

Responding to Suicidal Risk

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This chapter is divided into the following sections:

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4. avoidable pitfalls: advice from the experts (Norman Farberow, Marsha Linehan, Nadine Kaslow, Ricardo Munoz, Jessica Henderson Daniel, David Rudd, Daid Barlow, Erika Fromm, Larke Nahme Huang, Gary Schoener, Marla Craig, Jesse Geller, Don Hiroto, Helen Block Lewis, Hans Strupp, Michael Peck)
5. difficult scenarios & questions
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Few responsibilities are so heavy and intimidating as responding to suicidal risk. The need for careful assessment is great. Suicide remains among the top dozen causes of death in the United States, as high as number two for some groups. Homicide rates seize popular attention, but far more people kill themselves than kill others. Authorities in the field are almost unanimous in their view that the reported figures vastly understate the actual incidence because of problems in reporting procedures.

Evaluating and responding to suicidal risk is a source of extraordinary stress for many therapists. This aspect of our work focuses virtually all of the troublesome issues that run through this book: questions of the therapist's influence, competence, efficacy, fallibility, over- or under-involvement, responsibility, and ability to make life-or-death decisions. Litman's (1965) study of over 200 clinicians soon after their clients had committed suicide found the experience to have had an almost nightmarish quality. They tended to have intense feelings of grief, loss, and sometimes depression as anyone—professional or nonprofessional—might at the death of

someone they cared about. But they also had feelings associated with their professional role as psychotherapist: guilt, inadequacy, self-blame, and fears of being sued, investigated, or vilified in the media. In a similar study, both the short-term and permanent effects of a client's suicide upon the therapist were so intense that Goldstein and Buongiorno (1984) recommended providing support groups for surviving therapists.

Solo practitioners may be even more vulnerable than their colleagues who practice within the contexts of institutions with their natural support systems. Those in training may constitute one of the most vulnerable groups. Kleespies, Smith, and Becker (1990) found that "trainees with patient suicides reported stress levels equivalent to that found in patient samples with bereavement and higher than that found with professional clinicians who had patient suicides" (p. 257). They recommend that all training programs have a protocol for assisting trainees with client suicide: "There is a need for an immediate, supportive response to the student to prevent traumatization and minimize isolation . . . and . . . for a safe forum that will allow the student to express his or her feelings, will ensure positive learning from the experience, and will help the student to integrate it constructively into future work with high-risk patients" (pp. 262-263).

If the challenges of helping the suicidal client evoke extraordinary feelings of discomfort from many therapists, they also show the extraordinary efforts that some therapists take to help their clients stay alive. Davison and Neale (1982), for instance, described the ways in which "the clinician treating a suicidal person must be prepared to devote more energy and time than he or she usually does even to psychotic patients. Late-night phone calls and visits to the patient's home may be frequent."

Bruce Danto, a former director of the Detroit Suicide Prevention Center and former president of the American Association of Suicidology, stated: "With these problems, you can't simply sit back in your chair, stroke your beard and say, 'All the work is done right here in my office with my magical ears and tongue.' There has to be a time when you shift gears and become an activist. Support may involve helping a patient get a job, attending a graduation or play, visiting a hospital, even making house calls. I would never send somebody to a therapist who has an unlisted phone number. If therapists feel that being available for phone contact is an imposition, then they're in the wrong field or they're treating the wrong patient. They should treat only well people. Once you decide to help somebody, you have to take responsibility down the line" (Colt, 1983, p. 50).

Norman Farberow, one of the preeminent pioneers in the treatment of the suicidal client, described instances in which the therapist provided very frequent and very long sessions (some lasting all day) to a severely suicidal client as "examples of the extraordinary measures which are sometimes required to enable someone to live. Providing this degree of availability to the client gives the client evidence of caring when that caring is absolutely necessary to convince that client that life is both livable and worth living, and nothing less extreme would be effective in communicating the caring. In such circumstances, all other considerations -- dependence, transference, countertransference, and so on --become secondary. The overwhelming priority is to help the client stay alive. The secondary issues—put 'on hold' during the crisis—can be directly and effectively addressed once the client is in less danger" (Farberow, 1985, p. C9).

Stone (1982) describes a vivid example of the lengths to which a therapist can go to communicate caring in an effective and therapeutic manner to a client in crisis. Suffering from schizophrenia, a young woman who had been hospitalized during a psychotic episode continuously vilified her therapist for "not caring" about her. Without warning, she escaped from the hospital: "The therapist, upon hearing the news, got into her car and canvassed all the bars and social clubs in Greenwich Village which her patient was known to frequent. At about midnight, she found her patient and drove her back to the hospital. From that day forward, the patient grew calmer, less impulsive, and made great progress in treatment. Later, after making substantial recovery, she told her therapist that all the interpretations during the first few weeks in the hospital meant very little to her. But after the 'midnight rescue mission' it was clear, even to her, how concerned and sincere her therapist had been from the beginning" (p. 171)

Assessing Suicidal Risk

Awareness of the following twenty factors may be useful to clinicians evaluating suicidal risk. Four qualifications are particularly important. First, the comments concerning each factor are extremely general, and exceptions are frequent. In many instances, two or more factors may interact. For example, being married and being younger, taken as individual factors, tend to be associated with lower risk for suicide. However, married teenagers have historically shown an extremely high suicide rate (Peck & Seiden, 1975). Second, the figures are not static; new research is refining our understanding of the data as well as reflecting apparent changes. The suicide rate for women, for example, has been increasing, bringing it closer to that for men. Third, the list is not comprehensive. Fourth, these factors may be useful as general guidelines but

cannot be applied in an unthinking, mechanical, conclusive manner. A given individual may rank in the lowest-risk category of each of these factors and nonetheless commit suicide. These factors can legitimately function as aids to, not as substitutes for, a comprehensive, humane, and personal evaluation of suicidal risk for a unique person. Again it is worth emphasizing a central theme of this book's approach to ethics: Perhaps the most frequent threat to ethical behavior is the therapist's inattention. Making certain that we consider such factors with each client can help us prevent the ethical lapses that come from neglect.

