Best Practice Clinical Interventions for Working with Suicidal Adults

Mary L. Bartlett, PhD, LPC, NCC, CFLE
Vice President, Behavioral Health and Leadership, Cape Fox Professional Services

Nicole Siegfried, PhD, CEDS
Clinical Director, Magnolia Creek Treatment Center for Eating Disorders

Tracy K. Witte, PhD
Assistant Professor, Department of Psychology, Auburn University

Abstract

Drawing from existing empirical literature, this article examines best practices for working with adults who are in suicidal crisis. An explanation of suicidal thinking and how to assess for suicidality is provided, and specific clinical interventions and techniques that have been empirically evidenced as useful with this population are highlighted. Based on the premise that understanding the suicidal mind leads to more effective intervention, a consideration of psychache as the basis for behavior in suicidal clients is discussed. Finally, dialectical behavioral therapy, problem solving therapy, and cognitive therapy are examined as mechanisms for addressing the needs of suicidal clients, with a consideration of specific counseling techniques available and effective within those contexts.

Working with suicidal clients is challenging. Given that more suicidal clients at moderate and high levels of risk are being treated in outpatient facilities, often by overworked or undertrained counselors, it becomes critical for persons treating such clients to be familiar with the latest empirical developments in this area. Counselors often report struggling to understand suicide, to assess suicidality in their clients, and to properly classify suicide risk level. Further, utilizing empirically-evidenced interventions represents the present standard of care in this area but are commonly misunderstood and underused.

Understanding the Suicidal Mind

Suicide as Psychache

According to Shneidman (1993), people die by suicide because they have an overwhelming psychological pain that drives their need to end what he coined "psychache" (p.51). This psychological pain, pressured by fear, shame, anxiety, rejection, threat, guilt, unhappiness, and other negative emotions facilitates a pain in the mind. It is described as so debilitating that the person experiencing it wants only to have the psychache end, which makes suicide a viable option. While it is acknowledged not all people die by suicide because they experience psychache, this phenomenon is an explanation for many suicides (Shneidman, 1996). Leading suicidologists agree this storm of the mind includes many elements (e.g., biological, interpersonal). Yet, at its root is the essential element of psychological chaos that drives the suicidal drama leading to a decision of

death by suicide (Joiner, 2005; Joiner, Van Orden, Witte & Rudd, 2009; Peterson, Luoma, & Dunne, 2002; Shneidman, 1996, 2004).

Commonalities of psychache and suicide exist and include seeking escape as a solution and an end to an unbearable psychological pain. The desire to escape stems from frustrated needs and a sense of hopelessness and helplessness, which lead to constricted thinking, in spite of any previous ambivalence toward death (Shneidman, 1993). The profound psychache drives a suicidal person to experience an inability to effectively problem-solve, seek alternate solutions, or imagine a future. It also includes difficulty with eating, sleeping, working, and soliciting help from others, as well as feeling unable to live with the burden they perceive themselves as carrying (American Association of Suicidology, 2011). Early on, psychache was described as a drama of the mind that stems from a variety of thwarted or distorted psychological needs (Shneidman, 1996). More recently, Joiner (2005) proposed *The Interpersonal Theory of Suicide,* which provides greater specificity regarding causes of psychache that are most likely to result in suicidality. According to Joiner's theory, the pain that results from feeling as though one's death is worth more than one's life (i.e., perceived burdensomeness) and feeling disconnected from others (i.e., thwarted belongingness) are key causal factors for suicidal desire. Further, Joiner explains if a person acquires a sense of fearlessness toward death and tolerance of physical pain, he or she may become more capable of suicide. It is where burdensomeness, thwarted belongingness, and acquired capacity intersect in which the suicidal mind erupts and can lead to a fatal outcome.

Traditionally, people feel uncomfortable discussing suicide because killing oneself goes against societal expectations and Western norms (Suicide Prevention Resource Center, 2008). However, for a counselor, understanding the suicidal mind and suicidal thinking is critical to the process of helping a suicidal person. In any treatment of suicidality, addressing psychache is fundamental to treatment. Addressing psychache necessarily includes identification, understanding, and mitigation. This approach represents the core of effective work with suicidal clients, and begins with the assessment process (Granello &Granello, 2007; Shneidman, 2005).

Assessment of Suicide Risk: Best Practice

Barriers to Conducting Appropriate Suicide Risk Assessment

In a survey of 376 professional counselors, nearly one-quarter reported one of their clients had died by suicide (McAdams & Foster, 2000). The likelihood of encountering a client experiencing suicidal ideation is even higher. Essentially all clinical psychologists report they encountered at least one client who was suicidal during graduate school (Dexter-Mazza, & Freeman, 2003), and this likelihood is probably comparable to a counselor encountering a suicidal client at some point in his or her career.

