Ten Questions to Promote Excellence when Working with Patients with Suicidal Thoughts

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Working with persons who have suicidal thoughts is one of the most common professional stressors experienced by psychologists. PPA data showed that in 2016, 87% of PPA members treated at least one patient who had thoughts of suicide, 23% had a patient attempt suicide while in treatment, and 4% had at least one patient die from suicide (Leitze & Knapp, 2017). Competent psychologists look for ways to improve the quality of their services to patients who have suicidal thoughts. In this article we present questions that can help psychologists turn a good intervention into an excellent one. As readers may note as they go through this article, the 10 questions have common themes which will be discussed at the end of the article.

The ten questions we pose are:

1. What do you think and feel about persons who have suicidal thoughts?
2. Are you alert for false deniers?
3. Do you ask your patients about a back-up plan for suicide?
4. Do you ask patients to rate their suicidal risk?
5. Do you focus on the relationship?
6. Do you review the safety management plan with your patients?
7. Do you ask patients how likely they are to follow the safety plan?
8. Do you make treatment expectations explicit?
9. Do you monitor patient progress?
10. Are you alert for binary thinking?

1) What Do You Think and Feel about Persons Who Have Thoughts of Suicide?

About 50% of Americans know someone who has died from suicide and many have had family members or close friends who have died from suicide (Fogelman et al., 2018). Psychologists are not immune from this experience. Also, all Americans have been exposed to media reports of persons who have died from suicide. Writing and presenting about suicide has further sensitized us to the pervasiveness of suicide in our culture. Think of the popular songs in the 1960s, such as "Moody River" by Pat Boone, "Patches" by Dickey Lee, "Ode to Billie Joe" by Bobbie Gentry, and others that deal with suicide, as well as books like "The Bell Jar." These and others illustrate how much suicide has become part of our cultural heritage, even though most of us rarely step back and think about it. Sometimes the popular portrayals of persons with suicidal thoughts are sympathetic; at other times they perpetuate harmful stereotypes.

Reflective psychologists will ask themselves, "What do I think about suicide?" Like other Americans, psychologists may have adopted popular cultural beliefs about people with suicidal thoughts. For example, one stereotype is that people who die by suicide are selfish or cowardly (Joiner, 2010). Being an effective psychologist means becoming aware of these stereotypes and adopting more evidence-based and compassionate attitudes. A careful review of evidence shows that suicidal persons are not cowardly. Many persons who died from suicide have been soldiers, police officers, first responders, or individuals who have endured or witnessed great suffering. Furthermore, it takes considerable effort to overcome the natural tendency toward self-protection that a suicidal act involves. In fact, one of the characteristics of patients who die by suicide is that they have acquired the capability to kill themselves. Usually this acquired capability occurs because of habituation to pain and suffering which has gradually reduced the natural fear of death (Joiner, 2010). This commonly arises when individuals have been
exposed to suffering through illness or injury, or through exposure to violence as either a victim, witness, or perpetrator.

People with suicidal thoughts do not intend to be selfish. On the contrary, many patients with suicidal thoughts see suicide as an unselfish act because they perceive themselves as a burden on others. They believe that the world would be better off without them. This belief is so common that Joiner (2010) has identified perceived burdensomeness as one of the critical characteristics of persons with suicidal thoughts.

Psychologists should also consider their role in preventing the suicide of a patient. Psychologists often report that their treatment of patients with suicidal thoughts can involve great worry and concern. When these worries morph into unproductive rumination or lost sleep, it is a good idea for a psychologist to step back and consider their role and professional limitations.

Every patient ultimately decides whether to live or to die, and no psychologist can assume full responsibility for the life of any patient. On the surface this statement may appear insensitive or even cruel, but we ask our readers to think it through carefully. During the 160+ hours of a week when patients are not in the office of the psychologist, the psychologist has little control over what they do or the events that they will experience. As much as psychologists may wish to prevent a suicide, the state of the field is that we simply do not know enough to prevent all suicides, in the same way that we do not know enough to prevent or cure all mental illnesses.

Ironically, psychologists who remind themselves of their limited control over patients with suicidal thoughts often become more effective in working with those patients. They may find themselves freed to concentrate their attention on quality clinical work, and on understanding and helping the patient to ameliorate the pain that underlies the wish to die.

