When in contact with a patient presenting with SI, it is essential to screen appropriately but also to be aware of one’s OWN perceptions and anxieties around SI.

A Note on Terminology
Please note that for the purpose of this article we use the terms “suicidal ideation” or “SI” as umbrella terms to reference ideations/thoughts, communications, and behaviors related to a desire to end one’s life or stop living, regardless of the degree of suicidal intent (Silverman, Berman, Sanddal, O’Carrol, & Joiner, 2007). Only suicide intent was adapted from Silverman, Sanddal, O’Carrol, and Joiner (2007), which includes self-injury in the definition. Based on more recent research (Whitlock, Minton, Babington, & Ernhout, 2015) differentials between suicidality and no-suicidal self-injury was further explored. In this paper we will not include self-injury.

Introduction
Suicide rates have risen by 30% in the past 15 years with more people dying by suicide in the United State each year (Hedegaard, Curtin, & Warner, 2018). Thoughts of suicide, or suicidal ideation (SI), can be precipitated and/or accompanied by feelings of isolation and worthlessness along with feelings of depression (Klosses, Szanto, & Alexopoulos, 2014; Maine et al., 2001). According to the Interpersonal-Psychological Theory of Suicidal Behavior, a primary risk factor for SI is a person’s sense of “perceived burdensomeness” or “feeling alienated” (Ribeiro & Joiner, 2009, p.1292). Joiner (2005) conceptualized suicidal behaviors as serving purposes of preservation of oneself; that is, people consider ending their lives over the ongoing pain of isolation and feeling like a burden to others. Suicidal ideation manifests as a symptom of many mental health illnesses such as Major Depressive Disorder and Post-Traumatic Stress Disorder (PTSD) and also of physical illnesses such as chronic pain (Klosses, Szanto, & Alexopoulos, 2014; Ilgen et al., 2008). Although there is a broad range of physical and mental illnesses that increase the likelihood for SI, mental health professionals (“therapists”) alone are left to treat it. The importance of therapists’ role and the therapeutic relationship in treating SI is well established in the literature (Alexander et al., 2009; Dunster-Page et al., 2017; Winter et al., 2013).

Methods
Participants were recruited through email listservs, social media posts, and snowball sampling. Criteria for inclusion in the study included a provisional or full clinical mental health license (e.g., LCSW, or LCSW-A, LMFT or LMFT-A, LPC or LPC-A) and experience working with SI. We defined this as experience working in a setting in which suicide-related thoughts and behaviors were common. Most participants worked in medical settings (private/university hospitals or department of Veterans’ Affairs). Nine participants were recruited for the study; five participants identified as female and four as male. Participants ranged in age from 24 to 49 (M = 34.44, SD = 8.8). Participants ranged in years of clinical practice from 2 to 21 (M= 10.25, SD=7.99). Using a semi-structured interview guide one researcher conducted interviews at locations of the participants’ choosing. All interviews were audio recorded and then transcribed by two members of the research team.
Results
This qualitative phenomenological study was designed to build understanding around two concepts: (1) what it is like to be a therapist working with clients at risk for suicide, and (2) what do therapists do when working with clients at risk for suicide. Major findings from this study center on self-of-the-therapist issues, issues of power, and issues relating to treatment. Self-of-the-therapist issues is related to how the provider understands themselves in the room and their own feelings towards suicide. Findings included themes about issues regarding (a) power of therapist(provider), (b) transparency (of treatment), (c) collaboration (with patient and other peers), and (d) empowerment of patient. Lastly we found information about issues relating to treatment were using (a) direct and clear language, (b) the importance of validation, and (c) including the family.

Discussion
Due to the increased rates of death by suicide in the U.S., it is more vital than ever that researchers evaluate the effectiveness of assessment and the availability and effectiveness of comprehensive treatment options that address the needs of the whole person. The purpose of this poster is to share information gathered from therapists’ experiences of treatment for SI and the transferability to other providers. In doing so, we hope to elucidate potential areas for further training and/or collaboration with other fields in ensuring that not only patients, but providers, are supported in addressing SI.

Clinical Applications for Providers:
- Self-of-the-Provider Implications
  - Seek supervision: Talk to supervisors about SI to get other perspectives on patient and treatment plan
  - Be upfront about your own anxiety towards suicide: Building awareness of own anxiety normalizes the provider stress and allows for other providers to relate
  - Self-care: Make sure you provide space for yourself to digest the intensity of the patient’s needs
- Issues Related to Power
  - Anxiety around the weight of responsibility of knowing someone has SI
  - Power of position as a provider in the room and utilize this power appropriately for treatment
  - Be transparent with patient about treatment
  - Collaborate with family, collaborate with other providers
  - Give patient the power to make decisions with you
- Treatment
  - Use clear and direct language: You want direct and clear answers so ask clear and direct questions.
  - Validate the pain of the patient: Stating to patient, “That must be tough what you are going through,” creates a non-judgmental space for patient to share their vulnerability
  - Include supports in treatment: Allow family and friends to be a part of treatment to allow more people to be aware of the safety concern as well as support for treatment
References