

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, Dahm, & 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., Slaikeu, 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., Maltzberger, 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., Jobes, Jacoby, Cimboic, & Husted, 1997; Maltzberger, 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, 1990; 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 nonpsychiatric 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 ease of access (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 (Lieberman & Eckman, 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, & Kreitman, 1973; Hawton et al., 1981; Welu, 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 a period ranging from 6 to 12 months (Gibbons et al., 1978; Hawton 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; Patsiakos & 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, Scheftner, Fawcett, & Fogg, 1987; Mackinnon & Farberow, 1975; Motto, Heilbron, & Juster, 1985; Murphy, 1972, 1983, 1984; Pokorny, 1983, 1992). Moreover, these studies have led 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 in-

formed 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 attempters 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.

9. Evaluate for *DSM-IV* Axis I and Axis II diagnoses and document supporting symptomatology.

10. Provide diagnostic and symptom-specific treatment recommendations.

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, Cimboric, & Husted, 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 (Lieberman & 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, Courmoyer, & 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 & Maltsberger, 1995). Nevertheless, the challenges of working with such patients may elicit nontherapeutic reactions in the clinician (e.g., fear, malice, aversion, "empathic 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 & Maltsberger, 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-multilatory 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 implications for the treatment of suicidal adolescents.

The family serves a number of significant functions for adolescents (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 behavior). 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 communication problems, low levels of family support, and parental psychopathology have been correlated with attempted suicide during 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 adolescents seeking psychiatric treatment, they are consistent with an unhealthy developmental trajectory and the exacerbation of psychopathology. This link between family characteristics and suicidality 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 community controls (e.g., Brent et al., 1994; Shafii, Carrigan, Whittinghill, & 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' treatment outcomes. Brent et al. (1998) found the efficacy of cognitive-behavioral therapy in the treatment of depression plummeted 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, & Trautman, 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 adolescents 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 literature 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 recommendations are specific to adolescents.

20. Involve parents or guardians in the initial assessment, treatment planning, and ongoing suicide risk assessment process. Acknowledge 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 parental 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 offered 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 suicidality. 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 professional debate. This is a first step in what will be a long and productive process of improving the care for individuals in the greatest need of therapeutic help for suicidality.

References

- Allard, R., Marshall, M., & Plante, M. (1992). Intensive follow-up does not decrease the risk of repeat suicide attempts. *Suicide & Life-Threatening Behavior*, 22, 303-314.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist*, 47, 1597-1610.
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.
- Berman, A. L., & Jobes, D. A. (1991). *Adolescent suicide: Assessment and intervention*. Washington, DC: American Psychological Association.
- Bongar, B., Maris, R. W., Berman, A. L., & Litman, R. E. (1992).