1. *Direct verbal warning.* A direct statement of intention to commit suicide is one of the most useful single predictors. Take any such statement seriously. Resist the temptation to reflexively dismiss such warnings as "a hysterical bid for attention," "a borderline manipulation," "a clear expression of negative transference," "an attempt to provoke the therapist," or "yet another grab for power in the interpersonal struggle with the therapist." It may be any or all of those and yet still foreshadow suicide.
2. *Plan.* The presence of a plan increases the risk. The more specific, detailed, lethal, and feasible the plan, the greater the risk.
3. *Past attempts.* Most, and perhaps 80 percent of, completed suicides were preceded by a prior attempt. Schneidman (1976) found that the client group with the greatest suicidal rate were those who had entered into treatment with a history of at least one attempt.
4. *Indirect statements and behavioral signs.* People planning to end their lives may communicate their intent indirectly through their words and actions—for example, talking about "going away," speculating on what death would be like, giving away their most valued possessions, or acquiring lethal instruments.
5. *Depression.* The suicide rate for those with clinical depression is about twenty times greater than for the

general population. Guze and Robins (1970; see also Vuorilehto, Melartin, & Isometsa, 2006), in a review of seventeen studies concerning death in primary affective disorder, found that fifteen percent of the individuals suffering from this disorder killed themselves. Effectively treating depression may lower the risk of suicide (Gibbons, Hur, Bhaumik, & Mann, 2005; Mann, 2005)

6. *Hopelessness*. The sense of hopelessness appears to be more closely associated with suicidal intent than any other aspect of depression (Beck, 1990; Beck, Kovaks & Weissman, 1975; Maris, 2002; Petrie & Chamberlain, 1983; Wetzel, 1976; however, see also Nimeus, Traskman-Bendz & Alsen, 1997).
7. *Intoxication*. Between one-fourth and one-third of all suicides are associated with alcohol as a contributing factor; a much higher percentage may be associated with the presence of alcohol (without clear indication of its contribution to the suicidal process and lethal outcome). Moscicki (2001; see also Kõlves, Värnik, Tooding, & Wasserman, 2006; Sher, 2006) notes that perhaps as many as half of those who kill themselves are intoxicated at the time. Hendin and his colleagues' study of "Problems in Psychotherapy With Suicidal Patients" emphasized that "Addressing and treating suicidal patients' substance abuse, particularly alcohol abuse, is critical in effective treatment of other problems, including lack of response to antidepressant medication" (2006, p. 71).
8. *Clinical syndromes*. As mentioned earlier, people suffering from depression or alcoholism are at much higher risk for suicide. Other clinical syndromes may also be associated with an increased risk. Perhaps as

many as 90% of those who take their own lives have a DSM-IV diagnosis (Moscicki, 2001). Kramer, Pollack, Redick, and Locke (1972) found that the highest suicide rates exist among clients diagnosed as having primary mood disorders and psychoneuroses, with high rates also among those having organic brain syndrome and schizophrenia. Palmer, Pankratz, and Bostwick (2005) found that the lifetime risk for suicide among people with schizophrenia was around 5%. Drake, Gates, Cotton, and Whitaker (1984) discovered that those suffering from schizophrenia who had very high internalized standards were at particularly high risk. In a long-term study, Tsuang (1983) found that the suicide rate among the first-degree relatives of schizophrenic and manic-depressive clients was significantly higher than that for a control group of relatives of surgery patients; furthermore, relatives of clients who had committed suicide showed a higher rate than relatives of clients who did not take their lives. Using meta-analytic techniques, Harris and Barraclough (1997) obtained results suggesting that "virtually all mental disorders have an increased risk of suicide excepting mental retardation and dementia. The suicide risk is highest for functional and lowest for organic disorders" (p. 205).

9. *Sex.* The suicide rate for men is about four times that for women (Joiner, 2005). For youths, the rate is closer to five to one (see, e.g., Safer, 1997). The rate of suicide attempts for women is about three times that for men.
10. *Age.* The risk for suicide tends to increase over the adult life cycle, with the decade from the mid fifties

to the mid sixties constituting the age span of highest risk. Attempts by older people are much more likely to be lethal. The ratio of attempts to completed suicides for those up to age sixty-five is about seven to one, but is two to one for those over sixty-five. Suicide risk assessment differs also according to whether the client is an adult or minor. The assessment of suicidal risk among minors presents special challenges. Safer's review of the literature indicated that the "frequent practice of combining adult and adolescent suicide and suicide behavior findings can result in misleading conclusions" (1997, p. 61). Zimetkin, Alter, and Yemini (2001) note that the "rate of suicide among adolescents has significantly increased in the past 30 years. In 1998, 4153 young people aged 15 to 24 years committed suicide in the United States, an average of 11.3 deaths per day. Suicide is the third leading cause of death in this age group and accounts for 13.5% of all deaths.... Children younger than 10 years are less likely to complete suicide, and the risk appears to increase gradually in children between 10 and 12 years of age. However, on average, 170 children 10 years or younger commit suicide each year" (p. 3122).