The feelings of the psychologist are also important. What is it like to be in a room with a suicidal patient? Does it elicit fear? A psychologist may ask, “What consequences might I face if this patient dies from suicide? Is it possible that I could get sued?” Another psychologist may feel compassion and may ask, “How can I alleviate the suffering of this patient?” Still another psychologist may experience anger toward the patient. A psychologist may ask, “Will this create many more professional demands on my time?” A psychologist may experience any combination of these emotions at different times. A certain amount of fear or anxiety is understandable and perhaps desirable if it helps increase one’s attention and alertness. But at a certain level fear becomes unproductive.

Working effectively with patients with suicidal thoughts also requires the ability to tolerate uncertainty. The prediction of suicide is inherently unreliable. No single test or procedure is infallible in detecting who is at risk to attempt suicide. Nonetheless, research and clinical experience have identified steps that psychologists can take to become better at identifying those at risk. Psychologists who have mastered these steps will approach patients with confidence, knowing that most patients who have thoughts of suicide or even past suicide attempts will not die from suicide, and that most will go on to lead productive and meaningful lives.

Knowledgeable psychologists also put the risk of a malpractice lawsuit in perspective. It is true that the death of a patient by suicide is one of the common causes of malpractice suits against psychologists, but malpractice suits against psychologists are rare and most malpractice suits related to suicide involve the treatment of inpatients (Knapp, Younggren, VandeCreek, Harris, & Martin, 2013).

Psychologists may err by being either alarmist or dismissive when responding to a patient’s expressed thoughts of suicide. However, the most competent psychologists will adopt an attitude of concerned alertness.

When a patient expresses any suicidal ideation, an alarmist may overinterpret this statement as meaning that the risk of death is imminent, without conducting an evaluation thorough enough to accurately assess the risk. Alarmists may also err on the side of adopting intrusive interventions which are clinically contraindicated. They may overrefer to hospitals or emergency departments or inform the family of the patient about the risk of suicide without first processing that step directly with the patient. Their behaviors convey a lack of respect for the feelings and wishes of the patients and, paradoxically, risk driving patients away from treatment and increasing the overall risk of suicide.

When a patient expresses any suicidal ideation, a dismissive psychologist may ignore or minimize the patient’s risk of suicide. They may adopt the attitude of, “If you were really going to do this, you would have done it already” or “If you were really going to do this, you would not be here talking to me about it.” Because of this attitude, the psychologist may fail to conduct as thorough an evaluation as would be indicated. They may not, for example, consider notifying other members of the family when clinically indicated to do so, fail to take steps to restrict access to the means of dying from suicide, or fail to develop a careful crisis intervention plan for the patient. Their attitudes and behaviors minimize the very real concern and pain of their patients, causing patients to feel less connected to their psychologists and more likely to drop out of treatment. However, psychologists who demonstrate concerned alertness will take the necessary time to do a thorough evaluation, build rapport with the patient, invite the patient to participate in clinically meaningful decisions, consider clinically relevant management strategies, focus treatment on the underlying factors that sustain the suicidal ideation, and so on.

2) Are You Alert for False Deniers?

It is common for a patient to withhold information about suicidal ideation from their psychologist. About 75% of patients who died from suicide had denied such thoughts in their last meeting with a health care professional (Berman, 2018). It is possible that some of these suicidal decedents did not have suicidal thoughts at their last encounter. However, it is likely that many did have suicidal thoughts but simply decided not to tell their health care professional about it.

We recommend that psychologists screen all mental health patients over the age of 12 for suicidal risk, although there may be exceptions based on unusual circumstances. In most mental health settings, most patients screened will deny thoughts of suicide. Of the patients who deny such thoughts, most are true deniers. That is, they truly do not
have thoughts of suicide. A smaller number are false deniers, patients who have thoughts of suicide, but deny such thoughts to their treating psychologist when asked. It can be difficult to distinguish between true deniers and false deniers. Because of the importance of identifying patients who have suicidal thoughts, it is worth stepping back and reviewing screening and assessment steps.

We recommend that the screening involve both a written question and a verbal question. The written question can be a simple one, such as the question on suicide found in the PHQ-9. Regardless of how the patient responds to the written question, it is recommended that the psychologist also ask a verbal question as well such as “Have you ever had thoughts of suicide?” Psychologists can modify the wording based on their own preferences or style of interviewing.

For example, one of the authors (BES) typically asks patients a series of questions: “Do you sometimes find yourself thinking about dying?” “Do you sometimes wish you were dead?” “Do you sometimes think about taking your life?” If any of these are answered in the affirmative, he follows up with questions that help establish the degree of risk.

