The Outpatient Treatment of Suicidality: An Integration of Science and Recognition of Its Limitations

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The clinical assessment of suicidality is one of the most challenging tasks the mental health clinician can face. This article offers 22 recommendations for the outpatient psychotherapeutic treatment of suicidality in adults and adolescents. These recommendations cut across all domains of clinical practice. A rationale is presented that the stated recommendations need an empirical base, in contrast to the existing litigation-determined standard of care that has emerged over the last several decades. The authors review empirical literature, acknowledge identifiable limitations, and emphasize implications for day-to-day clinical practice and the continuing evolution of standards of care.

Two interdependent forces have emerged in the last decade that have significantly altered the nature of care for suicidal patients—managed care and practice guidelines. Regardless of one’s theoretical orientation, psychotherapy as provided in today’s mental health arena will be time limited in some form or fashion. Time limitations are most frequently imposed externally; that is, by the managed care company or insurance provider involved and, most often, by restricting the frequency, duration, or actual type of care provided. The dilemma many practitioners confront today is how to provide effective psychotherapeutic services for high-risk individuals within such rigid constraints, particularly for those patients who are suicidal, all the while balancing escalating liabilities.

Within, and possibly in response to, this environment, practice guidelines have simultaneously emerged to drive the very nature of care provided and directly affect the clinician’s day-to-day work. Additionally, these published guidelines will more than likely be used by the court system to establish the standard of care when a bad clinical outcome is experienced. Despite considerable disagreement as to their appropriateness, scientific foundation, and clinical utility, guidelines continue to emerge (e.g., Garfield, 1996; Havik & Vandenbos, 1996; Nathan, 1998). Simply put, whether we like it or not, practice guidelines appear to be here to stay.

Seligman (1996) and Seligman and Levant (1998) discussed how cost-containment efforts by managed care companies have compounded the problem by essentially redefining the necessity of psychotherapy, with a minimal level of day-to-day functioning commonly the therapeutic goal, irrespective of the presenting problem. They also noted that not only has the duration of care been markedly reduced but that efforts are being made to reduce costs by routing patients to therapists with less training, experience, and qualifications. In a worst-case scenario, the trend would favor routing more severely suicidal patients to those with the least experience and training. All of this appears to be taking place without adequate empirical justification or because of simple misrepresentation and misinterpretation of current outcome research.

There is a need for focused clinical effectiveness studies addressing the duration of therapy for different disorders and related cost–benefit analyses. This is particularly true for suicidal patients, the majority of whom present with a broad range of diagnoses and considerable comorbidity across both Axis I and II (e.g., Linehan, 1993; Rudd, Dahn, & Rajab, 1993; Rudd, Joiner, & Rajab, 1996). Seligman’s (1996) recommendation that science be viewed as an ally of practice is an essential one for effective treatment of suicidality in today’s psychotherapy environment.

The implicit tragedy in this evolution of care for suicidal patients is that, although suicidal crises are most frequently time limited, even for chronically suicidal individuals, the underlying psychopathology is often enduring (e.g., Maris, 1991; Rudd,

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Joiner, et al., 1996). Consistent with the commonly accepted definition of crisis (e.g., Slaight, 1990), acute emotional upset, dysphoria, and the associated sense of urgency to act in a self-destructive and potentially life-ending way will undoubtedly subside with adequate time and protective constraints (e.g., brief hospitalization). Underlying skill deficits in emotion regulation, distress tolerance, interpersonal dysfunction, impulsivity, problem solving, and related cognitive distortion and rigidity will probably not improve, at least not without appropriate intervention and targeted care (e.g., Rudd, 1998).

Changes in the nature of the psychotherapy delivery system have been particularly challenging for those clinicians treating suicidal patients. Others have documented the negative impact of managed care on the overall sense of well-being and satisfaction experienced by practitioners in today's mental health marketplace (Hersch, 1995; Sherman & Thelen, 1998). This problem is compounded by the complexity of clinical and practical demands presented by suicidal patients. With considerable restrictions in access to inpatient care or long-term psychotherapy, those clinicians and treatment centers that provide outpatient services to suicidal patients are left with no proven treatment alternatives (e.g., Malsberger, 1993, 1994; Rudd & Joiner, 1998). The net result has, at times, been a climate characterized by fear and anxiety (e.g., Pope & Tabachnick, 1993). Concerns have also been raised that some clinicians and outpatient treatment centers are refusing to accept suicidal patients given the considerable risks, limited resources, and the need for more intensive training and experience (e.g., Jobs, Jacoby, Cimbrolic, & Hustrud, 1997; Malsberger, 1993).

Empirically derived practice guidelines offer the clinician a valuable resource that can provide some structure to the services offered and even some ammunition to argue for long-term treatment when indicated and needed for those patients who are chronically suicidal.

**Practice Recommendations for the Treatment of Suicidality**

A coherent and scientifically based set of practice recommendations is critical for the provision of care with this high-risk and diagnostically complex population as well as for the psyche of the therapist. Although inpatient and outpatient standards of care have emerged over the last decade (Bongar, Maris, Berman, & Litman, 1992; Bongar, Maris, Berman, Litman, & Silverman, 1993; Silverman, Berman, Bongar, Litman, & Maris, 1994), they have, to some degree, been litigation determined and represent the outcome of clinical failure scenarios. They have, for the most part, articulated failure in standard clinical practice with suicidal patients and have neglected the literature that explores what actually works or does not work with this population.

