

**35 YEARS of WORKING with SUICIDAL PATIENTS:
LESSONS LEARNED**

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**35 Years of Working With
Suicidal Patients:
Lessons Learned
Donald Meichenbaum, Ph.D.**

LESSON 1. THE WIDESPREAD INCIDENCE OF CLINICAL PRACTICE AND SUICIDE

- a) **A brief review of my professional experiences with suicidal patients (work with victimized patients, combat veterans, Native populations, individuals with traumatic brain injuries, suicidal adolescents and suicidal college students)**
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LESSON 1: THE WIDESPREAD INCIDENCE OF CLINICAL PRACTICE AND SUICIDE (Data gleaned from Bongar, 2002; Brown, 1987; Chemtob et al., 1989; Hendin et al., 2004; Kleespies et al., 1993; Meichenbaum, 2005; Norcross & Guy, 2007) (Also see the American Association of Suicidology Clinician Survivor Task Force mypage.usb.edu/~jmcintos/basicinfo.html)

As was mentioned in my presentation, the first patient I treated as a graduate student was at a Veteran's Administration Hospital. He committed suicide. Since that time, I have worked with various groups for whom suicide is a common presenting problem including combat veterans, institutionalized adolescent offenders, Native populations both in the U.S. and Canada, individuals with Traumatic Brain Injuries, and various psychiatric populations who have experienced some form of victimization. The following data indicates that my clinical experiences were not unique. In fact:

- 1 in 4 interns/trainees will have a patient who attempts suicide at some point during their training and 1 in 9 will experience a completed patient's suicide.
- Clinical psychology graduate programs typically provide only brief discussion of suicide and minimal training in treating suicidal patients.
- A practicing psychologist will average 5 suicidal patients per month.
- 25% of psychologists and 50% of psychiatrists will experience a patient's suicide.
- 1 in 6 psychiatric patients who die by suicide die in active treatment with a healthcare provider.
- Approximately 50% of those who die by suicide in America will have seen a mental health provider at some time in their life.
- Work with suicidal patients is considered the most stressful of all clinical endeavors. One third of psychotherapists who experienced a patient's suicide subsequently suffer from severe emotional distress. Several factors may contribute to such severe distress including failure to hospitalize a suicidal patient who then died; a treatment decision that the therapist may feel contributed to the suicide; negative reactions from the therapist's institution; and the fear of a lawsuit by the patient's relatives.
- 25 % of family members of suicidal patients take legal actions against the patient's mental health treatment team.

SOME FACTS ABOUT SUICIDE

I consult to a number of psychiatric settings where I spend a good deal of time working with patients who are hospitalized because of current and past suicidal attempts. The following epidemiological data puts these consultations into some perspective.

SUICIDE IN ADULTS

(Data gleaned from Bongar, 2002; Hendin, 1995; Jacobs, 2000; Meichenbaum, 1994)

- Around the world suicide takes nearly 1 million lives each year. Ellis and Rutherford (2008) indicate that suicide accounts for fully one-half of violent deaths worldwide, outpacing homicide and war combined as the cause of death.
- Suicidality varies across cultures. Southern European countries have the lowest suicide rates (Spain, Italy), while Scandinavian and Central European countries (Hungary, Denmark, Austria) have the highest suicide rates.
- About 30,000 people in the U.S. commit suicide each year. It is estimated that there are 10 X as many suicide attempts in the U.S. each year.
- Suicide is the 11th leading cause of death in the United States, with a rate of one completed suicide every 17 minutes. General population data suggest that upwards of 13.5% of individuals report lifetime suicidal ideation and 4.6% report making suicide attempts at some point in their lives.
- It is estimated that 10.5 million people in the U.S. experience suicidal ideation each year, but only 30,000 complete suicide.
- Those most prone to engage in suicide are the elderly. Approximately 20% of all suicides occur in elderly persons. In the U.S., the elderly constitute 13% of the population, but they make up 18% of all suicides. The major risk factor for elderly suicide is Major Depressive Disorder (MDD). Most older Americans have seen a doctor within a month of the suicidal act.
- The lifetime risk of suicide for adult individuals with Major Depressive Disorder (MDD) is estimated to be 15% among psychiatric inpatients. Individuals with MDD are 22 X higher to be suicidal completers, especially when they also have comorbid psychiatric and medical disorders such as psychotic disorders and substance abuse disorders. Most individuals with MDD are highest risk for suicide during the early years within the course of their illness. Those who attempt suicide most often do so in the first 3 months of a depressive episode and within 5 years of their depression onset.
- Anxiety increases the risk of early suicide in the course of major depression. Rector et al. (2008) observe that the incidence of suicidal behaviors increases with the number of anxiety disorders, and moreover, the presence of anxiety disorder in combination with a mood disorder increases the suicide risk beyond a mood disorder alone.
- Stable levels of hopelessness also increase the long-term risk of suicide.

- Depressed individuals with suicidal ideation and previous suicide attempts constitute the most high risk group.
- Suicide ideation has been estimated to be 2.3% in the U.S. for individuals aged 18-54. 28% of this vulnerable group made a plan to kill themselves and 32% of these individuals carried out a serious attempt to commit suicide.
- The likelihood of suicide is increased when the depressed patient has a history of victimization and is currently suffering from PTSD. Elsewhere (Meichenbaum, 2006), I have summarized the increased risk of suicide among combat veterans, especially those with combat guilt; refugees with a history of exposure to severe trauma; victims of childhood maltreatment; victims of spouse abuse; individuals with substance abuse; victims of traumatic brain injuries. (see Kaplan & Huguet, in press; Simpson & Tate, 2002; Teasdale, 2006). In fact, among abused women, some 49% to 66% have a history of suicide attempts, and about one in four or five rape survivors will actually consider suicide at some point following the attack.
- Rector et al. (2008) indicate that the risk of suicide is highest at transition points. They observe that suicide rates are most prevalent in the first month after arrival at a prison; suicide rates in psychiatric hospitals are highest during the first week of being institutionalized, and bereavement-related suicides occur soon after the death of a loved one.
- The presence of mood disorders, substance abuse disorders and schizophrenia are risk factors for suicidal behavior, elevating suicide risk by 60-70 times the general population. There is a presence of psychiatric disorders in approximately 90% of suicidal cases, with mood disorders being most common (Cavanagh et al. (2003).
- ***“Yet few individuals with MDD receive adequate treatment for depression before and after a suicide attempt” (Ghahramanlou-Holloway et al., 2008. p 60).***
- Only 20%-40% of suicidal patients continue with outpatient treatment following their psychiatric hospitalization.
- Patient dropout from treatment is another risk factor for suicide.

SUICIDE IN ADOLESCENTS

(Data gleaned from Asarnow and her colleagues, 2005; Baraff et al., 2006; Forwood et al., 2007; Shaffer et al., 2001)

Other populations I have worked with are adolescents who attempt suicide and with college students who attempt suicide. I gave a presentation to General Practitioners in Montreal on adolescent suicide. Quebec has the highest rate of adolescent suicide in Canada. My former student Joan Asarnow and her colleagues (2005) and Baraff et al. (2006) have reported that physicians need to be trained to become gatekeepers and initial screeners of adolescents, just as in the case of the elderly. The following epidemiological data underscores the nature of the challenge of working with suicidal adolescents.

- Of the 30,000 suicide attempts in the U.S. each year, approximately 5000 American adolescents

are successful.

- Among individuals 15-24 years old, suicide is the third leading cause of death after accidents and homicides.
- Suicide is least likely to occur before age 12 and it increases yearly in frequency between 12 and 23.
- Community surveys indicate that 27% of high school students think about suicide, and 10% plan suicidal acts. The Youth Risk Behaviors Survey conducted by the Center for Disease Control and Prevention found that 36% of high school students admitted to having seriously thought about suicide in the previous year.
- 30% to 40% of eventual suicide completers have made at least one prior attempt that may have begun during adolescence. A previous suicide attempt increases suicide risk by 38-40 times.
- Youth tend to use more lethal methods with repeat attempts.
- 8% of high school students attempt suicide each year. 10% to 13% of junior and senior high school students report having moderate to serious levels of suicidal thoughts. Only 10%-15% of suicide attempters ever complete suicide.
- The rate of suicide among adolescents has tripled since the 1950's, but it is still a relatively rare event.
- Compared to adults, adolescent suicidal behavior more often has an identifiable, precipitating event that has had direct and discernible impact on the adolescent's identity, sense of autonomy and independence (e.g., conflict with family, disciplinary action, change in peer group status, relocations, social isolation, rejection, termination of romantic relationship). Forwood et al., (2007) reported that a suicide attempt is likely to be highest among youth presenting with a combination of depression and externalizing behavior and those with a romantic breakup, being assaulted, or being arrested.
- 60%-70% of suicide completers commit suicide on their first known attempt.
- More than 90% of adult suicide attempters and 80% of adolescent attempters and completers communicate suicidal ideation prior to the attempt.
- Youths who make fewer suicidal communications (some 20%) prior to the attempt tend to make more lethal attempts. Drug abuse is higher in the low communication group.
- Adolescents rarely leave suicide notes.
- Girls attempt suicide 3x more often than boys, but boys commit suicide 5x more frequently than do females. Boys tend to use more lethal forms of suicide attempts.
- Gay and lesbian youth are 2 to 3x more likely than heterosexual peers to attempt suicide. 30% of adolescent suicides (20 or younger) each year are by gay and lesbian youth. They are 15x

more likely to avoid school because they feel unsafe.

- Caucasian teenagers of either sex are more likely to commit suicide than African American or Hispanic teens.
- Native American youth have a much higher incidence of suicide (up to 20x higher than non-Indian population), but this varies by the particular tribe. There are 560 different tribes in the U.S., so there is a need not to stereotype Native American youth.
- One third of adolescents with DD (Dysthymic Disorder) and MDD (Major Depressive Disorder) will have their first suicide attempt by age 17.
- Nearly 30% of depressed children make a suicide attempt in adult life. Among those with adolescent MDD, 7% will commit suicide by adult years.
- MDD is 22x higher among suicide completers. 90% of youths who attempt suicide have an Axis I diagnosis and many have seen a doctor or mental health worker in the three months prior to a suicidal attempt.
- Among those adolescents who commit suicide, the interval between the onset of depression and completed suicide averages about 7 years.
- Half of adolescent suicide attempters will improve following a suicide attempt and remain suicide-free.
- 5% to 40% will make another attempt, with the higher incidence being among those adolescents who were hospitalized for depression. As noted, subsequent suicidal attempts are likely to reoccur within 3 months of the initial episode. There is a need to discriminate between those with chronic suicidal behavior (multiple attempters) and those who experience a suicidal crisis (single attempters). Risk assessment should occur over short periods of time (hours, days, weeks at most).
- One third of youth suicide attempters will have made a second attempt prior to the completed suicide. Adolescents with prior attempts are 18x more likely to make future attempts. As noted, subsequent suicidal attempts are likely to be more lethal in nature.
- 60% -70% of suicide completers commit suicide on their first known attempt.
- Half of the youth who attempt suicide do not receive any treatment beyond psychotropic medication. In the U.S., annually there are 8 million prescriptions written for antidepressants for children and adolescents.
- ***For examples of suicide prevention efforts with suicidal youth see the following websites. See Prepare: School Crisis Prevention and Intervention Training Curriculum (<http://www.nasponline.org/prepare/index.aspx>) and the University of South Florida Youth Suicide Prevention School-based Guide (<http://www.fmhi.usf.edu/institute/pub/bysubject.html>) (<http://cfs.fmhi.usf.edu/cfsinfo/hotpubs.html>) SAMHSA Evidenced-based practices (http://www.sprc.org/featured_resources/bpr)***

SUICIDE IN COLLEGE STUDENTS

(Data gleaned from Berman et al., 2006; Gutierrez et al., 2000; Onestack, 2005; Rudd, 1989; Silverman et al., 1997).

- 10% of college students have been diagnosed with depression which is a risk factor for engaging in suicidal behavior.
- Self-reports of suicidal ideation in college students have ranged from 32% to 70%.
- It is estimated that there are 1100 suicides on college campuses in the U.S. each year (which actually is a relatively rare event on college campuses). Silverman et al. (1997) reported a rate of 7.5 per 100,000 which is lower than a comparable non-student population.
- College students are at a lower risk while they are in school, but they may be engaging in behaviors (suicidal ideation and suicidal attempts) that put them at higher risk later in life.
- Suicide is the second leading cause of death in college-age students.
- One in 12 college students have seriously contemplated suicide.
- 1.5 % have made a suicide attempt
- 50% report feeling very sad, 33% report feeling hopeless, and 22% feel so depressed as to be unable to function
- 6 % of males and 12% of female college students meet the diagnostic criteria of Major Depressive Disorder.
- Numerous factors have been identified as contributors to the suicidal thoughts or suicidal attempts of college students, including loneliness, hopelessness, depression, relationship problems, helplessness, academic problems, difficulties with parents and financial concerns.
- Most of these depressed students are not receiving adequate treatment.

(See the JED Foundation website for a discussion of Ways to Safeguard College Students Against Suicide, www.jedfoundation.org)

(See A. Berman, D.A. Jobes and M.M. Silverman (2006) Adolescent suicide: Assessment and intervention. Washington, DC: American Psychological Association, pp 329-334 for a discussion of essential services for addressing suicidal behaviors on campus)

LESSON 2: IMPLICATIONS OF EPIDEMIOLOGICAL DATA ON SUICIDE

1. There is a need for an integrative Case Conceptualization Model (CCM) that incorporates findings from epidemiological research. This CCM should include information about current and past risk assessment, the presence of comorbid psychiatric and medical disorders, a history of victimization, and a treatment history. The CCM should also include a consideration of current and future protective factors.
2. There is a need to obtain a time line of the sequence of psychiatric disorders, especially Major Depressive Disorders (MDD), Eating Disorders, PTSD, and Substance Abuse Disorders. Most MDD begins in adolescence and is a forerunner of later suicidal risk. For instance, it is important to determine the sequence of MDD, PTSD, Substance Abuse Disorders and suicidal attempts.
3. There is a need to obtain a detailed assessment of treatment responsiveness and the factors that contributed to treatment noncompliance (level of chronic hopelessness, barriers to treatment).
4. There is a need to conduct ongoing routine suicide risk assessments. Risk assessment should occur over short periods of time. There is a need to not only assess the patient, but a need to also conduct ecological assessments of high-risk suicide-engendering environmental factors, as discussed below.
5. There is a need to train physicians and other potential gatekeepers on how to identify, assess and refer potentially suicidal patients.
6. There is a need to intervene early in the development trajectory of the depression and suicidal behavior.
7. There is a need to develop a treatment team approach that ensures active aftercare, especially in the high-risk period soon after an initial suicide attempt and after being discharged from a psychiatric facility.

