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SUICIDE: WHAT THERAPISTS NEED TO KNOW

There are many misconceptions about suicide. This continuing-education article helps to set the record straight.

By Lisa Firestone

The statistics about suicide are alarming, yet largely unrecognized. Worldwide, more people die by suicide than from all homicides and wars combined. In the United States, suicide is the 11th leading cause of death, with an average of one person dying by suicide every 15.2 minutes, and one person attempting suicide every 38 seconds. Seventy-one percent of psychotherapists report having at least one client who has attempted suicide, while 28 percent report having had at least one client die by suicide.

For the general population, suicide is often a silent tragedy. For the media, it is a treacherous taboo. For those of us in the mental health professions, it is a deeply disturbing occupational hazard and the most common psychiatric emergency we face. Although we as clinicians cannot prevent all suicides, we can lessen the number of suicides. This is why we need to learn all we can about suicide to better understand, assess and treat suicidal individuals.

There are many misconceptions about suicide, one of them being that suicidal people want to die and cannot be helped. What both mental health professionals and the public should know is that the suicidal state is almost always transient and treatable. Therapists can prepare themselves for working with such clients by learning to implement the tools and techniques that have been found effective to assess and treat suicidal individuals.

Unfortunately, when therapists are not equipped to deal with the challenges of treating a suicidal client, the client often ends up being passed from therapist to therapist without ever receiving optimal care or even the basics of the standard of care. By understanding what's going on inside the suicidal person's mind, recognizing warning signs, having a decision tree for assessing and managing suicide risk, and knowing which treatments are most effective, therapists can save lives. First, they can actively help clients out of the suicidal state; then secondly, they can assist them in developing the skills needed to create and sustain lives worth living.

What is going on in the mind of a suicidal person?

There are some who consider suicide a human right, and who therefore believe no one should interfere with a person's decision to consider suicide. But this thinking fails to understand that people are divided within themselves: One part of them wants to live and is goal-directed and life-affirming, while the other part is self-critical, self-hating and ultimately self-destructive. This ambivalence is always a factor when it comes to suicide. More than 3,000 people have leapt to their death from San Francisco's Golden Gate Bridge, but out of the 26 people who survived the jump, all 26 reported that the moment they leapt from the bridge, they regretted their action and wanted to live.

In his work, Separation Theory, Robert Firestone, PhD, has identified this split within the person as the "real self" and the "anti-self." The real self represents the life-affirming side of the individual while the

anti-self represents the self-destructive elements of the personality. The critical inner voice is a negative thought process that can be conceptualized as the language of the anti-self. These negative thoughts exist on a continuum, from mild self-criticism to extreme self-hatred to injunctions directing a person to suicide. Self-destructive behaviors also exist on a continuum from self-denial to substance abuse to actual suicide. Research demonstrates that a relationship exists between these two continuums; thus, how a person is thinking is predictive of how he or she is likely to behave. When someone decides to take his or her life, that person is acting out the will of the anti-self. The therapist who understands how this division operates within a suicidal person can challenge the distorted filter of a client's anti-self while developing and supporting his or her real self. This will enable the client to reconnect with and strengthen the real self and rediscover the natural desire to survive.

What developmental factors lead to suicidal tendencies?

Recent research into the biological factors in suicide indicates that what puts people at risk for suicide is the result of a genetic and environmental interaction. Genetic influences, such as serotonin polymorphisms, increase risk for suicide if accompanied by childhood trauma. Childhood trauma also affects a child's developing HPA axis, neural connections and neurochemistry. By design, humans are programmed to remember what scares them as a means to avoid future danger. Thus, traumatic evidence in childhood have a lasting influence and correlate with their suicide risk later in life. Not all suicidal individuals are victims of parental abuse; however, all children are impacted by parental ambivalence while growing up.

At those times when a parent is under stress and exhibits a level of anger and aggression that is traumatizing to a child, children often disconnect from themselves and identify with the parent so as not to experience their own powerlessness in the situation. Children incorporate the hostility the parent was directing toward them and take on these negative attitudes as their own. Children then re-enact the initial trauma by mistreating themselves in a manner similar to how they were mistreated. Research demonstrates that physical and especially sexual abuse has a high correlation with suicide. People who acquire the ability to disassociate and disconnect in times of stress have a higher suicide risk. Suicidologist Israel Orbach, PhD, states that suicidal people have "a very high tolerance for physical trauma, physical pain, through the disassociation. And a very low tolerance for mental pain. And mental pain is something that characterizes the suicidal person."