11. *Race*. Generally in the United States, Caucasians tend to have one of the highest suicide rates. Gibbs (1997) discusses the apparent cultural paradox: "African-American suicide rates have traditionally been lower than White rates despite a legacy of racial discrimination, persistent poverty, social isolation, and lack of community resources" (p. 68). EchoHawk (1997) notes that the suicide rate for

Native Americans is "greater than that of any other ethnic group in the U.S., especially in the age range of 15-24 years" (p. 60).

12. *Religion*. The suicide rates among Protestants tend to be higher than those among Jews and Catholics.
13. *Living alone*. The risk of suicide tends to be reduced if someone is not living alone, reduced even more if he or she is living with a spouse, and reduced even further if there are children.
14. *Bereavement*. Brunch, Barraclough, Nelson, and Sainsbury (1971) found that 50 percent of those in their sample who had committed suicide had lost their mothers within the last three years (compared with a 20 percent rate among controls matched for age, sex, marital status, and geographic location). Furthermore, 22 percent of the suicides, compared with only 9 percent of the controls, had experienced the loss of their father within the past five years. Krupnick's (1984) review of studies revealed "a link between childhood bereavement and suicide attempts in adult life," perhaps doubling the risk for depressives who had lost a parent compared to depressives who had not experienced the death of a parent. Klerman and Clayton (1984; see also Beutler, 1985) found that suicide rates are higher among the widowed than the married (especially among elderly men) and that, among women, the suicide rate is not as high for widows as for the divorced or separated.
15. *Unemployment*. Unemployment tends to increase the risk for suicide.
16. *Health status*. Illness and somatic complaints are associated with increased suicidal risk, as are disturbances in patterns of sleeping and eating.

Clinicians who are helping people with AIDS, for example, need to be sensitive to this risk (Pope & Morin, 1990).

17. *Impulsivity*. Those with poor impulse control are at increased risk for taking their own lives (Patsiokas, Clum & Luscumb, 1979).
18. *Rigid thinking*. Suicidal individuals often display a rigid, all-or-none way of thinking (Maris, 2002; Neuringer, 1964). A typical statement might be: "If I don't find work within the next week then the only real alternative is suicide."
19. *Stressful events*. Excessive numbers of undesirable events with negative outcomes have been associated with increased suicidal risk (Cohen-Sandler, Berman & King, 1982; Isherwood, Adam & Homblow, 1982). Bagley, Bolitho, and Bertrand (1997), in a study of 1,025 adolescent women in Grades 7-12, found that "15% of 38 women who experienced frequent, unwanted sexual touching had 'often' made suicidal gestures or attempts in the previous 6 months, compared with 2% of 824 women with no experience of sexual assault" (p. 341; see also McCauley, Kern, Kolodner, Dill, et al., 1997). Some types of recent events may place clients at extremely high risk. For example, Ellis, Atkeson, and Calhoun (1982) found that 52 percent of their sample of multiple-incident victims of sexual assault had attempted suicide.
20. *Release from hospitalization*. Beck (1967, p. 57) has noted that "the available figures clearly indicate that the suicidal risk is greatest during weekend leaves from the hospital and shortly after discharge."
21. *Lack of a sense of belonging*. Joiner's review of the research and his own studies led him to conclude that

"an unmet need to belong is a contributor to suicidal desire: suicidal individuals may experience interactions that do not satisfy their need to belong (e.g., relationships that are unpleasant, unstable, infrequent, or without proximity) or may not feel connected to others and cared about" (2005, p. 97).

10 Steps To Reduce Risk

The risk of client suicide creates a special set of responsibilities. The themes stressed throughout this book gain exceptional importance: Failure of the therapist to take necessary steps can literally be fatal for the client. The following steps, which extend or supplement this book's themes, may be helpful in identifying and coping with the chance that a client may be at risk for suicide.

1. *Screen all clients for suicidal risk during initial contact and remain alert to this issue throughout the therapy.*

Even clients who are seriously thinking of taking their own life may not present the classic picture of agitated depression or openly grim determination that is stereotypically (and sometimes falsely) portrayed as characteristic of the suicidal individual. Some suicidal clients seem, during initial sessions, calm, composed, and concerned with a seemingly minor presenting problem. Clients who are not suicidal during initial sessions and who sought therapy for a relatively minor problem may, during the course of therapy, become suicidal. The increase in suicidal risk may be due to external events, such as the loss of a job or a loved one, or to internal events, such as setting aside psychological defenses or the onset of Alzheimer's. What is crucial is an assessment of the client's suicidal potential at adequate intervals. In

some cases, comprehensive psychological testing or the use of standardized scales developed to evaluate suicidal risk may be useful (see, for example, Beck, Resnick & Lettieri, 1974; Butcher, Graham, Williams & Ben-Porath, 1990; Lettieri, 1982; Neuringer, 1974; Nugent, 2006; Schulyer, 1974; Weisman & Worden, 1972). Range and Knott (1997) evaluated 20 suicide assessment instruments for validity and reliability. On the basis of their analysis, they recommended 3 most highly: Beck's Scale for Suicide Ideation series, Linehan's Reasons for living Inventory, and Cole's self-administered adaptation of Linehan's structured interview called the Suicidal Behaviors Questionnaire.

