Recognizing, Assessing, & Responding to Suicidal Risk

skip navigation
home
using this site
change text & contrast
TOPICS ON THIS SITE
alzheimer's & other dementias
assessment
Bev Greene: 9-11
boundaries
cancer resources
CBD & cannabis for pain, nausea, PTSD
caregiver resources
Carolyn Payton
clinicians' self-care & well-being resources
cognitive functioning & exercise
compassion & empathy
coronary heart disease
detainee interrogations
end-of-life, nursing homes, hospices
ethics codes
ethics & malpractice
fallacies & pitfalls
forgiveness resources
informed consent
laws & boards
medication help

home » suicide risk

Recognizing, Assessing, and Responding to Suicidal Risk

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This chapter is divided into the following sections:

Working with a suicidal patient gives us a chance to help save a life. It brings the weight, worry, and uncertainty of professional responsibilities when life or death decisions are on the line as well as joy, satisfaction, and a deep sigh of relief when things go well. Other times it can bring shock, numbness, grief, second-guessing, and guilt.

Few if any of us work in settings where no one ever thinks of ending it all. The statistics are stark. Suicide remains among the top dozen causes of death in Canada and 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. Experts voice the view that the reported figures vastly understate the problem because reporting procedures are flawed. Some groups face greater risks than they once did. Hempstead and Phillips (2015), for example, report that the U.S. suicide rates for middle-aged men and women have risen since 1999, and in 2007 started a much steeper climb.

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meta-analyses
military & families
mindfulness
pain
parkinson's
resilience
sexual issues
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suicide
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Assessing and responding to suicidal risk is a source of extraordinary stress for many therapists. This part of our work focuses all 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 study (1965) of over 200 clinicians soon after their patients had committed suicide found the experience to have had an almost nightmarish quality. They felt intense grief, loss, and sometimes depression as anyone—professional or nonprofessional—might at the death of someone they cared about. But as therapist they also felt guilt, inadequacy, self-blame, and fears that they would be sued, investigated, or vilified in the media. A study of short-term and permanent effects of patient's suicide on the therapist led Goldstein and Buongiorno (1984) to recommend providing support groups for surviving therapists.

Mangurian and her colleagues (2009) wrote that the "suicide of a patient is arguably the most traumatic event that can occur during a psychiatrist's professional life" (p. 278). Reviewing the research, Séguin, Bordeleau, Drouin, Castelli-Dransart, and Giasson (2014) noted how a patient's suicide can affect the therapists' practice, especially when working with other patients around suicidal issues. Support from friends, colleagues, and—if needed—a therapist can serve a protective function and lower the risk of negative effects on the therapist's practice (Gulfi, Dransart, Heeb, & Gutjahr, 2015).

Solo practitioners may be even more vulnerable than their colleagues who practice in groups and clinics with their natural support systems. Trainees may be among the most vulnerable. 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 create a plan to help 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; see also Mangurian et al., 2009; Prabhakar, et al., 2014)

If the challenges of helping the suicidal patient can make many of us uncomfortable, at least some of the time, they also show the extraordinary efforts that some therapists take to help their clients stay alive. Some of the examples in this chapter may seem deserving of criticism by some in our profession. Those who use this subset of approaches must understand that they open the therapist to criticism and perhaps formal complaints. Risk management workshops rarely endorse late night telephone calls or going to the home of a suicidal patient, to say the least. And yet Gerry Davison, University of Southern California (USC) Professor of Psychology, who served as Chair of the Department of Psychology, Director of the Clinical Training Program, and President of the Association for Advancement of Behavior Therapy, and his co-author, the late John Neale, who was Professor of Psychology at SUNY Stony Brook 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" (1982).

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, a preeminent pioneer in helping suicidal clients, 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 patient 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. 271)

Assessing Suicidal Risk

Clinicians may find the following 22 factors useful in assessing suicidal risk. Four qualifications are key. First, the factors are 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, these factors are not static. New research enriches our understanding as well as reflects changes. The suicide rate for women, for example, has been increasing, bringing it closer to that for men. Third, the list is far from comprehensive. Fourth, these factors may be useful as guidelines but cannot be applied in an unthinking, mechanical, conclusive manner. Someone may rank in the lowest-risk category of each factor and still commit suicide. These factors can help us think through a situation but never replace a comprehensive, humane, and personal evaluation of a unique patient's suicidal risk. Again it is worth returning to 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 patient can help us prevent the ethical lapses that come from neglect.