When patients are asked both verbally and in writing, some patients will acknowledge suicidal thoughts in one form, but not the other. The reasons for this discrepancy aren’t entirely clear. It may be simply that the question was asked twice, but it is also possible that some patients feel shame at having suicidal thoughts and are more willing to open up on paper than in person. Nonetheless, the two-question strategy may identify some patients with suicidal thoughts who would not be identified by one question alone.

Despite this step, some patients with suicidal thoughts will still fail to acknowledge them in response to either written or verbal questions. The reasons may vary. Some may feel shame at having such thoughts and have internalized prejudices that suicidal persons are weak or selfish. Others may fear that the psychologist will try to hospitalize them or share personal information without their consent. Some may believe it is sinful to have suicidal thoughts. Still others may believe that treatments do not work or that they personally are not worth the time and effort of the psychologist. Some patients have a mixture of these reasons or there may be other reasons not identified above.

Psychologists can take several steps proactively in consideration of these concerns. For example, during the informed consent process when discussing exceptions to confidentiality, psychologists can emphasize that they very seldom would reveal patient information without the consent of the patient and only do so if it seemed like the only way to save a life. The preferred approach is to work cooperatively with the patient.

Also, psychologists have steps that they can take in the interview to increase the likelihood that a patient will open-up. First, they can normalize having thoughts of suicide (Shon, 2011). If a patient has gone through an especially difficult time or stressful experience, the psychologist can say, “Wow! That is a lot you have been through. Some people going through all those experiences might have thoughts of harming themselves. Have you ever had those thoughts?”

Some patients believe that having suicidal thoughts is a sign of weakness. If patients are struggling to share painful emotions, it is appropriate for psychologists to recognize the courage that it took for them to share those thoughts. Psychologists can validate the patient’s thoughts and feelings and tell the patient that they have enough strength and courage to acknowledge these problems and to commit themselves to doing something about them.

A final consideration for identifying false deniers is to consider the timing of asking questions about suicide. If patients have acknowledged suicidal thoughts on the written questionnaire, psychologists can ask directly about those thoughts at the start of treatment. However, if patients did not acknowledge suicidal thoughts on the patient questionnaire, then psychologists can start the interview by asking more general information about their well-being and life circumstances and then, as the interview goes on and more rapport is built, can ask about suicidal thoughts later in the interview.

3) Do You Ask Your Patients about Back-Up Plans for Suicide?

Good psychologists will ask patients with suicidal thoughts about their plans for suicide including the method that they intend to use. If patients intend to kill themselves by taking an overdose of medications, for example, then the psychologist could take steps to restrict their access to lethal amounts of medication. They may talk to the prescribing physicians and ask them to limit the amount of medication to a non-lethal dose or have a family check on the supply of prescription and non-prescription medications in the house.

Death by firearms is the most common method of a completed suicide, so it is indicated to ask all patients with suicidal thoughts if they have access to firearms and, if so, to take steps to remove or immobilize those firearms. It may mean using gun locks, removing ammunition from the household, or even removing the guns entirely from the household.

These restrictive methods are effective in preventing suicides. Means restrictions (or means safety) interventions are part of a comprehensive safety plan for patients. Some mistakenly believe that if suicidal persons have one means of dying from suicide removed, they will simply find another way to kill themselves. This theory is not empirically supported, however (Anestis et al., 2018). Most suicide attempts occur during a suicidal crisis, or a period of intense feeling of dysphoria that can sometimes arise in a matter of hours or even minutes. These suicidal crises are time-limited, so the goal is to keep the patients safe during this relatively brief suicidal crisis.

Of course, the patient could always look up lethal doses of non-prescription medication on the internet and drive to the drug store and purchase them. But patients in a suicidal crisis

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1. That question is “Have you had thoughts that you would be better off dead or of hurting yourself in some way for at least several days in the last two weeks?” See http://www.brmedreport.com/archives/54638

2. This may be especially common among Muslim patients for whom suicide represents a terrible sin. For such patients it may be prudent to begin with indirect questions such as, “Do you ever feel tired of living?” or “Do you ever wish God would take you home?”
are seldom thinking through things clearly, and during the time that it would take them to develop and act on an alternative plan, the crisis may have passed.

Nonetheless, some patients have secondary or tertiary suicide plans and psychologists will not learn about these plans unless they ask. It will not be sufficient to develop a safety plan for one means of suicide without having a safety plan for the secondary or tertiary means of suicide. Therefore, we recommend that psychologists ask all patients with suicidal plans if they have secondary or tertiary plans for killing themselves, or if they had other plans in the past which have temporarily become dormant. Psychologists can ask, “If that does not work, have you thought of other ways that you would kill yourself?” and “Did you ever in the past have other plans for killing yourself?”