2. *Work with the suicidal client to arrange an environment that will not offer easy access to the instruments the client might use to commit suicide.*
Suicidal clients who have purchased or focused upon a specific gun or other weapon may agree to place the weapon where they will not have access to it until the crisis or period of greatest risk is over. Suicidal clients who are currently taking psychotropic or other medication may be planning an overdose. The use of materials prescribed by and associated with mental health professionals may have great symbolic meaning for the client. Arrange that the client does not have access to sufficient quantities of the medication to carry out a suicidal plan.
3. *Work with the client to create an actively supportive environment.*
To what extent can family, friends, and other

resources such as community agencies and group or family therapy help a suicidal person through a crisis?

4. *While not denying or minimizing the client's problems and desire to die, also recognize and work with the client's strengths and (though temporarily faint) desire to live.*

5. *Make every effort to communicate and justify realistic hope.*

Discuss practical approaches to the client's problems.

6. *Explore any fantasies the client may have regarding suicide.*

Reevaluating unrealistic beliefs about what suicide will and will not accomplish can be an important step for clients attempting to remain alive.

7. *Make sure communications are clear and evaluate the probable impact of any interventions.*

Ambiguous or confusing messages are unlikely to be helpful and may cause considerable harm. The literature documents the hazards of using such techniques as paradoxical intention with suicidal clients. Even well-meant and apparently clear messages may go awry in the stress of crisis. Beck (1967, p. 53) provides an example: "One woman, who was convinced by her psychotherapist that her children needed her even though she believed herself worthless, decided to kill them as well as herself to 'spare them the agony of growing up without a mother.' She subsequently followed through with her plan."

8. *When considering hospitalization as an option, explore the drawbacks as fully as the benefits, the probable long-term and the immediate effects of this intervention.*

Norman Farberow (see Colt, 1983, p. 58), cofounder and former co-director and chief of research at the Los Angeles Suicide Prevention Center, warns: "We tend to think we've solved the problem by getting the person into the hospital, but psychiatric hospitals have a suicide rate more than 35 percent greater than in the community."

9. *Be sensitive to negative reactions to the client's behavior.*

Alan Stone, professor of psychiatry and law at Harvard, has been a pioneer in the acknowledgment of the ways in which some overly fatigued therapists may react with boredom, malice, or even hatred to some suicidal clients. James Chu (quoted by Colt, 1983, p. 56), a psychiatrist in charge of Codman House at McClean Hospital, comments: "When you deal with suicidal people day after day after day, you just get plain tired. You get to the point of feeling, 'All right, get it over with.' The potential for fatigue, boredom, and negative transference is so great that we must remain constantly alert for signs that we are beginning to experience them." Colt notes that "Maltzberger and Buie discuss therapists' repression of such feelings. A therapist may glance often at his watch, feel drowsy, or daydream-or rationalize referral, premature termination, or hospitalization just to be rid of the patient. (Many studies have detailed the unintentional abandonment of suicidal patients; in a 1967 review of 32 suicides . . . Bloom found 'each .

. . . was preceded by rejecting behavior by the therapist.') Sometimes, in frustration, a therapist will issue an ultimatum. Maltzberger recalls one who, treating a chronic wrist-cutter, just couldn't stand it, and finally she said, 'If you don't stop that I'll stop treatment.' The patient did it again. She stopped treatment and the patient killed herself" (1983, p. 57).

10. *Perhaps most important, communicate caring.*

Therapists differ in how they attempt to express this caring. A therapist (cited by Colt, 1983, p. 60) recounts an influential event early in her career: "I had a slasher my first year in the hospital. She kept cutting herself to ribbons—with glass, wire, anything she could get her hands on. Nobody could stop her. The nurses were getting very angry. . . . I didn't know what to do, but I was getting very upset. So I went to the director, and in my best Harvard Medical School manner began in a very intellectual way to describe the case. To my horror, I couldn't go on, and I began to weep. I couldn't stop. He said, 'I think if you showed the patient what you showed me, I think she'd know you cared.' So I did. I told her that I cared, and that it was distressing to me. She stopped. It was an important lesson." The home visits, the long and frequent sessions, the therapist's late-night search for a runaway client, and other special measures mentioned earlier are ways some therapists have found useful to communicate this caring, although such approaches obviously would not fit all therapists, all clients, or all theoretical orientations. One of the most fundamental aspects of this communication of caring is the therapist's willingness to listen, to take seriously what the client has to say.

Farberow (1985, p. C9) puts it well: "If the person is really trying to communicate how unhappy he is, or his particular problems, then you can recognize that one of the most important things is to be able to hear his message. You'd want to say, 'Yes, I hear you. Yes, I recognize that this is a really tough situation. I'll be glad to listen. If I can't do anything, then we'll find someone who can.'"

Avoidable Pitfalls: Advice from Experts

A central theme of this book is that inattention or a lack of awareness is a—if not the—most frequent cause for a therapist's violation of his or her clinical responsibilities and of the client's trust. We asked a number of prominent therapists with expertise in identifying and responding to suicidal risk to discuss factors that contribute to therapists' inattention or lack of awareness when working with potentially suicidal clients. Careful attention to these factors can enable therapists to practice more responsively and responsibly.