Suicide warning signs

The therapist can look for specific signs that indicate whether a client is in crisis or at risk. Research shows that therapists consistently underestimate clients' suicidality. However, for therapists, the responsibility of treating a person in a suicidal state can cause anxiety and apprehension. Suicidal clients can even induce feelings of dislike or malice in their therapists. Therefore, while clinical judgment is essential, it is valuable to use an objective assessment instrument when evaluating a client's risk. The Firestone Assessment of Self-Destructive Thoughts (FAST), an assessment scale developed by The Glendon Association, is a reliable and valid tool that can assess suicide potential by measuring where an individual is located along the continuum of self-critical thoughts and the intensity of those feelings.

The following are common thoughts and feelings associated with suicide:

- Extreme self-hatred: "You don't deserve to live."
- Personalized hopelessness: "Nothing matters anymore. You should just kill yourself."
- Pushing away friends and family: "What's wrong with you? Look at all this trouble you're causing the people who love you."
- Isolation: "Just be by yourself. You are better off alone."
- Thoughts of not belonging: "You don't fit in anywhere."

- Thoughts of being a burden to others: "You're just dragging everyone down. You are such a burden; they would be better off without you."

The following are common behaviors that indicate suicide risk:

- Past attempts.
- Disrupted sleep patterns.
- Increased anxiety and agitation.
- Outbursts of rage or low frustration tolerance.
- Risk-taking behavior.
- Increased alcohol or drug use.
- Sudden mood change for the better.
- Any talk or indication of suicidal ideation or intent, planning or actual actions taken to procure a means.

Assessing suicidal individuals

There are many psychiatric and psychological risk factors for suicide that all mental health professionals should be aware of. In relation to psychiatric disorders, people with mood disorders have the highest risk for suicide, particularly within the first five years of experiencing the disorder. People who are in the early stages of any physical or emotional challenge are at greater risk. This is because even though people can learn to live with difficult conditions, the adjustment to living with them takes time. People who suffer from agitated depression are most at risk for suicide. Those with schizophrenia are also at greater suicide risk, both in an active phase of the disorder and when they become cognizant of the chronic nature of the disorder. Alcohol dependence is another considerable risk factor, as people who abuse alcohol account for a quarter of all suicides, while 50 percent of suicides occur when a person is under the influence of alcohol.

Looking at a person's history of suicidal behavior is essential, as past attempts are a significant risk factor. People who have made multiple attempts are easily triggered into crisis at progressively lower levels of distress. In our research at The Glendon Association, when we tested outpatients who had a history of suicide attempts, we found that half of them had not revealed this crucial fact to their ongoing therapist. The lesson to learn from this is: the therapist always needs to ask. It is also advisable to ask questions about a client's past; particularly, a family history of suicide puts people at increased risk, as genetic factors and unresolved loss impact a person's suicidal potential. Trauma or loss creates risk because unresolved feelings from the past can be triggered by a current situation, such as a job loss or a break up.

Deterioration in psychological functioning increases risk; therefore therapists should explore how the client's functioning has changed. Therapists can ascertain whether someone is viewing themselves, the events in their life and the world around them through the filter of their critical inner voice. Therapists should look closely at how clients view their social support systems. Do they perceive themselves as a burden or as having been abandoned and forgotten? Do they feel that they are not getting the support they need from friends or family? And finally, when someone at risk makes a will or begins to give items away, it is a red flag that they are taking steps toward ending their lives. In their interactions with these clients, therapists must be sure to connect with the part of the person that wants to live and be very careful not to side in any way with the part that wants to die.

Treating the suicidal person

People who are suicidal make up a diverse group; however, one commonality is that they have trouble regulating and tolerating emotion. It is the aim of the therapist to help clients feel connected and valued, while assisting them in developing the fundamental skills to regulate and tolerate emotions. It is important that the therapist join with the person to form an alliance in which the client is viewed as an expert on his

or her own condition. A therapist should provide structure for the client, as those who are suicidal usually feel fragmented. It is also valuable for the therapist to actively include any people in the client's life who are capable of being a source of support during this time of crisis. The more clinical care that is available to clients, the more personal resilience they adopt and the more they feel part of a group, the better chance they have to persevere.

