of other risk factors does not contraindicate it.

Be concerned if you notice signs that the client is unlikely to engage in continued treatment, including these:

- The client seems unconnected to you.
- The client seems uninterested in treatment recommendations and uninvolved in the treatment process.
- The client repeatedly talks about barriers to mental health treatment (e.g., "I can't come in because I have to take care of my elderly mother").
- The client indicates that only weak people need treatment.

- The client has a history of stopping treatment immediately after past crises resolved.

As Simon (1988) states, "The presence of a therapeutic alliance is a bedrock indicator of the patient's willingness to seek help and sustenance through personal relationships during emotional crisis, and is one of the most important nonverbal statements of a desire to live" (pp. 92–93). So be aware of any signs that your client is not engaging in treatment or has been unable to in the past because a suicidal client who is unwilling to engage in continuing treatment is at greater risk (Joiner et al., 1999).

PLAN: DETERMINE THE APPROPRIATE INTERVENTION LEVEL

Tony asks both Phil and Susie back into his office since he sees that they are close, and he realizes that involving Susie in the treatment will enhance the likelihood of success. He says to Phil, "I see that you have been suffering a lot lately. Unfortunately, your grief has been so severe that it has turned into ongoing depression. Depression is very treatable. I can see that we need to take what is going on with you very seriously. I'd like to ask you to attend an intensive daily program that we have here at this facility. You would come every weekday for intensive treatment, but you'd get to stay in the comfort of your own home at night. Would you be willing to do that?" Phil agrees to this plan.

You will need to choose between three levels of intervention for your clients who have suicidal ideation. Here are the levels:

- Individual weekly psychotherapy as usual: suitable only for no-risk or low-risk clients.
- More intensive outpatient treatment, tailored to the client's needs: suitable for clients with moderate risk who readily and believably agree to suicide prevention plan and attend treatment. Tailor the more intensive treatment to the client's individualized needs. Consider the following:
  - Partial hospitalization program
  - Substance abuse treatment
  - Dialectical behavior therapy or other psychotherapy group
  - More individual therapy sessions per week
  - Community support groups (such as AA)
- Hospitalization: suitable for a high-risk client.

PLAN: MAKE A SUICIDE PREVENTION PLAN AND SECURE CLIENT'S VERBAL AGREEMENT

Tony says to Phil, "I'm still concerned about your suicidal thoughts. We can't help you if you aren't alive to be helped. I know that it has been painful to lose your wife, but I also know that you have a lot of family members who love you and want you to be around for them." Phil nods his agreement. Tony continues, "I'd like to ask you to make a suicide prevention plan with me. I'd like you to agree to give up the gun and let Susie dispose of it or keep it in a safe place for you to have later when you are feeling better. Would you be okay with that?" Phil indicates his agreement. Tony continues, "I'd also like you to agree to call 911 or go to the nearest emergency room if you are having these ideas of hurting yourself and you think that you might be at risk of actually doing something to hurt yourself. Can I count on you to do that?" Phil readily agrees.

Should you suggest that the outpatient client call you when feeling more suicidal? I do not recommend it. You cannot be available 24/7, so if the client is depending on you and you are not available by your phone, then what should the client do? This uncertainty may confuse someone who is feeling acute distress. Do not take responsibility for saving your client's life; this is a clinical mistake (Simon & Gutheil, 2004), and it is not realistic. If you can't trust the client with that responsibility, the client should be hospitalized.

An appropriate suicide prevention plan is one that is available to the client 24/7 and is not dependent on your constant availability (McWilliams, 2004). If the client will be treated as an outpatient, the client must agree to a suicide prevention plan. Give the client two alternatives if the suicidal ideation worsens: either call 911 or go to the nearest emergency room. The 911 operators can dispatch appropriate personnel to the client's home to take the client for evaluation. Any emergency room will be able to evaluate the client and hospitalize as needed. Obtain and document the client's verbal agreement to adhere to this plan. If the client has any hesitation, ask what the concerns are and address them thoroughly until the client can accept the plan. If the client cannot accept the plan, there may be more ambivalence about continuing to live than the client initially revealed. This should be further evaluated and addressed as you decide whether to treat the client as an inpatient or an outpatient.