Norman Farberow, Ph.D., cofounder and former co-director and chief of research at the Los Angeles Suicide Prevention Center, believes that there are four main problem areas. First, therapists tend to feel uncomfortable with the subject; they find it difficult to explore and investigate suicidal risk: "We don't want to hear about it. We discount it. But any indication of risk or intention must be addressed." Second, we must appreciate that each client is a unique person: "Each person becomes suicidal in his or her own framework. The person's point of view is crucial." Third, we tend to forget the preventive factors: "Clinicians run scared at the thought of suicide. They fail to recognize the true resources." Fourth, we fail to consult: "Outside opinion is invaluable."

Marsha Linehan, Ph. D., ABPP is a Professor of Psychology, Adjunct Professor of Psychiatry and Behavioral Sciences at the University of Washington and Director of the Behavioral Research and Therapy Clinic. Her primary research is development of effective treatments for suicidal behaviors, drug abuse, and borderline personality disorder. She believes that

the single biggest problem in treating suicidal clients is that most therapists have inadequate training and experience in the assessment and treatment of suicidal behaviors. More distressing than that is that there does not appear to be a hue and cry from practicing therapists demanding such training. Deciding to limit one's practice to non-suicidal clients is not a solution because individuals can and do become suicidal after entering treatment. Secondary problem are as follows. 1) Therapists treating clients with disorders that make them high risk for suicide (e.g., depression, borderline personality disorder, bipolar disorder) do not ask about suicide ideation and planning in a routine, frequent way: depending on clients who have decided to kill themselves to first communicate risk directly or indirectly can be a fatal mistake. 2) Fears of legal liability often cloud therapists' abilities to focus on the welfare of the client: fear interferes with good clinical judgment. Many outpatient therapists simply "dump" their suicidal clients onto emergency and inpatient facilities believing that this will absolve them of risk. There is no empirical data that emergency department and/or inpatient treatment reduces suicide risk in the slightest and the available literature could support a hypothesis that it may instead increase suicide risk. 3) Therapists often do not realize that when treating a highly suicidal client they must be available by phone and otherwise after hours: treating a highly suicidal client requires personally involved clinical care.

Nadine J. Kaslow, Ph.D., ABPP, Professor and Chief Psychologist at Emory School of Medicine, a well-funded researcher on the assessment and treatment of abused and suicidal African American women, and the recipient of the American Psychological Association's 2004 award for Distinguished Contributions to Education and Training told us that

assessment and intervention of suicidal persons needs to be culturally competent, gender sensitive, and developmentally informed. Our approach to suicidal individuals needs to consider both the relevant evidence base and sensitive attention to the person's unique struggles, strengths, and sociocultural context. We need to interact with suicidal people with compassion and a desire to understand why their pain feels so intolerable that they believe that suicide will offer the only form of relief. It is always important to take suicidal concerns seriously, convey an appreciation for the person's plight, and engage in a collaborative process. Since suicidal people often feel socially isolated and social support is a buffer against suicidal behavior, it is imperative that we assist suicidal men and women in mobilizing their social support networks. We must build upon people's strengths, help them find meaning and hope, and empower them to

overcome the trials and tribulations that lead them to feel and think that life is not worth living. As therapists, we will find our own countertransference reactions to be a very useful guide with regards to risk assessment, disposition planning, and the implementation of therapeutic strategies. Our own histories with suicide, whether that be our own suicidality, the loss of a loved one to suicide, or the death of a former patient to suicide, will greatly impact how we approach and respond to people who think actively about suicide, take steps to end their own life, or actually kill themselves. Our histories and reactions can also be instrumental in our efforts to help suicidal people heal from their pain so that they find life worth living. This in turn, enriches our own lives.

Ricardo F. Munoz, Ph.D., is professor of psychology at the University of California, San Francisco; is principal investigator on the N.I.M.H.-funded Depression Prevention Research Project involving English, Spanish, and Chinese-speaking populations; and is coauthor of *Control Your Depression*. Here are his thoughts:

First, clinicians often fail to identify what suicidal clients have that they care about, that they are responsible for, that they can live for. Include animals, campaigns, projects, religious values. Second, inexperienced liberal therapists in particular may fall into the trap of attempting to work out their philosophy regarding the right to die and the rationality or reasonableness of suicide while they are working with a client who is at critical risk. These issues demand careful consideration, but postponing them till the heat of crisis benefits no one. In the same way that we try to convince clients that the darkest hour of a severe depressive episode is not a good time to decide whether to live or die, clinicians must accept that while attempting to keep a seriously suicidal person alive is not a good time to decide complex philosophical questions. Third, don't overestimate your ability to speak someone else's language. Recently, a Spanish-speaking woman, suicidal, came to the emergency room talking of pills. The physician, who spoke limited Spanish, obtained what he thought was her promise not to attempt suicide and sent her back to her halfway house. It was later discovered that she'd been saying that she'd already taken a lethal dose of pills and was trying to get help.