Because the therapist's first contact with a suicidal person could be the only contact they have with them, the initial session could be their only chance at intervention and treatment. To take advantage of this situation and to ensure a suicidal client's well-being, a therapist can follow these suggestions for safety planning:

- **Team up with the client to formulate a personal set of warning signs.** Is the client not sleeping? Feeling increasingly agitated? Are they having the critical inner voices that usually indicate that they are descending into a suicidal way of thinking or feeling? Being aware of these will help clients recognize when they are getting into a suicidal state.
- **Work with clients to make their home safe.** Have them remove any items that could be dangerous such as medications or weapons. Easy access to means makes suicide more likely.
- **Collaborate with clients to develop a complete safety plan.** Referring to it regularly will strengthen their real self and help them if they start to get into a suicidal state.
- The safety plan should include a list of specific behaviors that will help the client calm down, such as taking a run, baking brownies or listening to specific music.
- It should have suggestions for interfering with passivity and isolation, two behaviors that fuel a suicidal state. It should include a set of actions clients can take if they find themselves being isolated or passive.
- It should recommend ways for the client to socialize, even simple behavioral changes such as going to a public place to be among people. It is harder for a person to listen to the critical inner voices when in the company of other people.
- Ask if there is anyone in the client's family or friendship circle who they can call if they start to feel bad. Help the client plan to notify these people, thereby creating a safety net from their existing social network.
- In addition to making yourself available for the client to call, inform them of professional help that is available at any time they may need it, such as a walk-in clinic. Be sure the client has the number to the National Suicide Prevention Lifeline: (800) 273-8255.
- Write the safety plan down, and make a copy for the client to have in hand and another to keep in your chart.

In terms of treatment, it is important to:

- **Obtain a commitment to treatment from the client.** Outline a clear treatment plan of what you will do and what they will do to create a life worth living. Specify the tasks of therapy, i.e., engaging in homework, attending therapy multiple times a week.
- **When clients are in crisis, see them more often.** The frequency of treatment should be a response to the level of the crisis.
- If you believe psychotropic medication will help, **refer the client for treatment** and follow up to see how they respond.
- **Pay full attention to suicidal clients** and try to get into their mindset by understanding the present crisis from their perspective. An important question, from the CAMS Model (Collaborative Assessment and Management of Suicide Risk) created by David Jobes, PhD, to ask: What one thing would have to change for you not to feel suicidal?
- In the therapy session, **allow the client to express the strong negative feelings** that are creating intense psychological pain. Clients are less likely to act on self-destructive thoughts and feelings

if they have the opportunity to share them. Often, after releasing their emotions, they experience a shift away from their negative thoughts and take their own side.

- **Follow up if the client drops out of therapy** or does not show up for a session. This will indicate that you care and will reach the client's real self, whereas failing to follow up will be supporting their self-hating voices.
- **Help clients learn coping strategies, which** include:
- Generating a list of reasons for living, drawing from what has made them light up, what has sparked their interest, the people they matter to and who matter to them, and the activities they've enjoyed in the past. Encourage and support their involvement with any of these people, or in any of these activities or interests.
- Constructing a hope kit is a strategy that was developed by Aaron Beck and Gregory Brown. This can be a scrapbook or container that holds mementos that serve as personal reminders of the client's real self and of reasons to live. It may include a DVD or CD of favorite music from a good time in their life. This is good advice because music is mood inducing.
- Creating coping cards to remind clients of positive actions they want to take or a compassionate point of view they want to maintain. They can use them to combat their voice attacks by listing critical voices they have experienced in the past; writing constructive answers to these self-attacks that reflect the point of view of their real self; and listing actions they can take that go against what their voice is telling them.

It is important for therapists to monitor their relationships with suicidal clients: does my client feel connected to me? They must be especially attuned in this relationship and mindful of how the client feels about it. If there are any ruptures created in the course of therapy, the therapist must repair them quickly and thoroughly. Research demonstrates that ruptures in the therapeutic relationship with a suicidal client can have serious consequences. A therapist treating a person at risk can gain support by seeking consultation regarding the decisions they make, collaborating on a treatment plan and implementing it. This demonstrates practicing up to the standard of care. It is especially important that therapists with clients in crisis keep contemporaneous case notes that document their decision making process in regard to the treatment they provide.

