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AN INTEGRATIVE CONCEPTUAL AND ORGANIZATIONAL FRAMEWORK FOR TREATING SUICIDAL BEHAVIOR

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The current article provides an integrative conceptual and organizational framework for addressing suicidal behavior in clinical practice with three identifiable goals. The first goal is to provide a clinically accessible summary of treatment and assessment tasks *(i.e., the* content *of therapy and assessment) consistent with existing standards of care and supported by empirical findings but not dependent on psychotherapeutic orientation. The second goal is to summarize and discuss the uniformity and clinical implications of relevant* process *variables, as well as the complicating role of time and chronicity in assessment and treatment. The third goal is to emphasize the varied roles, tasks, demands, and limitations of psychotherapy with suicidal patients. In general, the current article provides a flexible, yet comprehensive and thorough, template for treatment planning, risk assessment, patient management, and ongoing monitoring that is applicable regardless of the psychotherapeutic model employed. The hope is to impose functional structure on what, at times, can be a chaotic and crisis-filled process in order to facilitate efficient and effective treatment.*

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Over the last decade, the assessment and treatment of suicidal behavior has received increasing attention in day-to-day clinical practice. This trend is likely the result of a number of identifiable factors. First, the development and scientific testing of treatment approaches specifically targeting suicidal behavior has led to the refinement and direct clinical application of several integrative treatment models (e.g., Lerner & Clum, 1990; Linehan, 1993; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Rudd et al., 1996). Second, the emergence and proliferation of managed-care entities and related insurance restrictions on the frequency, intensity, duration, and type of treatment available to patients exhibiting severe psychopathology such as suicidal behavior has frequently forced providers to pursue outpatient alternatives rather than hospitalization (e.g., Rudd, Joiner, & Rajab, 1997). Third, a number of researchers have emphasized the diagnostic and, accordingly, treatment complexity (i.e., both Axis I and II) presented by suicidal patients (e.g., Linehan, 1993; Rudd, Dahm, & Rajab, 1993). Finally, the convergence of the following have forced clinicians to consider carefully the specific tasks (i.e., the content of assessment and psychotherapy) involved in providing care for suicidal patients and seek appropriate training and supervision: (a) the exponential increase in malpractice claims brought against care providers in cases of both inpatient and outpatient suicide (e.g., Jobes & Berman, 1993); (b) the emergence of ethical guidelines defining and mandating specific training, clinical experience, and areas of competence in working with suicidal patients (e.g., Bongar, 1992; Bongar & Harmatz, 1989; Kleepsies, 1993); (c) refinement in applied and research nomenclature in suicidology (O'Carroll et al., 1996); and (d) the recent publication of initial inpatient and outpatient standards of care (Bongar, Maris, Berman, & Litman, 1992; Bongar, Maris, Berman, Litman, & Silverman, 1993; Silverman, Berman, Bongar, Litman, & Maris, 1994).

The net result of this convergence of factors has essentially been threefold. First, there is a heightened level of awareness of the complexity of the issues clinicians face when working with suicidal patients, clinically, ethically, and legally. Second, there is increasing recognition of the specific, identifiable tasks of assessment and treatment that are unique to working with suicidal patients and uniform regardless of the psychotherapeutic orientation employed. And finally, clinicians have become acutely aware of the limitations in existing research on suicidality, noting the limited empirical support for much of what is routine in the clinical practice of assessment and treatment and highlighting the need for a clear, rational, and organized approach.

Although a number of theoretical models of suicidal behavior have been offered in the literature, they have essentially been competing and potentially contradictory in nature, often with limited clinical relevance (e.g., Bunney & Fawcett, 1965; Dublin, 1963; Durkheim, 1951; Freud, 1957; Hendin, 1964). Similarly, empirically-derived models, such as the oft-cited diathesis-stress-hopelessness model (e.g., Schotte & Clum, 1982, 1987; see Rudd, Rajab, & Dahm, 1994 for review), have had limited success in efforts at integration within the broader theoretical literature, despite greater clinical relevance and improved ease of direct application. Pulokas (1993) recently noted the competing nature of even crisis intervention and ongoing-therapy approaches to suicidal behavior. These theoretical inconsistencies are due, in part, to the failure to recognize that despite the variable nature of treatment tasks over time, there is relative uniformity in assessment and treatment tasks across the broad range of individual patients presenting with suicidal behavior. To date, the lack of an integrative conceptual and organizational framework that incorporates and emphasizes therapeutic and assessment tasks, regardless of psychotherapeutic orientation, hinders efforts to develop integrative approaches to psychotherapy for suicidal behavior. In addition, the lack of clearly articulated conceptual and organizational models limits our ability to monitor treatment outcome effectively and compare results across the few studies available. Although the specific mechanism of action may vary from clinician to clinician (i.e., the psychotherapeutic model), the content of therapy (i.e., treatment and assessment agendas and related tasks) is essentially identical, given both the distinct nature of the problem being targeted and the consistency in applicable research findings. This fundamental assumption is consistent with emerging empirical support for relatively broad-based approaches to treating suicidal behavior and provides a foundation for integrative conceptualization and organization (e.g., Layden, Newman, Freeman, & Morse, 1993; Linehan, 1993; Rudd et al., 1996).

The current article provides an integrative conceptual and organizational framework for treating suicidal behavior in clinical practice with three identifiable goals. The first goal is to provide a clinically accessible summary of treatment tasks (i.e., the content of therapy and assessment) consistent with existing standards of care and supported by empirical findings but not dependent on psychotherapeutic orientation. The second goal is to summarize and discuss the uniformity and clinical implications of relevant process variables, as well as the complicating role of time and chronicity in assessment and treatment. The third goal is to emphasize the varied roles, tasks, demands, and limitations of psychotherapy with suicidal patients. The current article provides a flexible, comprehensive, and thorough template for treatment planning, clinical risk assessment, patient management, and ongoing monitoring that is applicable regardless of psychotherapeutic orientation. Consistent with the discussion of emerging trends in psychotherapy integration offered by Norcross (1997), the integrative approach described is organized around identifiable problem areas, treatment goals, and related tasks that are uniform across suicidal patients, irrespective of diagnosis (both Axis I and II) and specific symptomatic presentation.

In paradoxical fashion, the organizational framework offered accentuates the complexity of treating suicidal behavior while simultaneously simplifying the treatment-planning process. As has been demonstrated, the suicidal patient represents perhaps the greatest and most anxiety-provoking challenge the practicing clinician faces. In response, many clinicians and outpatient facilities are simply refusing to accept suicidal patients for treatment (Jobes, Jacoby, Cimbolic, & Hustead, 1997). It is hoped that the framework provided will help diffuse some of the fear, anxiety, and apprehension associated with treating this population.

Psychotherapeutic Approaches to Treating Suicidal Behavior: A Paradigm Shift?