Despite the high likelihood of counselors working with suicidal individuals, it is not clear that all counselors routinely assess for suicide with all clients. Although no studies were identified regarding the frequency of suicide risk assessment among counselors specifically, Simon (2002) reported it is extraordinarily difficult to ensure that psychiatrists routinely perform suicide risk assessments, and it seems reasonable to assume there is a similar level of noncompliance among others who are charged with mental health care (e.g., counselors, clinical psychologists).

Given the importance of preventing suicide among clients, why is it that relatively few counselors and other mental health professionals routinely assess suicide risk? Lang, Uttaro, Caine, Carpinello, and Felton (2009) conducted a feasibility study for a suicide screening process in an outpatient mental health facility that may shed light on this matter. The authors found the most common reasons for this failure to assess suicide risk included concerns that the discussion of suicide with vulnerable clients could make the idea of suicide seem more appealing and therefore increase danger and/or that routine screening could increase risk for legal liability on the part of counselors.

Regarding the former of these concerns, there is fairly compelling evidence across multiple research studies that the act of suicide risk assessment does not appear to elevate risk even among vulnerable populations (Reynolds, Lindenboim, Comtois, & Linehan, 2006). Regarding the latter, failing to assess for suicide risk, take action given that risk, and/or document the counselor's actions can actually increase liability. It is important to keep in mind counselors are not expected to predict who will attempt or die by suicide with 100% accuracy. This would be impossible, given the extremely low base-rate of suicide even within clinical populations. Rather, the expectation is that counselors take steps to meet the standard of care in their profession, which would typically involve performing systematic risk assessment and implementing a treatment plan based upon this assessment (Simon, 2002).

What Not to Do: Widespread but Insufficient Practices

A competent suicide risk assessment must be comprehensive in nature. Although self-report suicide risk assessment checklists are commonly found in clinical settings (Simon, 2009), these checklists have not usually been subjected to rigorous psychometric validation that provides evidence they have any utility in predicting suicide risk. As such, they do not necessarily protect mental health providers in suicide malpractice cases when they are not combined with a comprehensive clinical suicide risk assessment (Simon). Even more importantly, with a lack of psychometric data providing evidence for their utility, these forms do not necessarily ensure the physical safety of clients. This does not necessarily indicate that such checklists have no place in counseling settings; rather, they can only be considered one tool in the counselor's toolbox. It is necessary to also conduct a more comprehensive and integrative clinical assessment with each client that is encountered; simply documenting that a client completed a suicide risk assessment checklist is not sufficient to meet the standard of care.

Along similar lines, it is also fairly common for clinical settings to routinely utilize no-suicide contracts (Miller, Jacobs, & Gutheil, 1998), which require a client to agree he or she will not engage in suicidal behavior. Simon (1992) noted counselors might mistakenly believe that they have met the standard of care with a no-suicide contract and therefore engage in insufficient suicide risk management procedures otherwise. To date, there is no evidence that no-suicide contracts actually prevent suicidal behavior (Joiner, Van Orden, Witte, & Rudd, 2009), and there are documented instances where individuals who had signed a no-suicide contract have died by suicide (Kroll, 2000). Additionally, there has been no legal precedent in which a no-suicide contract has protected clinicians in liability (Simon). In sum, documenting that a client has signed a no-suicide contract without further detail regarding a comprehensive suicide risk assessment and other actions taken is not adequate to protect clients from self-harm or to protect oneself from liability (Miller et al., 1998).

What to Do: Evidence-based Suicide Risk Assessment

There are several available evidence-based risk assessment frameworks that have been published in the last decade, and a comprehensive review of all of these is beyond the scope of the current article. For a fairly detailed exposition of several different frameworks, we encourage interested readers to consult Chapter 2 of Joiner et al. (2009). Provided is an abbreviated discussion of just one assessment framework, the Suicide Risk Assessment Decision Tree (Joiner, Walker, Rudd, & Jobes, 1999) that is both evidence-based and has been demonstrated to be feasible, even with novice graduate student clinicians (Cukrowicz, Wingate, Driscoll, & Joiner, 2004). Interested readers are encouraged to consult Cukrowicz et al. (2004), Joiner et al. (2009) or Joiner et al. (1999) for more detail on this particular risk assessment tool.

The Suicide Risk Decision tree involves assessing three "core" indicators of suicide risk (i.e., past suicidal behavior, current suicidal desire/ideation, and current resolved plans and preparations, all of which will be discussed in more detail below) as well as some additional risk and protective factors. The interview outlined in Figure 1 should be conducted in full during the first session with a client. In subsequent sessions, this can be abbreviated as appropriate, as it is not necessary to assess for long-standing risk factors at every session (e.g., family history of suicide). This interview is semi-structured in nature and was not created for use by individuals without appropriate clinical training to assess for suicide risk. In this way, it differs from the more formulaic suicide risk checklists discussed above that are not integrative in nature. It is designed to assess for the most notable risk factors for suicide that have been borne out by the literature, although it is not intended to be exhaustive. Counselors are encouraged to use their clinical judgment when conducting suicide risk assessments and to include other risk and protective factors as warranted.