Effective therapy approaches

Recent research has proven several methodologies to be particularly effective in treating a suicidal client. Some key elements of these empirically supported treatment approaches are outlined below.

- **Cognitive therapy** for suicidal people was developed by Aaron Beck, PhD, and Gregory Brown, PhD. Unlike other CBT treatments, this approach is not time limited. The third and last stage is "Relapse Prevention with a Twist," which involves inducing a suicidal crisis for the client while they are in session. The theory behind this technique draws from the fact that people who are suicidal have trouble using newly acquired skills when in crisis. By evoking the crisis in session, the client is able to apply and test coping skills with the therapist's help and support. Clients do not graduate from treatment until they demonstrate that they are ready to do this on their own.
- **Dialectical behavior therapy**, developed by Marsha M. Linehan, PhD, is designed to treat emotion regulation difficulties and suicidal behavior. One element, the skill-building component of DBT, addresses the issues of distress tolerance and the development of healthy affect regulation strategies, both of which are essential for suicidal clients.
- **Mentalizing treatment**, developed by Jon Allen, PhD, and Peter Fonagy, PhD, emphasizes emotional regulation and expressiveness. The techniques implemented assist clients in forming good affect regulation and tolerance through the process of developing the mentalizing capability to observe and understand their minds and the minds of others, accurately seeing the mind behind the behavior.

- **Transference-focused Therapy**, developed by Kernberg, Clarkin and Yeomans, concentrates on the intermediate interaction between the client and therapist in session by focusing on the therapeutic relationship.

Israel Orbach, PhD, says, "It is not enough to love the suicidal patient, it's not enough to give him hope, it's not enough to change the external environment. You must deal with changing the self-destructive processes, these inner patterns that erode the self and mental well-being."

Voice therapy, which was developed by Robert Firestone, is a cognitive-affective-behavioral therapeutic methodology that brings introjected hostile thoughts, with the accompanying negative affect, to consciousness, rendering them accessible for treatment. This technique facilitates the client's identification of the negative thoughts that are driving the suicidal actions, which in turn helps them gain a measure of control over all aspects of their self-destructive or suicidal behaviors. They develop a greater understanding of themselves and how these self-destructive voices adversely affect their lives. Their sense of self is also strengthened, giving them a more realistic perspective on themselves and their circumstances, so that they can more effectively cope with adverse life events. This process helps clients expand their personal boundaries, develop a sense of meaning in life, and reduce the risk of self-destructive behavior, including suicide.

A survey of people who had once been suicidal and had been successfully treated in psychotherapy, asked: What were the most helpful aspects in therapy? They cited three:

- **Validating relationships:** Clients described the existence of an affirming and validating relationship as a catalyst for reconnecting with others and themselves.
- **Working with emotions:** Dealing with the intense emotions underlying suicidal behavior. Clients who did not receive acknowledgement of such powerful and overwhelming feelings as despair and helplessness, reported being unable to move beyond them.
- **Developing autonomy and identity:** Understanding suicidal behaviors, developing self-awareness and constructing personal identity. Clients identified the therapeutic process as discarding negative patterns while establishing new, more positive ones.

Even though some suicides are more planned and some are more impulsive, all suicides have elements of both. That is why it is vital that we, as therapists, act quickly and effectively within the space in time between planning and action. This is our opportunity to help a person who is in crisis.

A woman who was effectively treated after making a potentially lethal suicide attempt once said, "I've gone a whole circle from looking at suicide as a refuge or as a last resort to 'I don't want to die. I want to live my life a lot.' And things matter to me. I want to make my life nice. I don't have recurrences of that, ever. I feel bad sometimes, but I never look at suicide as a refuge or last resort." This message is one of hope for anyone who is suicidal: You can feel better and learn to love and value the life you are leading.

Lisa Firestone, PhD, is a clinical psychologist and the director of research and education at the Glendon Association. Since 1987, she has been involved in clinical training and applied research in the areas of suicide and violence. These studies resulted in the development of the Firestone Assessment of Self-destructive Thoughts, Firestone Assessment of Suicide Intent, as well as the Firestone Assessment of Violent Thoughts published by PAR Publications. Firestone consults on the management of high risk clients and is in private practice in Santa Barbara, Calif.