The hope here is to begin to articulate scientifically derived practice recommendations, in order to offer our patients a distillation of the best scientific knowledge and clinical experience available. The fact is that we train clinicians daily in the practice of assessing and treating suicidality. The recommendations offered are by no means comprehensive nor are they definitive. The science of clinical suicidology remains seriously limited at present, particularly when it comes to outpatient psychotherapeutic treatment and management.

In offering practice recommendations for the outpatient psychotherapeutic treatment of suicidality, we need first to answer some fundamental questions. What treatments have been demonstrated effective for the targeted problem? Within identified treatments, are there core interventions associated with positive outcome? Are there identified treatments that clearly should not be used as a result of consistently poor outcome data? As will become evident in the following review, we can only tentatively answer a few of the most fundamental questions regarding the treatment of suicidality. They do, nonetheless, provide an empirically derived set of practice recommendations on which to build. Evolution of these recommendations is dependent on continued growth in the science of clinical suicidology, as well as collegial debate and discussion.

**An Empirical Foundation for Treating Suicidality**

What do we know about treating suicidality? To answer this question we need to rely on scientific data. A large number of studies currently exist in the suicidality literature, incorporating case examples, theoretical articles, and studies without comparison or control groups. The current review includes only those studies that are randomized or controlled in some fashion. This is consistent with the goal of integrating science into practice recommendations, as well as articulating and acknowledging current limitations in the state of the science.

A thorough review of the literature (PsycINFO and MEDLINE) yielded a total of 23 randomized or controlled studies targeting suicidality. Of the 23 studies identified, 3 explored pharmacological treatment of suicidality (Hirsch, Walsh, & Draper, 1983; S. Montgomery & Montgomery, 1982; D. Montgomery, Roy, & Montgomery, 1981). These were excluded from the review given that the focus is on psychotherapeutic treatment. It is interesting to note that the 3 pharmacological studies were all completed more than two decades ago, prior to some of the recent advances in the use of medications for diagnosed psychiatric disorders, particularly selective serotonin reuptake inhibitors. This highlights a common problem. In the scientific study of suicidality, those evidencing some form of suicidality are ordinarily excluded from clinical trials, both medication and psychotherapy, because of their high-risk nature.

On exclusion of the 3 medication studies, 20 controlled or randomized studies targeting the treatment of suicidality remain. This total incorporates both intervention and treatment studies. Those classified as intervention studies (n = 6) included those with the study condition described as "not providing any identifiable form of psychotherapy." These studies essentially made procedural changes in both the provision of, and ease of access to, traditional therapeutic services and explored any subsequent reductions in suicide attempts. The pool of articles we review here is consistent with a recent review by Linehan (1997). The current article includes 3 studies not previously reviewed (i.e., Joiner, Rudd, & Rajab, in press; Lerner & Clum, 1999; Rudd, Rajab, et al., 1996). As noted above, 6 of the 20 studies are simple intervention studies, which leaves only 14 treatment studies for critical review. This is a truly surprising finding, given that the area is one fraught with so much controversy and importance.
A Critical Review of Intervention Studies

Of the intervention studies reviewed, three had positive findings, but each also has methodological limitations. Termansen and Bywater (1975) found that what was described as intensive case management by volunteer workers reduced subsequent suicide attempts during the 3-month follow-up period relative to those receiving no follow-up care. The findings are compromised by the fact that the intervention was not specifically defined in either the content or the application, experimental and comparison groups were not comparable at intake, the follow-up period was inordinately brief, standardized outcome measures were not used, a relatively high attrition rate (37%) occurred, suicide intent was not assessed at intake and prior to randomization, and no exclusion criteria were stated. The findings reported by Termansen and Bywater (1975) have limited utility and practical application.

Van Heeringen et al. (1995) explored the use of home visits by a community nurse in enhancing treatment compliance and reducing subsequent attempts in comparison to usual outpatient care. Analysis of the findings revealed better treatment compliance among those in the experimental group, and, although not significant, a favorable trend \( p = .056 \) was noted in the reduction of subsequent attempts. Although the attrition rate was 24%, the study was well designed for its stated purpose, posing no serious methodological problems. The study did, however, exclude the highest risk cases, limiting the utility of the findings.

Morgan, Jones, and Owen (1993) found that improved ease of access to 24-hr emergency services (over the period of 1 year following a first suicide attempt) significantly reduced subsequent attempts among those in the experimental group relative to those receiving management as usual after an attempt. In elegant fashion, improved ease of access was accomplished by giving the patient a green card with emergency numbers and encouragement to seek services early in a crisis by going to the emergency room, calling by telephone, or seeking emergency admission. It is both interesting and paradoxical to note that Morgan et al. further found that this simple procedural change also significantly reduced service demand in the experimental group.

Among negative intervention findings, Motto (1976) found that simple follow-up letters and phone calls to those refusing treatment after presenting in crisis did not reduce suicide rates over a 4-year period, although a favorable trend was noted. This finding is not surprising. Actually, what is surprising is that an encouraging trend was noted after 4 years, with fewer suicides among those receiving the follow-up contacts.