The risk assessment framework begins with assessing for past suicidal behavior, which has been identified as the most potent predictor of subsequent suicidal ideation (Rudd, Joiner, & Rajab, 1996), suicide attempts (Putnins, 2005), and death by suicide (Brown, Beck, Steer, & Grisham, 2000). In particular, these studies demonstrate that a history of more than one suicide attempt is substantially more predictive of future suicidal behavior than a history of one suicide attempt. Thus, a multiple suicide attempter would be assigned to a higher risk category than a non- or single-attempter, all other risk factors being equal. This is followed by assessing the nature of any current thoughts of suicide. Thoughts that fall into the category *Suicidal Desire and Ideation* (i.e., relatively vague thoughts about wanting to be dead) have been demonstrated to have a weaker association with suicidal behavior than thoughts that fall into the category *Resolved Plans and Preparations* (i.e., more specific thoughts about and planning for a suicide attempt; Holden, & DeLisle, 2005; Joiner, Rudd, & Rajab, 1997; Pettit, Garza, Grover, Schatte, Morgan, Harper, & Sanders, 2009). Therefore, a counselor should be more concerned about a client expressing Resolved Plans and Preparations for suicide than a client expressing only Suicidal Desire and Ideation, with all other risk factors being equal. Next, the counselor should assess for other significant findings (e.g., precipitant stressors, such as a recent divorce) and protective factors (e.g., strong social support). Positive endorsement of additional significant findings would result in possibly increasing the risk designation of the client (e.g., from *low* to *moderate*). In contrast, clients who endorse many important protective factors might be placed in a lower risk category than they would be otherwise, although it is prudent to err on the side of caution when making the decision to adjust a risk category downward based upon protective factors (Joiner et al., 1999).

Subsequently, the information gleaned from the clinical interview found in Figure 1 is utilized to categorize the suicide risk of an individual into *low*, *moderate,* and *high* risk, using the flow chart from Figure 2. This flow chart provides a method for weighting risk factors that are believed to be more pernicious than others (e.g., a history of multiple suicide attempts is weighted more heavily than a family history of suicide). These risk categories help the clinician identify the most appropriate actions to take (Figure 3).

The Suicide Risk Assessment Decision tree provides a fairly straightforward method to assess suicide risk and clinical interventions taken to mitigate that risk, yet it also allows for some degree of flexibility on the part of the counselor. Further, the use of a systematic, research-based assessment tool greatly simplifies the documentation process for a risk assessment. A counselor using the Suicide Risk Assessment Decision tree can include a variant of the following in his or her progress notes: "The client was assessed for suicide risk according to the Joiner et al., (1999) Suicide Risk Assessment Decision tree. Risk category = low (*provide details regarding the basis for this; for example, no current suicidal desire and ideation and no history of attempts*). Actions taken: created a coping card with the client that included the following recommendations if the client experiences increased suicidality/distress [*list everything from the coping card*]. The counselor will continue to monitor risk in subsequent sessions and adjust interventions accordingly." In this way, the counselor is meeting the standard of care by conducting a comprehensive risk assessment that includes distal and proximal risk factors, selecting interventions based upon that level of risk, and documenting all of this in the client's file.

Interventions for Suicidality in Clients

Several outpatient psychotherapies have been shown to be effective in the treatment of suicidality, including dialectical behavior therapy (DBT; Linehan, Comtois, Murray, et al., 2006), problem solving therapy (PST; Rudd, Rajab, et al., 1996), and cognitive therapy (CT; Brown et al., 2005). It is noteworthy that most studies have only addressed non-fatal suicidal behavior as outcome variables, and to date only one has demonstrated an effective intervention for reducing death by suicide (Motto & Bostrom, 2001). In terms of death by suicide, the most effective intervention appears to be a restriction in access to lethal means (Hawton et al., 2001).

Dialectical Behavior Therapy (DBT)

DBT is a type of cognitive behavior therapy that facilitates change through assisting the client in achieving a life worth living, even in the face of intense emotions (Linehan, 1991). DBT includes four components: mindfulness, distress tolerance, interpersonal effectiveness, and emotional regulation. DBT is delivered in four necessary integrated modalities: individual psychotherapy, group skills training, team consultation, and between-sessions phone calls. It has been found to reduce suicide attempts among clients with recent suicide attempts, individuals with self-harm behaviors, and clients with borderline personality disorder (Linehan, Comtois, Murray, et al., 2006).

Of the types of outpatient psychotherapy discussed in this article, only DBT has been replicated in randomized controlled trials by independent research groups, and is thus the only outpatient therapy recognized as an "efficacious" treatment for suicidality based on the criteria outlined by Chambless and Hollon (1998, p.9). Initial research indicates that DBT may also hold promise for suicidal adolescents with borderline personality features and for older adults (Lynch, Morse, Mendelson, & Robbins, 2003).