GENERIC CASE CONCEPTUALIZATION MODEL

One of my major clinical activities is to consult at various psychiatric hospitals, residential settings for adolescents, VA Hospitals, and rehabilitation centers for individuals with Traumatic Brain Injuries. In each of these settings I am going to be asked to interview the most difficult and challenging patients, who often have a history of suicidal behavior. First, however, a Case presentation is conducted where all the Health Care Providers will come together and share relevant clinical information and then they adjourn to watch the interview from behind a one-way mirror.

I needed some way to summarize the plethora of information and to ensure that the staff presented the “full story” of risk and protective factors and information that can guide clinical decision-making. The following multi-component Case Conceptualization Model (CCM) is one that I have found helpful. The CCM provides a means for me to share, not only with the staff, but also with the patient (see Feedback sheet) the results of the assessment interview.

The staff can keep Progress Notes indicating how they intend to develop a treatment plan. For example, 2A (Focus on presenting problem) and reducing risk with the help of the family (6B) while anticipating possible treatment delays(9C). In fact, I often point out to the staff that the CCM reduces their entire professional activities to one page. There is nothing that they do that is not codable. See Meichenbaum (2002) for a description of the CCM.

GENERIC CASE CONCEPTUALIZATION MODEL

1 A. Background Information
1 B. Reasons for Referral

2A. Presenting Problems (Symptomatic functioning)
2B. Risk Assessment Toward Self and Toward Others
2C. Level of Functioning (Interpersonal problems, Social role performance)

9. Barriers
9A. Individual
9B. Social
9C. Systemic

3. Comorbidity
3A. Axis I
3B. Axis II
3C. Axis III

8 Outcomes (GAS)
8.A Short-term
8.B Intermediate
8C. Long-term

4. Stressors (Present/Past)
4A. Current
4B. Ecological
4C. Developmental
4D. Familial

7. Summary Risk and Protective Factors

6. Strengths
6A. Individual
6B. Social
6C. Systemic

5. Treatments Received (Current/Past)
5A. Efficacy
5B Adherence
5C. Satisfaction

FEEDBACK SHEET ON CASE CONCEPTUALIZATION

Let me see **if I understand:**

BOXES 1& 2: REFERRAL SOURCES AND PRESENTING PROBLEMS

- “What brings you here...? (distress, symptoms, present and in the past)
- “And is it particularly bad when...” “But it tends to improve when you...”
- “And how is it affecting you (in terms of relationship, work, etc)”

BOX 3: COMORBIDITY

- “In addition, you are also experiencing (struggling with)...”
- “And the impact of this in terms of your day-to-day experience is...”

BOX 4: STRESSORS

- “Some of the factors (stresses) that you are currently experiencing that seem to maintain your problems are...or that seem to exacerbate (make worse) are... (Current/ecological stressors)
- “And it's not only now, but this has been going on for some time, as evidenced by...” (Developmental stressors)
- “And it's not only something you have experienced, but your family members have also been experiencing (struggling with)...” “And the impact on you has been...” (Familial stressors and familial psychopathology)

BOX 5: TREATMENT RECEIVED

- “For these problems the treatments that you have received were”-note type, time, by whom
- “And what was most effective (worked best) was... as evidenced by...”
- “But you had difficulty following through with the treatment as evidenced by...” (Obtain an adherence history)
- “And some of the difficulties (barriers) in following the treatment were...”
- “But you were specifically satisfied with...and would recommend or consider...”

BOX 6: STRENGTHS

- “But in spite of...you have been able to...”
- “Some of the strengths (signs of resilience) that you have evidenced or that you bring to the present situation are...”
- “Moreover, some of the people (resources) you can call upon (access)are...” “And they can be helpful by doing...” (Social supports)
- “And some of the services you can access are...” (Systemic resources)

BOX 7: SUMMARY OF RISK AND PROTECTIVE FACTORS

- “Have I captured what you were saying?” (Summarize risk and protective factors)
- “Of these different areas, where do you think we should begin?” (Collaborate and negotiate with the patient a treatment plan. Do not become a “surrogate frontal lobe” for the patient)

BOX 8: OUTCOMES (GOAL ATTAINMENT SCALING PROCEDURES)

- “Let's consider what your expectations are about the treatment. As a result of our working together, what would you like to see change (in the short-term)?
- “How are things now in your life? How would you like them to be? How can we work together to help you achieve these short-term, intermediate and long-term goals?”
- “What has worked for you in the past?”
- “How can our current efforts be informed by your past experience?”
- “Moreover, if you achieve your goals, what would you see changed?”
- “Who else would notice these changes?”

BOX 9: POSSIBLE BARRIERS

- “Let me raise one last question, if I may. Can you envision, can you foresee, anything that might get in the way- any possible obstacles or barriers to your achieving your treatment goals?” (Consider with the patient possible individual, social and systemic barriers, do not address the potential barriers until some hope and resources have been addressed and documented.)
- “Let's consider how we can anticipate, plan for, and address these potential barriers.”
- “Let us review once again...” (Go back over the Case Conceptualization and have the patient put the treatment plan in his/her own words. Involve significant others in the Case Conceptualization Model and treatment plan. Solicit their input and feedback. Reassess with the patient the treatment plan throughout treatment. Keep track of your treatment interventions using the coded activities (2A, 3B, 5B, 4C, 6B, etc.) Maintain progress notes and share these with the patient and with other members of the treatment team.

LESSON 3: IMPLICATIONS OF A CONSTRUCTIVE NARRATIVE PERSPECTIVE (CNP) OF SUICIDE

The following descriptions of the characteristic thinking patterns of clinically suicidal individuals highlight the cognitive vulnerability factors and sequelae of suicidal behaviors. Ellis and Rutherford (2008) have provided a similar account of the relationship between cognition and suicide. Consider what suicidal individuals have to tell themselves and others in order to convince themselves that self-annihilation should outweigh self-preservation. Below I will consider the assessment and treatment implications.

The nature of the “stories” that individuals who engage in other forms of suicide (e.g., “altruistic suicide,” suicide bombers, or end of life suicides) may be quite different and involve concepts of “perceived burdensomeness on others” and “self-sacrifice” for a higher good. (Joiner & Van Orden, 2008). Whatever the exact nature of such “story telling,” it is proposed that a CNP will help explain such suicidal behaviors.

CHARACTERISTIC THINKING PATTERNS OF SUICIDAL INDIVIDUALS: IMPLICATIONS

- a) **dichotomous (black-white) thinking**
- b) **cognitive rigidity and constriction**
- c) **perfectionistic standards toward self and others with high levels of self-criticism**
- d) **lack of specificity in autobiographical memory- Such overgeneral and vague autobiographical memory has been associated with depression, PTSD, and suicidal behavior. Ellis and Rutherford (2008) highlight that such overgeneral memories interfere with interpersonal problem-solving because past experiences cannot be used as references for effective coping strategies in the present.**
- e) **impaired problem-solving and poor problem-solving confidence**
- f) **“looming vulnerability” or the perceived experience of negative occurrences as rapidly escalating, mounting, quickly approaching adversities that generate distress (Riskind et al., 2000)**
- g) **such looming vulnerability can stoke hopelessness and helplessness with negative expectations about the future (Anticipate few positive events or outcomes and accompanying vagueness in future thinking).**
- h) **ruminative process- - feeling “locked-in” to their current perceptions, unable to imagine alternatives, or consider new courses of action**
- i) **more present-oriented and view death in a more favorable light**
- j) **have difficulty generating Reason for Living**
- k) **absence of protective factors such as attraction to life, repulsion by death, surviving and coping beliefs, sense of personal self-efficacy, moral and religious objections to suicide, fear of self-injury, and sense of responsibility to one's family**

Examples of the Narratives of Suicidal Individuals

“I can't stand being so depressed anymore.” “I can stop this pain by killing myself.” “I am damaged goods.” (Schneidman, 2001 has characterized this intractable emotional pain as psychache)

“Suicide is the only choice I have.” (The word “only” is considered one of the most dangerous words in suicidology)

“My family would be better off without me.” “I was just a lifeless thing-breathing, but worthless. I knew everyone would be better off if I were dead. It would end my misery and relieve their burden.” “My death will be worth more than my life to my family.” (Joiner, 2005 and Joiner and Van Orden, 2008 have highlighted the perception of being a burden on others as related to suicidal tendencies).

“I am useless and unwanted.” (Joiner, 2005, highlights a sense of “thwarted belongingness,” as contributing to suicidal ideation and actions.) Perceive others as uncaring and unsupportive; feel socially disconnected and lack emotional intimacy

“No one cares whether I live or die.” (Feel rejected, marginalized, worthless, unlovable, isolated, alone, and a failure)

“I am worthless and don't deserve to live.” (The presence of guilt and shame exacerbates suicidal ideation)

“I have an enemy within that I have to escape.” (Baumeister, 2004, has viewed suicide as a form of escape from self. It also reflects the “drama of the mind” that suicidal individuals are prone to engage in).

“I am in a tailspin, like a freight train or tsunami hit me. There is no hope. I can't get caught up. What is the point?” (Riskind et al. 2000 and Rector et al. 2008 have noted that anxious and suicidal individuals are prone to produce elaborate mental scenarios anticipating rapidly rising risk with multiply increasing threats. They tend to exaggerate the time course of perceived catastrophic outcomes and have an increased sense of urgency for escape and avoidance).

“I hate myself.” (Suicidal individuals have an over-generalized memory and tend to selectively recall negative events that contribute to invalidating themselves).

“I can't fix this problem and I should just die.” (Tunnel vision, inflexibility in generating alternatives, feel trapped and perceived inescapability)

“I would rather die than feel this way.” (Evidence poor distress tolerance)

“I have lost everything that is important to me.” “My future looks empty.” “Life is no longer worth Living.” “Nothing will change.” “There is no hope for me.” (Ghahramanlou- Holloway et al., 2008, highlight the impact of such loss-related cognitions and the role of feelings of helplessness and hopelessness that exacerbate suicidal tendencies).

“I have screwed up, so I might as well screw up all the way.” (Perception that he or she does not deserve to live which contributes to suicidal ideation)

“Those who hurt me will be sorry.” (Perceived benefits of suicide, revenge)

“Suicide is a way of life for me and I can't stop it.” (Kernberg, 2001)

IMPLICATIONS OF A CONSTRUCTIVE NARRATIVE PERSPECTIVE (CNP) OF SUICIDE

- There is a need for the psychotherapist to become an “exquisite listener” of how suicidal patients tell their “story,” paying particular attention to the patients' thinking patterns and accompanying feelings and behaviors. There is a need to explicitly assess for suicidality and for the accompanying narrative.
- There is a need to assess the individual's capacity for self-injury and determine suicidal history, differentiating between single versus multiple attempters by conducting a detailed assessment, as discussed below.
- There is a need to be attuned to the presence of earlier victimization and the resultant conclusions that patients draw about themselves, others, the world, and the future.
- There is a need to consider the role of developmental schemas, metaphors and images, mental and behavioral scripts and conditional assumptions (“If...then” rules) that predispose individuals towards suicidal behavior.
- There is value in specifically treating the cognitive vulnerabilities that predispose individuals to engage in suicidal behaviors. Recent studies that focused on reducing suicidal thinking (Berk et al., 2004; Brown et al., 2005) and nurturing coping skills (Linehan et al., 2006) have reported a 50% reduction in suicidal behaviors. ***(A description of such cognitive behavioral interventions is offered below.)***
- Interventions need to help suicidal patients transform hopelessness into hopefulness. Treatment needs to help suicidal individuals to develop healthy coping strategies, employ problem-solving skills to challenge and combat, what the English poet and critic A. Alvarez called “**The Savage God.**” As he described:

“Suicide is a closed world with its own irresistible logic...Once a man decides to take his own life he enters a shut off, impregnable, but wholly convincing world, where every detail fits and each incident reinforces his decision.”

Suicide may be seen as the only option, and even a “rational course of action,” as Aaron Beck (1976) observed some time ago.

LESSON 4: ASSESSMENT OF SUICIDAL IDEATION and SUICIDAL BEHAVIOR: NEED FOR COMPREHENSIVE ASSESSMENT STRATEGIES

1. There is a need to conduct comprehensive evaluations of current and past suicidal behaviors that occur prior to and during treatment for purposes of risk management and treatment planning.
2. Risk assessment cannot rely on a single indicator. There is a need to combine clinical interviews with self-report scales and with objective behavioral measures.
3. There is a need to conduct risk assessment on an ongoing basis. For example, Bisconer and Gross (2007), highlight the importance of repeating the suicide risk assessment before discharge from an inpatient setting, given that as many as 50% of patients with schizophrenia complete suicide within 3 months of discharge from a psychiatric hospital.
4. Self-report measures of suicidality have considerable error rates (false negatives and false positives). When screening for suicidal risk it is important to use a multigating procedure employing follow-up assessment to a preliminary screening.
5. There is a need to assess both risk factors and protective factors that capture the ambivalence and internal debate that often characterizes the mind of the suicidal individual. It is not only the presence of high risk factors, but the absence of protective factors that place individuals at higher risk.
6. There is a need to employ a Case Conceptualization Model (CCM) that incorporates both risk and protective factors. Protective factors include individual, familial and cultural signs of resilience and strengths.
7. Assessment and feedback to the suicidal patient and significant others can be a useful form of psychotherapeutic intervention.
8. Assessment strategies can incorporate the following features.
 - a. Conduct Clinical Interviews that assess directly for suicidal ideation and suicidal behaviors.
 - b. Conduct Ongoing Risk Assessments
 - c. Use Self-report Measures (for example, those developed by Beck, Linehan and Jobes)
 - d. Assess for protective factors
 - e. Assess for Possible Barriers to treatment:

Individual barriers -- stigma, shame, level of psychopathology, degree of hopelessness, denial, chronic substance abuse

Social barriers --negative culturally-based attitudes about mental health services; High Expressed Emotion environment (eg., criticism and

intrusiveness that contributes to relapse); suicidal peer group.