A possible alternative suicide prevention plan would be to have the client call you first, but if you are not available, then to seek help from 911 or the nearest emergency room (Simon, 2004). However, that plan can be problematic with certain borderline clients who might decide to call you, tell you that they are going to commit suicide, and then expect that you will exert all efforts

to rescue them by phone while they are actively resisting your efforts. The client needs to work out ambivalence about the suicide plan in the psychotherapy session, not act it out when in a crisis. So if you sense that the client may act out ambivalence about suicide in this way, *do not* tell the client to call you when suicidal; instead, use the 911/emergency room suicide prevention plan and address ambivalence about living at every psychotherapy session until it is resolved (or hospitalize if at risk).

Whether to make a written or verbal no-suicide contract with the client is a controversial topic. I tend to agree with Simon (1988, 2004), who feels that the primary purpose of a suicide contract is to alleviate the anxiety of the therapist. He goes on to caution that making a suicide contract "may falsely relieve the therapist's concern and lower vigilance without having any appreciable effect on the patient's suicidal intent" (Simon, 1988, p. 93). There is no evidence that written contracts reduce suicidal behavior, and repeated studies show that many clients will commit suicide even with a written contract (Simon, 2004). *Always do a thorough suicide risk assessment whether or not the client signs a written contract.*

Be concerned if you notice any signs of continued suicidal intent. These signs could include the following:

- The client has tunnel vision and is unable to accept therapist's input or reframe.
- The client seems reluctant, sarcastic, or hopeless about treatment recommendations.
- The client's affect or verbalizations suggest reluctance to comply with suicide prevention plan.

If you notice any of these signs, reconsider hospitalization.

IMPLEMENT: PRECAUTIONS FOR OUTPATIENTS

Tony turns to Susie: "Susie, can I count on you to go to Phil's house right after we meet today and take the gun and the ammunition away with you?" Susie indicates her agreement. Tony cautions, "Could you be sure that the gun is secured in a locked area and that Phil has no access to it?" Susie agrees to do so. Tony asks if there are any other guns available to Phil, but both of them indicate that there aren't.

Sometimes, when weighing the risks, benefits, and protective factors, you will decide that a client with suicidal ideation can be effectively treated as an outpatient. This will probably be a client who has passive suicidal ideation and a good treatment alliance. However, clients like Phil, with occasional active suicidal ideation, who can be trusted to seek help if their urges to hurt themselves worsen, can be effectively treated as outpatients.

Safety precautions must be considered when treating clients with suicidal ideation as outpatients (Simon, 2004). Sixty percent of suicides are by firearms, the most frequently used method of suicide for both men and women (National Institute of Mental Health, 1999), so if there are any guns in the home, they should be removed, disarmed, and secured in a location outside the home by a responsible adult (not the client). Too many medications in the home can be a suicide risk, so others in the home should secure their personal medications, and the psychiatrist may wish to limit the client's medications to a week's supply. If the client has been having thoughts of suicide by car, it would be wise to take public transportation or have others do the driving for now. To achieve these goals, you may need to meet with a responsible friend, relative, or significant other of the client and obtain that person's assistance.

Note, however, that no home environment can be truly made safe for someone who is intent on committing suicide; all that can be done is to remove some potential means that could be used impulsively, allowing the client more time to think clearly and obtain professional help. If you find yourself obsessing over how to make the client's home safer, that might be a sign that you don't trust the client to seek help if needed; in that case, the client should be hospitalized instead.

IMPLEMENT: REDUCE RISK FACTORS AND ENHANCE PROTECTIVE FACTORS

Tony talks to Phil about other interventions. Tony says, "As I mentioned before, depression is very treatable, and I think that there is an excellent chance that you can feel much better within the next few weeks. In order for this to happen, I'd suggest several things. First, it's very important that you attend regular weekly psychotherapy sessions. Can I count on you to do that? Let's schedule a regular session time for you [takes a few minutes to schedule session]. Second, I see that your sleep is not good at all. I would like you to talk to a psychiatrist today and get some medication so you can sleep better. Usually, getting better sleep makes a significant impact on how a person is feeling. How does that sound?" Phil indicates that he is willing to see the psychiatrist. Tony then says, "I think it is great that you have been going to AA with Susie. Can I count on you to continue to do that every day for the next few weeks?" Phil says that he will do so. Tony then says, "One last thing that

I think is crucially important is for you to start seeing your grandsons again. I suspect that they miss you a lot and would like to see you. How soon can you go over and see them?" Susie jumps in and says that she can drive him over to see the grandsons this evening. Phil agrees to go even though he seems somewhat reluctant.