The possible mechanisms by which DBT is effective in reducing suicidality have been reviewed (Lynch, Chapman, & Rosenthal, 2006) and can be separated into interventions common to all behavioral therapies and interventions unique to DBT (see Table 1). As it pertains to suicidality, several specific DBT interventions may be particularly effectual: 1) *Behavior Chain Analysis*. As part of the DBT treatment package, clients are taught to dissect their behaviors, identifying urges, thoughts, situations that contributed to the behavior. A solution analysis is then conducted to develop an alternative solution to the problem behavior; 2) *Between Sessions Phone Calls*. Central to DBT treatment is use of between-session telephone calls. These calls may be effective in reducing suicidality by strengthening the client-therapist relationship, allowing for *in vivo* coaching through urges, and by fostering distress tolerance skills (e.g., "I can call my therapist if this doesn't work, but if I cut I can't call her."); 3) *Mindfulness.* In DBT mindfulness skills are the foundation of all other DBT skills. These skills may be particularly helpful in suicidality by allowing clients to approach situations with perspective rather than emotionality and with a stance of acceptance rather than judgment; and 4) *Distress Tolerance.* Distress tolerance skills allow clients with suicidality to experience and accept intense emotions rather than acting on them in self-destructive ways. These skills may also allow clients to feel more equipped for difficult situations, thereby increasing feelings of self-mastery.

Although specific DBT techniques may be responsible for reduction of suicidality, the underlying philosophy of DBT may be one of the strongest influences in its success. DBT's dual focus on acceptance and change may connect to the ambivalence in clients with suicidality. Additionally, the authenticity of the therapist inherent to DBT may be responsible for an interpersonal connection that may reduce suicidality (Joiner et al., 2009).

Problem Solving Therapy (PST)

There have been mixed results in terms of the effectiveness of PST in reducing suicidality. Some research has shown that PST is no more effective than other interventions in treatment of suicidality (McLeavey, Daly, Ludgate, & Murray, 1994; Donaldson, Spirito, & Esposito-Smythers, 2005). Other research has indicated that PST and variants of PST decrease suicide attempts and suicidal ideation (Salkovskis, Atha, & Storer, 1990; Rudd, Rajab, et al., 1996). The effectiveness of PST in patients with suicidality centers on the idea that individuals who are suicidal have a deficit in problem solving skills and in interpersonal problem solving skills (Sourander, Helstelä, Haavisto, & Bergroth, 2001; D'Zurilla, Chang, Nottingham, Faccini, 1998). PST appears to be effective by teaching skills that compensate for problem solving deficits (Wingate, VanOrden, Joiner, Williams, & Rudd, 2005). This treatment includes six steps (i.e., Define the problem; Identify the goal; Generate alternatives; Evaluate alternatives; Implement an alternative; Evaluate efforts and modify approach as needed) that center on identifying and evaluating problems and pursuing solutions as alternatives to suicide. These six steps can be written on a portable note card for easy accessibility to reduce impulsive coping (Berk, Henriques, Warman, Brown, & Beck, 2004).

Cognitive Therapy (CT)

CT has also been supported in the literature as an effective intervention in reducing and delaying subsequent suicide attempts and in individuals who have attempted suicide (Brown et al., 2005). Additionally, clinical trials have supported the use of various forms of CT in the treatment of many psychiatric disorders associated with suicidality (e.g., major depressive disorder; Butler, Chapman, Forman, & Beck, 2006). The central premise of cognitive theory is that behaviors and emotions are

a result of the meanings assigned to events (Wenzel, Brown, & Beck, 2009). It has been hypothesized that the route by which cognitive therapy reduces suicidal behavior is through its impact on depressive thinking and symptoms of hopelessness, as opposed to a reduction in suicidal ideation (Brown et al.,). CT therapy for suicide involves three stages of treatment: (1) Establishing a framework for treatment; (2) In depth focus on suicidal behavior utilizing cognitive restructuring and behavioral interventions; (3) Relapse Prevention (Henriques, et al., 2003; Berk et al., 2004). Several specific CT interventions may be particularly helpful for clients with suicidality:

Hope Kit. Henriques et al. (2003) described an intervention in which clients construct a kit of mementos, pictures, souvenirs, and reminders of their reasons for living. The actual assembly of the kit may provide hope through correction of cognitive errors related to reasons to die versus reasons to live. The completed kit can then serve as a tangible reminder of reasons for living during times of crisis (Wentzel, et al., 2009).

Crisis Coping Card. Several versions of crisis cards (Rudd, Joiner & Rajab, 2001) and coping cards (Berk et al., 2004) have been described in the literature. These cards can be used as a safety plan of what to do when feeling overwhelmed when it is difficult to think clearly (e.g, call a friend at XXX-XXXX); ways to counteract core beliefs (e.g., reasons I am not a failure); and reminders of skills to employ during stressful situations (e.g., listen to music on my iPod). Clients tend to respond well to coping cards/crisis cards because they provide a tangible and concrete method of coping during difficult situations, when intense emotions can often interfere with healthy coping (Wenzel et al., 2009).