In the last decade in particular, a number of psychotherapeutic approaches specific to treating suicidal behavior have emerged. For the most part, they have been empirically grounded, emphasizing aspects that, although not entirely unique to suicidality, have been clearly linked to risk severity and treatment outcome (e.g., Maris, Berman, Maltsberger, & Yufit, 1992). In particular, researchers and clinicians alike have emphasized the importance of chronic suicidal behavior, identifiable skill deficits (e.g., problem-solving, emotion regulation, distress tolerance, cognitive rigidity), self-image disturbance, and related interpersonal functioning problems (e.g., Layden et al., 1993; Lerner & Clum, 1990; Linehan, 1993; Linehan et al., 1991; Rudd et al., 1996). Earlier and predominantly psychodynamic approaches emphasized developmental issues and the therapeutic relationship as central to treatment success (e.g., Schneidman, 1993). In sharp contrast, the more recent psychotherapeutic models summarized above have acknowledged the importance of both developmental trauma and the establishment of a strong therapeutic alliance, but have consistently emphasized individual deficits as the focus and core of treatment. These deficits essentially fall into three identifiable categories: (a) practical skills, (b) self-image, and (c) interpersonal relationships.

To some degree this paradigm shift has been influenced by the emergence of managed-care entities in the mental health landscape, mandating shorter-term, targeted, and symptom-focused treatment. Of importance, however, is that the approaches that have emerged are empirically grounded, with identifiable and quantifiable treatment targets. It is hoped that the result will be efficient and effective treatment and a more precise understanding and measurement of treatment outcome, both in terms of direct and indirect markers of suicidality (see Rudd, 1998 for a detailed discussion). Essentially, the content of treatment and, accordingly, the monitoring of psychotherapeutic change is more readily accessible and quantifiable. We can discuss clearly and cogently what we are actually doing in therapy, what we are working on specifically, what type of change we expect to occur, and where we are in the treatment process (i.e., what level of change has occurred) and measure this change over time. As discussed below, these approaches have lead to the identification of treatment and assessment tasks that provide a foundation for psychotherapeutic integration.

An Integrative Conceptual and Organizational Framework: An Overview of the Treatment Process and Planning

Consistent with existing standards of care, the assessment and therapeutic tasks essential in working with suicidal patients can be organized into four broad categories: (a) diagnosis, (b) assessment, (c) treatment, and (d) safeguarding and protection of the patient (Bongar, 1991, 1992; Jobes & Berman, 1993; Rudd & Joiner, 1998). The current article provides an integrative conceptual framework for organizing and monitoring these tasks throughout the duration of therapy, assuming accurate and thorough initial diagnosis. The primary focus of this article is on treatment, with integration of risk assessment tasks and, accordingly, safeguarding and protecting the patient in a somewhat superficial fashion. A detailed and thorough discussion of risk assessment is provided elsewhere (Rudd & Joiner, 1998).

Table 1 provides a treatment matrix, summarizing the treatment process. As illustrated, the treatment process is segmented into three phases: (1) crisis, (2) skill-building, and (3) personality development. Each phase has an identifiable, predominant treatment agenda; specific treatment targets or tasks; related goals; a specific therapeutic focus; and associated clinical techniques. The imposition of phases to treatment is somewhat artificial in nature, but provides necessary structure to the organization of assessment and therapeutic tasks. Clearly, patients will cycle through phases multiple times during the course of treatment, in all likelihood, exploring and solving similar problems in different ways as they build skills and enhance and modify their self-image and sense of confidence. Actually, for a significant number of suicidal patients it is anticipated that they will experience multiple suicidal crises during the course of treatment and, accordingly, cycle through each phase multiple times. In recognition of this

TABLE 1. Treatment Matrix

Phase:	Crisis	Skill-Building	Personality Development
Agenda:	Crisis Intervention	Short-Term	Long-Term
Targets:	Symptom Relief and Crisis Resolution: 1. Depression 2. Anxiety 3. Other identifiable symptoms (i.e., anger, guilt, panic, anhedonia, insomnia, attention-concentration impairment) 4. Hopelessness 5. Helplessness 6. Suicidal ideation 7. Suicidal behavior 8. Substance abuse 9. Sense of immediacy and urgency 10. Poor distress tolerance-impulsivity	Skill Development: 1. Problem-solving: a. Eliminate extreme responding and avoidance b. Develop structured and methodical approach c. Skill acquisition, strengthening, generalization 2. Emotion-regulation a. Learn to identify, understand feelings b. Learn to express constructively c. Learn to moderate feelings 3. Self-monitoring a. Awareness (label feelings) b. Understanding (normalizing experience) c. Responding (effective regulation) 4 Distress tolerance (i.e., impulsivity) a. Raise threshold for reaction b. Lower reactivity (lessen severity) c. Shorten recovery 5. Interpersonal skills a. Assertiveness: address passivity, avoidance, subjugation b. Attentiveness c. Responsiveness 6. Anger management a. Identify, recognize early signs b. Appropriate, constructive expression c. Empathy, acceptance, forgiveness	Self-Image and Interpersonal Functioning: Cognitive Restructuring 1. Hopeless nature of belief system 2. Identify, explore esteem, & efficacy issues a. Defective, inadequate, incompetent b. Unlovable c. Helpless 2. Identify, explore developmental trauma a. Abuse b. Neglect c. Abandonment 3. Identify, explore conflicts within the family and social systems a. Attachment b. Enmeshment c. Detachment, separation
Goals:	1. Resolve immediate crisis 2. Reduce suicidality 3. Instill hopefulness 4. Reduce symptoms	1. Improve level of functioning, return to premorbid or better 2. Develop or refine basic skills summarized above	1. Improve self-image 2. Resolve internal conflicts, developmental trauma, underlying core issues 3. Improve interpersonal relationships, including family
Level:	I: Stabilization II: Self-management III: Utilization	I: Skill acquistion II: Skill refinement III: Skill generalization	I: Stabilization II: Modification III: Refinement
Therapeutic Focus:	Crisis	Skill development	Personality development
Techniques:	Crisis intervention, Risk assessment, Pharmacotherapy	Individual, group psychotherapy	Individual, group, and/or family therapy
Role:	Active/directive	Collaborative	Reflective/supportive
Process Task:	Engagement	Attachment	Separation
Process Marker:	Past orientation	Present orientation	Future orientation

natural process, each phase has three identifiable levels, indicative of the variations in therapeutic and individual change and growth over time. Not all suicidal crises are identical. Although Slaikeu (1990) defined crisis as "a temporary state of upset and disorganization, characterized chiefly by an individual's inability to cope with a particular situation using customary methods of problem-solving" . . . (p. 15), the recurrent crises experienced by suicidal patients will vary in nature and quality over time. Nor is skill development or enduring personality change in psychotherapy by any means a uniform process.