Don't stop planning after you make a suicide prevention plan. In order to deescalate the client's suicidality, you must begin to reduce risk factors and enhance protective factors as soon as possible. Identify any risk factors that can be modified (e.g., recent relapse on alcohol or a lack of sleep that contributes to feelings of desperation) and address them immediately. Identify any possible protective factors that can be reinforced (e.g., involve family and friends or return to regular social events) as soon as possible (Simon, 2006).

Working with the client to develop a plan to reduce suicidality over the short term can help your client reduce feelings of hopelessness that have been linked strongly to suicidality (A. T. Beck, Brown, & Steer, 1989; Joiner et al., 2005). The following paragraphs address three key intervention points.

First, you will want to assess the social support of the client and work with the client to make a plan to increase social support over the short term. If there are any supportive family members, discuss with the client how to enlist their emotional support (Packman, Pennuto et al., 2004). In the previous vignette, Tony enlists Susie to help Phil make it to AA and to see his grandchildren. If the client has a history of being interested in religion and has a religious group that he has found uplifting in the past, reengaging with that group can be helpful. However, note that certain religious involvements might add to the client's distress (e.g., the client is gay, and church preaches against it) and should not be encouraged early in treatment.

Cultural considerations can be important in determining social support. If the client belongs to an ethnic group where there is strong family interdependence and/or extended family support, this can help support the client (unless there is significant conflict). Of concern, White clients may be the most socially isolated since they probably are not embedded in an actively involved extended family and may not be highly engaged with a faith community.

Second, you will want to help the client realize that the problems are treatable. Tony has mobilized resources within the mental health system to improve Phil's emotional functioning as soon as possible. He is clarifying that treatment is possible, available, and likely to help. In addition, note that Tony emphasizes the likelihood of improvement without actually making any concrete promises since each client is different and improvement cannot be predicted with certainty.

Third, use psychotropic medications to quickly reduce symptoms and acute distress (Simon, 2004). Symptoms that can be treated quickly with medications include insomnia, agitation, anxiety, panic attacks, and psychotic symptoms. Educate the client about how these medications should help within days.

IMPLEMENT: HOSPITALIZE IF NECESSARY

Fred suggests to Crystal that hospitalization would be most appropriate given how distressed she has been feeling. Crystal agrees but says she feels discouraged that she needs hospitalization again. Fred takes steps to initiate hospitalization.

When starting at a new mental health facility, you should always be familiar with how clients are hospitalized in that setting before starting to see any clients. Paperwork and procedures for psychiatric hospitalization vary from facility to facility and from state to state. In some states, outpatient commitment is also possible. Be aware of the laws regarding involuntary inpatient and outpatient treatment in your state. Talk to your supervisor about how involuntary hospitalization is initiated at your facility. Your supervisor should orient you to both the voluntary and the involuntary hospitalization protocols.

Voluntary hospitalization is when your client agrees to be hospitalized. An *involuntary hospitalization* is the hospitalization of a client who refuses to be hospitalized but whom clinicians believe is a danger to self or others. Involuntary hospitalization generally requires considerable paperwork and a secure location to keep client and may require the agreement of two mental health professionals.

In the process of hospitalization, do not leave the client alone and unattended unless you have a very good reason to assume that the client will not leave or engage in self-harm in your absence. If you work in a facility that has an emergency room and an inpatient facility, you or another staff member should walk the voluntary client down to the emergency room and ensure that the client is under observation. If the facility does not have these services, a reliable individual, such as a family member or friend, should escort the client directly to the agreed-on hospital. Personal items can be brought to the client later; the top priority is for the client to be taken to the hospital immediately and directly.