Jessica Henderson Daniel, PhD, ABPP, Director of Training in Psychology in the Department

of Psychiatry and Associate Director of the Leadership Education in Adolescent Health Training Program in the Division of Adolescent Medicine, at Boston's Children's Hospital states:

As some adolescents can be prone to be dramatic i.e. saying things that they do not mean, there can be a reluctance to take comments about suicide seriously. The adolescent may make several statements before actually engaging in suicidal behavior. The adolescent needs to know that such comments are in fact taken seriously and that action may be taken i.e. follow-up by their therapist, evaluation in the ER and/or inpatient hospitalization. Also, adolescents can become very upset about matters that may seem trivial to adults. Providers are reminded that the perspective of the patient trumps their views. When adolescents are in the midst of despair, minimizing the worry, hurt, and hopelessness can be problematic. Some providers may feel that life really cannot be that bad. Then, parents matter. With adolescents, state regulations can determine the legal role of parents. It is important to know this information. Should parents be legally responsible for their adolescent, providers may be reluctant to override the decision of parents who cannot bear to think that their child may be suicidal and who insist on taking them home. When the patient is a child or an adolescent, the parents are critical part of the management of the case and may need their own providers as well. Finally, consultation is critical in thinking through how to best provide under the particular circumstances.

M. David Rudd, Ph.D., is Professor and Chair of the Department of Psychology at Texas Tech University and Past-President, American Association of Suicidology and President-Elect of APA, Division 12, Section VII (Behavioral Emergencies). He told us:

One of the all too frequently neglected areas in suicide risk assessment is recognizing, discussing and implementing a distinction between acute and chronic risk. Assessment of acute risk alone is how the overwhelming majority of clinicians approach the task. Over the last decade, converging scientific evidence suggests it is important to address enduring or “chronic” suicidality in patients. More specifically, those that have made two or more suicide attempts likely have a “chronic” aspect to their presentation. Although acute risk may well resolve, it is important for the clinician to make a note about the individual’s enduring vulnerabilities and continuing suicide risk. It’s as straightforward as making a note such as: “Although acute risk has resolved, the patient has made three previous suicide attempts and there are aspects of the clinical scenario that suggest chronic risk for suicide. More specifically, the patient’s history of

previous sexual abuse, episodic alcohol and cannabis abuse, along with two previous major depressive episodes, all indicate the need for longer-term and continuing care in order to more effectively treat these chronic markers of risk.”

David H. Barlow, Ph.D., is a Diplomate in clinical psychology and Director of the Center for Anxiety and Related Disorders at Boston University. He is former President of the Society of Clinical Psychology of APA, and maintains a private practice. He believes that there are 2 common problems often encountered in working with young or inexperienced therapists confronting a possible suicidal patient:

First, after forming an alliance with a new patient, some therapists begin to spin away from a professional, objective clinical stance and treat seemingly offhand comments about not wanting to live as casual conversation that might be occurring after work over a drink with a friend or in a college dormitory. Thus, they may respond sympathetically but not professionally, by downplaying the report. "Sometimes I feel that way too--I can understand how you'd get to that place..." Of course, one must always step back if this comes up and conduct the proper exam for intent, means etc., and take appropriate action. Second, some therapists undervalue the power of a contract, since patients sometimes say something like "Well...I'll say that if you want me to , but I don't know if my word is worth anything." The fact is--in the context of a good therapeutic relationship, the contract is very powerful, the occasional report to the contrary notwithstanding.

The late **Erika Fromm**, Ph.D., a diplomate in both clinical psychology and clinical hypnosis, was professor emeritus of psychology at the University of Chicago, clinical editor of *The Journal of Clinical and Experimental Hypnosis*, and recipient of the American Psychological Association Division 39 (Psychoanalysis) 1985 Award for Distinguished Contributions to the Field. She stated:

Perhaps it's the countertransference or the highly stressful nature of this work, but some clinicians seem reluctant to provide suicidal patients anything more than minimal reassurance. We need to realize that the people who are about to take their own lives are crying out, are communicating their feelings that no one really cares about them. They are crying, in the only way they know how: "Show me that you really care!" It is so important for us to communicate that we care about them. When my patients are suicidal, I tell them that I care deeply about them and am fond of them. I do everything I can to let them know this."

Larke Nahme Huang, Ph.D., formerly on the faculty of the University of California, Berkeley, is currently an independent research and clinical consultant in the Washington, D.C., area. She stresses the problems involved in treating people with schizophrenia:

Especially as the treatment becomes a matter of years, there's a tendency to become less sensitive, to forget how painful their life can be. This can lead to problems as the clinician sets ever higher goals as the client continues to improve. A client can experience these goals as insufferable pressure. Frequently the client may make a very serious suicide attempt in an effort to escape the pressure. In working with people with severe disorders, clinicians may need to utilize hospitalization in times of crisis. Inpatient management issues, power struggles, rivalries between professional disciplines, and so on can aggravate the client's crisis. Don't wait until the last minute, when you're in the midst of a crisis, to learn about these realities and to take steps to prevent them from adding to your client's distress.

Gary Schoener, Clinical Psychologist and Executive Director of the Walk-In Counseling Center in Minneapolis for more than 33 years, consults, trains, and testifies around North America concerning professional boundaries and clinical supervision. He states:

Four most common deadly failures are (1) the failure to screen for the possession of firearms (it's not enough to ask about "weapons") with all distressed clients; (2) when acute suicidality becomes chronic, failure to appropriately refer to a DBT [Dialectic Behavior Therapy] program or qualified provider for cases of chronic suicidality; (3) reliance on the QPR [Question, Persuade, Refer] method with refugees and others, especially Muslims, for whom suicide is a serious sin and who should not be asked directly about suicidal thinking; and (4) over-reliance on "no-suicide agreements" despite the fact that they do not work. (No problem in using them clinically, but don't count on them.)