- Outpatient standards of care and the suicidal patient. *Suicide & Life-Threatening Behavior*, 22, 453–478.
- Bongar, B., Maris, R., Berman, A. L., Litman, R., & Silverman, M. (1993). Inpatient standards of care and the suicidal patient: Part I. General clinical formulations and legal considerations. *Suicide & Life-Threatening Behavior*, 23, 245–256.
- Brent, D. A., Kolko, D. J., Birmaher, B., Baugher, M., Bridge, J., Roth, C., & Holder, D. (1998). Predictors of treatment efficacy in a clinical trial of three psychosocial treatments for adolescent depression. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 906–914.
- Brent, D. A., & Perper, J. A. (1995). Research in adolescent suicide: Implications for training, service delivery, and public policy. *Suicide & Life-Threatening Behavior*, 25, 222–230.
- Brent, D. A., Perper, J. A., Moritz, G., Liotus, L., Schweers, J., Balach, L., & Roth, C. (1994). Familial risk factors for adolescent suicide: A case-control study. *Acta Psychiatrica Scandinavica*, 89, 52–58.
- Chowdhury, N., Hicks, R., & Kreitman, N. (1973). Evaluation of an after-care service for parasuicide (attempted suicide patients). *Social Psychiatry*, 8, 67–81.
- Clark, D. C., & Fawcett, J. (1992). Review of empirical risk factors for evaluation of the suicidal patient. In B. Bongar (Ed.), *Suicide: Guidelines for assessment, management, and treatment* (pp. 16–48). New York: Oxford University Press.
- Clark, D., Young, M., Scheffner, W., Fawcett, J., & Fogg, L. (1987). A field-test of Motto's risk estimator for suicide. *American Journal of Psychiatry*, 144, 923–926.
- Cohen-Sandler, R., Berman, A. L., & King, C. A. (1982). Life stress and symptomatology: Determinants of suicidal behavior in children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 21, 178–186.
- Dusek, J. B. (1987). *Adolescent development and behavior*. Englewood Cliffs, NJ: Prentice-Hall.
- Ellis, T. E., & Newman, C. F. (1996). *Choosing to live: How to defeat suicide through cognitive therapy*. Oakland, CA: New Harbinger Publications.
- Garfield, S. (1996). Some problems associated with “validated” forms of psychotherapy. *Clinical Psychology: Science and Practice*, 3, 218–229.
- Gaston, L., Thompson, L., Gallagher, D., Cournoyer, L. G., & Gagnon, R. (1998). Alliance, technique, and their interactions in predicting outcome of behavioral, cognitive, and brief dynamic therapy. *Psychotherapy Research*, 8, 190–209.
- Gibbons, J., Butler, J., Urwin, P., & Gibbons, J. (1978). Evaluation of a social work service for self-poisoning patients. *British Journal of Psychiatry*, 133, 111–118.
- Havik, O., & VandenBos, G. (1996). Limitations of manualized psychotherapy for everyday clinical practice. *Clinical Psychology: Science and Practice*, 3, 264–267.
- Hawton, K., Bancroft, J., Catalan, J., Kingston, B., Stedford, A., & Welch, N. (1981). Domiciliary and out-patient treatment of self-poisoning patients by medical and non-medical staff. *Psychological Medicine*, 11, 169–177.
- Hawton, K., McKeown, S., Day, A., Martin, P., O'Connor, M., & Yule, J. (1987). Evaluation of outpatient counselling compared with general practitioner care following overdoses. *Psychological Medicine*, 17, 751–761.
- Hersch, L. (1995). Adapting to health care reform and managed care: Three strategies for survival and growth. *Professional Psychology: Research and Practice*, 26, 16–26.
- Hirsch, S., Walsh, C., & Draper, R. (1983). The concept and efficacy of the treatment of parasuicide. *British Journal of Clinical Psychopharmacology*, 15, 189S–194S.
- Horvath, A. O., & Greenberg, L. S. (Eds.) (1994). *The working alliance: Theory, research, and practice*. New York: Wiley.
- Jobes, D. A. (1995). The challenge and promise of clinical suicidology. *Suicide & Life-Threatening Behavior*, 25, 437–449.