IMPLEMENT: REDUCE RISK OF SELF-HARM

Self-harm behaviors are often used to cope with distressing feelings. In a study of 93 clients with self-injurious behavior, clients were asked their reasons for

engaging in the behavior (Briere & Gil, 1998). At least a third of the clients endorsed each of these reasons: feel body is real (43%), distraction from memories (58%), distraction from painful feelings (80%), feel inside body (43%), mark to show pain inside (60%), stop guilt (38%), stop flashbacks (39%), self-punishment (83%), feel alive (38%), feel self-control (71%), get attention or ask for help (40%), make body unattractive (37%), manage stress (77%), stop hurt by others (45%), reduction of tension (75%), feel something (57%), and release pent-up feelings (77%). As you can see, many of these reasons involve affect regulation, specifically trying to cope with distressing feelings, flashbacks, and dissociation. After engaging in self-harm, the subjects felt less anger at self, less anger at others, and less fear, emptiness, hurt, loneliness, and sadness. After self-harm, they had more feelings of relief and shame (Briere & Gil, 1998).

The findings of this study clearly indicate that individuals who use self-harm to cope are in need of alternative coping methods. And, in fact, research has found that individuals who engage in self-harm have deficits in their problem-solving abilities (J. Evans, 2000). Until the client learns alternatives and is motivated to use them, the self-harm will likely continue.

Given these findings about coping deficits, here are some early interventions you can consider using to deescalate self-harm behavior:

- Maintain your empathy to the client throughout and gently emphasize the importance of addressing self-injurious behavior consistently in therapy.
- Ask the client how the self-injurious behavior helps:

  "How were you feeling before you burned yourself with the cigarette?"
  "What was happening that led you to have that feeling?"
  "How did you feel after you burned yourself?"

- Agree that the client needs effective ways to ease distress and acknowledge the client's feeling that self-injurious behavior has helped:

  "I certainly agree that you need something effective to do when you feel fearful or when you are having flashbacks. I can see that you feel that biting yourself has really helped you when you felt like that."

- Educate the client about the dangers of the self-injurious behavior:

  "I'm concerned because you could end up getting a serious infection or permanent scarring, or you could cut too deep and injure a blood vessel or a nerve."

- If appropriate, reframe the relationship between the client's trauma history and the self-injurious behavior:

  "You've already suffered more than enough hurt in your life. I don't think you deserve to suffer any more injuries."

- Suggest that alternative ways of coping can be used when the client is feeling in distress:

  "I'm hoping that we can work together and help you figure out healthier ways to cope when you are upset. I understand how important it is to have something you can do to feel better."

- Recognize that the self-injurious behavior may not stop immediately. Discuss how to reduce its dangerousness—perhaps by substituting holding an ice cube in the hand or snapping a rubber band on the wrist (Linehan, 1993).
- Tell the client in a nonjudgmental way that you'd like to discuss the self-injurious behavior every week that it occurs and help the client think about other ways to cope in those situations.
- Enroll client in a dialectical behavior therapy (DBT) group or teach DBT skills on an individualized basis.

The DBT approach has the greatest research evidence of effectiveness in treating self-harm (Burns, Dudley, Hazell, & Patton, 2005). Specifically, it is effective in reducing self-harm episodes among clients with borderline personality disorder and multiple self-harm episodes (Linehan et al., 2006), probably because it is a structured approach that directly addresses coping effectively with distress.

DOCUMENT

Thorough documentation of suicidal ideation and risk factors is an essential portion of the suicide risk assessment (Moline et al., 1998). In the future, you or other clinicians may need this information when assessing another suicidal crisis in the same client. In addition, you will want to be sure to delineate all the risk factors so that you and other clinicians can work to reduce the client's risk.

You must document completely so that in case of legal action sufficient information is available to prove that your evaluation and actions were up to your profession's "standard of care" (Packman, Pennuto et al., 2004). Remember that, in a legal context, "if it wasn't written down, it didn't happen" (Gutheil, 1980, p. 479). As Moline et al. (1998) assert, "Clear, specific and objective written documentation of treatment and preventative actions taken by you are a good safeguard against liability" (p. 74).

Your thought processes in clinical decision making must be documented. If you did not hospitalize, make your reasons for this perfectly clear in the chart (Packman, Pennuto et al., 2004). *If you do not hospitalize, the client's risk level should be no more than moderate.* Document clearly why you made that risk determination. *Never* state that a client is high risk unless you plan to hospitalize the client.