Systemic barriers--poor economic resources and lack of insurance; lack of availability of services; long waiting lists; practical problems involving transportation, child care; scheduling problems; cultural mismatch between the patient and service providers; absence of resources for aftercare interventions.

9. There is a need to document, document, and document on an ongoing basis, risk and protective factors and assessment treatment and follow-up efforts.
10. Finally, it is important to conduct an assessment of not only the suicidal individual, but also conduct an ecological assessment of the individual's environment and document this, as well. (See Huey et al., 2004 for an example of Multisystemic treatment approach for suicidal youth).

ASSESSMENT STRATEGIES

I will now consider several assessment strategies designed to measure directly for suicidal ideation and suicidal behaviors. I will examine:

1. Short Forms of Assessment using brief interviews (for example, scales developed by Posner et al. 2007; Ghahramanlou-Holloway et al. 2008; Joiner et al. 1997; and Rudd, 1998).
2. More detailed follow-up clinical interviews for both adults (Meichenbaum, 2005; Rudd et al., 2002) and children and adolescents (Jacobson et al., 1994; McArthur Foundation, 2002).
3. Comprehensive Collaborative Assessment and Management of Suicidality (CAMS) offered by Jobes (2006).
4. Self-report measures of suicidality, depression and hopelessness offered by Beck and his colleagues (Ghahramanlou-Holloway et al., 2008) and other researchers. These Self-report Scales should assess both risk factors (suicidal ideation, level of hopelessness, and history of prior suicidal attempts) and protective factors (Reasons for Living, repulsion of suicide, social supports). There is a need to tap the ambivalence and “internal debate” with regard to suicide.
5. Summary of risk and protective factors and accompanying documentation (Joint Commission Guidelines JCAHO).
6. Finally, the need for conducting an Ecological Assessment.

These various assessment components have been summarized by Jacobs (1999) as a SAFE-T model.

Suicide Assessment Five-step Evaluation Triage SAFE-T (Douglas Jacobs)

(www.psych.org/psych_pract/treatg/pg/SuicidalBehavior_05-15-06.pdf)
(www.mentalhealthscreening.org)

- 1) Identify Risk Factors
- 2) Identify Protective Factors
- 3) Conduct Suicide Inquiry
- 4) Determine Risk Level/Intervention
- 5) Document (Assessment of risk and protective factors, level of suicidal risk, interventions and follow-up)

SHORT FORM ASSESSMENT

A number of researchers have developed Brief Interviews to directly assess for suicidality that can be used as an initial screening tool in a multigating process.

1. Posner et al. (2007) have developed the **Columbia Classification Algorithm of Assessment Classification (C-CASS)** that is being proposed for use in future drug trials to assess for possible side-effects of increased suicidality. The **C-CASS** assesses for both Suicidal Behavior and Suicidal Ideation.

COLUMBIA SUICIDE SEVERITY SCALE (C-SSS)

SUICIDAL BEHAVIOR

Have you done anything to harm yourself because you wanted to end your life?

Has there been a time when you started to do something to end your life but someone or something stopped you, or you stopped yourself, before you actually did anything?

Have you taken any steps toward making a suicide attempt or preparing to kill yourself (like collecting pills, getting a gun, giving valuables away or writing a suicidal note)?

SUICIDAL IDEATION

Have you wished you were dead or wished you could go to sleep and not wake up?

Have you actually had any thoughts of killing yourself?

Have you been thinking about how you might do this?

Have you had some intention of acting on these thoughts?

Have you worked out the details of how to kill yourself?

2. Ghahramanlou-Holloway, Brown and Beck (2008) and Joiner et al. (1999) proposed that the clinician ask the following questions:

1. *Are you currently having any thoughts of killing yourself?*
2. *Do you currently have any desire to kill yourself?*
3. *Do you have a specific plan to kill yourself?*
4. *Do you intend to carry out this plan?*

This query is followed up with further questions about the frequency, timing, persistence and current severity of suicidal ideation. If an individual describes a specific plan for suicide, then he/she should be asked about the perceived lethality of such a plan. Individuals who report a detailed plan involving

violent and/or irreversible methods are likely to be at significantly higher risk.

Examples of **follow-up assessment questions** were offered by Rudd (1998).

**INTERVIEWING FOR SUICIDE IDEATION, PLANS AND
REASONS FOR LIVING AND DYING**

(Source: Rudd, M.D. (1998). An integrative conceptual and organizational framework for treating suicidal behavior. *Psychotherapy*, 35, 346-360)

Frequency, Intensity, Duration of Suicide Ideation

*Do you ever have thoughts of killing yourself...thoughts of suicide?
How often do you think about suicide...daily, weekly or monthly?
Have you ever wished you were dead?
How long do these thoughts last, seconds, minutes? How severe or
overwhelming are they? Could you rate the intensity on a scale from one
to 10, where 10 is most intense?
Have you ever thought about trying to hurt yourself?
Do you intend to hurt yourself?
Have you ever attempted suicide?*

Specificity of Plans

*When, where and how?
Do you have a plan to hurt yourself?*

Availability of Method

*Do you have [methods]? Do you have access to [methods]?
Do you feel in control now?
Have you had times when you felt out of control?
What were you doing?
Were you drinking, using any substances?
Could you rate how much in control you feel on a scale from one to 10, where
10 is completely out of control? (give specific examples of the phrase,
control)*

Reasons for Living and Dying

*Have you ever thought that life was not worth living?
Have you ever acted on these thoughts...what keeps you alive right
now? What keeps you going? What kept you going in the past when
you've had these thoughts?*

Intention

*Do you have any intention of acting on the thoughts of suicide? Could you
rate your intent on a scale from one to 10, where 10 means most intent*

to act on your plan to try and kill yourself?

FOLLOW-UP CLINICAL INTERVIEW QUESTIONS: The clinician can sample from these questions.

Supplemental Questions for adults that could be incorporated in the suicidal assessment as suggested by Meichenbaum, 1995; Rudd & Joiner, 1998; Rudd et al., 2002.

Are you thinking of suicide (killing yourself) at the present time (right now)?

Have you thought about suicide in the last 24 (48) hours?

This past week, have you had any thoughts that life is not worth living or that you would be better off dead?

Have these feelings/symptoms that we have been talking about led you to think you would be better off dead?

Is it difficult to talk about what happened? Could you tell me how you came to the point where you would attempt suicide (attempt to kill yourself)?

I would like you to tell me, in your own words, what led up to your suicide attempt?

Do you still have thoughts of killing yourself now?

How often do you think of suicide, daily, weekly or monthly? (Duration and intensity are more important predictors than frequency).

How long do the thoughts about suicide usually last... a few seconds, a few minutes, hours, more?

How severe, intense or overwhelming are the thoughts about suicide?

Could you rate the intensity or severity of your suicidal thoughts on a 1 to 10 scale, where 10 is the most intense or severe and 1 is the least intense and severe? Where do you think you are at this moment on this 1 (least) to 10 (most) severe intensity scale of suicidal thoughts?

When people think about suicide, it is not unusual for them to think about how they might do it, when or where? Have you had these thoughts? Can you tell me about them?

Have you thought about other methods or ways of committing suicide?

Do you have access to possible methods—own a gun or can get one, taking medication?

Have you acted on these thoughts in any way?

Have you taken steps in preparation for killing yourself? (e.g., acquired a weapon, written a suicide note, taken steps to avoid discovery?) (60% of completed suiciders in the U.S. use firearms. Lethality increases with precautions to avoid intervention by others)

Do you have intention of acting on your thoughts of suicide?

Could you rate your suicidal intent on a scale of 1 to 10, where 10 is the most intent on acting on your suicidal thoughts and 1 is the least intent? Where do you think you fall on this continuum of 1 being least intent and 10 being most intent?

Do you have a desire to kill yourself that you think you might act on?

Do you have a plan for killing yourself and intend to carry out the plan? (How organized and specific?)

Have things reached the point (again) that you have thoughts of killing yourself?

When did you first notice such thoughts?

What led up to those suicidal thoughts? (e.g., interpersonal loss, a sense of thwarted belongingness, sense of burdensomeness on others, mood changes, hopelessness)

What things (events) lead you to want to escape from life or be dead?

How close have you come to acting on those thoughts and feelings?

Have you ever started to harm (or kill) yourself, but stopped before doing something? (Lethality increases when the suicide plan has been practiced or experimented with)

Have you engaged in any activities that have resulted in some form of self-injury or engaged in some form of what might be considered “high-risk” behaviors or “high-risk” activities? (An acquired capacity to enact lethal self-injury is a risk factor for suicide).

Have you received a diagnosis of a mental disorder in the past or currently? (90 % of completed suiciders have one or more DSM-IV disorders. Comorbid disorders increase suicidal risk)

Are you experiencing any medical problems? What are these and what is the impact?

How does the future look to you?

What things would lead you to feel more (or less) hopeful about the future (e.g., treatment, reconciliation of relationship difficulties, reduction of stressors)?

When you have suicidal thoughts and feelings who can you turn to for help?

What are the reasons for wanting to kill yourself?

What, if anything, prevents you from acting on your suicidal thoughts?

What are the reasons for living? What things in your life make you want to go on living?

What kept you going in the past when you had suicidal thoughts?

What do you envision happening if you actually killed yourself (e.g., escape, reactions of others- revenge, hurt others, reunion with previously deceased)?

Are there others who think that you might be responsible for what you are experiencing or what happened? Who are they? Are you having any thoughts of harming them?

Are there any other people you would want to die with you?

Are there other people who you think would be better off if they would die with you? Who are they? How did you come to these conclusions?

INTERVIEW QUESTIONS THAT CAN BE USED WITH DEPRESSED AND SUICIDAL CHILDREN

SAMPLE QUESTIONS FOR INTERVIEWING CHILDREN ABOUT SUICIDE IDEATION AND BEHAVIOR

(Source: Jacobsen et al., 1994. Interviewing prepubertal children about suicidal ideation and behavior. Journal of American Academy of Child and Adolescent Psychiatry, 33 (4), 439-451.)

Ascertaining the Presence of Previous or Current Suicidal Ideation or Behavior

1. *Did you ever feel so upset that you wished you were not alive or wanted to die?*
2. *Did you ever do something that you know was so dangerous that you could get hurt or killed?*
3. *Did you ever hurt yourself or try to hurt yourself?*
4. *Did you ever try to kill yourself?*
5. *Have you ever tried to make yourself dead?*

Assessment of Suicidal Intent

1. *Did you tell anyone that you wanted to die or were thinking about killing yourself?*
2. *Did you do anything to get ready to kill yourself?*
3. *Was anyone near you or with you when you tried to kill yourself?*
4. *Did you think that what you did would kill you?*
5. *After you tried to kill yourself did you still want to die or did you want to live?*

Interviewing Children Whose Grasp of the Concepts of Time, Causality, and Death May Not be Mature

1. *Do you think about killing yourself more than once or twice a day?*
2. *Have you tried to kill yourself since last summer/since school began?*
3. *What do you think would happen when you tried to ...jump out the window?*
4. *What would happen if you died, what would that be like?*

Assessing The Potential Impact of the Child's Current Emotional State Upon Recall of Suicidal Ideation or Behavior

1. *How do you remember feeling when you were thinking about or trying to kill yourself?*
2. *How is the way you felt then different from how you feel now?*

Determine Precipitating Factors and Risk Factors

3. *Have you ever thought about or tried to kill yourself before?*
4. *How have you been getting along with your family? With your friends?*
5. *Has anything happened recently which has been upsetting to you? To your*

family?

- 6. Have you had a problem with feeling sad? Have trouble sleeping? Not feeling hungry? Get angry easily? Feel tired a lot?*

Interview Parents about their child's suicidal Ideation and Behavior

- 1. What exactly happened (step by step) on the day that your child spoke of wanting or tried to hurt him/herself?*
- 2. How did you find out that your child was thinking about or trying to hurt him/herself?*
- 3. What were you doing when your child was thinking about trying to hurt him/herself?*
- 4. What happened after your child thought about, told you, or tried to hurt him/herself?*
- 5. Is there anything else I should know that would help us better understand what led your child to the point of having suicidal thoughts and trying to hurt him/herself?*

The following ADOLESCENT ASSESSMENT PROTOCOL offered by the McArthur Foundation Screening Institute for Depression in Primary Care provides another screening tool.

Two Question Screen

During the past month, have you often been bothered by:

- 1. Little interest in doing things?
YES or NO*
- 2. Feeling down, depressed or hopeless?
YES or NO*

If patient responds "NO" to both, the screen is negative.

If patient responds "YES" to either question screen further.

Depressed Mood

How has your mood been lately?

Effects of Symptoms on Function

How are things at home/school/work?

How have (the symptoms-be specific) affected your home, school or work life?

Anhedonia (loss of interest)

What have you enjoyed doing lately?

Physical Symptoms

How have you been sleeping?

What about your appetite?

How is your energy?

Psychological Symptoms/Suicidal Ideation

How is your concentration?

Have you been feeling down on yourself?