As detailed in Table 1, the identifiable levels for the crisis phase include: crisis stabilization, crisis self-management, and crisis utilization. Although others have discussed the role of crises in the treatment of suicidal patients (e.g., Layden et al., 1993; Linehan, 1993), they have not offered an organizational framework for conceptualizing and monitoring change in the patient's experience over time. Not all crises are the same; their characteristic features and process of resolution can help gauge treatment progress across episodes. Crisis stabilization is characterized by the need for external stabilization, that is, direct intervention on the part of the mental health professional. This can take many forms including intervention via telephone, emergency sessions, or hospitalization. Crisis self-management refers to improved skill-level on the part of the patient so that direct intervention is no longer required. The patient can effectively manage the crisis on his or her own, despite acute emotional upset and dysphoria. The final phase labeled crisis utilization refers not only to effective management of the crisis but use of the crisis as an opportunity for personal growth and change, consistent with both skill generalization and enduring personality growth (see discussion of other phases below). For example, crisis utilization involves not only effective regulation of emotional upset such as acute anxiety or anger, but evidence of skill generalization from one stressor or circumstance to another (e.g., resolving recurrent interpersonal conflicts with a family member to spontaneous relationship problems at work) consistent with emerging personality transformation. Consistent with the definition offered in Diagnostic and Statistical Manual of Mental Disorders–4th Ed. (DSM-IV) (American Psychiatric Association, 1994), a personality disorder is characterized by inflexible, rigid, and problematic traits, which result in social and occupational dysfunction. Accordingly, the manifestation of change in the context of crisis is consistent with identifiable changes in personality structure and organization, despite the fact that they may be quite minor.

The levels identified for the skill-building phase are consistent with the conceptualization offered by others and are essentially self-explanatory. Specific skill development in psychotherapy is thought to progress in a fairly predictable fashion, particularly with suicidal patients, from acquisition to refinement and ultimately generalization across situations and circumstances (e.g., Layden et al., 1993; Linehan, 1993; Nezu, Nezu, & Perri, 1989). The identified levels for the personality-development phase are also consistent with other conceptualizations but more specific in nature (e.g., Beck & Freeman, 1990). Personality stabilization is characterized by skill acquisition and crisis management that allows the patient an improved level of day-to-day functioning, with elimination of extreme suicidal, self-mutilatory, and self-destructive behaviors, along with noticeable symptom remission. Personality modification is characterized by identification and specific targeting of maladaptive traits (e.g., passive-aggressiveness, avoidance) while the patient attempts to refine targeted skills and engage in self-management of crises. Finally, personality refinement is accomplished in concert with crisis utilization and skill generalization. In other words, the patient has experienced some fundamental and enduring changes and is making use of each available opportunity to further refine and generalize skills. The net result is a decrease in frequency and severity of crises and associated symptomatology and improved day-to-day functioning (i.e., both socially and occupationally).

Specific treatment targets from different phases will routinely be addressed simultaneously, although those from other than the predominant phase will be targeted to a lesser degree. During crisis intervention, for example, not only will acute symptomatology, suicidality, and hopelessness be the focus of intervention, but their successful resolution will also assist in skill-building and self-image and personality development.

Each phase demands variation in the role orientation of the therapist, ranging from directive to collaborative to reflective. The identified treatment phases are also hierarchical in nature, that is, in terms of the amount of time devoted to particular agenda items (i.e., targets) during treatment sessions. More specifically, in the crisis phase of treatment, a disproportionate amount of time will be spent with crisis-intervention tasks, depending on the patient's day-to-day stressors, symptom severity, and individual skill level. As a result, less time will be available for specific skill-building (e.g., problem-solving, emotion-regulation, interpersonal assertiveness, distress-tolerance and impulse control, anger management) and minimal time will be available to address self-image, interpersonal functioning, and developmental trauma issues. Naturally, the role-orientation of the clinician will be directive during this beginning phase, given the crisis-intervention nature of treatment. Identifiable goals during this phase of treatment include crisis resolution, reduction in suicidality (e.g., reduction in frequency, intensity, and duration of suicidal ideation; elimination of substance abuse; reduction in the risk of suicidal behavior by removing access to a method(s); adequate patient monitoring, cultivation of a sense of hopefulness, and general symptom reduction.

As the patient establishes an adequate skill repertoire, crises will resolve quickly and effectively, and concern for active symptomatology will be reduced with a disproportionate shift in time available to address specific skill deficits and target enduring issues of self-image, interpersonal functioning, and related developmental trauma. Accordingly, a collaborative orientation will predominate. As individual skill level develops further, the majority of time in treatment will be spent on the long term issues summarized above, with limited time devoted to skill refinement and little time to crisis intervention. There will be a natural shift in the therapeutic role orientation, taking on a reflective and supportive position, although active collaboration will continue. Goals during the personality-development phase of treatment revolve primarily around improvement in self-image; resolution of internal conflicts and related developmental trauma; and improvement in interpersonal, social, and family functioning. Each treatment phase, along with related goals and targets, is discussed in detail below, with reference to the case example provided.

A Clinical Example: The Case of Ms. A.

A clinical example is provided to illustrate how the initial treatment plan can be established (and continuously updated and modified) by applying this broad conceptual and organizational framework. The treatment matrix provided in Table 1 allows the practicing clinician to identify where the patient is at any point in the treatment process and, accordingly, clearly articulate the treatment plan. Such organization and structure have proven important for chronically suicidal patients (i.e., those making multiple attempts) and is likely one reason why cognitive-behavioral approaches have demonstrated success with this population (e.g., Layden et al., 1993; Lerner & Clum, 1990; Linehan, 1993; Linehan et al., 1991; Rudd et al., 1996).

The Case of Ms. A.

The patient, a middle-aged, recently separated, and twice-divorced white female presented for evaluation reporting that she had been acutely suicidal over the course of the last 2 weeks. She noted specific suicidal thoughts about shooting herself. She reported having thoughts about 10 times a day but described them as enduring "only for a few seconds" and that she "didn't intend on doing anything about them." The patient reported no prepatory behaviors of any type and noted that she did not own nor did she have access to a gun. She did, however, report three previous overdose attempts, all with no follow-up medical care nor psychiatric hospitalizations. She also noted a 20-year history of chronic suicidality with recurrent self-mutilatory behavior, reporting that she would cut on her arms and legs (i.e., in areas covered by clothing so that others would not notice) with a razor blade to "relieve tension." The patient reported that she had experienced extensive depressive symptomatology for 2 months since the breakup of her last relationship. More specifically, she reported persistent depressed mood, anhedonia, weight loss of 20 pounds, insomnia, some agitation, poor energy and fatigue, feelings of worthlessness, and diminished attention-concentration. She also noted episodic alcohol abuse, which has been chronic in nature, but most recently took the form of binge drinking during weekends. She reported feeling "guilty and ashamed" about childhood sexual abuse and "worthless most of the time." In particular, she noted feeling hopeless and angry about her marriage, stating "This is my third failed relationship; I don't think I'll ever have a decent marriage." She reported that she felt "angry all the time" about her estranged husband and was having trouble "controlling it," often "blowing up at people at work." She reported few friends and social activities outside of her work environment.

