Risk Assessment, Treatment Planning, and Management of the At-Risk-for-Suicide Client

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Clinical Suicidology rarely gets the attention it needs in competition with all else that must be taught to the developing clinician. All too often, it is after the fact of a suicide of a client that the MFT is confronted with recognizing this gap in their training.

The American Association of Suicidology (AAS), in collaboration with the Suicide Prevention Resource Center, through a federally funded grant, has completed the development of a training curriculum built around 24 clinical competencies. These competencies, based on best practices described by a task force of experienced suicidologists, encompass clusters of knowledge and attitudes required for clinicians to more effectively work with clients at-risk. Further, with the support of the Suicide Prevention Partnership, the AAS is in the process of translating these knowledge and attitude competencies into a behavioral training curriculum that will be disseminated in early 2007.

A mother calls seeking family therapy. Her 17-year-old daughter died by self-inflicted hanging a month ago. Her husband has closed off and won’t talk about their daughter or his grief. She is paralyzed by the pain of her loss and is terrified because her daughter’s twin brother recently expressed a wish to be with his sister.

A wife calls seeking marital therapy. She says her husband and she have been fighting for years, but things have been getting worse ever since his drinking got out of hand. He reluctantly has agreed to come into therapy as a last ditch effort to save the marriage from dissolving.

A family therapist notices that the 15-year-old daughter in a family she has been seeing has superficial lacerations on her left forearm. The therapist extracts a contract from the girl to not cut, and to call her or inform her parents if she has the urge to cut herself, and the girl agrees. Two weeks later, the girl’s mother calls and says she had noticed her daughter wearing a long-sleeved sweater on a very warm day and confronted her, discovering that she was covering up very recent cuts on her arm.
Clinical Competencies

I. Working with Individuals At-Risk for Suicide: Attitudes and Approach

No matter how competent the MFT is in his or her therapeutic technique, no treatment will be successful without the establishment of a good therapeutic alliance with the client. That said, at-risk for suicide clients are often interpersonally dysfunctional and/or have significant pathology that makes difficult creating a strong working relationship. One study of severely at-risk patients admitted to a hospital for clinical depression and suicidal thoughts and/or attempt found that those patients who went on to suicide within two years of being hospitalized, compared to others still alive, were those most often described at their intake session as guarded, hostile, difficult to interview, etc.

What approaches and attitudes make a difference in creating a therapeutic alliance?

First, being aware of how at-risk patients affect us, and effectively managing our reactions, matters greatly. Fear, anger (even hate), helplessness, hopelessness, and protectiveness are all common responses that lead therapists to overreact or underreact to suicidal clients. These reactions must be understood, tolerated, and managed. Suicidal clients need to be supported, understood, and validated. Being suicidal may be the only means of coping available to the client in managing his or her distress. It is up to the therapist to maintain a collaborative, non-adversarial stance in creating a safe harbor for these clients to share information essential for understanding their level of risk, and to develop a treatment plan that will reduce that risk. This work requires an active role for the therapist truly invested in understanding the client. Further, it requires that the therapist be available, accessible, and willing to foster a dependency to strengthen the initial attachment. To effectively move ahead, the therapist and client need to develop a shared perspective and work as a team toward decreased risk.

II. Understanding Suicide

The therapist needs to be able to accurately characterize suicidal and self-destructive behaviors to reasonably understand concepts of intent and lethality. Intent refers to the aims, purposes, or goals of the behavior—death (ending all further experience of pain by never more being conscious), a wish for rebirth, or to join a loved one in heaven, are commonly expressed statements that describe suicidal intent. When a client who self-cuts or self-burns, on the other hand, describes feeling empty or cut off from herself, and that self-harm behavior allows her to feel pain or, because she bleeds, to feel alive, then her intent is not suicidal. Understanding the data of suicide and what characterizes chronic and acute risk (see article on Data and Statistics in this issue) significantly provides the foundation of knowledge that informs what to look for to better assess the client at-risk.

III. Collecting Accurate Assessment Information

Gathering assessment information early in the clinical encounter; eliciting risk and protective factors; eliciting suicide ideation, behaviors, and plans; and obtaining collateral information are all necessary skill-sets to effectively move on to formulating risk. Knowing how to ask questions about suicidality, how to ask these questions in different ways at different times and with a sequenced plan, knowing how to decrease a client's reluctance to be open about their thoughts and feelings, and how to gather information from collateral sources (such as family members and prior caregivers) allow the MFT to be a skilled investigator without alienating the client in the process of collecting essential information about history and current suicidality. Collecting accurate information is never as simple as asking, Are you thinking about suicide? Rather, the MFT must expect that the typical at-risk client needs to be assessed in great detail and helped to provide the needed information so that help can be provided effectively.

IV. Formulating Risk

Learning how to make a clinical judgment about a client's risk for acting on suicidal thoughts is a competency rooted in having as much good data as possible that informs this judgment, knowing signs of acute risk, using data relevant to the quality of the therapeutic alliance, etc. Judgments need to be made regarding both chronic and acute risk, and the potential that acute risk can or cannot be contained (for example, is it likely that the client's use of alcohol when depressed and suicidal will increase irrational thinking and impulsive behavior?). These judgments should be documented, along with the rationale for assessing level of risk in such a way that treatment planning follows naturally.

For example, a client who expresses unendurable psychological pain and frequent and intense suicidal thoughts with a plan, is agitated and likely to act on impulse (perhaps because of their tendency to self-medicate with alcohol), and has other acute risk factors, would reasonably be seen as a serious, high risk for near-term suicidal behavior.

V. Developing a Treatment and Services Plan

Learning how to develop a treatment plan collaboratively is a competency that significantly increases the client's compliance with that plan. There is no evidence that a "No Suicide Contract" is at all effective in preventing suicide. In contrast, one best practice recommendation is to develop a crisis response or safety plan that makes sense to, and is considered doable by the client. Safety plans spell out specific actions the client will take if feeling uncontrollable urges toward suicidal behavior—whom to contact, how to reach them, immediate steps the client can take to relax. There is research evidence to support that carrying this information on one's person increases the likelihood that proactive behaviors will occur and that suicidal behaviors occur less frequently in response to these crisis response plans.
Any diagnosis for which there is some available evidence that medication may be effective is a call for a medication consult. Concurrently, there is no anti-suicide pill. Moreover, medication regimens are likely to be more effective and complied with in the context of psychotherapy. Under conditions of assessed risk, the availability of a firearm in the home needs to be addressed both with the client and the client’s spouse or family, and restricted. Family members also need to be developed as collateral caregivers and observers during periods of increased risk. The need for hospitalization must be addressed and when not acted upon, suitable alternatives to closely monitor and observe the client during periods of increased risk need to be in place.

The client described above, with high and serious risk for near-term suicidal behavior, should not be left alone, needs to be hospitalized, not be able to drink, and needs to be closely monitored.

VI. Managing Care
MFTs need to pre-define policies and procedures for working with suicidal clients. For example, how will the therapist handle the client’s stash of medications? How often is it feasible for the therapist to see the client during periods of crisis or increased risk? Who else might or needs to be built in as a collateral caregiver? How will the therapist respond to middle-of-the-night calls from an intoxicated, at-risk client?

An assessment of risk that has identified precipitant events that are likely to increase potential for suicidal behavior, the client’s level of self-control, and the degree to which the client feels burdened or hopeless allow the therapist to effectively target priorities in treatment. First and foremost, at-risk clients need treatment plans that reduce their acute suicidality; second, the focus can then shift to treating the underlying vulnerabilities that give rise to the client being suicidal.

VII. Understanding Legal and Regulatory Issues Related to Suicidality
It behooves the MFT to understand how to get informed consent; HIPAA rules regarding confidentiality and safeguarding patient records; the importance of documenting observations, judgments, rationales, and treatment interventions consistent with the treatment plan; and the legality of disclosing information about a client after their death in the unlikely, yet ever possible event of an untoward outcome when working with at-risk clients.

In a recent survey of more than 1,000 therapists in one state, approximately 15% of practicing clinicians stated that they “did not see” at-risk for suicide clients. Nothing could be more untrue. Each and every practicing clinician has the possibility of having to deal with the next client as the at-risk client; one simply can’t pre-screen these clients out of one’s clinical practice. Knowing what to do, even if one wants to quickly refer such clients to others, involves significant skill-sets to avoid being in a position of abandoning an at-risk client. Knowing what we have learned from forensic cases where suicides have resulted in complaints of negligence against therapists significantly informs risk management strategies and proactive care versus defensive practice.

Lastly, the MFT would benefit greatly from understanding how best to work with families and other clients devastatingly bereaved by suicide. This involves familiarity with the literature on suicide bereavement and the unique aspects of this complicated grief work; impacts of suicide on clients at different ages (children); and how to address the myriad questions raised by survivors regarding the suicide (most often, Why?) left unanswerable by their now deceased loved one.

Suicide happens, but in a great many cases it is preventable. We owe it to our clients to be skilled at doing what we can to expect its possibility, to recognize its risk, and to effectively intervene.

To learn more about the Competency-based Training in Assessing and Managing Suicide Risk, contact the Suicide Prevention Resource Center: www.sprc.org.