1. Direct verbal warning. A direct statement of intention to commit suicide serves as 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 (see, e.g., Stack, 2014). The more specific, detailed, lethal, and feasible the plan is, the greater the risk.

3. *Past attempts*. Most, and perhaps 80% of, completed suicides follow a prior attempt. Schneidman (1975; see also Wong, Stewart, & Claassen, 2008) 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 20 times greater than for the general population. Guze and Robins (1970; see also Stack, 2014; Taliaferro & Muehlenkamp, 2014; Vuorilehto, Melartin, & Isometsa, 2006), in a review of seventeen studies concerning death in primary

affective disorder, found that 15% 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; see also Maris, 2002; Martin, Dorken, Simpson, McKenzie, & Colman, 2014; Petrie & Chamberlain, 1983; Taliaferro & Muehlenkamp, 2014; Violanti, Andrew, Mnatsakanova, et al. 2015; Wetzel, 1976).

7. Intoxication. Between one-fourth and one-third of all suicides are linked to 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 Buri, Von Bonin, Strik, et al., 2009; Crosby et al., 2009; Kõlves, Värnik, Tooding, & Wasserman, 2006; Sher, 2006; Sher et al., 2009) notes that perhaps as many as half of those who kill themselves are intoxicated at the time. Darke, Duflou, and Torok (2009) found that

> alcohol was more common where a suicide note was left and where relationship problems were involved. Pharmaceuticals were more common where a previous attempt was noted. Licit and illicit substances are strongly associated with suicide, even when the method does not involve drug overdose. (p. 490)

Hendin, Haas, Maltsberger, Koestner, and Szanto's study, "Problems in Psychotherapy with Suicidal Patients" (2006), 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" (p. 71; see also Zhang, Conner, & Phillips, (2010)).

8. *Marital separation (distinct from divorce).* Wyder, Ward, and De Leo (2009) found that "for both males and females separation created a risk of suicide at least four times higher than any other marital status. The risk was particularly high for males aged 15 to 24 ..." (p. 208).

9. *Clinical syndromes*. People suffering from depression or alcoholism are at much higher risk for suicide. Other clinical syndromes may also be linked to an increased risk. Perhaps as many as 90% of those who take their own lives have a formal 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 (see also Draper, Peisah, Snowdon, & Brokaty, (2010); Novick, Schwartz, & Frank, (2010)). Palmer, Pankratz, and Bostwick ((2005); see also Brenner, Homaifar, Adler, et al., (2009); Loas et al., (2009); Pretti, Meneghelli, & Cocchi, 2009) 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; see also Chan et al., 2009).

10. *Sex*. The suicide rate for men is more than three times that for women (CDC, 2010; see also Joiner, (2005) (2010)). For youths, the rate is closer to five to one (see Safer, (1997)). The rate of suicide attempts for women is about three times that for men.

11. *Age*. A significant change occurred in this category. The earlier editions of this book had noted that the risk for suicide tended to increase over the adult life cycle. However, more recently suicide has peaked in middle age: "The highest rates of suicide by age group occurred among persons aged 45–54 years, 75–84 years, and 35–44 years (17.6, 16.4, and 16.3 per 100,000 population, respectively" (CDC, 2010, p. 9). As noted earlier in this chapter, Hempstead and Phillips (2015) report that 1991 marked the start of a significant rise in middle-age suicide rates, a rise that speeded up beginning in 2007.
Suicide risk assessment differs also according to whether the client is an adult or a 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). Zametkin, 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)

12. Race. Generally in the United States, Caucasians tend to have one of the highest suicide rates (CDC, 2010). 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). In Canada, the Nunavut Inuit suicide rate is 13 times higher than the rate in the rest of Canada ("Suicide Numbers in Nunavut in 2013 a Record High; Nunavut Youth Decry Lack of Help for Those Thinking About Suicide," 2014).