Guided Imagery. Wenzel et al. (2009) presented a relapse-prevention intervention that utilizes guided imagery adapted for suicidal clients. The client is instructed to imagine a future situation in which she may feel suicidal and guided through cognitive restructuring, healthy coping, and problem solving. This intervention serves as a role-play for future events and creates an imaginal self-mastery experience to strengthen resilience in preparation for those events.

Discussion

Working with suicidal clients represents a unique challenge for counselors who are conventionally trained and certified to assume that the client will act in synergy with the counselor and contribute to a helping partnership toward a resolution of the presenting issues. For most clients seeking the help of a counselor represents the first of many steps toward recovery—a step that in many cases may be the most difficult one to take. Suicidal clients turn the traditional client-counselor partnership on its head in that suicidal clients are typically cognizant of the fact their presence in counseling is as a result of an overt and intentional self-initiated act that was conceived by them and intended to meet a predetermined need. This need includes a degree of psychache as described above, which may be only one of many factors that have played into the client's decision to die by suicide. The challenge for the counselor is to understand the psychological basis for arriving at the decision to attempt a suicide as part of a reasoned and reasonable chain of logic—most suicidal clients will be able to conceive and describe their justification for engaging in this behavior.

Most of the techniques that have been shown to be effective with this population involve a recalibration of the thinking processes that have led to this decision. Additionally, addressing the often deficient problem-solving, conflict-resolution, and personal-interaction skills of suicidal clients can be a useful adjunct in addressing the problems that forced them into the path of

reasoned conclusions that ended with a decision to suicide. However untenable this chain of logic is to the client's family members and significant others or even the counselor, it must be examined and understood if effective means of addressing the deficits in thinking that, in combination with the client's actual challenges, have led to the problem behavior.

Figure 1. Decision Tree Interview. Adapted From *The Interpersonal Theory of Suicide: Guidance for Working with Suicidal Clients,* by T. E. Joiner, Jr., K. A. Van Orden, T. K. Witte, and M. D. Rudd, 2009, p. 72. Copyright 2009 by the American Psychological Association (APA). Reprinted under APA's fair use policy.

Assess History of Suicidal Behavior:

1. Past suicidal behavior: Have you attempted suicide in the past? How many times? Methods used? What happened (e.g., went to hospital?).
2. Do you have a history of non-suicidal self-injury? (e.g., burning, cutting, etc.)

Assess Suicidal Desire and Ideation:

3. Have you been having thoughts or images of suicide?
4. Do you ever think about wanting to be dead?
5. Frequency of ideation: How often do you think about suicide?
6. What reasons do you have for dying? What reasons do you have to continue living?

Assess Resolved Plans and Preparations:

7. Duration [look for pre-occupation]: When you have these thoughts, how long do they last?
8. Intensity: How strong is your intent to kill yourself? (0 = *not intense at all*, 10 = *very intense*)
9. Specified plan [look for vividness, detail]: Do you have a plan for how you would kill yourself?
10. Means and opportunity: Do you have [the pills, a gun, etc.]? Do you think you'll have an opportunity to do this?
11. Have you made preparations for a suicide attempt? [e.g., buying pills]
12. Do you know when you expect to use your plan?
13. Courage & competence: How scared do you feel about making an attempt? How courageous do you feel about making an attempt? How able do you feel to make an attempt?

Assess "other significant findings":

14. Precipitant stressors: Has anything especially stressful happened to you recently?
15. Hopelessness: Do you feel hopeless?

16. Impulsivity: When you're feeling badly, how do you cope? Sometimes when people feel badly, they do impulsive things to feel better. Has this ever happened to you? [e.g., drinking alcohol, running away, binge eating]

17. Has anyone in your family made a suicide attempt or died by suicide? Relationship to you? Thoughts and feelings about this?

18. Presence of psychopathology (rated by interviewer)

19. Thwarted belongingness: Do you feel connected to other people? Do you live alone? Do you have someone you can call when you're feeling badly? [are supportive relationships completely absent?]

20. Perceived burdensomeness: Sometimes people think: "The people in my life would be better off if I were gone." Do you think that? In what ways to you feel like you contribute meaningfully to those around you? (e.g., at work, at home, in the community)

Protective Factors:

21. Adequate social support (use responses to item 19 to assess this)

22. Responsibility to others (use responses to item 20 to assess this)

23. Good problem-solving ability: When you are experiencing distress, what do you do to resolve it? When you encounter something difficult, do you sometimes feel like you have no idea what to do to get through it?

24. Cultural and religious beliefs against suicide

Figure 2. Suicide Risk Assessment Decision Tree. Adapted from "Scientizing and Routinizing the Assessment of Suicidality in Outpatient Practice," by T. E. Joiner Jr., R. L. Walker, M. D. Rudd, & D. A. Jobes, 1999. *Professional Psychology: Research and Practice, 30,* p. 451. Copyright 1999 by the American Psychological Association. Reprinted under APA's fair use policy.