Initial Treatment Plan: 1) Crisis Phase, Level I (stabilization). The patient is not currently capable of managing her suicidal crises without external assistance and intervention. Accordingly, initial efforts would be characterized by crisis intervention and stabilization with a focus on specific symptomatology including (a) remission of depressive symptoms, (b) reduced suicidality (ideation frequency, specificity, intent), (c) resolution of acute anger, hopelessness, (d) elimination of binge drinking, and (e) elimination self-mutilatory behavior. In addition to psychotherapy, medication would likely be effective and a necessary component of treatment, assisting with symptom remission.

2) Skill-Building Phase, Level I (acquisition). The patient possesses minimal skills and would require comprehensive skill training and development, but initial efforts would focus on improved self-monitoring, emotion-regulation, distress tolerance, and anger management.

3) Personality Development, Level I (stabilization). The patient would require stabilization of recurrent and severe crises in order to focus on skill acquisition and enduring changes in long-standing maladaptive personality traits. Personality components that would naturally be woven into ongoing interventions would include (a) image of self as defective, (b) perception of others are rejecting, abandoning, and (c) resolution of childhood sexual abuse (PTSD symptoms, feelings of guilt and responsibility).

As the case of Ms. A. illustrates, the initial treatment plan is relatively broad in nature. Paradoxically, however, the focus of the treatment is specific, given that we have used the treatment matrix to target specific skills and personality components. In a managed-care environment, it is essential that we discuss in a specific and conceptually meaningful way what we are doing in psychotherapy so that it is readily understandable from provider to provider not just to those who apply the same theoretical model.

Monitoring the Treatment Process: Changes in Phase and Level

Essentially, the process (i.e., phase and level) of treatment can be accurately gauged and monitored by the content (i.e., treatment agenda and associated assessment and treatment targets or tasks) of therapy, not its duration. The important point with respect to this conceptual and organizational framework is that an individual successfully treated for suicidal behavior will transition through the same treatment process, regardless of the duration of treatment. He or she will address the same treatment agenda(s) and specific target areas, simply in a different time frame and potentially by a different mechanism of action (i.e., the psychotherapeutic model). The question of where the patient is in the treatment process can be answered rather simply by answering the question, What do you spend the majority of your session time discussing and targeting?

The organizational framework offered provides a means of clearly articulating where a patient is in the treatment process. As illustrated by the case of *Ms. A. (i.e., Crisis Phase-Level I, Skill-Building-Level I, and Personality-Development-Level I)*, each patient can be placed within the treatment process by describing both phase and level. This translates into a clearly articulated treatment agenda with respect to active symptomatology being targeted, particular skills being developed, and enduring personality traits being explored. It is hoped that such clarity would not only ease communication (i.e., between patient and therapist as well as between therapist and case managers) but offer potential for an efficient treatment process. The increased ease of communication and clarity between patient and therapist may have implications on many fronts, all revolving around an improved therapeutic relationship and alliance, a variable almost universally agreed as critical to treatment success (e.g., Safran, 1990; Safran & Segal, 1990). Improved clarity with respect to the treatment agenda in targeting suicidal behavior can potentially help engender a sense of hopefulness, reduce resistance and anxiety, and facilitate the patient's commitment to change.

Treatment Targets: Short- and Long-Term Agendas in Treatment

Research to date has failed to answer even some of the most fundamental questions about treatment (i.e., both short- and long-term) of those exhibiting suicidal ideation and behavior. Aside from facilitating symptom resolution and acute stabilization, the efficacy of traditional, long-term approaches with an emphasis on hospitalization have been neither rigorously examined nor clearly supported (Rudd, Rajab et al., 1996). We simply do not know if restrictive approaches work, what individual changes actually occur (i.e., symptomatology, personality structure/organization), what is responsible for any identifiable change (i.e., mechanism of action such as pharmacotherapy, psychotherapeutic orientation, individual or group format, simple environmental change), or for how long any change endures. In addition, we do not know what individuals (e.g., diagnostic subgroups, comorbid problems across both Axis I and II, severity of suicidal risk, familial conditions, such as a history of physical or sexual abuse, particular personality traits) are best suited for specific treatment approaches, ranging from hospitalization to various outpatient alternatives, or whether specific treatment approaches will prove effective both within and across the diverse range of specific diagnostic entities presented by suicidal individuals. Although relatively narrow in scope, existing data tend to point to the importance of addressing the following in treatment: (a) symptom reduction; (b) reduction in suicidal thinking and hopelessness; (c) skill development and refinement (i.e., emotion-regulation, distress tolerance and impulsivity, problem-solving, adaptive coping); and (d) self-image, interpersonal functioning and relevant developmental issues (for review see Rudd & Joiner, 1998).

The framework offered in Table 1 is consistent with the paradigm shift discussed earlier, that focuses on specific symptomatology, identifiable skills, and personality traits (i.e., self-image and interpersonal functioning). Treatment, in terms of both phases and levels, is conceptualized as incorporating three identifiable agendas: crisis intervention, short-term, and long-term treatment. The focus of each agenda is highly specific and comprises the content of assessment and therapy. The targets of crisis intervention revolve around symptom reduction and crisis resolution, consistent with the majority of the research regarding acute markers of risk (e.g., Maris et al., 1992). The crisis agenda incorporates the following goals: (a) resolution of the immediate crisis (e.g., marital discord, loss of a relationship, financial stressor); (b) symptom reduction (e.g., sleeplessness, anxiety, agitation, dysphoria, depression, and a sense of urgency or immediacy); (c) reduction in suicidality (i.e., frequency, intensity, duration of suicidal ideation and related hopelessness; elimination of access to a method[s]); and (d) development of a sense of hopefulness.

In terms of a short-term agenda, the targets revolve primarily around skill development, including the following: (a) problem-solving, (b) emotion regulation, (c) self-monitoring, (d) distress tolerance (i.e., impulsivity), (e) interpersonal skills (i.e., assertiveness), and (f) anger management. All of these are embraced as critical and core components of emerging treatment approaches with empirical support, the majority of which are described as being cognitive-behaviorally oriented (e.g., Freeman & Reinecke, 1993; Layden et al., 1993; Lerner & Clum, 1990; Linehan, 1993; Linehan et al., 1991; Rudd et al., 1996). Of critical importance for skill building is a consistent and methodical approach, regardless of the skill being targeted. A consistent approach will not only help motivate the patient, but will also facilitate the process of skill acquisition, refinement, and generalization across various skills. The following steps are suggested. First, identify specific skill deficits for the patient and keeping a running log by self-monitoring, either through a journal or a daily record of some type. Second, place the deficit in context, both developmentally and with respect to current functioning. Help the patient recognize and understand the implications of the deficit. Third, identify and explore the potentially recurrent nature of the problem or deficit—its chronicity—over time. Fourth, identify and address the disadvantages of the deficit(s) (e.g., emotionally, interpersonally, financially, and regarding self-image) to facilitate motivation for change. And finally, remediate the deficit using a blend of indirect techniques, such as education and information, and direct techniques, such as role-playing and behavioral rehearsal. Naturally, skill building is blended into psychotherapy in many ways, depending on the theoretical orientation and interpersonal style of the therapist. Nonetheless, it is clearly a critical component for suicidal patients, particularly those with multiple attempts.