Marla C. Craig, Ph.D., psychologist and director of outreach services and special projects at the Counseling & Consultation Center, and an instructor and coordinator of a campus-wide suicide prevention program at St. Edward's University. She reported that:

Most clinicians may not know that suicide is the second leading cause of death among college students. This information is important since there may be a tendency for clinicians not to take college students' presenting concerns seriously enough. Presenting concerns such as academic and relationship difficulties may mask the underlying condition of depression. Also, stereotypes of college students' being overly dramatic and emotional with fluctuating moods and situations can interfere with a clinician's judgment to thoroughly assess for suicide. It also may be easy for clinicians to forget that traditional college students are still adolescents transitioning into young adulthood, and they may or may not be able to verbally identify what is going on internally/emotionally. Hence, it is important to assess for suicide even if the college student does not present as depressed. Finally, due to confidentiality and college students being 18 years of age and older, clinicians may be reluctant to get parents involved. If the parents are a source of support, do not hesitate to work with the college student to get them involved.

Jesse Geller, Ph.D., formerly director of the director of the Yale University Psychological Services Clinic and director of the Psychotherapy Division of the Connecticut Mental Health Center, currently maintains an independent practice. He told us:

One of the two main problems in treating suicidal patients is our own anger and defensiveness when confronted by someone who does not respond positively—and perhaps appreciatively—to our therapeutic efforts. It can stir up very primitive and childish feelings in us—we can start to feel vengeful, withholding, and spiteful. The key is to become aware of these potential reactions and not to act them out in our relationship with the patient. The other main problem seems to be more prevalent among beginning therapists. When we are inexperienced, we may be very cowardly regarding the mention of suicide in our initial interviews. We passively wait for the patient to raise the subject and we may unconsciously communicate that the subject is "taboo." If the subject does come up, we avoid using "hot" language such as "murder yourself" or "blow your brains out." Our avoidance of clear and direct communication, our clinging to euphemisms implies to the patient that we are unable to cope with his or her destructive impulses.

Don Hiroto, Ph.D., maintains a private practice, is chief of the Depression Research Laboratory at the Brentwood Veterans Administration Medical Center, and is a former president of the Los

Angeles Society of Clinical Psychologists. He believes that a major area of difficulty involves alcohol use:

Alcoholics may constitute the highest risk group for violent death. The potential for suicide among alcoholics is extraordinarily high. At least 85 percent of completed suicides show the presence of at least some level of alcohol in their blood. There are two aspects to the problem for the clinician. First, there is the tendency for us to deny or minimize alcohol consumption as an issue when we assess all of our clients. Second, we are not sufficiently alert to the suicidal risk factors which are especially associated with alcoholics: episodic drinking, impulsivity, increased stress in relationships (especially separation), alienation, and the sense of helplessness.

The late *Helen Block Lewis*, Ph.D., was a diplomate in clinical psychology who maintained a private practice in New York and Connecticut; she also was professor emeritus at Yale University, president of the American Psychological Association Division of Psychoanalysis, and editor of *Psychoanalytic Psychology*. She believed that therapists tend to pay insufficient attention to the shame and guilt their clients experience. For example, clients may experience a sense of shame for needing psychotherapy and for being "needy" in regard to the therapist. The shame often leads to rage, which in turn leads to guilt because the client is not sure if the rage is justified. According to Lewis, the resultant "shame/rage" or "humiliated fury" can be a major factor in client suicides:

Clients may experience this progression of shame-rage-guilt in many aspects of their lives. It is important for the therapist to help the client understand the sequence not only as it might be related to a current incident 'out there' but also as it occurs in the session. Furthermore, it is helpful for clients who are in a frenzied suicidal state to understand that the experience of shame and guilt may represent their attempt to maintain attachments to important people in their lives. Understanding these sequences is important not only for the client but also for the therapist. It is essential that we maintain good feelings for our clients. Sometimes this is difficult when the client is furious, suicidal, and acting out. Our understanding that such feelings and behaviors by a client represent desperate attempts to maintain a connection can help us as therapists to function effectively and remain in touch with our genuine caring for the client.

Michael Peck, Ph.D., a diplomate in clinical psychology, maintains a private practice and was a consultant to the Los Angeles Suicide Prevention Center. He observes, "Many therapists fail to consult. Call an experienced clinician or an organization like the L.A. Suicide Prevention Center. Review the situation and get an outside opinion. Therapists may also let a client's improvement (for example, returning to school or work) lull them to sleep. Don't assume that if the mood is brighter, then the suicidal risk is gone." He stresses the importance of keeping adequate notes, including at least the symptoms, the clinician's response, and consultations and inquiries. "There are special issues in treating adolescents," Peck adds. "When they're under sixteen, keep the parents informed. If they are seventeen (when the client, rather than the parents, possesses the privilege) or older but still living with the parents, tell the client that you will breach confidentiality only to save his or her life. In almost every case, the family's cooperation in treatment is of great importance."

The late **Hans Strupp**, Ph.D., was a diplomate in clinical psychology, distinguished professor of psychology, and director of clinical training at Vanderbilt University. He believed that one of the greatest pitfalls is the failure to assess suicidal potential comprehensively during initial sessions. Another frequent error, he told us, is that there too often is a failure to have in place a network of services appropriate for suicidal clients in crisis: "Whether it is an individual private practitioner, a training program run by a university . . . , a small . . . clinic, or [therapists] associated in group practice—there needs to be close and effective collaboration with other mental health professions . . . and with facilities equipped to deal with suicidal emergencies. I'm not talking about pro forma arrangements but a genuine and effective working relationship. In all cases involving suicidal risk, there should be frequent consultation and ready access to appropriate hospitals."