Litman and Wold (1976) found that telephone calls, home visits, and "befriending contacts" (p. 531) by crisis volunteers did not reduce frequency of suicide attempts in the experimental group over a period of 24 months, despite an improvement in "quality of life" (p. 537). The findings, however, are compromised by several methodological problems: (a) lack of a defined intervention in type, duration, content, and frequency; (b) acknowledgment of considerable overlap between the experimental and control conditions approaching equivalence and nullifying the results; (c) no defined inclusion criteria for high risk; (d) no stated exclusion criteria; and (e) lack of standardized outcome measures.

The negative findings reported by Waterhouse and Platt (1990) are also questionable. The stated purpose of the study was to evaluate the utility of simple and brief medical hospitalization (with no psychiatric care of any type provided) by non-psychiatric staff at reducing subsequent attempts over the next 4 months. The control group was discharged to home. The average duration of the hospitalization for those in the experimental group was less than a day (i.e., 17 hr). It is not surprising that no subsequent differences were observed in attempts between groups. The two groups were essentially one group, the same group, without meaningful service differences.

As is evident from the above discussion, the intervention studies available allow for only a few tentative conclusions regarding psychotherapeutic treatment and clinical management of suicidal patients:

1. Intensive follow-up, case management, telephone contacts, or home visits may improve treatment compliance over the short-term for lower risk cases.
2. Improved means of contact (i.e., a clearly stated crisis plan) to emergency services can potentially reduce subsequent attempts and service demand by first-time suicide attempters.

A Critical Review of Treatment Studies

The treatment studies \( N = 14 \) available that address suicidality can be divided into two broad categories: those providing short-term treatment (i.e., less than 6 months, \( n = 12 \)) and those providing longer term therapy (i.e., 6 months or greater, \( n = 2 \)). The results have been decidedly mixed, with 8 rendering positive results about the efficacy of the treatment and 6 negative. However, among those with positive findings, the results are fairly consistent. Among the short-term studies, the majority \( n = 8 \) offered some variant of a cognitive–behavioral therapy, each integrating a problem-solving component in some form or fashion as a core intervention. This is not particularly surprising given that cognitive–behavioral therapy is perhaps the approach most amenable to a brief format. The duration of treatment varied across the studies ranging from a low of only 10 days (Liberman & Eekman, 1981) to a high of 3 months (Gibbons, Butler, Urwin, & Gibbons, 1978). It is important to note that 2 of the studies actually used the same sample (Joiner, Rudd & Rajab, in press; Rudd, Rajab, et al., 1996), which resulted in a total of 7 unique study samples on which to base conclusions about the efficacy of time-limited cognitive–behavioral (i.e., with a problem-solving core component) treatment for suicidality.

Of the remaining four studies that fall within the brief treatment category, three explored the utility of what can be best described as an additive component to treatment as usual, that is, intensive follow-up care of some type, rather than the specific treatment modality (Chowdhury, Hicks, & Kreitzman, 1973; Fawton et al., 1981; Wala, 1977). One explored the impact of improved continuity of care on subsequent suicide attempts (Moeller, 1989). Of those studies addressing what was essentially an additive component to short-term treatment, results were fairly negative. Both studies targeted intensive short-term follow-up utilizing a combination of home visits, telephone contact, and more frequent routine treatment appointments. Neither found appreciable impact on subsequent attempts over periods ranging from 6 to 12 months (Gibbons et al., 1978; Hafton et al., 1981). Moeller (1989) found that efforts to improve the continuity of care, by ensuring the same clinician before and after hospitalization, had no impact on suicide attempts during the year-long follow-up period.
In contrast, Welu (1977) found that more intensive follow-up using home visits, telephone contact, and more frequent routine treatment appointments did reduce subsequent attempts in the experimental group over the 4-month follow-up period. The results are of limited use, however, because of the brief nature of follow-up monitoring. It is interesting to note that of the three studies addressing more intensive follow-up as an additive component to treatment as usual, the two with negative results purposefully excluded high-risk patients (i.e., as defined by factors such as a history of multiple attempts, active psychiatric treatment or diagnosis, or comorbid problems). The one study that included, and actually targeted, high-risk cases was by Welu (1977). The pattern of results may well suggest that more intensive outpatient treatment, irrespective of approach, is most appropriate for those identified as high-risk, as indicated by psychiatric diagnosis, a history of multiple attempts, or diagnostic comorbidity.

Of the long-term treatment studies, 1 evaluated the efficacy of dialectical behavior therapy (DBT; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). The other long-term treatment study evaluated the role of more intensive long-term follow-up care, cutting across multiple therapeutic approaches rather than a specific therapy model (Allard, Marshall, & Plante, 1992). In summary, of the 14 studies that addressed treatment outcome, only 8 actually evaluated the efficacy of a specific therapy.