Do you feel like life is not worth living?

Do you have any plans to hurt yourself?

How does the future look to you?

Have you thought about killing yourself?

Have you tried to deliberately hurt or kill yourself?

Joan Asarnow and her colleagues have assessed the risk of suicide, using two items from the commonly used Achenbach et al. measures: the Youth and Young Adult Self-Report Scales (YSR/YARS).

“I think about killing myself.”

“I deliberately try to hurt or kill myself.”

Youth are asked to answer these two items on a Scale ranging from 0 (not true) to 9 (very often or often true). These measures provide a brief screen for recent suicidal ideation and deliberate self-harm. (See http://www.sprc.org/featured_resources/bpr/ebpp-PDF/spec_emergency_rm.pdf)

This approach can be supplemented by direct behavioral assessment, using procedures such as the Imminent Danger Assessment developed by Rotheram-Borus and colleagues. This assessment strategy uses a series of probes to examine whether protective factors and adaptive coping can be mobilized in a brief evaluation/ crisis intervention session.

(See http://www.sprc.org/featured_resources/ebpp_factsheets.asp#type)

The assessor tries to elicit 3 or more self-compliments.

- *What do you like best about yourself?*
- *What happened to you recently that made you feel good?*
- *What do you like better- your eyes or your hair?*

Try to elicit ≥ 3 positive comments regarding the youth from the parent/caregiver.

Try to elicit ≥ 3 positive comments regarding the family from the suicidal youth.

Since many suicidal youth evidence other high risk behaviors such as substance abuse, the teenagers can be screened using the Radhert (1991) Problem-oriented Screening Instrument for Teenagers (POSIT) that attempts to identify “Red Flags.” Illustrative questions include:

Do you get into trouble because you use drugs or alcohol at school or work?

Do you ever feel you are addicted to alcohol or drugs?

Do you have a constant desire for alcohol or drugs?

Finally, suicidal individuals can be asked to **self-monitor** their moods and accompanying situations (triggers) and cognitions. For example, Rotheram et al. and Asarnow et al. ask youth to use a **Feeling Thermometer** that asks the patient to record the degree of comfort to distress from 0 to 10 and to note their reactions. Another valuable screening tool is the Columbia Suicide Screen (CSS) (Shaffer et al., 2004).

ASSESSMENT OF ONGOING SUICIDAL RISK-JOBES (2006) CAMS-COLLABORATIVE APPROACH

David Jobes (2006) has provided a practical and promising approach to the assessment of suicidal risk in his book Managing suicidal risk: A collaborative approach (New York: Guilford Press). Also see Jobes and Drozd (2004). This assessment approach is called **CAMS**, which stands for **Collaborative Assessment and Management of Suicidality**, and combines both quantitative and qualitative tracking measures and case resolution forms.

At the quantitative level, Jobes has the patient rate him/herself on six areas that include:

1. **Psychological pain and suffering** (anguish, misery)
2. **Stress** (feel pressured, overwhelmed)
3. **Agitation** (emotional urgency, feeling have to take action)
4. **Hopelessness** (expectation that things will not get better, no matter what you do)
5. **Self-hatred** (general feeling of disliking yourself)
6. **Overall risk of suicide**

These patient ratings are followed by the patient filling out **Reasons for Wanting to Live and Reasons for Wanting to Die** forms and accompanying ratings. (Jobes provides a comprehensive rating system for the two Reasons Scales). There is also a set of Sentence Completion items that patients are asked to complete that are designed to capture the “nature of a patient's suicidal mind.” Jobes has provided a comprehensive coding system for the clinician to code the patient's responses, so this information can inform the treatment plan that the patient collaborates (“co-authors”) in establishing and implementing.

The Sentence Completion Items include:

- *“What I find most painful is...”*
- *“What I find most stressful is...”*
- *“I need to take action when...”*
- *“I am most hopeless about...”*
- *“What I hate most about myself is...”*
- *“The one thing that will help me no longer feel suicidal is...”*

The Collaborative Treatment Plan which is updated regularly covers the

- Problem Description
- Goals and Objectives and Evidence for Attainment of Specific Interventions (type and frequency)
- Estimated Number of Sessions

The Treatment Plan is designed to reduce Self-harm Potential and foster Outpatient Safety. **A Crisis Response Plan** is also formulated which emphasizes what a patient will do if he/she becomes acutely depressed, impulsive and suicidal. The patient is also asked:

“Were there any aspects of your treatment that were particularly helpful to you?”

“What have you learned from your clinical care that could help you if you became suicidal in the future?”

In the **CAMS**, there is also a **Checklist** for the clinician to fill out in order to assess the presence of **Suicidal Risk Factors** that include the presence of:

A Suicide plan Preparation and rehearsal History of suicidality (Ideation, frequency, duration) Prior attempts (single, multiple) Current intent Impulsivity Presence of substance abuse Significant loss Interpersonal isolation Relationship problems Health problems Physical pain Legal problems Shame Mental status and DSM-IV-R multiaxial diagnosis.

Jobes also advocates that this Risk Assessment be accompanied by having patients fill out a symptom-based assessment tool such as the Brief Symptom Checklist SCL-90/Brief Symptom Inventory-BSI, the Behavioral Health Monitor- BHM and the Outcome-Questionnaire (OQ 45.2) that assesses symptom distress, subjective discomfort, interpersonal relationships and social functioning. (See Jobes, 2006, pp. 43-46). For example, the endorsement of the item on the OQ **“I have thoughts of ending my life”** can trigger the need for administering the CAMS. The CAMS is administered using a side-by-side seating arrangement to reinforce the collaborative nature of the assessment process. This adjacent seating arrangement conveys to the suicidal patient that the clinician is trying to see the world through the patient's eyes.

Based on the documentation of these risk factors, the clinician is called upon to evaluate the patient's **Overall Suicide Risk Level.**

- **No Significant Risk**
- **Mild**
- **Moderate**
- **Severe**
- **Extreme**

The **CAMS** provides a practical, comprehensive and empirically-based way to collaboratively assess and manage suicidal risk and develop a suicide-specific treatment plan. A central message of the collaborative **CAMS** approach is”

“The answers to your struggle lie within you- together we will find those answers and we will work as treatment partners to figure out how to make your life viable and thereby find better alternatives for coping than suicide.”

“Let us see if together we can find viable alternatives to suicide to

better deal with your pain and suffering” (Jobes, 2006, p. 41).

SELF-REPORT MEASURES

Brown (2002), Ghahramanlou-Holloway et al. (2008) and Range and Knott (1997) provide comprehensive reviews of suicide measures for adults. (Also see Goldston's review to be found on <http://www2.endingsuicide.com/TopicReq?id=1919>). A variety of measures have been employed including the Beck Scale for Suicide Ideation (SSI) and SSI-Worst, the Beck Depression Inventory-II (BDI-II), the Beck Hopelessness Scale (BHS), the Beck Anxiety Inventory (BAI), Suicide Probability Scale (SPS), Adult Suicide Questionnaire (ASIQ), Suicide Behavior Questionnaire (SBQ), Suicide Ideation Scale (SDS), Linehan Reasons for Living Scales (RFL-Adult and Adolescent Versions), and the MultiAttitude Suicidal Tendency Scale (MAST). For example, Bisconer and Gross (2007) found that in an inpatient setting the BDI-II was the best predictor of suicide, but **it also had considerable error**. These self-report scales need to be supplemented by other risk assessment tools (clinical interview, observational data, history of risk and protective factors and current ecological assessment procedures). The following list provides information on the self-report measures.

SELF-REPORT ASSESSMENT TOOLS

Suicide Intent Scale-SIS

(Reactions to suicide attempt-glad to be alive, ambivalent, wish they were dead predicts subsequent suicide attempts)

Lethality Scale

(Planfulness, efforts not to be rescued, seriousness of attempts)

Scale of Suicidal Ideation (SSI) and SSI-Worse (SSI-W)

Assesses suicide ideation, intent and plan (current) and at its most severe point in the patient's life. (Suicide ideation at its most severe point has been found to be a stronger predictor of suicidal risk than assessment of current ideation).

Hopelessness Scale

(Psychiatric patients who score 9 + are 11 times more likely to commit suicide than patients who score 8 or below). Hopelessness should be assessed over time. Stable levels of hopelessness, even in remitted depressed patients, are more predictive of future suicide attempts. The value of Hopelessness in predicting suicide attempts has been found to vary across ethnic and racial groups.

Depression Inventory- BDI-II, ≤ 20 (Mild) BDI ≥ 20 (Moderate-severe)

Also see Jobes (2000) **Collaborative Assessment and Management of Suicidality (CAMS)**

Assess for Possible Barriers (scheduling conflicts, health insurance, child care, Transportation, language and cultural barriers, compensation issues, significant others interfere with treatment, individual's "paralysis of will" and therapeutic-interfering behaviors)

Joiner (2005) in his book Why people die by suicide proposes that precursors of suicide include:

- a) An acquired capacity to enact lethal self-injury (e.g., engaging in high-risk behaviors);
- b) A sense that one has become ineffective and a burden to loved ones;
- c) A sense that one is not interpersonally connected with a relationship or group (sense of thwarted belongingness)

Joiner (2005, p. 227) assesses these attributes by asking such questions as:

a) Acquired Ability to Enact Lethal Self-injury

**Things that scare most people do not scare me.
I can tolerate a lot more pain than most people.
I avoid certain situations (e.g., certain sports) because of the possibility of injury
(Reverse scored)**

b) Burdensomeness

**The people I care about would be better off if I were gone.
I have failed the people in my life.**

c) Belongingness

**These days I am connected to other people.
These days I feel like an outsider in social situations (Reverse scored)
These days I often interact with people who care about me**

As noted earlier, no one indicator is sufficient to predict suicide. Rather, the lesson to be remembered is that the combination of risk factors and the absence of protective factors improves the accuracy of suicidal risk assessment. For example, the combination of nonresponsiveness to treatment, treatment noncompliance, high scores on suicide ideation at worst period, and consistently elevated scores on Hopelessness Scale increases the level of suicide risk. (Ghahramanlou-Holloway et al. 2008). The following summary provides examples of other components of ongoing risk assessment.

ONGOING RISK ASSESSMENT

(See Joiner et al. 1997 for Resolved Plans and Preparation and Suicidal Desire and Ideation-Level of Intent and Thought Out Plan as tapped by the following questions)

“Do you have a desire to kill yourself that you think you might act on?”

“Do you have a plan for killing yourself and do you intend to carry out the plan?”

Resolved Plans and Preparation

- Sense of courage to make an attempt
- Sense of competence to make an attempt
- Specificity of a plan for an attempt
- Preparation for an attempt
- Duration of suicidal ideation
- Intensity of suicidal ideation
- Mental Practice

Suicidal Desire and ideation

- Reasons for living
- Wish to die-signs of increasing hopelessness
- Frequency of ideation
- Passive attempts
- Communication of desire-talk of death and suicide

Presence of Protective Factors

- Signs of hopefulness and future orientation
- Presence of social supports and other deterrents
- Engagement and compliance with treatment regimen
- Evidence of efficacy of previous treatment
- Treatment noncompliance and nonadherence to treatment regimen and manifests multiple antitherapeutic behaviors (no shows, lack of participation, treatment unresponsiveness)
(Reversed Scored)

RISK FACTORS FOR ATTEMPTED SUICIDES

- **Current and past psychiatric disorders**
- **Key symptoms** (anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations, complicated grief)
- **Suicidality** (frequency, intensity, duration, plans and suicidal preparatory behaviors such as steps taken to enact suicidal plan, rehearsals, preparation for dying, patient's expectations of lethality).
- **Previous suicide attempts** (Multiple attempter). (20%-40% of people who kill themselves have previously attempted suicide). Evidence of a prior capacity to enact self-injury. Over time through exposure, the individual may habituate to the fear and pain involved in self-injury (e.g., an increased pain tolerance) (See Joiner, 2005).
- **Family history of suicide.**
- **Substance abuse** (Nearly 50% of suicide victims have a positive blood alcohol level).

- **Access** to firearms or other means of self-injury.
- **Precipitants/stressors**- triggering events that lead to feelings of shame, humiliation, guilt, despair (e.g. interpersonal conflict, losses, exposure to suicidal peer group). Past history of abuse, neglect and parental loss.
- **Physical Illness and Medical Complications** such as chronic pain.
- **Social isolation** perceived “burdensomeness” and “thwarted belongingness”
- **Cognitive and affective factors**- thought constriction, polarized rigid thinking, poor problem-solving skills, negative self-concept, feelings of hopelessness and helplessness.
- **Demographic factors** - Male elderly groups, widowed, divorced, single, marital status, especially for males.
- **Being a veteran**- Male veterans have double the suicide rate of civilians, especially accompanied by guilt. Compared to civilian men who died by suicide, veterans were 58% more likely to use a firearm to end their lives (Kaplan et al, in press).

Proximal risk factors in combination with one or more distal risk factor heightens suicidal risk. But, it is the cumulative impact of risk factors that is most predictive of suicidal risk, as research on adolescent suicide indicates. For example, the more problem behaviors a teenager engages in (e.g., binge drinking, illicit drug use, unsafe sex, cigarette smoking, violent behavior, and disturbed eating behaviors), the more likely he or she is to attempt suicide. For those adolescents with six such behavioral problems the risk of suicide increases 277 times compared to adolescents with zero problems. The odds of a medically treated suicide are 2.3 times greater among adolescents with one behavioral problem; 18.3 with three, 30.8 with four, 50.0 with five and 277 with six behavioral problems (Miller & Taylor, 2005).

Another source of information that can guide risk assessment can be derived from functional and motivational analyses of suicidal individuals.

FUNCTIONAL AND MOTIVATIONAL ANALYSES OF RISK AND PROTECTIVE FACTORS

- What are the patient's complaints, problems, diagnoses (including presence of comorbidity), weaknesses, limitations ?
- What are interpersonal problems?
- What are the emotional and behavioral reactions needing change?
- What are the patient's priorities to change and hierarchy of needs?
- What are the patient's strengths, assets and intra-and interpersonal advantages? (Potential protective factors or buffers)

- What are the environmental changes that are needed that will reduce risk and bolster resilience?