Difficult Scenarios and Questions

You've been working with a moderately depressed client for 4 months. You feel that you have a good rapport but the treatment plan doesn't seem to be doing much good. Between sessions you check your answering machine and find this message from the client: "I want to thank you for trying to help me, but now I realize that nothing will do me any good. I won't be seeing you or

anyone else ever again. I've left home and won't be returning. I didn't leave any notes because there really isn't anything to say. Thank you again for trying to help. Goodbye." Your next client is scheduled to see you in 2 minutes and you have clients for the next 4 hours.

1. What feelings do you experience?
2. What do you want to do?
3. What are your options?
4. What do you think you would do?
5. If there are things that you want to do but don't do, why do you reject these options?
6. What do you believe that your ethical and legal obligations are?
7. Are there any contradictions between your legal responsibilities and constraints and what you believe is ethical?
8. To what extent do you believe that your education and training have prepared you to deal with this situation?

You have been working with a client within a managed care framework. You believe that the client is at considerable risk for suicide. The case reviewer disagrees and, noting that the approved number of sessions have been provided, declines, despite your persistent protests, to approve any additional sessions.

1. How do you feel?
2. What are your options?
3. What do you believe your legal obligations to client are?

4. What do you believe your ethical responsibilities to the client are?
5. What would you do?

You have been providing family therapy to a mother and father and their 3 adolescents for 4 sessions. After the fourth session, you find that one of the adolescents has left a note on your desk. Here is what the note says: "My father has molested me for the last 2 years. He has threatened to kill my mother and me if anyone else finds out. I could not take it if you told anyone else. If you do, I will find a way to kill myself." Your clinical judgment, based on what you've learned during the course of the 4 sessions, is that the adolescent is extremely likely to commit suicide under those circumstances.

1. How do you feel?
2. More specifically, what are your feelings about the client who left you the note? What are your feelings about the father? What are your feelings about the mother? What are your feelings about the other 2 adolescents?
3. What do you believe that your legal obligations are?
4. What do you believe that your ethical responsibilities are?
5. What, if any, conflicts do you experience? How do you go about considering and deciding what to do about these conflicts?
6. What do you believe that you would do?

A client you've been seeing in outpatient therapy for 2 years doesn't show up for an appointment. The client has been depressed and has recently experienced some personal and

occupational disappointments but the risk of suicide as you've assessed it has remained at a very low level. You call the client at home to see if the person has forgotten the appointment or if there's been a mix-up in scheduling. You reach a family member who tells you that the client has committed suicide.

1. What do you feel?
2. Are there any feelings that are difficult to identify or put into words?
3. What options do you consider?
4. Do you tell the family member that you were the person's therapist? Why or why not?
5. What, if anything, do you volunteer to tell the family?
6. Do you attend the funeral? Why or why not? Do you send flowers? Why or why not?
7. If a family member says that the suicide must have been your fault, what do you feel? What would you do?
8. Do you tell any of your friends or colleagues? Why? What concerns, if any, do you have?
9. Do your case notes and documentation show your failure to assess accurately the client's suicidal risk? Why or why not? Do you have any concerns about your documentation?

You've been discussing a new HMO patient, whom you've seen for 3 outpatient sessions, with both your clinical supervisor and the chief of outpatient services. The chief of services strongly believes that the client is at substantial risk for suicide but the clinical supervisor believes just as strongly that there is no real risk. You are caught in the middle, trying to create a treatment plan

that makes sense in light of the conflicting views of the 2 people to whom you report. One morning you arrive at work and are informed that your clinical supervisor has committed suicide.

1. What do you feel?
2. Are there any feelings that are particularly difficult to identify, acknowledge, or articulate?
3. How, if at all, do you believe that this might influence your work with any of your patients?
4. Assume that at the first session you obtained the client's written informed consent for the work to be discussed with this particular clinical supervisor who has been counter-signing the client's chart notes. What, if anything, do you tell the client about the supervisor's suicide or the fact that the clinical work will now be discussed with a new supervisor?
5. To what extent has your graduate training and internship addressed issues of clinician's own suicidal ideation, impulses, or behaviors?

Related Studies:

National studies containing at least one item about suicide that are presented in full-text form on this site:

- [Ethics of Practice: Beliefs & Behaviors of Psychologists as Therapists](#) [*American Psychologist*]
- [Ethical Dilemmas Encountered by Members of the American Psychological Association: A National Survey](#) [*American Psychologist*]

- [Therapists As Patients" A National Survey of Psychologists' Experiences, Problems, and Beliefs](#) [*Professional Psychology: Research & Practice*]
- [Therapists' Anger, Hate, Fear, and Sexual Feelings: A National Survey of Therapist Responses, Client Characteristics, Critical Events, Formal Complaints, and Training](#) [*Professional Psychology: Research & Practice*]
- [Prior Therapist-Patient Sexual Involvement Among Patients Seen by Psychologists](#) [*American Psychologist*]

**This chapter appears in the book *Ethics in Psychotherapy and Counseling: A Practical Guide, 3rd Edition* by Pope & Vasquez, published in 2007 by Jossey-Bass, an imprint of John Wiley (<http://kspope.com/ethics/ethics.php>) . It is included here with the permission of Ken Pope.*