4) Do You Ask Patients to Rate Their Suicidal Risk?

A good assessment of patients with suicidal thoughts includes gathering information on their suicidal thoughts, including their frequency, intensity and duration; any past suicide attempts including when they occurred, what precipitated them, and the methods used; and any plans for future attempts. It can also be clinically indicated to ask patients on a scale of 1 to 5 (with 5 being the highest risk), what is the likelihood that they will die from suicide or the likelihood that they will attempt suicide again. Evidence suggests that this simple statement helps predict future suicide attempts. For example, Czuy, Horwitz, and King (2016) found that adolescents who predicted that they would eventually die from suicide using a similar scale were more likely to attempt suicide in the future than adolescents who made no such prediction, even when other risk factors were controlled.

If patients say that they believe that they will die from suicide, then it becomes an opportunity to discuss what factors led them to make this prediction. If patients say that they do not believe that they would die from suicide, it becomes an opportunity to discuss the protective factors that lead them to this conclusion. With all patients it can also be productive to ask what factors might change that would increase or decrease the risk of suicide.

5) Do You Focus in the Relationship?

Joiner (2010) proposes three essential elements in a patient’s thinking and experience which are critical in determining risk for suicide. Two of these, acquired capability and perceived burdensomeness have been discussed above (see item 1). The third factor is thwarted belongingness. Patients who lack a sense of belonging or connection with others are more likely to have thoughts of suicide, and to act on those thoughts. Patients who decide to act on their thoughts of suicide often take steps to break any remaining sense of belonging or connectedness with others, either in actions, or in thought. For example, patients who are in an imminent suicidal crisis may convince themselves that no one cares, or that the one remaining significant relationship is irrevocably broken. Psychologists working with a patient in a suicidal crisis may forget the importance of the psychotherapy relationship or may overlook the power of verbalizing connection with a patient. Yet for some patients, connection with a psychologist can be the critical factor which keeps the patient alive. In a suicidal crisis, it is important to overtly express caring for the patient.

The psychotherapeutic relationship is an important element in effective psychotherapy (Wampold et al., 2017). This is not different when working with patients who have suicidal thoughts. When asked why they did not kill themselves, many patients say it is because their psychotherapist cared about them (Montross-Thomas et al., 2014). Few things are as strong and powerful as the opportunity to tell one’s story and to be heard. Sometimes alarmist psychologists will want to argue with patients about the desirability of suicide or automatically or immediately refer the patient to a hospital or notify family members. While each of these interventions may be indicated in some cases, they should seldom be the first steps in dealing with patients with suicidal thoughts. By listening closely to patients and accepting their pain and fears, psychologists can create an environment in which patients are more willing to share suicidal thoughts. They work collaboratively with the patient to develop meaningful treatment goals and strategies. One of the goals of the first interview is give patients a chance to tell their stories and to feel that they were heard. By listening carefully to patients, psychologists will learn more about their life history, their interpretations of events, and perspectives on how to develop an effective treatment program. Although the professional may be an expert on mental health in general, only the patient can be the expert of his or her own individual experience (Michel, 2011, p. 9).

It is a good idea to ask patients to think carefully through any decision to kill themselves. After all, this decision cannot be reversed. It can be a powerful intervention to remind a patient that if she does not die today, she can still make that choice at a future time. It is appropriate to ask a patient to review assumptions they hold that make it appear that suicide is a reasonable option. It is appropriate to remind patients of the pain that they will cause to survivors and the fact that most people who survive a suicide attempt never attempt again and go on to lead productive and meaningful lives.

Psychologists should ask these questions to help patients reflect on their experiences and interpretations. Asking questions, however, should not morph into an argument wherein the psychologist gives a reason for living and the patient responds vigorously with reasons for dying. Psychologists will never win that argument. However, paradoxically, the mere fact of listening to the patients carefully and trying to understand their feelings can reduce those very suicidal urges. Instead of berating patients into believing that their life has meaning, a psychologist who listens is providing the emotional connection that, in and of itself, gives meaning to life.

Validation of a patient’s feelings, thoughts, and experiences is critical in establishing and maintaining connection, and can be tremendously comforting (Linehan, 2014). It can be difficult to think of validating a patient’s thoughts of suicide. Psychologists who are familiar with the principles of validation will recognize the difference between validating the patient’s thoughts, feelings, and experiences versus agreeing with the patient’s intentions or actions. Validation involves acknowledging that the patient’s experienced pain and desire for relief are understandable. It
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does not mean agreeing with a plan to end one’s life.

6) Did You Review the Safety Management Plan with Your Patients?

Effective treatment of patients with suicidal thoughts requires the development of a safety plan. It is not sufficient for psychologists to treat the patient’s mental illness; they must also ensure the immediate safety of the patient. Such safety plans may include a crisis response plan and a treatment agreement in which the parameters of treatment are made explicit. In contrast to a “no-suicide contract” which simply tells patients that they cannot attempt suicide, a safety agreement is written cooperatively with patients and includes steps that they can take to reduce their distress (Rudd et al., 2006). These agreements are intended to be useful documents that patients can refer to in their daily lives. Psychologists can give patients a copy of the agreement that they can refer to during times that they experience suicidal thoughts.

These agreements may include, among other things, writing down the patient’s reasons for living. Often patients will focus on values (“to follow the teachings of Jesus”), or relationships (“to see my grandchildren grow up”). Writing these reasons down can remind patients of what is important to them at a time when there is a risk that their emotions and suicidal urges could get out of control.

The safety plan could also include warning signs or indicators that the patient is doing poorly psychologically. Warning signs can be unique for each patient and often they include symptoms such as sadness, anxiety, agitation, loneliness, insomnia, nightmares, ruminations and, of course, suicidal thoughts.

The agreement can also specify steps that a patient can take to reduce negative emotions. Activities could include talking with friends, going for walks, listening to music, and so on. Preferable activities involve interactions with others or involve movement such as walking or traveling to a restaurant.

Finally, the safety plan should include crisis numbers to call if the emotion-disrupting activities do not provide sufficient relief. It could include the number of a local crisis intervention agency, the number for the National Suicide Prevention Hotline (1-800-273-8255), and the number to reach their psychologist in time of crises. Going to an emergency room should be the last resort when other options have failed, or the patient has a medical issue that needs immediate attention.

Well-developed safety plans, however, are only effective if patients understand them and know how to use them. Safety plans will be remembered better if patients are involved in developing them and the patients and psychologists go over them together to ensure that the patient understands how to use them. When a patient participates in creating a safety plan, the patient is more likely to embrace and use it. We recommend against using pre-written or boilerplate safety plans. Such plans do not take into consideration the specific needs and interests of the patient and patients are unlikely to buy into them.

7) Do You Ask Patients How Likely They Are to Follow the Safety Plan?

It can be clinically indicated to ask patients, on a scale of 1 to 5, how likely they would be to follow through with the safety plan. This simple question gives patients and psychologists an opportunity to evaluate the quality of the plan. If a patient says that they believe that they are unlikely to follow through with the plan, then it becomes an opportunity to discuss the limitations of the plan and how to improve it.

Some patients may believe that the plan is fine, but they do not believe that they are worth saving or do not want to be a bother to their psychologist. One psychiatrist talks with patients about “the lies that depression tells” (William Heinz, M.D., personal communication). These lies can include a belief that the patient is a burden to others, including family, friends, and the psychologist. It can include the belief that the patient’s life has no value, that the patient has failed in life, or that others don’t want to be connected with them.

If patients do not believe they are worth saving, then it can be prudent to review the impact that their suicide will have on others. The average person who dies by suicide leaves 5 to 10 persons who are extremely hurt by the event. Some of the people who are hurt may be unrelated to the patient. For example, a patient who dies by jumping in front of a train causes trauma to the train operator and others. Patients have told us that thinking about the pain they may cause to other people who are unrelated helped them remain alive. It may be worth informing or reminding patients that their suicide will increase the likelihood that other members of the family or other members of their social circle will die by suicide.

A suicide will harm a family more than a death by other causes. When compared to families where a member died by natural causes, families where a patient died by suicide had poorer postmortem adjustment. They have worse mental health and physical health (Spillane et al., 2017). In addition to the grief of losing a loved one, they had to deal with the guilt that they might have missed an opportunity to save their loved one or had contributed to the decedent’s suicide. In addition, the family must deal with the social stigma involved with suicides. One could imagine the neighbors saying to themselves, “What kind of husband (wife, father, mother, etc.) would allow their family member to become suicidal?”

8) Did You Make Treatment Expectations Explicit?

Perhaps the most common reason for treatment failure is the patient’s failure to adhere to treatment. At the extreme it may mean failing to keep appointments, but it can also mean failing to complete homework assignments, completing them haphazardly, or failing to engage fully in treatment.

It is prudent to address non-compliance issues as part of the informed consent process. Some of the issues to be addressed include the expectation that patients will keep appointments or reschedule missed appointments promptly, complete homework assignments, and most importantly be open about their thoughts and feelings. If patients are not complying with treatment, then it is prudent to explore the reasons why. Noncompliance should be dealt with early in treatment.

Sometimes a patient’s reasons for not completing homework may be legitimate. Years ago, I (SJK) had one patient who was noncompliant with completing homework assignments. I later learned that he was functionally illiterate and too embarrassed to tell me that. At other times noncompliance may occur because patients did not see the
connection between the assignment and their treatment goals, or perhaps they were too
demoralized to see the value in completing the assignment. The initial reaction to
noncompliance should not be to blame or shame the patient, but to use it to better
understand the patient and, if necessary, to revise the intervention to make it more
appropriate to their needs.

9) Do You Monitor Patient Progress?
One of the goals of the initial assessment is to get a baseline of functioning. Monitoring
progress means monitoring the overall progress in treatment and monitoring the
risk of suicide. Often this is done by a simple question at each session, such as “Tell me
the frequency, strength, and duration of the suicidal thoughts you have had in the last
week (or since we last met)?” This is a better question than just, “Do you feel suicidal?”
which only asks about their present suicidal thoughts and may not capture the suicidal
thoughts that they have had in the last week.

Another option is to repeat the question asked on the intake, “On a scale of one to five
(with five being the highest risk), what is the likelihood that you will kill yourself?”
This question can be asked over a period of weeks and the psychologists will have a number
to record in the record. One advantage of monitoring progress is that it gives patients
a chance to see how much their suicidality is decreasing. If patients go through a period
of demoralization, then their psychologists can show them the ratings over time and the
overall trend toward improvement.

If the patient has especially strong suicidal thoughts or risk factors, it may be prudent
to get sources of information other than the patient's self-report such as reports from
the patient's family or loved ones. The progress of patients can be measured by a formal
questionnaire. Psychotherapists might give their patients a simple questionnaire such as
the Beck Depression Inventory at the start of treatment to get an objective score on their
response to treatment.

Whatever method is used, we urge psychologists to be vigilant about monitoring
progress. It is true that some patients get worse before they get better. However, early response
is a good prognostic sign and a lack of early progress should be grounds for concern and a
reason to involve the patient in a reevaluation of the treatment plan.

Question Ten: Are You Alert for Binary Thinking?
Like all-or-nothing thinking, binary thinking occurs when a patient believes that only two
options exist in a given situation. Worse, one of the options may be unacceptable or may
not be viable. If the other option is suicide, the patient has created his or her own trap. For
example, if the patient says, “If the doctor can't cure my chronic pain, I will kill myself,”
then the patient creates a binary choice in which one choice is not viable, leaving suicide as the
only remaining option. The same is true for the patient who says, “If my girlfriend breaks up
with me, I will kill myself.”

The way out of the trap is to work with the patient to generate a range of options. When we
recognize binary thinking, we start by validating the patient's pain and the patient's perception
of being trapped. We can then begin to ask questions to help the patient generate a
range of options. For example, the patient may be asked what level of pain is tolerable. Then
the psychologist can work with the patient to develop a better pain management plan,
perhaps including the patient's physician in the process. In the second instance, the patient
has limited control over his or her girlfriend's choice to remain in the relationship. But the
psychologist can help the patient plan to talk with the girlfriend or recognize other important
relationships and reasons for remaining alive.

What Do These Ten Questions Have in Common?
Several themes emerge in the 10 questions that we have identified to improve the
treatment of patients with suicidal thoughts. These questions attempt to increase the
self-reflection of the psychologist, maximize patient involvement in treatment, and to make
explicit assumptions about treatment explicit. Psychologists can increase their self-
reflection by asking themselves about their attitudes and feelings when working with
patients who have suicidal thoughts. They can also use feedback on patient progress to reflect
on the benefits of treatment and the need, if any, to modify treatment. Patient autonomy
is increased by having patients involved in the treatment as much as possible by, for example,
helping create the safety plan and eliciting their opinions about their perceptions of
their own risk of suicide, the likelihood that they would use the safety plan, and so on. A
final theme is that the psychologist tries to be as transparent as possible concerning the
tools involved in psychotherapy including importance of adhering to the treatment
protocol. These perspectives are consistent over all ethical principles and have evidence
to support their effectiveness.

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