

## Introduction

Those who belong to a community in which they feel loved and valued are much less likely to die from suicide. Unfortunately, many people lack that sense of connection. Often, they end up in the offices of psychotherapists who must help them build or reestablish the social connections and resources needed to make life worth living.

I wrote this book to help psychotherapists become better at assessing, managing, and treating patients who are suicidal. This topic is important to me. During the 1970s and 1980s, I delivered emergency services in two community mental health centers in rural Pennsylvania. I remember the faces and the stories of many of my patients. I remember the young man who shot himself in the head with a pistol (and lived); the young woman who took an overdose of drugs, came into my office the next day, and refused to talk; and the middle-aged mother who hated herself because she had neglected her children years ago during a depressive episode. These memories evoke strong emotions even 40 years later. The emotional quality to these stories is hard to capture fully in written text.

I also worked with the survivors of suicide. They often stated that their lives were shattered by guilt and loneliness. Suddenly they questioned basic assumptions about themselves as good parents or good spouses. Their expectations for the future changed for the worse.

During those years, my colleagues and I tried to deliver effective and respectful services (see Knapp, Dirks, & Magee, 1982). Most patients were cooperative and received outpatient treatment. But some seriously suicidal

patients resisted treatment. Although I was not yet well-versed in bioethical concepts such as beneficence, nonmaleficence, or respect for patient autonomy, my colleagues and I worked hard to get reluctant patients to “buy into” treatment. We believed that we should not force treatment without exhausting efforts to secure the patient’s cooperation.

I made many mistakes during those years, but fortunately none of my patients died from suicide. In part, it was because I had some basic competence in evaluating and managing suicidal patients. I never discounted the possibility of suicide. It is a frightening enemy, and I never underestimated its power. But at the same time, I was lucky. I have known psychotherapists, far more competent than I, who have had patients die from suicide. Since that time that I worked in crisis intervention, I have conducted many workshops on suicide prevention, consulted with many psychologists on suicidal patients, and written articles and book chapters dealing with suicide.

### **INTENDED READERSHIP**

This book is intended for professional psychologists and other psychotherapists who deal with adult outpatients with suicidal behavior. In selecting the content, I ask, “What will psychotherapists with suicidal patients in front of them need to know?” To reach this goal, this book links its recommendations both to science and to the real-life experiences of patients and psychotherapists. It incorporates the most recent research findings on suicide that the well-established books on suicide intervention have not had the opportunity to cover. It emphasizes a caring attitude that is neither alarmist nor dismissive. It identifies competencies that effective psychotherapists need to acquire, including emotional competence and the ability to make ethical decisions.

Suicide is caused by many factors embedded in the personal histories and experiences of every patient. Nonetheless, research has generated some commonalities that can guide effective interventions. I relied on that evidence to inform the recommendations made in this book. I explain suicidal behavior primarily through the lens of the ideation-to-action theories of suicide such as the interpersonal theory of suicide (e.g., Joiner, Van Orden, Witte, & Rudd, 2009), and I justify treatment decisions through the lens of principle-based ethics (e.g., Knapp, VandeCreek, & Fingerhut, 2017). I inserted personal experiences when they illustrated or supported important concepts.

In addition to making specific recommendations, this book also explains why these recommendations were made. No book, no matter how comprehensive, can predict all the contingencies that psychotherapists will face when treating suicidal patients. Therefore, effective psychotherapists will need to modify, discard, or adapt some of the recommendations made herein. Psychotherapists will make better decisions if they understand why the recommendations were made.

Roush et al. (2018) found that psychotherapists who felt the most anxiety around suicidal patients were most likely to endorse interventions lacking in

evidence. Ideally, this book will give psychotherapists more confidence in assessing, managing, and treating suicidal patients; keep them from exaggerated fears of liability; and lead them to study and learn evidence-informed interventions.

## OVERVIEW OF THE BOOK<sup>1</sup>

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Chapter 1 (“Facts, Theories, and Perspectives on Suicide”) describes the public health importance of suicide; attitudes toward suicide in society and among psychotherapists; and essential competencies needed to assess, manage, and treat suicidal patients. Later chapters expand on each of these competencies. Finally, it reviews the ideation-to-action theories of suicide, including the interpersonal theory of suicide and the role of principle-based ethics in informing treatment.

Chapter 2 (“Screening and Assessment”) reviews the steps in screening and assessing suicidal risk, including learning about the patient’s suicide ideation, suicide plans, and past suicide attempts. Also, Chapter 2 expands on the psychological states that often precede suicide attempts. The emotional or behavioral symptoms expressed by the patient in these crisis states can be viewed as warning signs that will help predict the immediate risk of suicide. Also, Chapter 2 emphasizes the importance of establishing and maintaining a good treatment alliance with the patient.

In addition, Chapter 2 describes additional information that psychotherapists need in assessing their patients. It describes certain topics that should be explored, including the patient’s history, recent stressors, social network, physical health, religious or spiritual values, and mental health diagnosis. The ideation-to-action theories of suicide can guide psychotherapists on what patient factors to look for in these evaluations.

Chapter 3 (“Intervention Part One: Including Managing Suicidal Risk”) presents recommendations for the first stages of treatment, which emphasize informed consent, establishment of a good treatment relationship, and suicide management. Chapter 3 describes how psychotherapists can use the fluid vulnerability theory to integrate patient information and determine the appropriate level of care. The goal of suicide management is to keep patients alive until psychotherapy has a chance to work. Psychotherapists can manage suicidal risk through motivating patients (and creating a crisis-response plan), restricting access to lethal means, monitoring patients, and other options to reduce risk.

Chapter 4 (“Intervention Part Two: Suicide-Informed Psychotherapy”) describes how psychotherapists can adopt their interventions to address

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<sup>1</sup> All case examples in this book are either composites of several real patients or single patients whose identifying characteristics have been changed to protect confidentiality.

issues that arise in the treatment of suicidal patients. It does not endorse any one treatment approach but rather recommends that any treatment approach for suicidal patients should consider how to respond when suicide attempts happen during treatment, and so on. Finally, Chapter 4 identifies trans-theoretical interventions that can address the symptoms commonly associated with suicidal behavior and considers how psychotherapists can integrate religion and value perspectives into psychotherapy.

Chapter 5 (“Professional Liability, Quality Enhancement, and Emotional Competence”) describes how to reduce the risk of professional liability. It covers ethically based quality enhancement (risk management) strategies and documentation. Finally, it highlights the importance of emotional competence as an essential quality for doing good clinical work.