13. Religion. The suicide rates among Protestants tend to be higher than those

among Jews and Catholics.

14. 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.

15. Bereavement. Bereavement tends to place survivors at increased risk of taking their own lives (Hollingshaus & Smith, 2015; Pitman, Osborn, King, & Erlangsen, 2014). Brunch, Barraclough, Nelson, and Sainsbury (1971) found that 50% of those in their sample who had committed suicide had lost their mothers within the past three years (compared with a 20% rate among controls matched for age, sex, marital status, and geographical location). Furthermore, 22% of the suicides, compared with only 9% of the controls, had experienced the loss of their father within the past five years. Krupnick's review of studies (1984) 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. The suicide risk tends to rise around the anniversary of the loss (Rostila, Saarela, Kawachi, & Hjern, 2015). 16. *Unemployment*. Unemployment tends to increase the risk for suicide.

17. 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).

18. Impulsivity. Those with poor impulse control are at increased risk for taking their own lives (Rimkeviciene & De Leo, 2015; see also Maloney et al., 2009; Patsiokas, Clum, & Luscumb, 1979; Wu et al., 2009).

19. 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 can't find a job by the end of the month, the only real alternative is suicide."

20. 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 to 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 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% of their sample of multiple-incident victims of sexual assault had attempted suicide.

21. 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." Hunt and colleagues' study of "Suicide in Recently Discharged Psychiatric Patients: A Case-control Study" found that the

> weeks after discharge ... represent a critical period for suicide risk. Measures that could reduce risk include intensive and early community follow-up. Assessment of risk should include established risk factors as well as current mental state and there should be clear follow-up procedures for those who have self-discharged. (p. 443)

Francis (2009) points out the relationship between suicidal risk and release from hospitalization may be complex when borderline personality disorder is at issue:

> People with borderline personality disorder (BPD) are sometimes admitted to inpatient wards due to risk to themselves. However, recent research indicates inpatient settings are detrimental to BPD and can worsen symptoms (unless they are planned short stays). Staff are often too fearful ... to release them if they are still expressing suicidal thoughts. If the presentation is not different (no major crises have occurred, no major losses made) then clinically indicated risk-taking is the recommended course of action. (p. 253)

22. 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)

Appelbaum and Gutheil (2007) focus on the risk factor of

> personal isolation, which can derive from a number of sources (for example, immigrants who have not found a local community, those who are retired or unemployed, those living alone, even those living in transient or disorganized areas such as resort towns whose populations fluctuate wildly on a seasonal basis). (p. 52)

10 Steps To Reduce Risk

Knowing and understanding the risks of patient suicide creates a special set of responsibilities. The way we handle those responsibilities can have life or death consequences. The following steps may be helpful in handling

those responsibilities:

Screen all patients for suicidal risk during initial contact, and remain alert to this issue throughout the therapy. Even patients who are seriously thinking of taking their own life may not present the classic picture of agitated depression or the stereotype of grim determination. Some suicidal patients seem, during initial sessions, calm, composed, and concerned with a seemingly minor presenting problem. Patients who are not suicidal during initial sessions and who started therapy for a minor problem may become suicidal. The rise in suicidal risk may be caused by 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 start of Alzheimer's disease. What is crucial is an assessment of the patient'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); Ostergaard et al., 2015; Weisman & Worden, (1972)). Range and Knott (1997) evaluated 20 suicide assessment instruments for validity and reliability. On the basis of their analysis, they recommended three 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.

Check the literature or consult with an expert in this area to see if current research and practice offer any approaches that might be particularly effective with a particular situation or population. For example, randomized research suggests dialectical behavior therapy seems effective and well-suited for people with borderline personality disorder who are suicidal (Linehan, et al. 2006).