The studies that evaluated the efficacy of brief cognitive-behavioral approaches, with an integrated problem-solving component, yielded results that were fairly uniform. Six of the eight studies rendered positive findings. Although differences were not found with respect to suicide attempts, reductions were noted in suicidal ideation (Joiner, Rudd, & Rajab, in press; Liberman & Eckman, 1981; Salkovkis, Atha, & Storer, 1990) and related symptomatology such as depression (Lerner & Clum, 1990; Liberman & Eckman, 1981; Salkovkis, Atha, & Storer, 1990), hopelessness (Lerner & Clum, 1990; Patsiokas & Clum, 1985), and loneliness (Lerner & Clum, 1990) over follow-up periods ranging from 3 months to 1 year. The two studies rendering negative findings found no reductions in suicide attempts during 9- to 12-month follow-up periods (Gibbons et al., 1978; Hawton et al., 1987). Both studies excluded individuals at high risk for subsequent suicide attempts. An additional problem for both studies is that the treatments were poorly defined and did not appear to be applied uniformly.

The long-term treatments had mixed results. Linehan et al. (1991) demonstrated efficacy of DBT in reducing subsequent attempts, hospital days, and improving treatment compliance over a 1-year follow-up period. Her results, along with those of Rudd, Rajab, et al. (1996), also suggest that outpatient treatment of high-risk suicidal patients is not only safe but can be effective when acute hospitalization is available. In contrast, Allard et al. (1992) did not find a reduction of subsequent attempts at 24 months, but they utilized a mixture of therapeutic approaches. The mixed approach raises some questions about the specifics of the intervention as well as methodological concerns about uniformity of application.

Available results allow for only a few conclusions. These are nonetheless important and provide a foundation for articulating specific practice recommendations. The following conclusions have adequate support in the existing literature:

1. Intensive follow-up treatment following an attempt is most appropriate and effective for those identified as high risk. High risk is indicated by multiple attempts, psychiatric history, and diagnostic comorbidity.

2. Short-term cognitive–behavioral therapy that integrates problem solving as a core intervention is effective at reducing suicidal ideation, depression, and hopelessness over periods of up to 1 year. Such brief approaches do not appear effective in reducing attempts over enduring time frames.

3. Reducing suicide attempts requires longer term treatment and treatment modalities that target specific skill deficits such as emotion regulation, poor distress tolerance (i.e., impulsivity), anger management, interpersonal assertiveness, as well as other enduring problems, such as interpersonal relationships and self-image disturbance.

4. High-risk suicidal patients can be safely and effectively treated on an outpatient basis if acute hospitalization is available and accessible.

Integrating Science and Practice: Recommendations for Clinical Practice

The current scientific literature on the treatment of suicidality is limited in quantity, interpretability, and specificity. Without question, we cannot effectively answer the most fundamental questions posed earlier regarding treatment of this population. Nonetheless, the data that has emerged helps to delineate practice recommendations founded in science and clinical experience, rather than litigation-derived failure scenarios.

Little scientific data is available addressing the efficacy of specific treatment modalities, treatment setting or identified conceptual models applied in clinical practice. Empirical prediction models have consistently failed, resulting in inordinately high false-positive and false-negative rates (e.g., Clark, Young, Scheltner, Fawcett, & Fogg, 1987; Mackinnon & Farberow, 1975; Motto, Heilbron, & Juster, 1985; Murphy, 1972, 1983, 1984; Pokorny, 1983, 1992). Moreover, these studies have lead to a single conclusion: Suicide or suicidal behavior cannot be reliably predicted in any individual case. As a result, we are limited in what can be recommended about setting, the formulation of a treatment plan, specific explanatory models, and modality-specific characteristics (e.g., efficacy, risks/benefits, costs, patient preference, and use of multiple modalities). Further, only a few studies have addressed issues of treatment withdrawal, help negation, or poor treatment response with this population (Jobes et al., 1997; Rudd, Joiner, & Rajab, 1995).

The existing literature has not reached a point of maturity regarding complex treatment issues. Suicidal patients are uniformly excluded from clinical trials because of liability and ethical concerns. Only in the last decade has clinical suicidology begun to embrace science as a means of finding out what works and under what conditions. A growing legion of creative souls, however, are venturing into the area of empirical clinical suicidology.

Practice recommendations. We can distill the existing literature down to the following practice recommendations:

1. When imminent risk does not dictate hospitalization, the intensity of outpatient treatment (i.e., more frequent appointments, telephone contacts, concurrent individual and group treatment) should vary in accordance with risk indicators for those identified as high risk.
2. If the target goal is a reduction in suicide attempts and related behaviors, treatment should be conceptualized as long-term and target-identified skills deficits (e.g., emotion regulation, distress tolerance, impulsivity, problem solving, interpersonal assertiveness, anger management), in addition to other salient treatment issues.

3. If therapy is brief and the target variables are suicidal ideation, or related symptomatology such as depression, hopelessness, or loneliness, a problem-solving component should be used in some form or fashion as a core intervention.

4. Regardless of therapeutic orientation, an explanatory model should be detailed identifying treatment targets, both direct (i.e., suicidal ideation, attempts, related self-destructive and self-mutilatory behaviors) and indirect (depression, hopelessness, anxiety, and anger; interpersonal relationship dysfunction; low self-esteem and poor self-image; day-to-day functioning at work and home).

5. Use of a standardized follow-up and referral procedure (e.g., letters or phone calls) is recommended for those dropping out of treatment prematurely in an effort to enhance compliance and reduce risk for subsequent attempts.

6. The lack of definitive data regarding the efficacy of one approach over another should be reviewed with the patient as a component of informed consent.

Informed Consent

The ethical guidelines of the American Psychological Association (APA, 1992) are explicit about the importance of providing appropriate and understandable informed consent to any patient seeking clinical treatment (Section 4.02), as well as the need for structuring the clinical relationship with the patient (Section 4.01). These ethical guidelines are certainly relevant across clinical presentations, but they are particularly critical to clinical work with suicidal patients.

At a fundamental level, the potential life-and-death nature of the suicidal presentation creates an inherent paradox that can potentially strike at the heart of therapeutic work. To be specific, it is axiomatic that confidentiality is essential to building a strong therapeutic alliance, yet legal statutes in the United States typically require the breach of confidentiality in cases where there is imminent physical danger to self or others. In cases of imminently suicidal patients, breaches of patient confidentiality by clinicians are done to ensure the physical safety of such patients (i.e., patients are hospitalized into inpatient settings, whether they want to be or not). Although the clinician may be following legal requirements, such interventions are not always welcomed by suicidal patients, who may feel coercively tricked, trapped, and otherwise disinclined to ever seek mental health treatment again (Szasz, 1986). Thus, the life-and-death nature of suicidality can potentially serve to pit a patient (who may see suicide as a personal right) against his or her clinician (who may understand that preventing suicide, using whatever means necessary, is both a statutory and professional obligation). Unfortunately, the potential for an adversarial power struggle around issues of safety and hospitalization tends to undermine the essential ingredient for any positive therapeutic outcomes—a strong and positive therapeutic alliance (Horvath & Greenberg, 1994). Given these considerations, it is clearly in the patient’s best interest to provide complete and appropriate informed consent prior to treatment and to carefully structure the therapeutic relationship early on in the course of developing a viable treatment plan.

If a potentially suicidal patient has received thorough informed consent about the legal parameters of confidentiality and the importance of outpatient physical safety, they can then proceed in good faith with their clinician toward developing an appropriate treatment plan. As discussed by Rice and Jobes (1997), this kind of informed consent can be provided to the prospective patient in written form as well as verbally in a no-strings-attached initial session of consultation. The goals of the initial consultation is for the clinician to make a preliminary set of recommendations about the best course of care for the patient and for the patient to thereby determine the best choices as to how to proceed. For example, the clinician may recommend treatment elsewhere in a different clinical setting or with another clinician if that is in the patient’s best interest. The patient, in turn, may agree or disagree with the clinician’s recommendations but is free to choose how to proceed in either case. In many cases, the best option is to contract for a specific period (e.g., three to four sessions) of extended evaluation. This approach then provides a second opportunity at the end of the contracted period for the clinician to make further treatment recommendations from a more knowledgeable perspective and for the patient to then choose the best course of care.

It is important to note that providing thorough informed consent from the start creates a shared understanding of the ground rules pertaining to confidentiality and safety. In that regard the imminently suicidal patient does not have to be surprised that inpatient hospitalization may be the recommendation and the necessary intervention of choice for the clinician. Short of the clear-and-imminent-danger threshold, there is considerable room for both parties to evaluate and discern the most viable course of outpatient treatment.

The value of carefully discussing various aspects of future treatment, as well as the structure of the clinical relationship, cannot be overemphasized. In the spirit of APA ethical guidelines, this might involve extensive detailed discussions of various treatment options and goals, the potential duration of such treatments, fees for service and longer term costs of treatment (including the limits of managed health care coverage), and various confidentiality and safety issues. Moreover, the clinician can further clarify his or her position on outpatient safety, availability between sessions, the treatment techniques he or she would anticipate using, and other considerations that are relevant to the clinical relationship. The patient, therefore, receives critical front-end information about the potential benefits, costs, time commitment, and other parameters of the available treatment options directly from the clinician so that he or she can make the most informed and best choice about his or her own clinical care (Rice & Jobes, 1997).

Practice recommendations. With respect to informed consent, we offer the following practice recommendations.

7. Provide informed consent pertaining to limits of confidentiality in relation to clear and imminent suicide risk and offer a detailed review of available treatment options, fees for service (both short- and long-term), risks/benefits, and the likely duration of treatment (especially for multiple attempts and those evidencing chronic psychiatric problems).

8. Provide an extended evaluation prior to specific treatment
recommendations when patients present with more complex diagnostic issues or chronic suicidality.

Diagnosis

The importance of diagnosis as it relates to the treatment of suicidality is striking. One of the most well-established empirical findings in the field of suicide research is the consistent presence of a major psychiatric mental disorder, or comorbid disorders, among individuals who complete suicide. Indeed, in a review by Clark and Fawcett (1992), a major psychiatric diagnosis was implicated in no less than 93% of cases of adult suicides according to six different psychological autopsy studies conducted in the United States, United Kingdom, Sweden, and Australia. Similarly, psychological autopsy findings about the presence of major diagnoses are seen among 90% of adolescents who kill themselves (Brent & Perper, 1995). Therefore, the presence of any DSM-IV (Diagnostic and Statistical Manual of Mental Disorders [4th ed.]; American Psychiatric Association, 1994) Axis I or Axis II mental disorder is a meaningful risk factor for suicidality.

The mental disorders most associated with completed suicides (e.g., mood-spectrum disorders, substance abuse, schizophrenia, organic brain syndromes, and personality disorders) have a variety of potentially effective psychopharmacological and psychosocial treatments that may help manage symptoms and ameliorate suffering (Jobes, 1995). Thus, successful treatment of suicidality must necessarily focus on the treatment of underlying psychiatric conditions that give rise to suicide. Treatment should make use of appropriate treatment modalities with proven efficacy. For example, unipolar depression may be treated by use of an antidepressant medication (Slaby & Dumont, 1992) and cognitive therapy (Beck, Rush, Shaw, & Emery, 1979). Psychotic symptoms may be managed by antipsychotic medications (Kahn, Prowda, & Trautman, 1995), whereas a borderline personality disorder might be treated using dialectical behavior therapy (Linehan et al., 1991). Whatever the case, the inherent value of diagnosis and treatment of the underlying psychopathology that is linked to suicide is simply beyond debate.

Practice recommendations. In terms of diagnosis, the following practice recommendations are offered.


Monitoring Suicidality

It is well known that suicidal states ebb and flow, wax and wane, over time, particularly when effective treatment is made available to an otherwise suicidal patient. As discussed by Jobes (1995), suicidality is not a unitary phenomenon. The psychosocial nature of being suicidal varies widely from patient to patient. For example, in the presence of an acute crisis and perhaps an Axis I mental disorder, a suicidal state can effectively “resolve” in short order with appropriate crisis-oriented psychotherapy and use of medications (Jobes, 1995). This is illustrated in one recent study of 106 suicidal college students treated in a counseling center setting, wherein 55 students met operational criteria for no suicidal thoughts, feelings, or behaviors after an average of only 6½ sessions (Jobes, Jacoby, Cimbolic, & Hustead, 1997). It should be noted, however, that 18 suicidal students remained chronically preoccupied with suicidality after an average of almost 17 sessions. Being suicidal clearly means different things to different people. Clinicians often do not make the thoughtful distinctions between different types of suicidality that may require distinctly different types of treatments (Jobes, 1995; Jobes et al., 1997).

Given that suicidal states inherently vary over time, and potentially in response to treatment, it is essential for the prudent clinician to continually monitor, assess, and document the ongoing risk of suicidality as well as the general status of the patient’s psychopathology (Bongar et al., 1992). This can be done in a relatively unstructured fashion by maintaining ongoing contemporaneous documentation of ongoing suicide risk in the form of clinical progress notes (Berman & Jobes, 1991) or through a more structured tracking approach (Jobes, 1995; Jobes et al., 1997; Jobes & Berman, 1993). Whatever the method, it is critical to monitor the continued risk of suicide so that a potentially suicidal patient does not fall through the cracks. Such monitoring is an essential component of good clinical practice and addresses malpractice-related concerns pertaining to potential negligence for failing to adequately document clinical judgements, rationales, and ongoing observations (refer to Bongar et al., 1992).

Practice recommendations. Practice recommendations for monitoring suicidality include the following:

11. Routinely monitor, assess, and document a patient’s initial and ongoing suicide risk and document interventions for maintaining outpatient safety until suicidality has clinically resolved.

12. For cases of chronic suicidality, monitor, assess, and document ongoing risk of suicidality and document interventions that address the chronic nature of the suicidal preoccupations. It is important to note the chronicity of some symptoms (e.g., specific suicidal thoughts with a definitive plan), indicating factors that escalate risk (i.e., emergence of intent) versus those that diminish risk (e.g., lack of intent).

Treatment Duration

The efficacy of relatively short-term, problem-solving, and crisis-oriented outpatient treatments for suicidal ideation has been well established within the empirical literature (Jobes et al., 1997; Lerner & Clum, 1990; Rudd et al., 1996). Other treatment studies of suicide attempters have consistently demonstrated the efficacy of cognitive–behavioral techniques (Liberman & Eckman, 1981; Linehan et al., 1991; Salkovskis et al., 1990).

Within the clinical suicidology literature, there is a growing consensus that it is useful to organize suicidality into at least two distinct typologies: acute suicidal states versus chronic suicidal states (Ellis & Newman, 1996; Jobes, 1995; Maris, 1991; Pulakos, 1993). As discussed by Jobes (1995), acutely suicidal patients tend to have more DSM-IV Axis I-oriented problems with more internally focused (“intrapsychic”) issues. In contrast, chronically suicidal patients tend to have more DSM-IV Axis II-oriented problems with more external–relational (“interpsychic”) issues.