There is a **need to document** on a regular basis risk and protective factors and interventions. The Joint Commission (JCAHO) have proposed the following protocol.

DOCUMENTATION

JOINT COMMISSION (JCAHO) ASSESSMENT

(<http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals>)

SUICIDAL DESIRE	CAPABILITY	INTENT	BUFFERS
	History of suicide attempts		
Ideation	History of violence towards others	Expressed intent to die	Social supports
Hopelessness Helplessness Alone	Available means	Plan (method known)	Plans for future
Perceived Burden	Substance Abuse	Preparatory Behaviors	
	Mood Swings		Sense of purpose
	Increased anxiety		Religious beliefs
	Decreased sleep		Engagement with helpers

LEVEL OF SUICIDAL RISK

<u>Risk Level</u>	<u>Risk Factors</u>	<u>Protective Factors and Interventions</u>
Low Risk	No Current thoughts or risk factors present	Follow-up and monitor both symptom level and treatment progress
Moderate Risk	Current suicidal thoughts, but <u>no</u> specific plans Presence of multiple risk factors	Presence of protective factors like social supports; Patient engagement in treatment; Follow-up assess; Provide treatment for symptom relief Provide Coping Card Check treatment compliance
High Risk	Current thoughts express strong intent, has plans and has rehearsed Psychiatric diagnosis (comorbidity) with severe symptoms such as Substance Abuse Presence of acute precipitant events History of victimization Multiple Attempts	Admission to emergency treatment center; Develop crisis management plan; Ensure safety(*) (Provide details)

**(For example, indicate how the patient, family members and friends were educated about the signs of increased suicide risk, such as sleep disturbance, anxiety and agitation, suicidal expressions and behaviors. Provide them with emergency numbers and website information www.StopASuicide.org, 1-800-273-TALK).*

ECOLOGICAL ASSESSMENT

There is one more lesson I learned and that is the need to assess whether the health care team has followed treatment procedures that meet so-called “Gold Standards” or “did things go by the book” when treating suicidal patients. As mentioned at the outset, up to 25% of family members of suicidal patients will sue the health care providers for patient suicide. A personal example underscores the need to assess more than the suicidal patient.

A suicidal adolescent came into the hospital where I consult on a Friday, and on Monday morning when his parents arrived to visit, he had committed suicide. I was asked by the hospital administrator to critically evaluate both their inpatient and outpatient assessment and treatment regimen for suicidal patients and generate a report/checklist concerning treatment standards. The article I wrote entitled “35 years of working with suicidal patients: Lessons learned” (Canadian Psychologist, 2005, 46, 64-72), summarizes the report I wrote on Practice Guidelines. As noted in my article, one can ask the mental health staff of a suicidal patient the following questions:

- 1. What did they do to establish and maintain a therapeutic alliance with their suicidal patient?**
- 2. What specific assessment strategies and assessment measures (interviews, observational data, self-report measures, measures of current and past risk and protective indicators) did the health care staff employ on an ongoing basis to monitor the patient's suicide risk?**
- 3. How was this information conveyed to the suicidal patient (feedback) and to significant others in the patient's life (family members and to members of the treatment team)?**
- 4. What specific diagnoses (primary and comorbid) were formulated and how did this information impact the treatment plan?**
- 5. What specific steps were taken to reduce the presence of risk factors (psychoeducation of patient and significant others, removal of risk factors, provision of aftercare interventions, provision of a specific safety plan and back-up supports)?**
- 6. What was done explicitly to address treatment adherence to psychotropic medications, address both barriers to treatment and antitherapeutic patient behaviors?**
- 7. What specific psychotherapeutic interventions were provided and evaluated for their efficacy?**
- 8. When the suicidal patient was an inpatient, what explicitly was done to ensure the patient's safety (supervision, safety checks, maintain and communicate risk status to other treatment team members)?**
- 9. Where and when were all of these steps documented?**

When members of JACHO visit a psychiatric setting or when a patient suicide occurs, the staff should consider each of these nine questions, as well as the additional items I raised in my article in the Canadian Psychologist. The lesson to be learned is that suicide should not be viewed as a result of the characteristics of a depressed patient, but as a byproduct of a complex transaction between an individual and significant others in his/her ecological and cultural niche.

For example, imagine that a recently discharged psychiatric patient commits suicide and you and the mental health workers are going to be sued for malpractice. If you were hauled into court because of a survivor's family lawsuit, do you believe that based on your progress notes you would be able to answer each of these nine questions? Where in your progress notes did you document on an ongoing basis the answers to each of these probes?

CORE PSYCHOTHERAPEUTIC TASKS WHEN WORKING WITH SUICIDAL PATIENTS

We can now consider the core psychotherapeutic tasks for working with suicidal patients and then examine illustrative ways these tasks can be implemented using Cognitive-behavior therapy. These tasks include:

1. Conduct ongoing risk assessments, including motivational and functional analyses. Collaboratively generate a safety plan.
2. Develop and maintain a collaborative therapeutic alliance with the suicidal patient and significant others.
3. Target suicidal behaviors and cognitive vulnerabilities explicitly. (Research indicates that treatments designed to reduce depression do not necessarily correlate with a reduction of suicidal behavior. Brent et al. 1997, 2008 and Bridge et al., 2006).
4. Conduct psychoeducational sessions, collaborative goal-setting and treatment interventions that teach and nurture coping strategies such as distress tolerance, emotional regulation, problem-solving and interpersonal skills on how to develop and maintain “healthy” social supports.
5. Address issues of comorbid disorders and provide integrative psychotherapeutic interventions.
6. Help the suicidal patient develop a life worth living and help change hopelessness into hopefulness.
7. Include relapse prevention trials where suicidal patients can rehearse, both in and out of the therapeutic session, how to handle potential stressful events and internal and external triggers for suicidal ideation and suicidal behaviors.
8. Help health care providers deal with the stress of working with suicidal patients. Address issues of vicarious traumatization. (*see Meichenbaum's handout on www.melissainstitute.org and mypage.iusb.edu/~jmcintos/basicinfo.htm*).

LESSON 5: CLINICAL INTERVENTIONS

The treatment model that I have developed over the past 35 years of working with suicidal patients derives from a Constructive Narrative Perspective and incorporates a number of cognitive behavior therapy (CBT) procedures. There is an indebtedness to the work of Beck, Joiner, Linehan, Rudd and their colleagues for their pioneering work in this area.

If suicidal patients have a specific manner in which they tell themselves, and others, “stories” that contribute to suicidal behaviors, then the question is how can psychotherapists help patients co-construct more adaptive stories and behaviors? I will consider below, the Core Tasks of Psychotherapy and offer illustrations of possible intervention procedures. I will consider possible intervention procedures that are designed to not only alter the nature of the suicidal patient's narrative, but also nurture coping skills.

While CBT is considered an effective intervention for a range of disorders (see Beck, 2005; Butler et al. 2006), debate continues about the mechanisms involved in instigating and maintaining such behavior change. In two Clinical Handbooks (Meichenbaum, 1994, 2002), I have offered an evidential model of change where patients collect data that is incompatible with their prior expectations and beliefs. Out of the strength of the therapeutic alliance, the therapist helps the patient accept such “data” as “evidence” to unfreeze the beliefs they hold about themselves, others, and the future. The psychotherapist also ensures that the patient has the courage and the intra- and interpersonal coping skills to undertake “personal experiments” that will yield disconfirming data. A variety of psychotherapeutic procedures including Socratic questioning, cognitive restructuring, problem-solving and coping skills training, and relapse prevention procedures may be used.

This evidential model of change is consistent with proposals offered by Brewin (2006), who noted that cognitive therapy does not directly modify negative information in memory, but rather influences the relative retrievability of different meanings of emotional content that is stored in memory. For example, some of the psychoeducational procedures described below (e.g., use of Clock metaphor, collaborative goal-setting and use of Time-lines that pull for the rest of the patient's story of strengths and signs of resilience), each illustrate ways to strengthen positive autobiographical representations. These interventions yield “data/evidence” that are in “retrievable competition” with the negative suicide-engendering representations and “stories.” These “mental heuristics” impact on the “internal debate” suicidal individuals engage in.

When such changes come about, the psychotherapist needs to ensure that patients take personal credit and ownership for the alterations in ideation and behavior that they have brought about. These various psychotherapeutic interventions are demonstrated in the recent APA film I made with a young lady, Missy, who attempted suicide seven times.

Before we consider specific interventions we need to first recognize the challenges of working with suicidal patients.

Meeting The Challenges of Working With Suicidal Patients

An important lesson to keep in mind is just how much energy and resources are required in conducting psychotherapy with suicidal patients. Suicidal patients have a high drop out rate from psychotherapy, they may be no-shows and often nonadherent to treatment plans, as well as evidence a number of antitherapeutic behaviors (being late, nonparticipation, denial, low distress tolerance and emotional explosiveness). As noted, only 20% to 40% of suicidal inpatients attend referred out-patient treatment services when they leave the hospital. The therapist has to be proactive in ensuring continuity of care, demonstrate flexible scheduling, use reminder phone calls, conduct phone sessions when

needed, and engage a treatment team including the suicidal patient's family members (where indicated) in encouraging treatment compliance. The therapist needs to collaborate with the suicidal patient to anticipate and address potential individual, social and systemic barriers to treatment. A number of practical qualities of life issues (like housing, transportation, self-care) may also need to be addressed.

Such psychotherapeutic contact with suicidal patients should begin soon after a suicide attempt (within 72 hours), as suggested by Ghahramanlou-Holloway et al. (2008). Such early intervention with suicidal patients can even begin in emergency settings.

Critical Role of Early Interventions: Some Examples

The earlier the intervention in the developmental course of suicidality, the greater the likelihood of success. Joan Asarnow and her colleagues (Asarnow et al. 2005; Baraff et al., 2001) have demonstrated that the Emergency Department is a site for intervening with youth to reduce suicide attempts. Suicidal youth tend to use more lethal methods with repeat attempts and most suicidal youth have substantial need for additional mental health services. 50% of suicidal youth are referred for follow-up care, but some 77% never attend such follow-up sessions and of those who do attend such sessions, many fail to complete the full course of treatment. In order to address these clinical challenges, Asarnow and her colleagues have developed the **SAFETY Program—A Crisis Intervention Program for Adolescent Suicide Attempters (SAFETY= Safe Alternatives For Teens and Youth)**. The intervention program resulted in a 50% reduction in suicide attempts. A key feature of the **SAFETY Program** is family education.

The importance of parent education of suicidal youth is highlighted by the finding that 17% of parents either keep firearms that they own or purchased new firearms, even after their child's suicide attempts (Brent, 2000). Parents are 3 times more likely to take protective actions when parent education is provided.

One such program is the Family Focused Intervention for Suicide Prevention (**FISP**) which was listed in the Specialized ER intervention of suicidal adolescents, as developed by Rotheram-Borus et al. (www.sprc.org/featured_resources/ebpp/ebppfactsheets.asp#type). The **FISP** treatment components involve family education regarding the importance of follow-up treatment; the need for restrictions to lethal means; reframing the youth's suicide as a maladaptive coping/problem-solving strategy; developing a plan for coping with future crisis; ways to increase positive interactions and family support. The **FISP** interaction model is a second generation adaptation of the specialized ER intervention (Rotheram et al.), one of several promising evidenced-based interventions.

Asarnow's work highlights the need to train physicians to become more knowledgeable “gate keepers” and referral resources. Research is needed to develop a similar screening/intervention program for depressed, potentially suicidal, elderly individuals.

The call for evidence-based interventions has been sounded by a number of investigators. (Brown et al., 2005; Freeman & Reinecke, 1993; Joiner et al., 1998; Linehan, 1999; Rudd, 2000; Shaffer et al., 1988, 2001; Weishaar & Beck, 1990).

The Use of Evidence-based Interventions in a Culturally-sensitive Manner

Another Lesson is to use evidence-based interventions with suicidal patients. (*See Suicide Prevention Resources Center: Best Practices Registry <http://www.sprc.org>*). Two evidence-based psychotherapeutic interventions are Cognitive Therapy (Brown et al. 2005) and Dialectical Behavior Therapy (Linehan et al., 2006). Brown et al. (2005) demonstrated that suicide attempters who receive 10 sessions of Cognitive therapy were 50% less likely to make repeated suicidal attempts over an 18 month follow-up period, compared with similar suicidal patients receiving treatment as usual. Other

forms of evidence-based interventions include interpersonal psychotherapy (Guthrie et al., 2001) and intensive follow-up treatment and active case management (Van Heeringen et al. (1995).

Whatever the form of intervention, either on a preventive or treatment basis, Goldston et al. (2008) highlight the need to tailor the intervention in a culturally-sensitive fashion. I have worked with Native populations in both the U.S. and Canada and consulted to mental health workers who treat torture victims (some 400,000 of whom now live in the U.S.). I have worked with various religious groups (Mormons, Hasidic Jews, Born-again Christians) and I have written about ways to conduct spiritually-oriented treatments (Meichenbaum, in press). In each instance, the lesson to be learned is how to be respectful and how to use members of the respective communities as confidants and co-therapists in adapting evidence-based interventions, accordingly.