Work with the client to arrange an environment that will not offer easy access to whatever the patient might use to commit suicide. Suicidal clients who have purchased a gun may agree to place it where they will not have access to it until the crisis 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 patient. Arrange that the patient does not have access to enough medication at one time to carry out a suicidal plan. In a study of the relationship between diagnosis and means in completed suicide, Huisman, van Houwelingen, and Kerkhof (2009) found:

> Possible means of suicide prevention suggested by this study include limiting access to tall buildings or structures to patients with psychotic disorders; careful prescription of medication to female patients and particularly to patients with substance-related disorders; and limiting easy access to railways near clinical settings to patients with bipolar and psychotic disorders. Limiting

> access to means of suicide may be less effective for suicidal patients with depressive disorders who may switch to other available methods.

Work with the patient 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.

While not denying or minimizing the patient's problems and desire to die, also recognize and work with the patient's strengths and desire to live. Patients' awareness of their strengths, resilience, and reasons to live can often help them regain perspective, often lost during despair.

Make every effort to communicate realistic hope. Discuss practical approaches to the patient's problems.

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.

Make sure communications are clear, and assess the probable impact of any interventions. Ambiguous or confusing messages are unlikely to be helpful and can 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 therapist 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."
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 codirector 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."

Be sensitive to negative reactions to the patient's behavior. James Chu (quoted by Colt, (1983), p. 56), a psychiatrist in charge of Codman House at McLean Hospital, a psychiatric hospital near Boston, 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.
> Maltsberger 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. Maltsberger 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. (Colt, (1983), p.57)

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.

Relatively unusual and rare interventions such as home visits, long and frequent sessions, therapist's late-night search for a runaway patient, and other special measures already noted are ways some therapists have found useful to communicate this caring, although such approaches obviously do not fit all therapists, all patients, all theoretical orientations, or all situations. Some ethics committee and licensing board members may be concerned about these strategies. However, these strategies may be options on occasion. One of the most basic aspects of this communication of caring is the therapist's willingness to listen, to take seriously what the patient 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."

Avoiding Pitfalls: Advice from Experts

A central theme of this book is that inattention or a lack of awareness is a frequent cause violating clinical responsibilities and patient trust. We asked 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 patients. Their advice can help us save lives.

Norman Farberow, PhD, cofounder and former codirector 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, PhD, 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 the 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 problems 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, PhD, 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, and a former American Psychological Association president told us that

> assessment and intervention of suicidal persons need 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 on 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 regard 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. Muñoz, PhD, is Distinguished Professor of Clinical Psychology at Palo Alto University, and served as principal investigator on the Depression Prevention Research Project involving English-, Spanish-, and Chinese-speaking populations, funded by the National Institute of Mental Health. 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 until 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, told us:

> As some adolescents can be prone to be dramatic, that is, 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: follow-up by their

> therapist, evaluation in the emergency room, and/or in-patient 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 a 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.

Danny Brom, PhD, is Director of the Israel Center for the Treatment of Psychotrauma of Herzog Hospital in Jerusalem (www.traumweb.org) and Professor at the Paul Baerwald School of Social Work and Social Welfare of Hebrew University. The mission of his community based trauma center is to develop and test new methods of intervention for mitigating the effects of trauma on children and adults. His latest book, with Pat-Horenczyk and Ford, is *Treating Traumatized Children: Risk, Resilience and Recovery* (Routledge, 2009). He told us:

> The client that taught me this lesson had been abused in ways that I had not heard about before and have rarely heard about after. Tortured, abused, made totally dependent and helpless. She suffered from DID. During the course of a long therapy she would become suicidal. When we discussed suicidality, I wanted to have a clear understanding with her that she would call me first if she would feel that she was going commit suicide. She then made it very clear to me that suicide for her had been and still was her only access to real freedom. If I would take that away from her or block that way by insisting on a contract, she felt that then she really would have to commit suicide. The freedom to commit suicide gave her the freedom to live.

M. David Rudd, PhD, ABPP, is Provost and Distinguished University Professor at the University of Memphis. He served as president of the American Association of Suicidology and as consultant to the U.S. Army, the U.S. Air Force, the Beijing Suicide Prevention

and Research Center, and other organizations. 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 past decade, converging scientific evidence suggests it is important to address enduring or "chronic" suicidality in patients. More specifically, those who 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, PhD, 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 two 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.