- Jobes, D. A., & Berman, A. L. (1993). Suicide and malpractice liability: Assessing and revising policies, procedures, and practice in outpatient settings. *Professional Psychology: Research and Practice*, 24, 91–99.
- Jobes, D. A., Jacoby, A. M., Cimboric, P., & Husted, L. A. T. (1997). Assessment and treatment of suicidal clients in a university counseling center. *Journal of Counseling Psychology*, 44, 368–377.
- Jobes, D. A., & Maltzberger, J. T. (1995). The hazards of treating suicidal patients. In M. Sussman (Ed.), *A perilous calling: The hazards of psychotherapy practice* (pp. 200–214). New York: Wiley.
- Joiner, T., Rudd, M., & Rajab, M. (in press). An intriguing interaction between comorbid diagnostic status and treatment type in predicting treatment response among suicidal young adults. *American Journal of Psychiatry*.
- Kahn, J. P., Prowda, K. J., & Trautman, P. D. (1995). Adolescent suicide: Diagnosis, psychopharmacology, and psychotherapeutic management. In J. K. Zimmerman & G. M. Asnis (Eds.), *Treatment approaches with suicidal adolescents* (pp. 219–240). New York: Wiley.
- King, C. A. (1997). Suicidal behavior in adolescence. In R. Maris, M. Silverman, & S. Canetto (Eds.), *Review of suicidology* (pp. 61–95). New York: Guilford Press.
- King, C. A., Segal, H., Naylor, M., & Evans, T. (1993). Family functioning and suicidal behavior in adolescent inpatients with mood disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, 32, 1198–1206.
- Lerner, M. S., & Clum, G. A. (1990). Treatment of suicide ideators: A problem-solving approach. *Behavior Therapy*, 21, 403–411.
- Lieberman, R. P., & Eckman, T. (1981). Behavior therapy vs. insight-oriented therapy for repeated suicide attempters. *Archives of General Psychiatry*, 38, 1126–1130.
- Linehan, M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Linehan, M. (1997). Behavioral treatments of suicidal behaviors. In D. M. Soff, J. J. Mann, et al. (Eds.), *Annals of the New York Academy of Sciences: The neurobiology of suicidal behavior* (pp. 302–328). New York: New York Academy of Sciences.
- Linehan, M. M., Armstrong, H. E., Suarez, A., Allman, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 48, 1060–1064.
- Litman, R., & Wold, C. (1976). Beyond crisis intervention. In E. Shneidman (Ed.), *Suicidology: Contemporary developments* (pp. 528–546). New York: Grune & Stratton.
- MacKinnon, D., & Farberow, N. (1975). An assessment of the utility of suicide prediction. *Suicide & Life-Threatening Behavior*, 6, 86–91.
- Maltzberger, J. (1993). Problems in the care of suicidal patients. *American Association of Suicidology Newslink*, 19, 3–5.
- Maltzberger, J. (1994). Calculated risk-taking in the treatment of suicidal patients: Ethical and legal problems. In A. Leenaars, J. Maltzberger, & R. Neimeyer (Eds.), *Treatment of suicidal people* (pp. 195–205). Washington, DC: Taylor & Francis.
- Maris, R. (1991). The developmental perspective of suicide. In A. Leenaars (Ed.), *Life span perspectives of suicide: Time-lines in the suicide process* (pp. 25–38). New York: Plenum Press.
- Moeller, H. (1989). Efficacy of different strategies of aftercare for patients who have attempted suicide. *Journal of the Royal Society of Medicine*, 82, 643–647.
- Montgomery, D., Roy, D., & Montgomery, S. (1981). Mianserin in the prophylaxis of suicidal behavior: A double blind placebo controlled trial. In *Depression and suicide: Proceedings of the 11th Congress of Suicide Prevention* (pp. 786–790). London: Pergamon Press.
- Montgomery, S., & Montgomery, D. (1982). Pharmacological prevention of suicidal behavior. *Journal of Affective Disorders*, 4, 291–298.
- Morgan, H., Jones, E., & Owen, J. (1993). Secondary prevention of