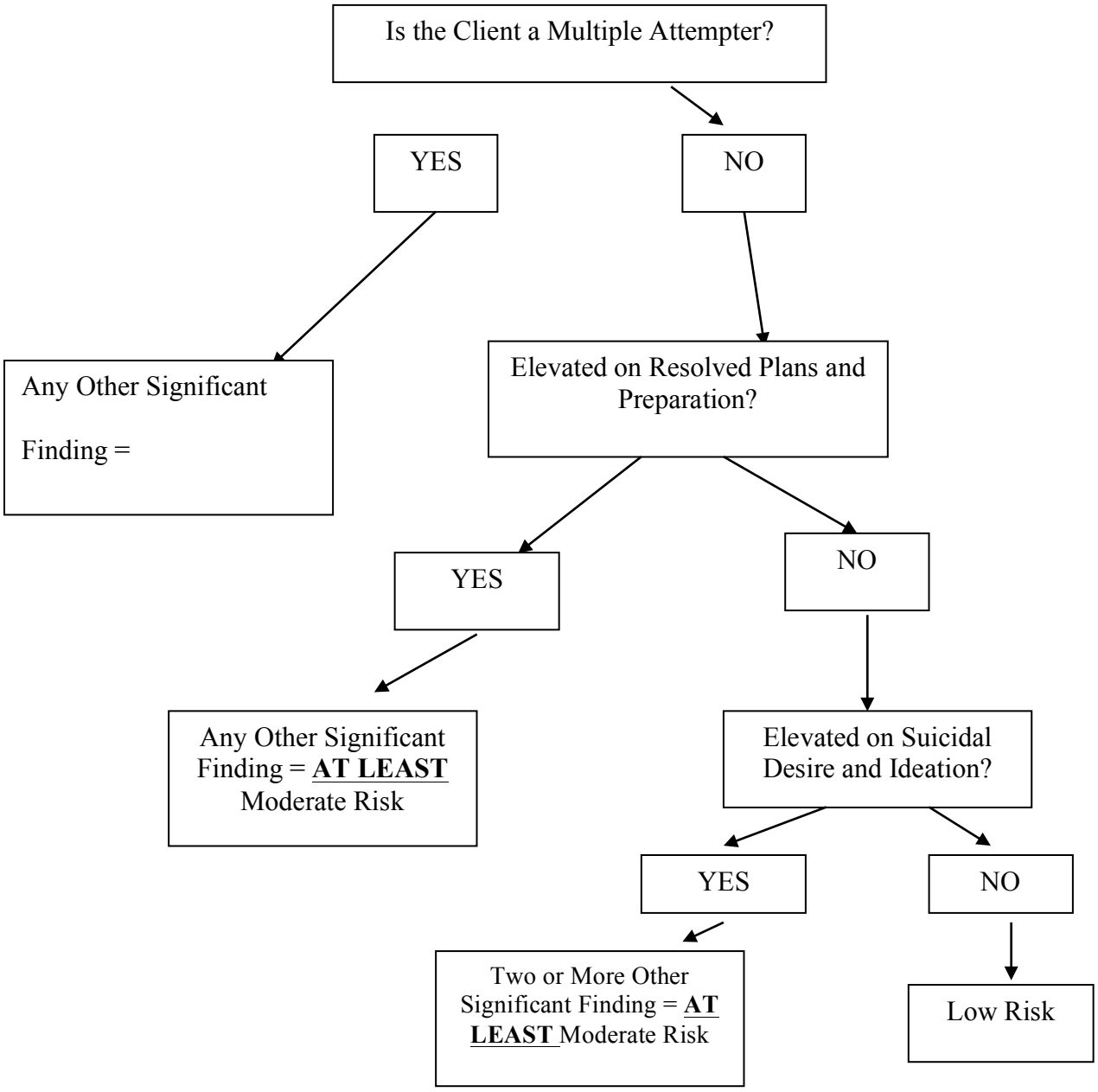

Figure 3. Interventions for each level of suicide risk. Adapted From *The Interpersonal Theory of Suicide: Guidance for Working with Suicidal Clients,* by T. E. Joiner, Jr., K. A. Van Orden, T. K. Witte, and M. D. Rudd, 2009, p. 106. Copyright 2009 by the American Psychological Association (APA). Reprinted under APA's fair use policy.