Table 1 provides a summary of specific targets within each skill area. For the most part, these are self-explanatory. A full discussion is beyond the scope of this article, given its organizational emphasis, and the reader is referred to Rudd, Joiner, and Rajab (1999) for a detailed examination. A few skill areas, however, deserve comment. A core component of treatment is the development of fundamental skills in self-monitoring, emotion-regulation, and distress tolerance. Those making multiple suicide attempts and exhibiting chronic suicidal behavior, in particular, are distinctive in this respect (e.g., Linehan, 1993; Rudd, Joiner, & Rajab, 1996). They frequently evidence limited emotional awareness (i.e., poor self-monitoring), experience difficulty in recovering when emotionally upset (i.e., emotion-regulation), and are often impulsive when dysphoric (i.e., poor distress tolerance). Consistent with one of the central goals of Dialectical Behavior Therapy (Linehan, 1993), considerable effort is expended to raise the patient's threshold for emotional upset, lower his or her reactivity (i.e., intensity of emotional reaction), and shorten the time necessary for recovery. As is evident, there is a clear interrelationship between self-monitoring ability, emotion-regulation, and distress tolerance. Essentially, it is posited that the emotionally aware patient is effective in regulating emotion, tolerant of distress, and unlikely to manifest impulsivity. If we look back at the case of Ms. A., the need for relatively comprehensive skill development is clear. The organizational scheme proposed will help clarify what exactly the targets are and the degree of progress with each.

As summarized in Table 1, the long-term treatment agenda integrates issues of self-image, interpersonal functioning, and developmental trauma.

As detailed, the principal defining feature of the patient's belief system is hopelessness, a variable that has been consistently linked to suicidality, from ideation to completions (see Weishaar, 1996 for review). Since the focus of this article is on organizational structure and not on treatment method, I will simply summarize the organizational framework. Long-term treatment targets have most consistently revolved around self-image disturbance (i.e., seeing self as defective, inadequate, helpless, unlovable); developmental trauma and abuse; and interpersonal dysfunction with problems of attachment, enmeshment, and separation, all cloaked within a veil of hopelessness (e.g., Freeman & Reinecke, 1993; Layden et al., 1993; Linehan, 1993; Rudd et al., 1999). The approaches to addressing personality dysfunction cover a broad range of therapeutic orientations and techniques, with the common feature being the requisite need for long-term contact and a strong therapeutic relationship. What is important for the organizational framework provided is that the therapist is able to identify what aspect of personality or interpersonal dysfunction is being targeted and by what methods.

Take for example, the case of Ms. A., in which long-standing, self-image disturbance could be targeted via schema-focused cognitive therapy, among a host of other approaches (e.g., Young, 1990). Issues regarding attachment, fears of abandonment, and rejection could be similarly addressed. In the case noted, however, its important to recognize that in the context of targeting long-standing personality disturbance, problem areas such as skill building and symptom resolution should not be lost, but viewed as inherent and critical components of this long-term change process. The organizational framework proposed provides a means to conceptualize and monitor these interrelationships and changes in a coherent and meaningful way.

Risk Assessment as a Continuous Clinical Responsibility: The Importance of Establishing a Baseline Rating and Consistent Reassessment During Treatment

The legal concept of foreseeability has led to an implicit assumption in the legal community that clinicians can predict or forecast their patients' suicidal behavior (Rudd & Joiner, 1998). To some degree, this has translated into a potentially unrealistic demand on the clinician, but perhaps more importantly, it highlights the need for a thorough and organized approach to risk assessment, always a component of ongoing treatment and management. This expectation persists despite considerable scientific evidence to the contrary. Empirical suicide prediction studies have consistently failed, rendering 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). These studies have led to the conclusion that we cannot reliably predict suicide or suicidal behavior in individual cases. We have, however, identified salient risk factors, variables that place an individual in what Litman (1990) has termed the *suicide zone*. Consistent with existing standards of care, it is the responsibility of the clinician to recognize when the patient has entered this zone (i.e., through risk assessment) and respond appropriately (i.e., through management and treatment).

The assessment of suicidality is an ongoing clinical responsibility throughout the duration of care, not simply during acute crisis periods. Accordingly, it is recommended that as a function of routine intake assessments and throughout ongoing treatment, the clinician establish a baseline level of suicide risk consistent with the approach offered by Rudd and Joiner (1998). In addition, it is important to be specific as to risk indicators, clearly detailing the variables for each risk category. For example, Rudd and Joiner (1998) have offered a model that utilizes eight essential risk categories: a predisposition to suicidal behavior, the presence of precipitants or stressors, a symptomatic presentation, the presence of hopelessness, the nature of suicidal thinking, previous suicidal behavior, impulsivity and self-control, and protective factors. A brief, but specific, suicide risk section or subsection should be standard for every intake and follow-up note. Although it need only be a few lines in length, it is critical to document risk criteria for each patient, if only to indicate that risk is nonexistent or minimal.

As discussed by Rudd and Joiner (1998), a baseline risk level can be indicated by category (i.e., mild to extreme) or by number (i.e., 1–10), depending on the risk indicators that apply. A detailed discussion of risk assessment is beyond the scope of the current article and the reader is referred to the above reference, which details an assessment framework, along with organizational categories, assessment questions, and a rating scheme. The numerical rating offers a convenient and easily understandable means of monitoring and communicating risk over time, as well as a precise rating within each category. Once a baseline risk rating has been established, the clinician only need update risk indicators each session, raising or lowering risk in accordance with the criteria offered. During periods of acute risk, specific interventions should be tailored to and target the risk indicators noted, such as pharmacotherapy for insomnia or acute agitation or panic, eliminating access to method(s), increasing availability or accessibility of social supports to address loneliness and isolation, and specifically treating acute or episodic alcohol or other substance abuse.

Subsequent risk assessment ratings should link lower (or higher) risk to observable and documented changes in specific risk criteria (e.g., marked reductions [or increase] in depressive symptomatology as indicated by both self-report and/or psychometric measures, renewed sense of hopefulness [or emergence of hopelessness] as indicated by self-report, affect changes, and/or psychometric indices, resolution [or exacerbation] of a specific stressor such as success in getting a job or resolution of marital conflict). As is discussed in more detail below, it is also recommended that the clinician further distinguish among those at chronic high risk (e.g., multiple attempters with active or chronic suicidal ideation), acute risk, and chronic high risk with acute exacerbation. Baseline risk assessment and recurrent updating of risk status session by session is a relatively easy clinical task, requiring only a few minutes of time both in terms of clinical interview and documentation. For some clinicians, it requires a fundamental change in standard practice, but one of critical importance when working with suicidal patients, particularly those at chronic high risk.

Take, for example, the following brief vignette:

The Case of Mr. Z.