- nonfatal deliberate self-harm: The green card study. *British Journal of Psychiatry*, 163, 111–112.
- Motto, J. (1976). Suicide prevention for high-risk persons who refuse treatment. *Suicide & Life-Threatening Behavior*, 6, 223–230.
- Motto, J., Heilbron, D., & Juster, R. (1985). Development of a clinical instrument to estimate suicide risk. *American Journal of Psychiatry*, 142, 680–686.
- Murphy, G. (1972). Clinical identification of suicide risk. *Archives of General Psychiatry*, 27, 356–359.
- Murphy, G. (1983). On suicide prediction and prevention. *Archives of General Psychiatry*, 40, 343–344.
- Murphy, G. (1984). The prediction of suicide: Why is it difficult? *American Journal of Psychotherapy*, 38, 341–349.
- Nathan, P. (1998). Practice guidelines: Not yet ideal. *American Psychologist*, 53, 290–299.
- O'Carroll, P., Berman, A., Maris, R., Moscicki, E., Tanney, B., & Silverman, M. (1996). Beyond the Tower of Babel: A nomenclature for suicidology. *Suicide & Life-Threatening Behavior*, 26, 237–252.
- Patsiokas, A., & Clum, G. (1985). Effects of psychotherapeutic strategies in the treatment of suicide attempters. *Psychotherapy*, 22, 281–290.
- Pokorny, A. (1983). Prediction of suicide in psychiatric patients: Report of a prospective study. *Archives of General Psychiatry*, 40, 249–257.
- Pokorny, A. (1992). Prediction of suicide in psychiatric patients: Report of a prospective study. In R. Maris, A. Berman, J. Maltzberger, & R. Yufit (Eds.), *Assessment and prediction of suicide* (pp. 105–129). New York: Guilford Press.
- Pope, K., & Tabachnick, B. (1993). Therapists' anger, fear, and sexual feelings: National survey of therapist responses, client characteristics, critical events, formal complaints, and training. *Professional Psychology: Research and Practice*, 24, 142–152.
- Pulakos, J. (1993). Two models of suicide treatment: Evaluation and recommendations. *American Journal of Psychotherapy*, 47, 603–612.
- Rice, R., & Jobes, D. A. (1997, April). *Suicide, malpractice, and HMOs*. Paper presented at the meeting of the American Association of Suicidology, Memphis, TN.
- Rudd, M. (1998). An integrative conceptual and organizational approach to treating suicidality. *Psychotherapy*, 35, 346–360.
- Rudd, M., Dahm, P., & Rajab, H. (1993). Diagnostic comorbidity in persons with suicidal ideation and behavior. *American Journal of Psychiatry*, 150, 928–934.
- Rudd, M., & Joiner, T. (1998). The assessment, management, and treatment of suicidality: Towards clinically informed and balanced standards of care. *Clinical Psychology: Science and Practice*, 5, 135–150.
- Rudd, M., Joiner, T., & Rajab, H. (1995). Help negation after acute suicidal crisis. *Journal of Consulting and Clinical Psychology*, 63, 499–503.
- Rudd, M., Joiner, T., & Rajab, H. (1996). Relationships among suicide ideators, attempters, and multiple attempters in a young adult sample. *Journal of Abnormal Psychology*, 105, 541–550.
- Rudd, M. D., Rajab, M. H., Orman, D. T., Stulman, D. A., Joiner, T., & Dixon, W. (1996). Effectiveness of an outpatient intervention targeting suicidal young adults: Preliminary results. *Journal of Consulting and Clinical Psychology*, 64, 179–190.
- Salkovskis, P. M., Atha, C., & Storer, D. (1990). Cognitive-behavioral problem-solving in the treatment of patients who repeatedly attempt suicide. *British Journal of Psychiatry*, 157, 871–876.
- Seligman, M. (1996). Science as an ally of practice. *American Psychologist*, 51, 1071–1079.
- Seligman, M., & Levant, R. (1998). Managed care policies relay on inadequate science. *Professional Psychology: Research & Practice*, 29, 211–212.
- Shaffer, D., Garland, A., Gould, M., Fisher, P., & Trautman, P. (1988). Preventing teenage suicide: A critical review. *Journal of the American Academy of Child and Adolescent Psychiatry*, 27, 675–687.
- Shafii, M., Carrigan, S., Whittinghill, J. R., & Derrick, A. (1985). Psychological autopsy of completed suicide in children and adolescents. *American Journal of Psychiatry*, 142, 1061–1064.
- Sherman, M., & Thelen, M. (1998). Distress and professional impairment among psychologists in clinical practice. *Professional Psychology: Research and Practice*, 29, 79–85.
- Silverman, M., Berman, A., Bongar, B., Litman, R., & Maris, R. (1994). Inpatient standards of care and the suicidal patient: Part II. An integration with clinical risk management. *Suicide & Life-Threatening Behavior*, 24, 152–169.
- Slaby, A. E., & Dumont, L. E. (1992). Psychopharmacotherapy of suicidal ideation and behavior. In B. Bongar (Ed.), *Suicide: Guidelines for assessment, management, and treatment* (pp. 187–203). New York: Oxford University Press.
- Slaikeu, K. (1990). *Crisis intervention* (2nd ed.). Boston: Allyn & Bacon.
- Szasz, T. (1986). The case against suicide prevention. *American Psychologist*, 41, 806–812.
- Termansen, P., & Bywater, C. (1975). S.A.F.E.R.: A follow-up service for attempted suicide in Vancouver. *Canadian Psychiatric Association Journal*, 20, 29–34.
- Van Heeringen, C., Jannes, S., Buylert, W., Hendrick, H., De Bacquer, D., & Van Remoortel, J. (1995). The management of non-compliance with referral to outpatient after-care among attempted suicide patients: A controlled intervention study. *Psychological Medicine*, 25, 963–970.
- Warner, V., Weissman, M. M., Fendrich, M., Wickramaratne, P., & Moroeau, D. (1992). The course of major depression in the offspring of depressed parents: Incidence, recurrence, and recovery. *Archives of General Psychiatry*, 49, 795–801.
- Waterhouse, J., & Platt, S. (1990). General hospital admission in the management of parasuicide: A randomized controlled trial. *British Journal of Psychiatry*, 156, 236–242.
- Welu, T. (1977). A follow-up program for suicide attempters: Evaluation of effectiveness. *Suicide & Life-Threatening Behavior*, 7, 17–30.

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