Document all suicide risk assessments contemporaneously for your professional protection against lawsuits since there remains a risk that the client will commit suicide anyway. *Documentation of a suicide risk assessment must be completed (and cosigned if necessary) before you leave the facility for the day.* If you work in a medical center, your client may later present for treatment at the emergency room when you are not available. Your notes will help the clinician on duty make an appropriate determination. In addition, if your client commits suicide and you haven't written a note documenting your earlier suicide assessment, you are in a highly problematic legal position.

For a suicide risk assessment, the following is an outline of what to address in the progress note. This outline is for a client who will be treated as an outpatient:

- Ms. A's current suicidal ideation is . . . [active, passive, intent, plans, means]
- Current behavior relevant to suicide risk assessment is . . .
- Ms. A reported the following past suicidal behavior and ideation . . . [discuss incidents in sufficient detail]
- The suicide risk factors for Ms. A are . . .
- The suicide protective factors for Ms. A are . . . She verbalizes that she does not intend to act on her suicidal ideation because . . .
- Ms. A's past compliance with treatment is . . .
- Ms. A's current engagement in treatment is . . .
- I consulted with [other professionals] regarding Ms. A and [their agreement/input regarding plan]
- Ms. A verbalizes her intent not to commit suicide, and if she feels that she is at greater risk of doing so, she agrees to come to the emergency room or call 911 for assistance.
- Given the above, Ms. A is at [low, moderate] risk for suicide at the present time.
- I did not hospitalize Ms. A because . . .
- Ms. A has agreed to participate in the following treatment and activities to reduce her risk of suicide . . . [include what interventions you chose, why you chose them, time frames for interventions, and why you didn't choose alternative interventions (Simon, 2004)]
- During the session . . . [detail other actions or plans undertaken during session; e.g., sister agreed to remove gun from home]
- Ms. A will be next seen by [insert person] at [insert date].

If you feel that you cannot make a persuasive argument using this outline for managing the client as an outpatient, then the client should be hospitalized.

If a client with significant suicide risk drops out of treatment, make a good-faith effort to reengage the client in treatment. In consultation with your supervisor, consider sending appointments by mail, contacting the client on the phone, and/or contacting family members for assistance in getting the client to attend. Document all these efforts carefully before you close the case.

COPING IF A CLIENT COMMITS SUICIDE

Leah Perry, a psychology intern, completed an intake interview with a new client in a medical center yesterday. As part of her interview, Leah had assessed depressive symptoms and suicidal ideation. Although apparently moderately depressed, the client denied any suicidal ideation and intent, and he denied any history of suicidal ideation or behavior. Today, she gets a message on her voice mail from the client's wife stating that the client committed suicide late last night.

Research suggests that the suicide of a client is one of the most stressful professional events possible (Horn, 1994). Trainees and early career professionals may be especially vulnerable to more intense emotional reactions and stress after a client suicide (Horn, 1994).

Experiencing a client's suicide is unfortunately all too common. Therapists who work with inpatients and/or those with more severe mental illness are more likely to have a client who commits suicide (Kleespies, 1993). Mental health practitioners have a 25% to 50% risk of having at least one client commit suicide in their careers, and of those, psychiatrists have the most risk (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989; McAdams & Foster, 2000). Three studies found that during psychology training alone, the risk for client suicide was 10% to 17% (Kleespies, 1993; Kleespies, Penk, & Forsyth, 1993; Kleespies, Smith, & Becker, 1990), and a sample of psychology trainees found that about 30% had a client attempt suicide during their training years (Kleespies, 1993).

If your client has committed suicide, there are several practical matters you must address (for a thorough treatment of these issues, see Simon, 2004). Tell your clinical supervisor and your administrative supervisor. The malpractice insurer who covers your training site should be contacted by the appropriate person within 30 days. You need to understand that confidentiality does not expire with the client, and you need to consider how you will relate to the family through this difficult time. Risk management, unfortunately, needs to be considered carefully. Read more about these complex issues *immediately* if a client commits suicide.