A 25-year-old single white male was referred for psychiatric evaluation following a conflict with his ex-girlfriend. The patient was picked up by the police at his ex-girlfriend's house. At the time, he had a loaded handgun and threatened to kill himself and his ex-girlfriend. The patient reported that he had experienced extensive depressive symptomatology for 2 months since the breakup of their relationship. More specifically, he reported persistent depressed mood, anhedonia, weight loss of 20 pounds, insomnia, some agitation, poor energy and fatigue, feelings of worthlessness, and diminished attention-concentration, as well as persistent daily suicidal thoughts. In terms of suicidal ideation, he reported thinking of shooting himself as frequent as 10–15 times a day. He reported the thoughts as overwhelming. He had purchased a weapon and acted on the thoughts by going to his ex-girlfriend's house, where he was arrested. At the time of his arrest, he was acutely intoxicated and reported that he had been drinking heavily for the past two months. He stated that he had been "drunk" everyday for the past 2 weeks. As a result, he recently lost his job. When questioned about intent, the patient stated that "when I get out of here I'm going to kill myself the second I walk out of the door." The patient reported a previous history of suicidal behavior, with an overdose attempt at the age of 18 and a second at 20. Both required acute hospitalization, but he declined further psychiatric treatment. He reported no supportive resources and had strained relationships with his parents and siblings. He stated "I haven't talked to them in 2 years."

Risk Assessment Markers: Category I (predisposition to suicidal behavior): Previous psychiatric history, prior attempts requiring medical care, chaotic family history. Category II (precipitant or stressors): Multiple losses (several relationships and job) and family instability. Category III (symptomatic presentation): Diagnosis of recurrent major depressive disorder, alcohol dependence, and likely personality disorder. Current severe symptomatology. Significant anger and agitation. Category IV (the presence of hopelessness): Marked hopelessness. Category V (the nature of suicidal thinking): Frequent, specific, and intense ideation. Available means with active behavior. Clear markers of explicit and implicit intent. No identifiable deterrents. Category VI (previous suicidal behavior): Multiple attempts, potentially lethal, requiring medical care. No help-seeking and subsequent help-negation. Category VII (impulsivity and self-control): Marked impulsivity, both subjective and objective. Active substance abuse. Category VIII (protective factors): No identifiable protective factors.

Risk rating: 10, The risk rating is severe. The indicated response is immediate hospitalization, involuntary if necessary.

Although brief, the vignette highlights the need for risk assessment as an ongoing component of treatment. Clinical documentation in this case would result in open risk markers from each category noted above. As a result, each open marker would need to be addressed in all subsequent clinical contacts, monitored closely, and treated with a plan tailored to meet them. The organizational framework offered earlier provides the needed structure to address each risk variable. They would need to be consistently targeted until each marker was successfully closed. For example, the patient presented with an alcohol dependency problem. The status of his alcohol abuse, participation in a treatment program, and its role in relation to his suicide risk would need to be actively monitored and documented until effectively resolved (i.e., cessation of all alcohol use). All open risk markers need to be addressed in clinical entries until they are effectively closed, that is, they no longer carry any clinical significance.

This is perhaps most easily accomplished by incorporation of a standard suicide risk assessment section into all clinical entries. If suicide risk is minimal, these entries are brief and, subsequent entries need only note that, "risk is minimal and unchanged since last assessment." As markers of risk emerge, they simply need to be opened, assessed, and monitored over time until they resolve and once again are effectively closed. As is evident, there should be agreement between the patient's suicide risk assessment section and the subsequent treatment plan. The treatment plan should evidence specific steps, such as medication, to address severe and debilitating depressive symptomatology or recurrent and severe panic attacks. The process of risk assessment is characterized by consistency in the model employed, as well as documentation and response in therapeutic fashion to markers of increased risk.

Although the time investment is minimal, the implications of adopting this approach are nonetheless numerous and significant for both clinician and patient. First, it allows the clinician to adopt a standard, consistent, and relatively comprehensive approach to both addressing and documenting the clinical assessment of suicidality. Second, it identifies (and when necessary elevates) suicidality as an ongoing treatment target, eliminating any potential ambiguity or ambivalence on the part of clinician or patient. Third, as is the case with most standard assessment approaches, it clarifies communication between clinician and patient and helps solidify the therapeutic relationship. This is particularly true with respect to subjective and objective markers of intent and self-control as discussed below. Fourth, it is likely to result in accurate risk assessment as a function of all of the above. And finally, treatment is likely to be enhanced as a result of accurate assessment, particularly an assessment approach that lends itself to specific treatment targets, identifiable goals, and related interventions.

The Role of Chronicity and Time in Risk Assessment and Treatment: Acute and Chronic Risk Versus Chronic High Risk with Acute Exacerbation

The treatment of suicidal behavior and ongoing risk assessment are complicated by the issue of time in two significant ways. First, identifiable risk periods are inconsistently defined in the literature. Accordingly, there is general confusion in clinical practice as to what variables are important in risk assessment over relatively short,but clinically relevant, periods of time, for example, hours, days, or weeks. For the most part, clinical practice demands and decision-making dictates that risk assessment and estimation occur over relatively short periods of time, such as a period of hours, days, or weeks at the most. Empirical studies addressing risk have routinely used time frames of up to 2 years (Beck, Brown, Berchick, & Stewart, 1990; Fawcett, 1988; Fawcett et al., 1990). Second, chronic suicidality or what Maris (1991) has referred to as suicidal careers complicates estimates of risk, particularly in cases where chronic patient factors such as multiple attempts have been ignored or poorly defined. For the most part, empirical studies addressing risk have failed to identify and distinguish adequately among those who engage in chronic suicidal behavior (i.e., multiple attempters), the self-mutilators, and those who experience acute suicidal crises (i.e., single attempters and ideators) (Rudd, Joiner, & Rajab, 1996).

As a result of the variable nature of risk periods identified in empirical studies and the failure to distinguish consistently among ideators, single attempters, multiple attempters, and self-mutilators, application of empirical findings to clinical practice is at best questionable. Whether many of the risk factors identified to date actually prove to be clinically useful over inordinately brief periods of time has yet to be demonstrated. Accordingly, it is recommended that risk assessment be continuous and routine throughout the course of treatment, with clinical response depending directly on assessed severity. It is critical that the clinician distinguish between chronic and acute suicidality, recognizing that some patients present chronic high risk, given their history (i.e., multiple attempters with chronic ideation), but also can experience acute and severe exacerbation of risk over brief periods of time. Accordingly, it is recommended that from the outset the clinician distinguish among those at acute risk (i.e., ideators and single attempters), those at chronic high risk (i.e., multiple attempters with active or chronic ideation), and those at chronic high risk with acute exacerbation.