Risk Category (circle one and check off each action taken):

Low Risk (actions taken)

- ☐☐ Create a coping card with the client that includes a variant of the following, "In the event that you begin to develop suicidal feelings (or if your existing feelings become more intense), here's what I want you to do:"
    - List at least three pleasant activities that a client could realistically do when feeling distressed (e.g., work on crossword puzzles, listen to soothing music)
    - List two or three people from the client's support network that could be called (e.g., mother, friend)
    - List emergency numbers (including that for the National Suicide Prevention Lifeline; 1-800-273-TALK and 911)
- ☐☐ Continue to regularly monitor suicide risk
- ☐☐ Document all activities in progress notes

Moderate Risk (actions taken)

- ☐☐ Consult with a supervisor if you are a trainee
- ☐☐ Create a coping card (see above)
- ☐☐ Consider midweek phone check-ins to assess suicide risk more frequently
- ☐☐ Inform about existence of adjunctive treatments (e.g., medication)
- ☐☐ Increase social support:
    - Encourage client to seek support from friends and family
    - Plan with client to have someone check in on him or her regularly
    - Ask client's permission for you to contact the person who will be checking in
- ☐☐ Attempt to remove access to lethal means (e.g., firearms, pills, etc.)
- ☐☐ Ask for permission to speak with an informant (e.g., family member, romantic partner), with the appropriate release
- ☐☐ Continue to regularly monitor suicide risk

- Document all activities in progress notes

High Risk (actions taken)

- Consult with a supervisor if you are a trainee or with a colleague if you are not a trainee
- Consider emergency mental health options (e.g., hospitalization)
- Client should be accompanied and monitored at all times
- If hospitalization is not warranted, use suggestions from the Moderate Risk category
- Document all activities in progress notes (including documentation that hospitalization was at least considered)

References

American Association for Suicidology. (2002). Statistic Fact Sheet. Retrieved August 28, 2011 from http://suicidology.org/associations/1045/files/2002datapgv2.pdf.

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

Brown, G., Beck, A. T., Steer, R., & Grisham, J. (2000). Risk factors for suicide in psychiatric outpatients: A 20-year prospective study. *Journal of Consulting and Clinical Psychology, 68,* 371-377.

Brown, G. K., Ten Have, T., Henriques, G. R., Xie, S. X., Hollander, J. E., Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. *Journal of the American Medical Association, 294*(5), 563-570.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting & Clinical Psychology, 66,* 7–18.

Cukrowicz, K. C., Wingate, L. R., Driscoll, K. A., & Joiner, T. E. (2004). A standard of care for the assessment of suicide risk and associated treatment: The Florida State University Psychology Clinic as an example. *Journal of Contemporary Psychotherapy, 34,* 87-100.

Dexter-Mazza, E. T., & Freeman, K. A. (2003). Graduate training and the treatment of suicidal clients: The students' perspective. *Suicide and Life-Threatening Behavior, 33,* 211-218.

Donaldson, D., Spirito, A., Esposito-Smythers, C. (2005).Treatment for adolescents following a suicide attempt: Results of a pilot trial. *Journal of the American Academy of Child Adolescent Psychiatry, 44*(2), 113-120.

D'Zurilla, T. J., Chang, E. C., Nottingham, E. J., & Faccini, L. (1998). Social problem solving deficits and hopelessness, depression, and suicide risk in college students and psychiatric inpatients. Journal of Clinical Psychology, *54*, 1091-1107.

Granello, D. H., & Granello, P. F. (2007). *Suicide: An essential guide for helping professionals and educators*. Boston: Pearson.

Hawton, K., Townsend, E., Deeks, J., Appleby, L., Gunell, D., Bennewith, O., & Cooper, J. (2001). Effects of legislation restricting pack sizes of paracetamol and salicylate on self-poisoning in the United Kingdom: Before and after study. *BMJ, 322,* 1203-1209.

Henriques, G. R., Beck, A. T., & Brown, G. K. (2003). Cognitive therapy for adolescent and young adult suicide attempters. *American Behavioral Scientist, 46*, 1258-1268.

Holden, R. R., & DeLisle, M. M. (2005). Factor analysis of the Beck Scale for Suicide Ideation with female suicide attempters. *Assessment, 12,* 231-238.

Joiner, T. E. (2005). *Why people die by suicide.* Cambridge, MA: First Harvard University Press.

Joiner, T. E., Rudd, M. D., & Rajab, M. H. (1997). The Modified Scale for Suicidal Ideation: Factors of suicidality and their relation to clinical and diagnostic variables. *Journal of Abnormal Psychology, 106,* 260-266.

Joiner, T. E., Van Orden, K. A., Witte, T. K., & Rudd, M. D. (2009). *The Interpersonal Theory of Suicide: Guidance for Working with Suicidal Clients.* Washington, D.C.: American Psychological Association.

Joiner, T. E., Van Orden K. A., Witte, T. K., Selby, E. A., Ribeiro, J., Lewis, R., & Rudd, M. S. (2009). Main predictions of the interpersonal-psychological theory of suicidal behavior: Empirical tests in two samples of young adults. *Journal of Abnormal Psychology, 118,* 634-646*.*

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

Kroll, J. (2000). Use of no-suicide contracts by psychiatrists in Minnesota. *The American Journal of Psychiatry, 157,* 1684-1686.