It follows that if these conceptual typologies are valid and their respective links to Axis I and Axis II diagnoses are true, then one can readily anticipate different treatment durations for effective clinical outcomes. To be specific, a quick remission of symptoms for an acute Axis I suicidal patient would be expected because of
the proven efficacy of problem-focused, crisis-intervention, psychotherapy, and the value of pharmacological therapies (Jobes, 1995). In contrast, a longer duration of treatment would be expected for a chronic Axis II suicidal patient because short-term crisis intervention work tends not to work with such patients and Axis II difficulties are not managed well by medications. Moreover, it is important to note that classic crisis-intervention techniques with chronically suicidal patients may actually serve to behaviorally reinforce, perpetuate, and even increase certain suicidal behaviors (see Pulakos, 1993). Fortunately, behaviorally oriented treatment that reinforces adaptive problem solving, teaches skill building, and emphasizes the importance of the patient taking responsibility for their behavior has been shown to be effective in decreasing suicidal behaviors and the need for inpatient care (Linehan et al., 1991). Nevertheless, successful treatment of chronically suicidal patients may take months, even years.

**Practice recommendations.** Relevant practice recommendations in terms of treatment duration include the following:

13. For acute crisis cases of suicidality (particularly in the presence of an Axis I disorder), provide a relatively short-term psychotherapy that is directive and crisis focused, emphasizing problem solving and skill building as core interventions.

14. For chronic cases of suicidality (particularly in the presence of an Axis II disorder), provide a relatively long-term psychotherapy in which relationship issues, interpersonal communication, and self-image issues are the predominate focus of treatment when crises have resolved.

**The Therapeutic Relationship**

In their now-classic text on the treatment of depression, Beck and colleagues (Beck, Rush, Shaw, & Emery, 1979) devoted an entire early chapter to the importance of the therapeutic relationship to successful treatment. Within the empirical literature, there is clearly a wealth of evidence that the alliance is the key variable for predicting successful outcomes across different types of treatments (e.g., Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998). The importance of the therapeutic relationship when working with suicidal patients is no less true. In fact, because of issues raised earlier (e.g., the inherent challenges of assessing and treating suicidality, fears of losing patients, and anxiety related to malpractice liability), the need for a strong alliance may be particularly germane to successful clinical work with suicidal patients (Jobes & Malsberger, 1995). Nevertheless, the challenges of working with such patients may elicit nontherapeutic reactions in the clinician (e.g., fear, malice, aversion, "emphatic dread"), which may lead to an avoidant or fear-based form of treatment that is not in the patient’s best interest. It is fortunate that training and knowledge in clinical suicidology can lead to clinical confidence so the clinician can build a healing relationship through empathic fortitude and perseverance. Through such a relationship, the suicidal patient may experience tangible relief from his or her sense of profound despair and realize a potentially life-saving connection in the midst of their inner experience of being abjectly alone (Jobes & Malsberger, 1995).

**Practice recommendations.** The importance of the therapeutic relationship is apparent in the following practice recommendations.

15. Develop a strong therapeutic alliance with the suicidal patient and make the clinical relationship central to the outpatient treatment plan (e.g., negotiating access, using the relationship as a source of safety and support during crises, attending to the patient’s sense of profound loneliness).

16. Monitor and respond to countertransference reactions to the suicidal patient (particularly those that are chronically suicidal) and routinely seek professional consultation, supervision, and support for difficult cases.

**Measuring Treatment Outcome**

Measuring change in the treatment of suicidal behavior depends on a range of factors. First, it is essential to use a standard nomenclature for distinguishing what is suicidal and what is self-multilateral and self-destructive. Without it, treatment progress is almost impossible to gauge and monitor. Second, it is important to distinguish between direct and indirect markers of suicidality. And, third, it is essential to distinguish between acute and chronic variables in the suicidal process. If these factors are addressed, then a general and useful framework can be established and maintained to monitor the progress of the suicidal patient.

In terms of nomenclature, it is recommended that the one proposed by O’Carroll et al. (1996) be universally adopted. It represents the best the field of clinical suicidology has to offer. O’Carroll et al. called for a differentiation between suicide attempts and instrumental suicidal behavior. This is a useful distinction for accurate risk assessment and effective treatment. The notion of direct and indirect markers of suicidality in treatment outcome is a concept that has not been previously addressed. It is critical to distinguish between the two. Direct markers of suicidality improve as acute risk wanes, whereas indirect markers might well endure for years. For a more thorough discussion of this concept, see Rudd (1998).

Direct markers are fairly straightforward and include suicidal ideation (i.e., frequency, intensity, duration, and specificity) and suicidal behaviors (attempts and instrumental behaviors). Indirect markers range from symptomatic variables (e.g., hopelessness, depression, anxiety, impulsivity, anger) to individual characteristics (e.g., attributional style, cognitive rigidity, problem-solving ability) to personality traits (i.e., in accordance with DSM–IV). Direct and indirect markers of suicidality can be monitored and assessed in a number of ways. Of importance, however, is the need to balance and integrate subjective and objective measures using available psychometric instruments during the course of treatment. Distinguishing between direct and indirect markers of suicidality allows the clinician to differentiate between acute and chronic variables in the suicidal process. Clearly articulating chronic variables helps establish reasonable expectations regarding the treatment process and outcome, facilitates more accurate risk assessment, and lends itself to a high-quality standard of care.

**Practice recommendations.** The following recommendations are offered to guide treatment outcome monitoring:

17. Use a clearly articulated scheme for identifying, classifying, and discussing suicidal behaviors in treatment (e.g., that provided by O’Carroll et al., 1996).