Distinguishing among those at acute risk, chronic high risk, and chronic high risk with acute exacerbation has several practical benefits. First, it clarifies for the clinician the nature of the treatment itself, in part, by clarifying the patient's behavioral and adaptive coping history. If a patient is assessed at chronic high risk because of multiple attempts and chronic suicidal ideation, it is likely that this will be the primary focus of treatment for some time. In accordance with existing standards of care, this will help clarify for the clinician whether such treatment falls within the scope of his or her competence. Second, it clarifies understanding of the nature of suicide risk, with recognition that some indicators of risk (e.g., specific ideation) have been chronic and are not indicative of acute exacerbation. Third, it identifies what indicators are important for the individual patient in terms of elevating risk over brief periods of time (e.g., loss of a relationship). Fourth, it allows for targeted and efficient crisis intervention efforts. Fifth, if the patient has been in treatment for some time, it helps the clinician recognize and document the limited efficacy of treatment to date and communicates the severe and chronic nature of disorder (both Axis I and II) and disturbance. And finally, it communicates the limited control and predictability (i.e., foreseeability) of the patient's behavior, given previous multiple attempts, sometimes despite active treatment, and the potential for a bad clinical outcome in the future.

Process Tasks in Treatment

In contrast to the predominant content focus of the current article, the assessment, treatment, and ongoing management of suicidal behavior involves a clearly identifiable process. The process is essentially uniform and consistent, regardless of treatment duration. Actually, the process is both experienced and repeated within and across each successive session. As detailed in Table 1, as the clinician and patient move through a process of engagement, attachment, and separation not only in each session but throughout ongoing treatment. The clinician can monitor this process by attending to content markers during and across sessions. More specifically, during the crisis phase of treatment, the majority of the content of a session or sessions will be past-oriented as the patient addresses recent or remote emotionally painful issues such as the ending of relationship or a job loss. During the skill-building phase of treatment, the focus will shift to current functioning, with an emphasis on identifiable skill deficits. Although historical and developmental issues will be addressed, the majority of time will likely be spent on current skill building. Similarly, during the personality-development phase of treatment the focus will shift to future goals, integrating developmental trauma and previous interpersonal conflicts. Although the patient will have improved his or her level of awareness and understanding of developmental issues that are relevant and targeted identifiable skill deficits, the focus of treatment will likely be self-image improvement and interpersonal functioning through future activities, rather than a perpetual rehashing of old problems.

As is the case across the course of treatment, each session mimics the process of engagement, attachment, and separation. Again, the actual content of therapy allows for monitoring of process. For example, early in session, the patient will discuss past issues such as fuctioning during the past week and homework assignment. Eventually the patient will transition to current functioning and related agenda items and ultimately will establish an agenda for the coming days, weeks, or month(s). Essentially, each session models the skill of appropriate attachment-separation, or independent functioning, in relationships. One of the primary benefits of applying the proposed organizational framework is an improved ability to identify and monitor what are often subtle skills that can be lost in the psychotherapeutic milieu. Such skills are, nonetheless, critical to treatment success and important indirect markers of treatment outcome.

Provocations and Resistance in the Therapeutic Relationship: How a Clear Organizational Framework Helps

The conceptual and organizational framework offered allows the therapist to specifically target relationship skills that are manifest in the therapy process, discussing them with the patient in a meaningful and understandable way from the outset. As Rudd, Joiner, and Rajab (1995) and Rudd and Joiner (1998) have discussed, help negation in treatment for suicidality, including provocations and resistance, is a serious concern, one that requires a compassionate and sensitive approach to transference-countertransference problems. Framing these somewhat abstract concepts as a skill has numerous advantages in treatment. First, it externalizes the problem to some degree, labeling it as a skill rather than an individual defect of some type. Second, it makes it conceptually easier to grasp and discuss, translating it into a concrete task. And third, it provides a means for monitoring and gauging progress over time.

The Role of an Organizational Framework in Termination: When, Why, and How

Ideally, termination occurs when patient and therapist agree that the treatment goals have been accomplished. As is evident, treatment of suicidal patients, and particularly chronically suicidal patients, is neither clear nor simple. Others have written in some detail about the role of provocation and acting out in the treatment process (see Newman, 1997, for review). In addition, the importance of ensuring that a patient's ongoing treatment needs have been addressed has been stressed by clinicians and researchers alike (e.g., Simon, 1987; Stromberg et al., 1988). The treatment of suicidal patients has been characterized by relatively high withdrawal rates, with those who abruptly stop treatment often continuing to experience marked symptomatology with continued high risk (Rudd, Joiner, & Rajab, 1995).

The organizational framework provided allows for relatively straightforward assessment of the treatment process, along with markers of acute and chronic risk. Accordingly, it provides some structure and guidance to potential termination issues. Barnett (1998) has offered a number of recommendations regarding appropriate termination. Among them is the need to be specific about and clarify expectations from the outset, something facilitated by the framework summarized in Table 1. In addition, it provides a means of identifying and clearly articulating the need for continued treatment in specific areas. Finally, use of this organizational framework allows for a clear documentation of the overall clinical picture, treatment goals and targets, an accompanying rationale, and a means to monitor change and progress. As Barnett (1998) noted about termination, "plan for it, prepare for it, and process it" (p. 22). I would add one additional caveat: organize the entire process in a manner that is meaningful and understandable to patients.

Quantifying Change: How to Measure and Monitor Change in Treatment

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-mutilatory 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. Without question, it represents the best the field of clinical suicidology has to offer. It clearly differentiates between suicide attempts and instrumental suicidal behavior, something critical to accurate risk assessment and effective treatment. The notion of direct and indirect markers of suicidality in treatment outcome is a concept that, surprisingly, has not been previously addressed. It is critical to distinguish between the two, particularly because as direct markers of suicidality improve, acute risk wanes, whereas, indirect markers may endure for years. For a thorough discussion of this concept see Rudd (1998).

Direct markers are fairly straightforward and include suicidal ideation (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. Consistent with the conceptual and organizational framework offered, clearly articulation of chronic variables helps establish reasonable expectations regarding the treatment process and outcome, facilitates accurate risk assessment, and lends itself to a reasonable standard of care.

Concluding Remarks

The current article provides an integrative conceptual and organizational framework for assessing and treating suicidal behavior, organized around the content (i.e., identifiable tasks) of assessment and treatment and supported by empirical research. Such an integrative conceptual approach provides not only a template for clinical practice but also a solid and uniform foundation for dialogue, theoretical development, and ultimately the study of psychotherapy for suicidal behavior. In a sense, it provides a simple step in the direction of what Norcross (1997) described as "a conceptually coherent, empirically validated, and educationally sound position for practice" (p. 86). In addition, the conceptual framework offered recognizes and documents the complicated nature of risk assessment and the general unpredictability of human behavior, particularly for those who engage in chronic suicidal and self-destructive behavior.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Barnett, J. (1998). Termination without trepidation. *Psychotherapy Bulletin, 33*(2), 20–22.

Beck, A., Brown, G., Berchick, R., & Stewart, B. (1990). Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients. *American Journal of Psychiatry, 147*, 190–195.

Beck, A., & Freeman, A. (1990). *Cognitive therapy for personality disorders*. New York: Guilford Press.