Lang, M., Uttaro, T., Caine, E., Carpinello, S., & Felton, C. (2009). Implementing routine suicide risk screening for psychiatric outpatients with serious mental disorders: I. Qualitative results. *Archives of Suicide Research, 13,* 160-168.

Linehan, M. (1991). Cognitive-behavioral treatment of borderline personality disorder. Guilford Press, New York.

Linehan, M., Comtois, K. A,. Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L., et al. (2006). Two year randomized controlled trial and follow-up of dialectical behavior therapy vs. therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry, 63*, 757-766.

Lynch, T. R., Chapman, A. L., & Rosenthal, M. Z. (2006). Mechanisms of change in dialectical behavior therapy: Theoretical and empirical observations. *Journal of Clinical Psychology, 62*(4), 459-480.

Lynch, T. R., Morse, J. Q., Mendelson, T., Robbins, C. (2003). Dialectical behavior therapy for depressed older adults: A randomized pilot study. *American Journal of Geriatric Psychiatry, 11,* 33-45.

McAdams, C. R., & Foster, V. A. (2000). Client suicide: Its frequency and impact on counselors. *Journal of Mental Health Counseling, 22,* 107-122.

McLeavey, B. C., Daly, R. J., Ludgate, J. W. & Murray, C. M. (1994). Interpersonal problem-solving skills training in the treatment of self-poisoning patients. *Suicide and Life-Threatening Behavior, 24*, 382–394.

Miller, M. C., Jacobs, D. G., & Gutheil, T. G. (1998). Talisman or taboo: The controversy of the suicide prevention contract. *Harvard Review of Psychiatry, 6*, 78-87.

Motto, J. A., & Bostrom, A. G. (2001). A randomized controlled trial of post-crisis suicide prevention. *Psychiatric Services, 52,* 828-833.

Peterson, E. M., Luoma, J. B., Dunne, E. (2002). Suicide Survivors' Perceptions of the Treating Clinician. *Suicide and Life-Threatening Behavior, 32,* 158-166.

Putnins, A. L. (2005). Correlates and predictors of self-reported suicide attempts among incarcerated youths. *International Journal of Offender Therapy and Comparative Criminology, 49,* 143-157.

Reynolds, S. K., Lindenboim, N., Comtois, K. A., Murray, A., & Linehan, M. (2006). Risky assessments: Participant suicidality and distress associated with research assessments in a treatment study of suicidal behavior. *Suicide and Life Threatening Behavior, 36,* 19-33.

Rudd, M. D., Joiner, Jr., T. E., & Rajab, M. (1996). Relationships among suicide ideators, attemptors, and multiple attemptors in a young adult sample. *Journal of Abnormal Psychology, 105*, 541-550.

Rudd, M. D., Joiner, T. E., & Rajab, M. H. (2001). Treating suicidality: An effective time-limited approach. New York: Guilford Press.

Rudd, M.D., Rajab, M. H., Orman, D.T., Joiner, T., Stulman, D.A., & Dixon W. (1996). Effectiveness of an outpatient intervention targeting suicidal young adults: Preliminary results. *Journal of Consulting and Clinical Psychology, 64*(1), 179-190.

Salkovskis, P. M., Atha, C., & Storer, D. (1990). Cognitive-behavioural problem solving in the treatment of patients who repeatedly attempt suicide. A controlled trial. *British Journal of Psychiatry, 157,* 871-876.

Shneidman, E. S. (1993). *Suicide as Psychache: A clinical approach to self-destructive behavior*. Northvale, NJ: Jason Aronson.

Shneidman, E. S. (1996*). The suicidal mind*. New York: Oxford University Press. Shneidman,

E. S. (2004). *Autopsy of a suicidal mind*. New York: Oxford University Press. Shneidman, E. S.

(2005). How I read. *Suicide and Life Threatening Behavior, 38*(4), 375‐386.

Simon, R. I. (2002). Suicide risk assessment: What is the standard of care? *The Journal of the American Academy of Psychiatry and the Law, 30,* 340‐344.

Simon, R. I. (2009). Suicide risk assessment forms: Form over substance? *The Journal of the American Academy of Psychiatry and the Law, 37,* 290‐293.

Sourander, A., Helstelä, L., Haavisto, A. & Bergroth, L. (2001). Suicidal thoughts and attempts among adolescents: A longitudinal 8‐year follow‐up study. *Journal of Affective Disorders, 63,* 59–66.

Suicide Prevention Resource Center. (2008). *Clinical competencies: Assessing & managing suicide risk*. Washington, DC: Education Development Center.

Wenzel, A., Brown, G.K., Beck, A. (2009). *Cognitive therapy for suicidal patients: Scientific and clinical applications*. American Psychological Association, Washington, DC.

Wingate, L. R., Van Orden, K. A., Joiner, T. E. Jr, Williams, F. M., Rudd, M. D. (2005). Comparison of compensation and capitalization models when treating suicidality in young adults. *Journal of Consulting and Clinical Psychology,73*(4), 756‐62.