18. Use a consistent approach to assessing treatment outcome, incorporating both direct (i.e., suicidal ideation, suicide attempts, instrumental behaviors) and indirect markers of suicidality (i.e.,
markers of symptomatology, personality traits, or general level of
day-to-day functioning).

19. Assess treatment outcome at predictable intervals, using
psychometrically sound instruments to compliment and balance
patient self-report.

Special Considerations for the Treatment of Adolescents

Adolescents develop and thrive within, and are dependent on, a
family and a broader social context. While dealing with rapid
physical growth and sexual maturation, striving for increased
behavioral freedom and emotional autonomy, and learning about
themselves (i.e., forming and independent identity), adolescents
are also living with other members of their family, attending
school, and interacting with peers each day. Even those who fail to
attend school regularly, or who have dropped out of school,
usually hang out with peers on a regular basis. These social
contexts—family, school, and peer group—have several implica-
tions for the treatment of suicidal adolescents.

The family serves a number of significant functions for adoles-
cents (Dusek, 1987). The healthy family context provides food and
shelter, attends to safety issues, offers structure and predictability,
offers affection and companionship, and provides some instruction
and role modeling. In some families, physical punishment, sexual
abuse, and other types of harmful behavior and negative role
modeling occur (e.g., suicidal behavior, drug abuse, illegal behav-
ior). Although family factors may not have a direct or linear
relationship to suicidal behavior in adolescence, they are clearly
woven into the matrix of risk factors (Berman & Jobes, 1991;
King, 1997).

Other family characteristics such as parent–adolescent commu-
nication problems, low levels of family support, and parental
psychopathology have been correlated with attempted suicide dur-
ing adolescence (e.g., Brent et al., 1994; Cohen-Sandler, Berman,
& King, 1982; King, Segal, Naylor, & Evans, 1993). Although
some of these characteristics may also be present in other adoles-
cents seeking psychiatric treatment, they are consistent with an
unhealthy developmental trajectory and the exacerbation of psy-
chopathology. This link between family characteristics and suicidal-
ity is also evident in findings from psychological autopsy studies of
adolescent suicide victims. In these studies, parents or close
relatives of adolescent suicide completers were found to have more
likely engaged in suicidal behavior than were relatives of commu-
nity controls (e.g., Brent et al., 1994; Shaffii, Carrigan, Whitting-
hill, & Derrick, 1985). These data indicate both family modeling of
suicide as a means of coping and suggest the presence of serious
parental psychopathology.

Parental psychopathology may also influence adolescents’ treat-
ment outcomes. Brent et al. (1998) found the efficacy of
cognitive–behavioral therapy in the treatment of depression plun-
met when maternal depression was present. Other studies have
also shown that paternal psychopathology negatively impacts the
outcome of youth depression (e.g., Warner, Weissman, Fendrich,
Wickramatne, & Moroeau, 1992). Although these data are not
specific to adolescent suicidality, depression is a well-established
suicide risk factor (e.g., Shaffer, Garland, Gould, Fisher, & Traut-
man, 1988), and this pattern of findings converges with others
concerning parental psychopathology in relation to adolescent
suicidality and treatment follow-through (e.g., King et al., 1993).

Clinicians who provide outpatient treatment for suicidal adoles-
cents are faced with determining how to help the adolescent shift
onto a healthier and less suicidal developmental pathway. This
requires a consideration of exacerbating environmental conditions
and their possible modification. A review of the empirical litera-
ture on family dysfunction in relation to adolescent suicidality
suggests that effective outpatient treatment may require helping
parents or caregivers to fulfill their multiple parenting functions
more competently.

Practice recommendations. The following practice recom-
endations are specific to adolescents.

20. Involve parents or guardians in the initial assessment, treat-
ment planning, and ongoing suicide risk assessment process. Ac-
knowledge their helpful contributions and empower them to have
positive influences in their roles as parents and caregivers.

21. Evaluate the parent or caregiver’s ability to fulfill essential
parental functions such as the provision of food and shelter and the
maintenance of a safe, nonabusive home environment for the
suicidal adolescent. If there exists a concern about the adolescent’s
basic care and safety, address with parents or caregivers directly
and notify protective services if appropriate.

22. Evaluate the parent or caregiver’s ability to fulfill other
parental functions such as consistent limit setting with follow-
through, healthy communication with the adolescent, and positive
role modeling. Recommend treatment for severe, identifiable pa-
rental psychopathology and recommend interventions as needed to
(a) assist and empower parents in fulfilling their supportive and
limit-setting functions, and (b) assist family members in improving
their communication skills and relationships with each other.

A Few Closing Words

Twenty-two succinct practice recommendations have been off-
ered for treating and managing suicidal patients on an outpatient
basis. This is only a start. It is critical that we acknowledge what
we do not know. In doing so, we may be motivated to overcome
the limitations of the current state of treatment research in suicid-
ality. The current literature does, however, provide an empirical
base on which to build practice recommendations in suicidality.
These recommendations will continue to evolve in response to
further scientific investigation and considerable collegial and pro-
fessional debate. This is a first step in what will be a long and
productive process of improving the care for individuals in the
largest need of therapeutic help for suicidality.

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