Bongar, B. (Ed.). (1991). *The suicidal patient: Clinical and legal standards of care*. Washington, DC: American Psychological Association.

Bongar, B. (Ed.). (1992). *Suicide: Guidelines for assessment, management, and treatment*. New York: Oxford University Press.

Bongar, B., & Harmatz, M. (1989). Graduate training in clinical psychology and the study of suicide. *Professional Psychology: Research and Practice, 20*, 209–213.

Bongar, B., Maris, R., Berman, A., & Litman, R. (1992). Outpatient standards of care and the suicidal patient. *Suicide & Life-Threatening Behavior, 22*, 453–478.

Bongar, B., Maris, R., Berman, A., 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.

Bunney, W., & Fawcett, J. (1965). Possibility of a biochemical test for suicide potential. *Archives of General Psychiatry, 13*, 232–239.

Clark, D., Young, M., Scheftner, W., Fawcett, J., & Fogg, L. (1987). A field-test of Motto's risk estimator for suicide. *American Journal of Psychiatry, 144*, 923–926.

Dublin, L. (1963). *Suicide: A sociological and statistical study*. New York: Ronald.

Durkheim, E. (1951). *Suicide: A study in sociology*. Glencoe, IL: Free Press.

Fawcett, J. (1988). Predictors of early suicide: Identification and appropriate intervention. *Journal of Clinical Psychiatry, 49*(suppl.), 7–8.

Fawcett, J., Scheftner, W., Fogg, L., Clark, D., Young, M., Hedeker, D., & Gibbons, R. (1990). Time-related predictors of suicide in major affective disorder. *American Journal of Psychiatry, 147*, 1189–1194.

Freeman, A., & Reinecke, M. (1993). *Cognitive therapy of suicidal behavior*. New York: Springer.

Freud, S. (1957). Mourning and melancholia. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 4, pp. 237–260). London: Hogarth Press.

Hendin, H. (1964). *Suicide in Scandinavia*. New York: Grune & Stratton.

Jobes, D., & Berman, A. (1993). Suicide and malpractice liability: Assessing and revising policies, procedures, and practice in outpatient setting. *Professional Psychology: Research and Practice, 24*, 91–99.

Jobes, D., Jacoby, A., Cimbolic, P., & Hustead, L. (1997). Assessment and treatment of suicidal clients in a university counseling center. *Journal of Counseling Psychology, 44*(4), 368–377.

Kleespies, P. (1993). Stress of patient suicidal behavior: Implications for interns and training programs in psychology. *Professional Psychology: Research and Practice, 24*, 477–482.

Layden, M. A., Newman, C. F., Freeman, A., & Morse, S. B. (1993). *Cognitive therapy of borderline personality disorder*. Needham Heights, MA: Allyn and Bacon.

Lerner, M., & Clum, G. (1990). Treatment of suicide ideators: A problem-solving approach. *Behavior Therapy, 21*, 403–411.

Linehan, M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Linehan, M., Armstrong, H., Suarez, A., Allmon, D., & Heard, H. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060–1064.

Litman, R. (1990). Suicides: What do they have in mind? In D. Jacobs & H. Brown (Eds.), *Suicide: Understanding and responding* (pp. 143–156). Madison, CT: International Universities Press.

MacKinnon, D., & Farberow, N. (1975). An assessment of the utility of suicide prediction. *Suicide & Life-Threatening Behavior, 6*, 86–91.

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.

Maris, R., Berman, A., Maltsberger, T., & Yufit, R. (Eds.). (1992). *Assessment and prediction of suicide*. New York: Guilford Press.

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 so difficult? *American Journal of Psychotherapy, 38*, 341–349.

Newman, C. (1997). Maintaining professionalism in the face of emotional abuse from clients. *Cognitive and Behavioral Practice, 4*, 1–29.

Nezu, A., Nezu, C., & Perri, M. (1989). *Problem-solving therapy for depression: Theory, research, and clinical guidelines*. New York: John Wiley.

Norcross, J. (1997). Emerging breakthroughs in psychotherapy integration: Three predictions and one fantasy. *Psychotherapy, 34*, 86–90.

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.

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. Maltsberger, & R. Yufit (Eds.), *Assessment and prediction of suicide* (pp. 105–129). New York: Guilford Press.

Pulokas, J. (1993). Two models of suicide treatment: Evaluation and recommendations. *American Journal of Psychotherapy*, *47*, 603–612.

Rudd, M. (1998). *Conceptualizing treatment outcome in the treatment of suicidal behavior*. Manuscript submitted for publication.

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*(2), 135–150.

Rudd, M., Joiner, T., & Rajab, H. (1995). Help negation after acute suicidal crisis. *Journal of Consulting & 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., Joiner, T., & Rajab, H. (1997). *Cost-implications and cost-effectiveness of an outpatient treatment program for suicidal behavior.*. Manuscript submitted for publication.

Rudd, M., Joiner, T., & Rajab, H. (In press). *Treating suicidal behavior: A time-limited approach*. New York: Guilford Press.

Rudd, M., Rajab, H., & Dahm, P. (1994). Problem-solving appraisal in suicide ideators and attempters. *American Journal of Orthopsychiatry*, *64*, 136–149.

Rudd, M., Rajab, H., Orman, D., Stulman, D., Joiner, T., & Dixon, W. (1996). Effectiveness of an outpatient problem-solving intervention targeting suicidal young adults: Preliminary results. *Journal of Consulting & Clinical Psychology*, *64*, 179–190.

Safran, J. D. (1990). Towards a refinement of cognitive therapy in light of interpersonal theory: II. Practice. *Clinical Psychology Review*, *10*, 107–121.

Safran, J. D., & Segal, Z. V. (1990). *Interpersonal processes in cognitive therapy*. New York: Basic Books.

Schotte, D., & Clum, G. (1982). Suicide ideation in a college population: A test of a model. *Journal of Consulting & Clinical Psychology*, *50*, 690–696.

Schotte, D., & Clum, G. (1987). Problem-solving skills in suicidal psychiatric patients. *Journal of Consulting & Clinical Psychology*, *55*, 49–55.

Shneidman, E. (1993). *Suicide as psycheache: A clinical approach to self-destructive behavior*. New Jersey: Jason Aronson.

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.

Simon, R. (1987). *Clinical psychiatry and the law*. Washington, DC: American Psychiatric Press.

Slaikeu, K. (1990). *Crisis intervention* (2nd ed.). Boston: Allyn and Bacon.

Stromberg, C., Haggarty, D., Leibenluft, R., McMillian, M., Mishkin, B., Rubin, B., & Trilling, H. (1988). *The psychologist's legal handbook*. Washington, DC: The Council for the National Register of Health Service Providers in Psychology.

Weishaar, M. (1996). Cognitive risk factors in suicide. In P. Salkovkis (Ed.), *Frontiers of cognitive therapy* (pp. 226–249). New York: Guilford Press.

Young. (1990). *Cognitive therapy for personality disorders: A schema-focused approach*. Sarasota, FL: Professional Resource Press.