COGNITIVE BEHAVIOR THERAPY WITH SUICIDAL PATIENTS

1. ESTABLISH THERAPEUTIC ALLIANCE WITH THE SUICIDAL PATIENT

The first and most critical task in working with suicidal patients is the ability to develop and maintain a good therapeutic alliance which can act as an excellent safe-guarding protective factor (see Messer & Wampold, 2002). Ghahramanlou-Holloway, Brown and Beck (2008, p. 162) offer sage advice on ways to establish a good working alliance with suicidal patients. They advise that the therapist should:

- ***“Be attentive, remain calm and provide the patient with a private, non-threatening and supportive environment to discuss experienced difficulties. Do not express anger, exasperation, or hostile passivity. Be forthright and confident in manner and speech to provide the patient with a stable source of support at a time of crisis. Stress a team approach to the problem(s) presented; for instance, freely use the collaborative pronoun “we” when discussing suicidal behavior. Model hopefulness, but make sure to acknowledge the patient's distress and perspective on the problem. Do not avoid using the word “suicide” because this gives the impression that you stigmatize the concept. Most importantly, do not immediately suggest hospitalization. In our experience, patients are most agreeable if the therapist carefully explores various safety options, then plans for the most appropriate clinical response to an acute suicidal episode.”***

Have the patient tell his/her "story," at his/her own pace. Conduct a behavioral chain analysis of events of the proximal factors that triggered the suicide attempt. Involve significant others as a source of information concerning the suicide attempt. Ensure the patient's safety.

Help the patient define the suicidal crisis. Remember that the patient is communicating how badly he or she feels.

As noted, use "we" and convey a collaborative team approach in understanding the events (stressors) that triggered the thoughts of suicide. Use phrases such as "murdering yourself" or "self-annihilation" when referring to suicide.

Help the patient view suicide as an attempt to solve a problem (see Section below for discussion of how to conduct problem-solving). Convey that you do not want the patient to employ a “permanent solution to what might be a temporary problem.” (Alter this message for patients with chronic medical conditions, such as Traumatic Brain Injuries or chronic illnesses).

Use Motivational Interviewing procedures. Zerler (2008) has discussed how to apply the principles of motivational interviewing of suicidal patients (EE, DD, RR and SS). The four principles of Motivational Interviewing are: Expressing Empathy; Developing Discrepancy between the patient's present behaviors and values; Rolling with Resistance as the therapist strives to understand and respect both sides of the ambivalence from the patient's perspective. The therapist can empathize with the needs that give rise to suicidal ideation, without approving suicidal behaviors. Finally, the therapist can Support the patient's Self-efficacy by acting as a guide or consultant, suggesting possible ways to proceed.

Address any barriers that may contribute to antitherapeutic behaviors

Use collaborative agenda-setting.

Periodically summarize throughout the session and at the end of the session. As psychotherapy progresses, ask the patient to summarize what was covered in the session and what he/she plans to do between sessions and, most importantly, the reasons why he/she should conduct these activities (“homework” assignments). Build in reminders that the patient and significant others can take home.

Therapists should model hopefulness and "dogged determination" and convey a “team” approach. (I have often wondered why CBT is effective with depressed suicidal patients and one answer I have come to is that CBT helps to prevent depression in psychotherapists. The CBT therapist does not get depressed as he/she recognizes that the “story” that the depressed suicidal patient is telling is only “one story”--tuned into the depressogenic channel. It is the task for the CBT therapist to help the suicidal patient tell (and act upon) the “rest of the story” of strengths, resilience and survival instincts. (For an example, see my recent APA film).

Earn the patient's and his/her family’s trust and confidence. They have to feel heard.

Solicit feedback regularly from the patient and significant others. Ask:

I want to check in with you about how you found our meeting today. Were there any things I said or did, or did not say or do, that you found particularly helpful, or particularly unhelpful, or that bothered you? What can we do differently the next time we meet?

The critical importance of a therapeutic alliance has been highlighted by Joiner (2005) and Joiner and Van Orden (2008). Under the heading of **Belongingness Therapy**, they describe the study by Motto and Bostrom (2001) who sent high-risk patients “caring letters” reflecting brief expressions of concern and reminders that the treatment agency was accessible when patients needed it. The “caring letter was personalized, signed by the person in charge of the person's care, and any note the patient sent in response to the previous letter was answered in the subsequent letter.

The “caring letter” that expressed caring and availability proved effective in reducing suicidality in patients who had refused further treatment after hospitalization. An example of the letter that was sent:

“Dear _____: It has been some time since you were here in the hospital, and we hope things are going well for you. If you wish

to drop us a note we would be glad to hear from you.”

2. PSYCHOEDUCATION

- Conduct assessment procedures. Provide feedback from the assessment and use the Case Conceptualization Model to help the patient and significant others better understand risk and protective factors.
- Educate the patient and significant others about the disorders and the cognitive model of depression and suicide and the proposed treatment plan.
- Help the patient and significant others to appreciate the role of warning signs and the role of setting factors that may potentiate suicide attempts (e.g., discontinuance of medication, sleep deprivation, substance abuse behaviors, manic episodes, disengagement and social withdrawal behaviors).
- Use self-monitoring, Clock metaphor, downward spiral explanation, *as described below*.
- Develop a safety plan (*see below*) on ways that the patient can solicit help.
- Provide bibliotherapy for both the patient and significant other. See Ellis and Newman (1996) (*Choosing to live: How to defeat suicide through cognitive therapy*)
- Use "urge" metaphor to describe suicidality.
- As part of the ongoing psychoeducation ensure that the patient
 - Has reminders of what went on during sessions and shares this with significant others
 - Has a self-help note-book that summarizes coping activities
 - Has a safety plan
 - Has crisis coping cards
 - Has an Anti-suicide Kit or Hope Chest with reminders of accomplishments and Reasons for Living (e.g. Scrapbook with pictures, mementos, Time Line 2 information, as described below)
 - Has specific information about ways to contact health care providers

3. NURTURE HOPE

- Engage in collaborative goal-setting (Hope has been equated with goal-directed thinking). Focus on concrete attainable goals.
- Help the patient appreciate the progress that has been made.
- Employ an Anti-suicide kit (*see below*). Explore "Reasons for Living."
- Introduce the patient to coping models.
- Involve significant others and adjunctive interventions.

- Assess and build on "strengths."
- Use Time Lines.--One can trace collaboratively with the suicidal patient and significant others ***three Time Lines***. (See below for a detailed description of how to use these Time Lines as ways to nurture hope and begin the co-construction of a new narrative or "story.")

Time Line 1- traces from birth to the present, the list of stressors and interventions

Time Line 2- traces evidence of individual, familial and cultural resilience and strengths

Time Line 3- engages the suicidal patient in collaborative goal-setting. This time line begins in the present and extends into the future

- Use Future Time Imaging Procedures (*see below*)
- Encourage the patient to reconnect with supportive and prosocial significant others and reengage in life tasks and undertake unfinished life projects.
- Convey that psychotherapy is concerned with "life-promotion" and not just suicide-prevention. It is designed to help patients develop a life worth living (Linehan, 1993).

4. TEACH COPING SKILLS

- Help the patient develop internal and external compensatory strategies.
- Address the patient's impulsiveness (*see below*) and nurture emotion-regulation and distress-tolerance skills.
- Engage in problem-solving and communication training with a focus on the problems that triggered the most recent suicidal attempt (*see below*).
- Conduct cognitive therapy of depression (*see below*).
- Increase the patient's adaptive use of social supports and develop ways to broaden social support network (*see below*).
- Build in Behavioral Activation and Activity Scheduling.
- Use cognitive behavior skills training procedures (e.g., Self-instructional training, Stress inoculation training).
- Use mindfulness and acceptance treatment strategies, willingness to experience thoughts, feelings and situations fully, in a non-judgmental fashion. (See Hayes et al., 2004; Hofmann & Asmundson, 2008 and Ost, 2008).

- Use cognitive rehabilitation procedures (e.g., memory and attentional pictorial reminders and supports) in order to build in self-efficacy trials for suicidal patients with Traumatic Brain Injuries and other such patients (See Hogan, 1999, and Meichenbaum, 2002 as ways to apply CBT procedures with TBI patients).
- Help foster positive, supportive, "cognitive prosthetic" social environments.
- Increase the patient's use of and compliance with adjunctive services to be conducted in an integrated fashion (e.g., use of medication). Brent et al. 2008 recently demonstrated that depressed suicidal adolescents who do not have a clinical response to an initial trial of SSRI, (some 40%), benefit most from a switch to a combination of CBT plus another medication regimen, as compared to being switched to only another medication alone. There is a need to provide integrative treatments. When psychotropic medications are used it is helpful to discuss with the patient how the medication allowed the patient to behave differently (e.g., notice warning signs, seek help, play a different CD in his/her head). There is value in having the patient attribute improvement to what the medication has allowed him/her to achieve or do differently.
- Where indicated, treat PTSD symptoms (e.g., hypervigilance and hyperarousal symptoms, reexperiencing symptoms, restricted affect, detachment from others).
- Follow generalization guidelines such as using "homework" assignments, involving significant others, build in reminders, behavioral rehearsal, self-attribution or "taking credit." Put the patient in a consultative role of showing, explaining and teaching. Use telephone consultation and home visits.

5. ADDRESS ISSUES OF COMORBID DISORDERS

Given the high incidence of suicidal behavior with such other disorders as Major Depressive Disorders, PTSD, Psychotic Disorders, Eating Disorders, Substance Abuse, Personality Disorders and Medical Disorders, there is a need to provide integrative treatments. The psychotherapist has a choice to provide sequential, concurrent, or integrative treatments.

- Integrative treatments highlight for suicidal patients how their suicidal ideation and suicidal behavior developed (see the use of Time Lines below) and how such suicidal acts fit within a "vicious cycle" process and how they are interconnected with triggering events, emotional reactions, thinking processes, and behavioral acts and resultant consequences (*see the use of a Clock metaphor, discussed below*).
- Evidence-based interventions should be employed to address comorbid psychiatric disorders. For example, Prolonged Exposure procedures with PTSD patients, Cognitive and Interpersonal Therapies and Behavioral Activation Procedures for suicidal patients with comorbid Major Depressive Disorders, Relapse Prevention Interventions with Substance Abuse Disorder suicidal patients, Dialectical Behavior therapy Procedures with suicidal patients with Borderline Personality Disorder and Active After-Care Interventions.
- The challenge is how to maintain communication and a common message to the suicidal patient when there are multiple therapists. This is highlighted when psychotropic medications

are combined with psychotherapy. Not only is there a need to provide adherence counseling to the suicidal patient across treatment agents, but there is also a need to provide a common psychoeducational model of suicidal ideation and behavior (See Meichenbaum, 2005).

6. RELAPSE PREVENTION PROCEDURES

- Need to equip the patient on how to deal with possible future adversities, lapses and reoccurrences, mood fluctuations and possible set-backs. (*"If I suffer a set-back, this does not mean that I am back to square one."*)
- Help the suicidal patient to decrease cognitive constriction and rigidity by learning how to engage in problem-solving in order to consider a wider range of possible options. Help the patient to chart a possible new course, accepting less-than-perfect solutions. (See Clum & Lerner, 1990; Salkovskis et al., 1990).
- Have the patient and significant others recognize how far he/she has come-- taking credit for improvement.
- Need to help the patient develop Reasons for Living and reclaim a life that is worth living.
- Have life-affirming experiences.
- Use relapse prevention tasks. Have patients visualize themselves in a future suicidal crisis. Use guided visual imagery of employing their coping skills in dealing with the events leading up to suicidal crisis and ways to handle suicidal urges.
- Help the patient make good choices in response to "bad feelings." Such imagery rehearsal procedures can be used as relapse prevention tasks involving past and potential stressful scenarios that might trigger suicidal ideation and suicidal behavior in a kind of stress inoculation fashion (see Meichenbaum, 2007). Successful accomplishment of such tasks can be used to determine whether gradual termination of treatment is required or whether further treatment is warranted. In this fashion, the length of the treatment is performance-based, rather than arbitrarily set ahead of time.
- Imagine possible obstacles and how these can be addressed.

"This time see if you can change the outcome. Can we go through this image again, but this time see if you can imagine coping with each problem as it arises? This time you are aiming for ending up with the best possible outcome. Imagine using the coping tools we have worked on."

- Raise such questions as:

Let's review our work together and the things we have figured out that tend to make you suicidal. What are you going to keep in mind at that time?

What kind of situations are triggers for you?

When you encounter W, you feel X, and you have the thought Y, and you do Z. (Use Clock metaphor of 12 o'clock being internal or external triggers; 3 o'clock being primary and secondary emotions; 6 o'clock being various cognitions; and 9 o'clock being specific behaviors and resultant consequences- - all of which contribute to a "vicious cycle.")

You get a picture in your head of

Your brain tells you

You're telling yourself ...

Let's talk through the chain of events that led up to the suicide attempt. Let's think of this as a video camera and in slow motion we can go over this and begin to change the sequence.

- Involve significant others like family members. The Family-based Cognitive-behavioral (FISP) interventions, as described by Asarnow, Huey, Rotheram-Borus, highlight the value of engaging parents to step-in and protect, while the suicidal youth develops coping skills. **FISP** works on enhancing family communication and problem-solving skills.
- Gradually taper treatment- once every two weeks, then once per month. Build in booster sessions every 3, 6, and 12 months.

DESCRIPTIONS OF ADDITIONAL INTERVENTIONS

DEVELOPMENT OF A SAFETY PLAN (See Brown et al. 2006)

The suicidal patient's **Safety Plan** should include the contact information (telephone numbers) for

- 1) therapist or care worker
- 2) on-call therapist who can be reached after business hours
- 3) psychiatric emergency evaluation center
- 4) other local support services who handle emergency calls
- 5) significant others
- 6) also, record the reasons why it is important to make these contacts and seek assistance

Joan Asarnow and her colleagues (2007) have developed a **Safety Intervention Plan** for suicidal patients that highlights the need to create **SPATS**.

- S** a) **Safe Setting**--restrict access to dangerous and lethal methods, increase time in safe settings
- P** b) **People**--increase contact with safe people and improve

interpersonal relationships

- A c) **Activities**--increase safe activities, actions and behaviors
- T d) **Thoughts**--increase hopeful problem-solving thoughts: decrease suicidal thoughts
- S e) **Stress Reactions**--strengthen abilities to regulate emotions, tolerate distress, and improve coping skills

SAFETY PLAN
(From Brown et al. 2006)

When I notice the following signs:	Anxious, irritable, signs can't cope
That lead to:	Thoughts of suicide; withdrawal
I plan to do the following:	Try my breathing exercises; call my husband
When others notice the following signs:	Crying a lot; agitation
I would like them to:	Be understanding: be patient
I know that I am in serious trouble when I or others notice that:	I have impulsive thoughts; my outlook becomes gloomy
When I am in serious trouble I will	I will ask my mom to come by; I will go to the ER; I will call my therapist

USE TIME LINES

The psychotherapist can collaboratively generate **3 Time Lines** with the suicidal patient.

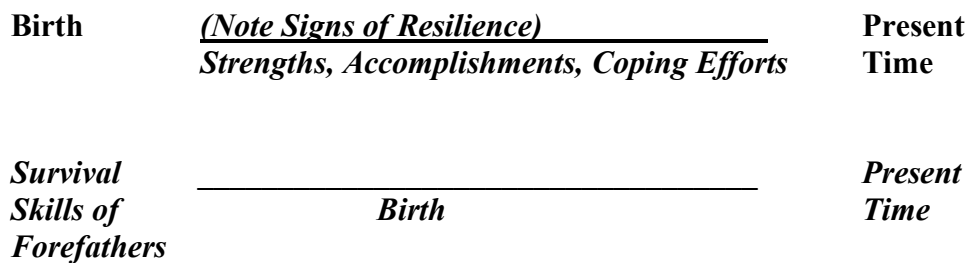
Time Line 1- traces from the time of birth to the present time, the variety of major stressors and when they occurred and the various treatment interventions (hospitalization, medication trials, psychotherapeutic efforts)

Time Line 1-

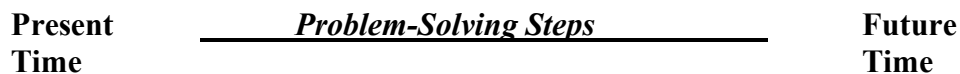
Birth	<u><i>(Note type of stressors and when)</i></u>	Present
	<u><i>(Note year, type, and duration of treatment)</i></u>	Time

Time Line 2- traces the signs of resilience and strengths that the suicidal patient,

family and cultural group have evidenced. This Time Line 2 constitutes the “**rest of the story**” and “**in spite of**” events that were characterized in Box 6 in the Case Conceptualization Model. Note that Time Line 2 can also extend back in time prior to the suicidal patient's birth by referring to the signs of “cultural resilience” of the patient's forefathers and previous generations. “**How did they survive and cope? What are the lessons to be learned that have been passed down?**” Remember Brewin's (2006) proposal that psychotherapy helps patients retrieve, attend to and find meaning and hope in alternative “positive” memories. The use of Time Line 2 is a useful way to help suicidal patients co-construct a new, more hopeful story.”



Time Line 3- is designed to help the suicidal patient to establish future-oriented goals and to engage in a problem-solving set. The Time Line begins now and extends into the future. The use of these Time Lines helps the patient to accept the “good and the bad” in his/her history and provides an opportunity and context to become freer of old conflicts so that he/she can develop more adaptive ways of coping and begin to “restory” his/her life.



ANTI-SUICIDE KIT

The Kit serves as a memory aid to be used at a time of crisis. It can be a Box in which the patient puts items that remind him/her of the Reasons to Live. Examples of information gleaned from Time Line 2 can be put in the Kit..

USE FUTURE TIME IMAGING

Have the patient imagine a time in the future, noting the date, how old he/she will be and describe what is happening in his/her life. Where are they, what do they see around them, who are they with. Involve all senses. How do they feel about the image? Anything they can do to improve the image or anything that they would like to change?

DEVELOP AFFECTIVE COPING SKILLS

(See Linehan's DBT mnemonics to teach emotion regulation and distress tolerance skills)

Physical self-soothing- relaxation methods

Cognitive self-soothing- distraction techniques (e.g., do enjoyable activity, recall positive memories, imagine a pleasant scene)

Acceptance- urges of self-harm often come in waves. Help the patient develop techniques to "ride out the wave of suicidality." Teach mindfulness skills.

Sensory self-soothing- use smell, sound, touch, warm baths, listen to music, scented candles, massage

ADDRESS PATIENT'S IMPULSIVENESS

Teach the patient how to "procrastinate" suicide and how to "stretch out time"

Ride out suicidal urges

Delay acting on impulse to self-harm

Compile and practice delaying strategies such as talking to someone, telephone therapist, engage in distracting tasks, sleeping

Safeguarding one's environment so it is unfriendly to suicide

One way suggested to help suicidal youth delay acting on their suicidal impulses is to use the quality of the relationship with the therapist as a means of delaying a suicidal response. Rotheram-Borus in the Imminent Risk Assessment asks the suicidal youth to make a promise for "no suicidal behavior" for a specific period of time.

"Promise me that if you feel suicidal you will call _____ and/or call _____ (last) about your feelings before you try to hurt yourself"

This is different from Safety Contracts that may give a false sense of security. In one study by Davis (2002) some 31% of admitted multiple attempters had previously signed no suicide contracts.

"The use of an oral or written "contract for safety" in the management of suicidality has been demonstrated to have serious limitations and to lack sufficient evidential basis for having a protective impact on acts of deliberate self-harm" (American Psychiatric Association, 2003, pp.5, 41-42).

WAYS TO INCREASE SOCIAL SUPPORTS

Make a list of possible social supports

Utilize family resources

Proactively develop healthy new social supports (e.g., join social club)

Teach the patient how to access and use social supports

Involve family members (significant others) in treatment with the patient's permission. For example, educate the patient's parents about the nature of depression and comorbid disorders and on ways they can provide support.

Help significant others understand that it is not dangerous to ask the patient how he/she is feeling.

Encourage the patient to let people know when he/she is suicidal.

Patients can be asked:

“Who are three people you will call if you are feeling like hurting yourself? Which adult or helper (counselor, therapist) do you feel comfortable calling? What is their name and telephone number?”

- 1.
- 2.
- 3.

This activity is designed to challenge the patient's belief that “No one cares” and to ensure that the patient contacts “safe” supportive people (non-suicidal).

PROBLEM-SOLVING SKILLS TRAINING

- Help the patient and significant others to prioritize problems.

What is upsetting you the most?

If you could change one thing about your life, that is changeable, what would it be?

If we could wave a "magic wand," what changeable problem would be different?

What have you tried in the past to solve this problem?

How did it work?

What difficulties did you have in working on this problem?

*What do you think we could try differently now?
How would we know if we were making progress?
If you were changing, what would others notice?
What difficulties might we anticipate that we can plan for?
Why would working on this be important? What would change?
Are you willing to work with me on addressing this problem?*

(In selecting a problem to work on, choose one that is potentially solveable and one that may have positive ripple effects)

Out of such social discourse, the suicidal patient can learn to:

1. identify and list problems, discerning what are potentially changeable and unchangeable problems
2. prioritize and specify problems worth working on and short-term, intermediate and long-term goals
3. see the connections between perceived problems and suicidality
4. generate alternative plans and weigh the pros and cons of various solutions. (Use problem-solving sheets and Decisional Balance Sheets)
5. break problem-solving into component parts and bolster self-confidence
6. review consequences

The goal of this problem-solving activity is to increase the likelihood that the suicidal patient will take the “therapist's voice” with him/her. The psychotherapist can ask the suicidal patient:

“Do you ever find yourself, out there, in your day to day experience, asking yourself the questions that we ask each other right here?”

COGNITIVE RESTRUCTURING/COGNITIVE THERAPEUTIC PROCEDURES

- Use the "art of Socratic questioning" which focuses on the patient's thinking processes. Use imagery reconstruction of behavioral scenes or chain analyses. Trace external and internal triggers that led to mood elevations, increased hopelessness, breakdown of problem-solving, suicidal thoughts and behaviors. (**Downward spiral**)
- Help the patient identify, monitor and decrease suicidal ideation. Help him/her collect "automatic thoughts." Explore with the patient the "internal debate" of the suicidal mind and the interpersonal aspects.
- Invite, entreat, persuade, convince and cajole the patient to consider alternatives to suicide.
- Help the patient reconceptualize "the can'ts," "won'ts," the "absolutes" and the "negotiables," to widen fixed blinders, to think the "unthinkable" and to move beyond "only."
- Learn how to challenge thoughts, instead of having an "emotional knee-jerk reaction" to situations.
- Help the patient label and rate emotions and identify "cognitive road blocks"
- Help the patient to monitor mood shifts and learn to ask oneself the following question. ***"What just went through my mind?"*** Learn the link between feelings and "downer" thoughts and how to "jump start" adaptive thinking. Can collaboratively generate wallet size **coping cards**
- Help the patient learn how to note mood shifts and develop plans for coping with trigger situations. If ...then plans so the patient is not "blind sided" by feelings and events
- Educate about cognitive errors--all or none, black-white thinking, overgeneralization. Teach the concept of the "middle road."
- Teach the patient how to question and challenge his/her thoughts and learn how to instill reasonable doubt. Thoughts don't always equal facts. Nurture the patient's sense of curiosity.
- Help the patient learn how to use a Dysfunctional Thought Record and collect data. Identify triggers, core beliefs and forms of "emotional reasoning."
- Address issues of denial and avoidance as a form of coping technique. Use a "stuckness" metaphor. The patient is "stuck" using a coping technique that worked in the past, but is no longer adaptive in the present.

Use **Clock Metaphor**

12 o'clock - external and internal triggers

3 o'clock - primary and secondary emotions

6 o'clock - automatic thoughts, thinking processes and core beliefs or schemas

9 o'clock - behaviors and resultant consequences

The therapist can use his/her hand to convey the **clock metaphor** by moving his/her hand slowly from 9 o'clock around to 6 o'clock. The therapist can say:

It sounds like this is just a vicious...(without completing the sentence), thus allowing the patient to interject- - "cycle or circle."

If you engage in such a "vicious cycle," then what is "the impact, the toll, the emotional price you and other's pay? Is that what you want to have happen?"

Moreover, what do you do with your emotions of X?(3 o'clock)

(The psychotherapist can treat the patient's emotions as a "commodity" to do something with. For example, does the patient "stuff" his/her emotions, explode, drink them away, etc?)

If the patient responds to the question, "What do you do with your emotions?" with a reply of "I do not know," the psychotherapist can say, "I don't know either. How can we go about finding out?" In this way the psychotherapist is not, what I call a "Surrogate Frontal Lobe," doing the thinking for the patient, but rather a supportive "detective" and collaborative guide.

The following **ADDITIONAL INTERVENTIONS** further illustrate ways to conduct cognitive restructuring therapy with suicidal patients.

POSSIBLE INTERVENTIONS

- (1) Freeman and Reinecke (1993) propose that the therapist adopt a phenomenological perspective in an attempt to understand and address the patient's concerns. The therapist should convey empathy with the patient's despair, explore the patient's motives for considering suicide (e.g., desire to escape emotional pain vs. desire to communicate their concerns to others), acknowledge the patients's belief that there is no other alternative. In order to nurture the patient's sense of being understood and accepted, the therapist can convey:

I need us to focus on the problem or problems that are making you feel like there is no other answer but to take your life. Are there ways to meet your needs in other ways without having to take your life?

The therapist needs to convey that while suicide always remains an option, it is not the patient's only option, nor the best option. The therapist should also convey his/her availability and explicitly indicate that he/she does not want the patient to commit suicide. See the patient as often as needed. Give the patient an emergency telephone number where help can be obtained 24 hours a day. The therapist can solicit from the patient a promise that he/she will call the therapist or the emergency center for help before engaging in any self-destructive behaviors.

- (2) In collaboration with the patient, develop and implement a plan to remove weapons and take appropriate safety precautions. This may involve contacting significant others, psychiatric consultation, or hospitalization, intensive outpatient treatment, medication, and develop a supportive and secure environment.
- (3) Probe the patient's level of hopelessness (use Hopelessness Scale) and ask, "What, if anything, prevents you (the patient) from taking your life?" This question will provide an opening to explore reasons for living and move toward problem-solving (use Reasons for Living Scale). The objective is to help the patient expand on his/her reason for living (viz., "What has kept the patient from suicide so far?"). Linehan's (1985) findings indicated that the absence of strong positive reasons to live is most indicative of suicidal behavior. Address the patient's sense of hopelessness, demoralization and fatalism.
- (4) Help "normalize" depression -- therapist might comment: "Given your (the patient's) life circumstance, I can understand that you might be depressed. (Cite specific examples.) Depression and disappointment should be viewed as a normal part of life, rather than believing that such feelings should not exist. The psychotherapist might observe "That does not make the emotional pain any less, but I can understand what might lead you to be so depressed" Moreover, convey that it is understandable and natural that someone might consider suicide when he/she sees no other way to fulfill his/her desires. If someone felt that there is no other way to handle "the emotional pain," or if someone feels that "the emotional pain will never end," then suicide may seem to the suicidal patient to be the only or best solution.
- (5) Reframe suicide as a possible solution to problems. For example: "Your feeling hopeless does not mean that your situation is hopeless. It simply means that you are depressed." Describe the effects of depression -- possibly, use metaphors such as: "depression acts as a prism (lens) that you see the world through," "a horse that wears blinders (like depression) and as a result has its vision restricted," "a person who only tunes into one channel," or "a person who is prejudiced toward oneself, only selectively focusing on negative data and disregarding any positive signs." Indicate that the patient experiences the world through blinders of which he/she has no awareness. Have the patient collaborate in citing specific examples from the patient's experience (supporting data) for the applicability of each metaphor. Ask the patient for his/her reaction -- Does this "ring true" with your experience? Convey to the patient that: "You are plain wrong in your belief that suicide is the only (emphasize only) solution, or for that matter the best (emphasize best) solution, to your problem(s). If you believe that suicide is the only or best solution to your problems, then that is depression speaking." Convey that you would hate to see the patient use a "permanent solution" for what may turn out to be a temporary problem. "Why don't we see how you feel in a few weeks? Let's take one day at a time and see if we can find a better way to deal with this situation." Discuss with the patient how he/she can anticipate possible problems.

- (6) Help the patient engage in problem-solving by tracing how he/she came to the solution that suicide was the only or the best solution. Trace the thinking process, and help the patient generate alternatives. Use imagery of various possible alternative solutions. Help the suicidal patient create the perception of options and nurture the hope for change. Time projection can be used to encourage the suicidal patient to adopt the notion that life could get better. Focus on the advantages and disadvantages of suicide and point out the advantages and disadvantages of other solutions to their problems. Help the patient break what appear to be numerous and overwhelming problems into smaller, behaviorally proscriptive units that can be addressed individually. Help the patient develop more adaptive ways of coping instead of using alcohol, drugs and avoidance strategies. Since drugs and alcohol exacerbate an individual's suicidal intentions and render patients less likely to be receptive to help, the addictive behaviors need to be addressed directly.
- (7) The therapist can help the "victimized" patient reframe suicide as a way of giving away "power" and "control" to the perpetrator, instead of taking her own power back. View suicide as a way to "escape from oneself."
- (8) Help the patient to look for "gray areas" instead of employing black or white thinking. As one suicidal patient concluded, "Gray can be a beautiful color." Cognitive restructuring procedures can be used to help the patient to question the conclusions that he/she is "worthless" or a "failure" and that "life is futile," and that the future is "hopeless."
- (9) Beebe (1975) suggests having the patient imagine his/her completed suicide and then confront "illogical justifications" such as:

"My family will be better off without me."

"They will be sorry."

"My family's pain will stop."

"I will remove the burden from my family and friends."

Discuss with the patient the advantages and disadvantages of solving the immediate problem by means of suicide versus the long-term effects on others such as family members (children when they grow up).

Ask what "legacy" the patient wants to leave his/her children? What does he or she want to be remembered for?

- (10) Beck (1994) has offered additional clinical suggestions on how suicidal patients can be helped. He indicated that he assesses the patient's level of hopelessness each session, since hopelessness is one of the best predictors of suicide. He will assess the patient's level of hopelessness at the beginning of the session and then explore with the patient what options exist beside suicide. Following this discussion, toward the end of the session the therapist

would once again assess the patient's level of hopelessness. Such assessments may be conducted by means of open-ended interview questions, or assessed by means of asking the patient to provide a rating on a 0% to 100% or 1 to 10 point scale of the degree of hopelessness, or assessed by the Beck Hopelessness Scale. The change in the level of hopelessness from the beginning to the end of the session reveals the patient's suicidal potential. But changes in a positive direction that are offered in therapy are not sufficient. As Beck observes, he is sensitive to the fact that the suicidal patient may have a "relapse" during the coming week. In anticipation of this possibility he comments to the patient:

"I can see that you seem more hopeful and feel better now than at the beginning of this session. But when you are home, it is possible that your feelings of hopelessness may return? Can you see that possibly occurring? ... Should your feelings of hopelessness return, I am wondering what you might do at that time? ... I also want you to know that your re-experiencing such feelings of hopelessness and thoughts of suicide are not all bad. At that moment it means that all your problems are present; that is, the time when you are having what we call "hot cognitions." It is critical to catch your cognitions when they are hot! At that very moment, you can call me on the phone if you need to or if you wish you can write down your thoughts and feelings, as well as what is happening. On the phone or when you come to our next session, we can go over them." (Note: Beck indicates that his patients have not abused the phone call privilege.)

In short, Beck is proposing that the clinician help the suicidal patient reframe his/her suicidal thoughts and feelings as a "learning opportunity" to be collaboratively explored with the therapist. Consistent with Beck's views that therapy is a "journey of exploration," he challenges his patients to adopt an attitude of "curiosity" and "inquiry." For example, if the suicidal patient conveys a negative self-image, the therapist may wonder aloud, "Where did all of these feelings of helplessness, hopelessness, and thoughts of suicide come from?" The therapist may convey that therapy is like a jigsaw puzzle, a puzzle to be solved with its many pieces. If the patient highlights developmental and familial factors that contributed to his/her distress, the therapist can encourage an inquisitive attitude by asking the patient if he/she has any brothers or sisters. "Is there any way that the patient could obtain information from his/her siblings that might help explain what was different about how they reacted versus how the patient reacted? ... Would this help provide useful information, another piece to the puzzle?"

Clearly, there are many additional variations on the clinical suggestions offered by Beck and the others included in this section. The important point is that the therapist is active in suggesting to the patient ways that he/she can become his/her own therapist, viewing his/her thoughts and feelings as occasions to engage in self-reflection, as occasions for learning, as opportunities to collect data where one's thoughts are viewed as "hypotheses worthy of testing". The ways in which the therapist goes about accomplishing these objectives will surely vary depending upon the patient.

A critical objective of the therapeutic process is to nurture hope and to ask patients to put this into their own words. "What prevents them from committing suicide? How can they find meaning given what has happened? How can they not only move on, but find ways to help themselves and others? How does one find hope?" (Note, the use of "How" and

“What” questions as a means of having the patient **take ownership and responsibility for behavioral change and for staying alive**). This process helps to change the nature and content of the suicidal patient's “story.”

- (11) These clinical procedures represent short-term immediate therapist interventions. For some traumatized patients who are suicidal, more long-term interventions are required. This is especially true of individuals who are diagnosed with Borderline Personality Disorders. (See Linehan et al., 2006).

SELF MUTILATION

A major concern with patients with Borderline Personality Disorders is the possibility of **self-mutilation**. There is a need to carefully consider each specific incident of self-mutilation and to better appreciate the patient's motivation for self mutilation. Messer and Fremouw (2008) highlight the importance of drawing a distinction between those who are mutilating with no intent to die versus those self-mutilators who are attempting suicide. As noted earlier, self-mutilators are more at risk for suicide attempts, most often by means of overdosing on drugs. There is a need to assess the degree to which the self-mutilation is deliberate, intentional, repetitive, socially unacceptable, causes tissue damage, and is tied into the inability to regulate and cope with negative emotions (sadness, anxiety, hostility, loneliness).

For eight years, I worked as a consultant to a Detention Center for female adolescent offenders where the prevalence rate of self-mutilation was as high as 40% (as compared to a rate of 15% in the community). Most of these girls had a severe history of separation, neglect and sexual abuse, as well as a history of other high-risk behaviors (Oppositional Defiant Disorder, Conduct Disorder, Major Depression and Dysthymia, substance abuse, and various forms of risk-taking behaviors). This was accompanied by PTSD and dissociative symptoms. The more risk factors that were present, the higher the risk for suicidal ideation and suicidal behaviors.

Fleming and Pretzer (1990) observe that there is a need to:

- (a) Examine with the patients the specifics about those occasions in which they have self-mutilated and occasions when they have been tempted to self-mutilate. Then to consider the commonalities evident across these situations. The following questions can be used to cover this information.
- (b) **Consider precipitants.**

What led up to your wanting to hurt yourself?

When did you start feeling like hurting yourself? What was going on before that?

How were you feeling beforehand?

What other feelings did you have?

What were your immediate reactions when (the precipitating event) happened?

What thoughts ran through your head?

(c) **Consider goals**

What did you hope to accomplish?

How did you expect to feel afterwards?

How did you expect others (be specific) to react? How would you like them to react?

*Suppose you had not done (self-mutilation), what do you think would have happened?
How would things have been different? How would you have felt then?*

PUTTING IT ALL TOGETHER: TREATMENT CHECKLIST FOR SUICIDAL PATIENTS

One final lesson I learned was the remarkable heterogeneity and uniqueness of suicidal patients. Thus, the length of treatment needs to be criterion-based and not time-based. Suicidal individuals vary markedly and require different lengths of treatment. Sometimes a time-based structured, but flexible, treatment manual such as the 10 Session protocol employed by Brown and his colleagues (2000, 2005) will be sufficient. In other instances, a year-long intervention may be required (Linehan et al., 2006). No matter the length of the psychotherapeutic intervention, the treatment goal is to demonstrate changes on the variety of assessment measures reviewed earlier (behavioral, self-report, Quality of Life indicators). The treatment goal is to help the suicidal patient to be able to implement the psychotherapeutic activities. The suicidal patient may be asked to fill out the following **Treatment Checklist** that “puts the various treatment elements together.”

PATIENT CHECKLIST

As a result of participating in treatment, I have learned how to:

- _____ **1. Notice warning signs of when I am becoming depressed and experiencing suicidal thoughts and feelings.**
- _____ **2. Be on the lookout for triggering events.**
- _____ **3. Use my Clock Analysis of noting the (Internal/External) Triggers, (12 o'clock), the Primary and Secondary Emotions (3 o'clock), My Thinking Patterns and Automatic Thoughts (6 o'clock), and What I Do or my behaviors and how others respond (9 o'clock).**
- _____ **4. Take action to break this “vicious cycle.”**
- _____ **5. Monitor my moods and accompanying thoughts.**
- _____ **6. Reduce risk factors and make sure where I spend time is “safe” and free from possible lethal items (firearms, drugs). Safeguard my environment so it is unfriendly to suicide.**
- _____ **7. Ask for help from family members, friends, and my treatment team.**
- _____ **8. Implement my safety plan.**
- _____ **9. Use my Coping Cards as reminders to “jump start” my healthy thinking**
- _____ **10. Procrastinate hurting myself and use my coping techniques.**
- _____ **11. Challenge, test out and change my thoughts and thinking processes. Change my “internal debate.”**
- _____ **12. Accept my thoughts and feelings and “ride out” the urge to hurt myself.**
- _____ **13. Remind myself of the Reasons to Live. Visit my Hope Kit and add to it. Remind myself of my Time Line 2 evidence of my “strengths,” “signs of resilience” and “survivor skills.”**
- _____ **14. Use my problem-solving skills. View perceived threats, disappointments and provocations as “problems-to-be-solved.”**
- _____ **15. Use my self-soothing techniques.**
- _____ **16. Look for the “Middle Road” and use my “If...then” plans, and take off my “emotional Blinders.”**

- ___ 17. **Develop a life worth living. Use my skills to escape, avoid isolation.**
- ___ 18. **Use my Future Imagery procedures.**
- ___ 19. **Take my medication as prescribed, and check with my doctor regularly.**
- ___ 20. **Cope with my lapses (relapses) and view them as “learning opportunities.”**
“Hot” cognitions are wake-up calls to use my coping skills and awaken my curiosity.
- ___ 21. **Plan for future high-risk situations like anniversary effects, reoccurrences so I am not**
“blindsided.”
- ___ 22. **Make a “gift” of what I learned and share it with others.**
- ___ 23. **Take pride in what I have been able to achieve.**
- ___ 24. **Recognize that I am on a journey, but not alone.**
- ___ 25. **These are some of the things I learned from my clinical care that I can use if I become**
suicidal in the future. In addition, I can also _____
- ___ 26. **Other things I have learned as a result of therapy include: _____**

I have found it useful to have the suicidal patient collaboratively fill out this **Patient Checklist** and give examples of each item they checked. It is critical to have the suicidal patients share this list of coping activities with significant others. It is important to have them “take ownership” by having the patients put into their own words why they are doing each task.

The major lesson I have learned in working with suicidal patients for 35 years is how much they have to teach me.

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WEBSITES

American Association of Suicidology

<http://www.suicidology.org/>

American Foundation for Suicide Prevention

<http://www.afsp.org/>

American Psychiatric Association Practice Guidelines for the Assessment And Treatment of Patients with Suicidal Behaviors

www.psych.org/psych_pract/treat/pg/suicidalbehavior_05-15-06.pdf

APA Guidelines Assessing and Treating Patients with Suicidal Behaviors

http://stopsuicide.org/downloads/Sites/Docs/APASuicideguidelinesReviewArticle.pdf

Aeschi Working Groups

www.aeschiconferenceunibe.ch/

CDC's SafeUSA Guide to Preventing Suicide

<http://www.cdc.gov/ncipc/pub-res/youthsui.htm>

Center for Disease Control and Prevention National Center for Injury Prevention and Control

<http://www.cdc.gov/ncipc/>

Connecting the Dots to Prevention Violence: American Medical Association

http://www.ama-assn.org/ama/pub/category/3242.html

JED Foundation to Safeguard College Students Against Suicide

www.jedfoundation.org

Joint Commission National Patient Safety Goals

http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals

National Institute of Mental Health (NIMH) Suicide Fact Sheet

http://www.nimh.nih.gov/research/suicide.cfm

NIMH Frequently Asked Questions About Suicide

<http://www.nimh.nih.gov/research/suicidefaq.cfm>

NIMH Review of Suicide Assessment Tools

A review of suicide assessment measures for intervention research in adults and older adults

G.K. Brown, 2002

www.nimh.nih.gov/suicideresearch/adultsuicide.pdf

Prevention Website

www.StopASuicide.org

1-800-273-TALK

1-800-273-8255

**Resource Guide for Implementing (JCAHO) 2007 Patient Safety Goals
On Suicide**

www.mentalhealthscreening.org/events/ndsd/JCAHO.aspx

Review of Suicide Measures for Adults

<http://www.nimh.nih.gov/research/adultsuicide.pdf>

Review of Suicide Measures for Children

<http://www.nimh.nih.gov/research/measures.pdf>

Selected Bibliographies on Suicide Research-1999

<http://www.nimh.nih.gov/research/suibib99.cfm>

Suicide Prevention Resource Center: Best Practices Registry For Suicide Prevention

<http://www.sprc.org>

Suicide Statistics from CDC's National Center for Health Statistics

<http://www.cdc.gov/nchs/fastats/suicide.cfm>

The Surgeon General's Call to Action to Prevent Suicide

<http://www.surgeongeneral.gov/library/calltoaction/default.htm>

U.S. Department of Health and Human Services

<http://www.afsp.org/>

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