The suicide of a client impacts your emotional functioning in two ways (this entire paragraph is informed by Horn, 1994). You have the feelings that go along with losing a significant person to suicide, and you experience the suicide as a critical event in your professional development. Ordinary emotional reactions to suicide may begin with shock, disbelief, and denial and then progress to guilt, shame, sadness, and blame. On a professional level, you may worry about professional competence and experience self-doubt. You may fear that fellow professionals are being silently critical. You may be preoccupied with intrusive thoughts about the client and worry about legal issues as well. You may also have some avoidance symptoms (McAdams & Foster, 2000).

Do not share all your feelings with the grieving family; they have enough emotional distress already. Any doubts are probably your emotional reaction and not based on the realities of the treatment you provided; talking about your doubts with the client's family will sow inaccurate concerns that your poor management contributed to the suicide—*don't do it.* Saying the words "I'm sorry" to the family could be problematic as well (Simon, 2004).

Instead, proactively address the emotional and professional impact by discussing feelings and concerns with trusted colleagues, including supervisors and consultants, especially those who have also lost a client to suicide (Kleespies, 1993). The emotional support of your family, friends, and peers can be helpful as well (S. Knox, Burkard, Jackson, Shaack, & Hess, 2006) as long as you are careful to not violate the deceased client's confidentiality.

If your supervisor approves, you can consider attending the client's funeral if the family feels it is appropriate, or you might write a note of condolence to the family. When ready, you may want to review the case in detail with a supervisor or with a consultation group in order to gain more understanding of what transpired.

Later, you will regain emotional equilibrium and reach acceptance and understanding of the event. As a result of the suicide, you may be more attuned to clients' emotional pain and may learn more about effectively managing high-risk clients (S. Knox et al., 2006). You may be more careful with clinical record keeping and more aware of legal liabilities, and you may be more willing to seek consultation regarding high-risk cases (McAdams & Foster, 2000). These reactions can lead to improved sensitivity and quality of care.

However, negative emotional effects are possible as well, as you could develop feelings of fear and helplessness when treating suicidal clients and become overly protective of high-risk clients (Horn, 1994). If you have these reactions, you should seek personal therapy and consultation for assistance.

CONCLUSION

No one chapter can be considered anything more than an introduction to the complex subject of assessing and managing suicidality in clients. It is essential that you continue to learn more about this subject through reading, consultation, and lectures. The following list of recommended readings will help you get started on this process.

RECOMMENDED READING

Jacobs, D. G., & Brewer, M. L. (2006). Application of the APA Practice Guidelines on Suicide to clinical practice. *CNS Spectrums, 11*, 447–454. Retrieved October 21, 2006, from http://www.cnsspectrums.com/aspx/articledetail.aspx?articleid=471. *This article has two particularly helpful tables: Table 2, "Questions About Suicidal Feelings and Behavior"; and Table 3, "Guidelines for Selecting a Treatment Setting for Patients at Risk of Suicide or Suicidal Behaviors."*

Packman, W. L., Pennuto, T. O., Bongar, B., & Orthwein, J. (2004). Legal issues of professional negligence in suicide cases. *Behavioral Sciences and the Law, 22*, 697–713. *Packman and colleagues provide a thorough discussion of legal malpractice issues relevant to client suicide and how the clinician can practice to minimize risk.*

Simon, R. I. (2004). *Assessing and managing suicide risk: Guidelines for clinically based risk management.* Washington, DC: American Psychiatric Publishing. *Although targeted to fellow psychiatrists, Simon's volume is essential reading for any clinician who wants to be well informed and confident in the clinical management of suicide risk. Chapters on inpatient management of suicidality and suicide aftermath are helpful in those situations. I recommend that you have a copy on hand so that, in the unfortunate event that a client commits suicide, you have an appropriate reference to help you.*

EXERCISES AND DISCUSSION QUESTIONS

1. Does your facility use suicide contracts with clients? Do you think this is a good idea with these particular clients? Why or why not?
2. Do you know any clinicians who have lost a client to suicide? Has your supervisor or any of your coworkers lost a client to suicide? Ask these colleagues how they dealt with it.
3. If a client were to commit suicide, what would you need to do from a procedural standpoint at the facility? What do you think would help you cope personally and professionally with this tragedy?
4. Write a progress note documenting Tony's assessment of Phil.
5. Write a progress note documenting Fred's assessment of Crystal.