Rosa E. Garcia-Peltoniemi, PhD, is Staff Clinical Psychologist and Senior Consulting Clinician at the Center for Victims of Torture. Since 1987 she has been at the forefront of developing clinical services for refugees and asylum seekers who have suffered torture at the hands of foreign government both in the U.S. and internationally. Here is what she states regarding specific issues in treating survivors of torture in this country:

> For torture survivor clients trying to obtain asylum in the U.S., adverse decisions carrying the risk of deportation to the very countries in which they were tortured are frequently times of increased suicidal risk. The prospect of being sent back becomes not only very frightening but also an intolerable repetition of a past that was already extremely costly to escape. It is not unusual for torture survivors in these situations to say that they would rather die by their own means than return to their countries and be tortured again. Even less drastic immigration outcomes such as being put on an ankle brace electronic monitor, a practice that has become increasingly common, can carry an increased risk of suicide for torture survivors. Diagnoses of illnesses perceived as terminal or to bring shame (e.g. HIV/AIDS) are also triggers for suicidal ideation in torture survivors; chronic, debilitating illnesses preventing the survivor from taking care of important obligations such as providing or caring for family members often lead to suicidal thinking based on the belief that loved ones would not be burdened, would be better off, happy, etc., following their deaths. Interpersonal losses, particularly the death of parents and children left behind in the country of origin, but also through divorce or abandonment, also tend to be triggers for suicidal risk amongst torture survivors. Many survivors from various different cultures have stated that they don't talk about problems unless they are asked; to talk about suicide carries an even higher burden due to cultural proscriptions for some or simply because of the belief that the rest of the community is also suffering in various different ways. Finding ways to give survivors permission to say how they are feeling then becomes extremely important for clinicians and includes knowing culturally sensitive ways to ask about suicidal ideation. Consultation with knowledgeable cultural providers is a must. Finally, it is important to

> keep in mind that many torture survivors have suffered traumatic brain injury which may lead to less predictable responses to psychiatric medications, increased risk for adverse outcomes, and an overall requirement of close collaboration across disciplines.

The late ***Erika Fromm***, PhD, 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.

Gary Schoener, clinical psychologist and executive director emeritus of the Walk-In Counseling Center in Minneapolis, consults, trains, and testifies around North America concerning professional boundaries and clinical supervision. He told us:

> 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) overreliance 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, PhD, is psychologist and clinical director at the University of Texas Counseling and Mental Health Center in Austin, Texas, She has previously worked as instructor and coordinator of a campus-wide suicide prevention program at St. Edward's University.

She reported:

> 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 eighteen 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, PhD, formerly 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.

Danny Wedding, PhD, MPH, is Chair of Behavioral Sciences, College of Medicine, American University of Antigua. Danny has completed Fulbright Fellowships in Thailand and Korea, and he has lectured widely on suicide prevention. He is especially concerned about the growing problem of adolescent suicide in Asian countries. He notes

> Suicide is a serious public health problem, and about a million people die by suicide each year—more than are lost to either homicide or war. Prevalence, methods, and risk factors vary widely across cultures and ethnic groups, and clinicians need to be sensitive to these cultural differences. For example, suicide by pesticide poisoning is common in China and Sri Lanka but rare in Thailand, and suicide rates among American Indian/Alaskan Native adolescents and young adults in the United States are about twice the national average. However, there are also commonalities across cultures—e.g., we know that glamorized media portrayal of suicide can lead to a contagion effect in almost every country. The growing access to the internet found in almost all developing countries poses special challenges (especially cyber bullying) for those of us interested in suicide prevention. Some of the techniques that have been shown to be effective in preventing youth suicide in other countries include screening, gatekeeper training, crisis hotlines, media education and skills training.

Don Hiroto, PhD, has maintained an independent practice for over 35 years while also teaching and supervising future psychologists at UCLA. He was 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 that 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***, PhD, 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, PhD, 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***, PhD, a diplomate in clinical psychology, is 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*]

[Back to Top]

Note: