Treating Patients with Chronic Thoughts of Suicide

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Workshop Description
Chronically suicidal patients may periodically escalate into an acute suicidal crisis. This workshop addresses the day-in, day-out challenges of working with individuals whose suffering leads them to think about suicide every day of their lives, with goals of helping patients find relief through a reliable set of self-soothing and other coping tools, challenging the thinking errors associated with suicidal ideation, and treating the underlying problems that sustain suicidal ideation.

Today will be presenting information about working with patients who think about suicide and encouraging each of you to think about your own experiences as a therapist when you work with such patients.

Learning Objectives
At the end of the workshop participants will be able to:

- List differences between working with acutely and chronically suicidal patients;
- Describe factors that move patients from suicidal ideation to action according to the interpersonal and integrated motivational volitional theories of suicide;
- Identify factors that protect patients from acting on suicidal thoughts;
- Describe how to teach patients to regulate their emotions and alter their thinking patterns; and
- Identify therapist challenges in working with chronically suicidal patients.

First a Note About Language
Died by suicide—not committed suicide, not successful suicide

As you listen to this presentation, we would like you to think of three ideas that you will take home with you.

How will you use these ideas in your practice?
Psychologists and Suicide

1 in 5 psychologists will have a patient die from suicide in their career (Chemtob et al., 1989)
In 2017, 5% of PPA members had at least one patient die from suicide
35% had a patient attempt suicide while in treatment
66% had patients with suicidal plans
92% had patients with suicidal thoughts

Psychiatrists and Suicide

At least half of psychiatrists will have a patient die from suicide. The increased rates compared to psychologists probably reflect work setting and patient factors
Some psychotherapists have had a patient die by suicide. But having a patient die by suicide is a possibility for every psychotherapist.

Demographics of Suicide

Women attempt suicide more often than men
Men complete suicides more often then women
European and Native Americans die from suicide more often than Black or Asian-Americans (may be factors that underestimate rates, however).

Data on Suicide

46,000 Americans died from suicide in 2017
10th leading cause of death in USA
Rate of suicide increased 30% since 1999

Suicide and Public Health

Suicide is an under-appreciated public health issue. Although the rates of death for most diseases are decreasing, the rates of death for suicide is increasing.
10th leading cause of death, yet very little funded research (1/20th of level of kidney or lung disease)

Suicide and Older Adults

Older adults, especially older white males, have the highest rates of suicide.
Old men are more likely to complete a suicide on their first attempt (25%), primarily because of the use of firearms in the attempt
Ideation, Plans, Attempts, Completions

Over a lifetime

15% to 30% have ideation
5% to 10% will have a plan
2-3% will attempt
LT 1% will complete a suicide

(Kessler et al., 1999)

What is it like to be in the room with a patient who is talking about suicide?

• What factors increase your discomfort?

What Is It Like?

What is it like to be in a room with a patient who is talking about suicide?

• What thoughts come up for you?
• What do you feel?

• What factors increase your discomfort?
• What are some things you do to decrease your discomfort?

Thinking about Suicidal Patients

The more you know about suicide, the less your discomfort.

What about the following myths (see the next slide) are inaccurate, incomplete, or harmful?
Some Myths about Suicide

• People who talk about suicide aren’t really going to kill themselves.
• People who attempt suicide usually don’t go on to complete suicide later.
• People who attempt suicide and live didn’t really want to die.
• Asking about suicide can plant the idea.
• A suicide attempt is a cry for help and should not be given attention.

The Interpersonal Theory of Suicide

Suicide involves

1. Acquired capacity to kill oneself
2. Thwarted belongingness
3. Perceived burdensomeness
   (hopelessness underlies these)
Developed by Thomas Joiner and colleagues

Next Steps

Theories of Suicide— to guide assessment and treatment

Acute suicidal states— to help identify common warning signs

Fluid Vulnerability Theory— to describe process by which warning signs can morph into a suicide attempt

Thwarted Belongingness

The person does not feel close connections with others, or does not identify with any valued group of people.

May be a recent loss of a valued relationship through divorce, family conflict, or death

Perceived Burdensomeness

The world is better off without me.
People may perceive themselves as an emotional, physical, or financial burden (may have illness or functional limitations)

Theories of Suicide

Help explain large amounts of data.

Help guide assessment and interventions.

The major theories today are “ideation-to-action” theories that identify a step or process that motivates a person with suicidal thoughts to act on those thoughts.
Implicit Factors
Implicit in perceived burdensomeness and thwarted belongingness are
Self-disgust and hopelessness

Integrated Motivational-Volitional Theory (IMV)
“Suicidal behavior is an individual’s attempt to end their pain or escape from unbearable life circumstances”
O’Connor & Portzky, 2018, p. 12

Acquired Capacity
Habituation to pain and loss of fear of death.
Common among those exposed to violence or suffering: anorexics, firefighters, physicians, prostitutes, veterinarians.
This is the feature that distinguishes ideation from action.

Sequence in the IMV
Motivational stage leads to suicidal thoughts—defeat, entrapment, perceived burdensomeness, thwarted belongingness, etc.
Volitional stage leads to suicidal behavior—acquired capability, access to means, social learning, etc.

A Second Theory of Suicide
Integrated motivational-volitional theory of suicide—Rory O’Connor
The experience of defeat, humiliation or entrapment motivates suicidal behavior

IPT and IMV Similarity
Both see a role for thwarted belongingness and perceived burdensomeness in predisposing a person to want to die.
Both identify a step that moves a person from thought to actions and both include acquired capability as that motivator (IMV defines acquired capability more broadly).
IPT and IMV Differences

IMV has entrapment/defeat as the major cause of suicidal desire.

IMV identifies more factors in the desire step than perceived burdensomeness, and thwarted belongingness.

IMV identifies more factors in the action step than just acquired capability.

Acute Suicidal Affective Disturbance (ASAD)

Akin to the concept of a suicidal mode— which is a mixture of thoughts, feelings, behaviors, and motivations linked to a suicide attempt.

The ASAD specifies what to look for in the suicidal mode.

Suicide Attempt

Be alert to:

- emotions found in the ASAD: Agitation, anxiety, irritability, insomnia, nightmares, and social withdrawal
- cognitions found in the ASAD: thwarted belongingness, perceived burdensomeness, self-disgust, hopelessness
- Defeat/humiliation/entrapment found in the IMV

Warning Signs

Previous lists of warning signs got so long that they became useless. Many of the dozens of variables listed had a very low relationship to suicide or overlapped with other variables.

Although every person is unique, the ASAD identifies those variables that are empirically linked to a suicide crisis state.
Fluid Vulnerability Theory (FVT)

All suicidal patients have a baseline of distress.

Their risk of suicide goes up and down depending on acute stressors.

During a crisis the distress goes above the baseline and the risk of suicide increases.

More on the FVT

Those with a higher baseline of distress will go into a suicidal crisis easier and have a harder time returning to their baseline.

Those with a lower baseline of distress will be less likely to go into a suicidal crisis and will have return to baseline quicker.

Assessment Tips

Understanding risk
Identifying plans
Moving from Ideation to Attempt
Protective Factors

Understanding Risk

Those with acquired capability have an increased risk of suicide.

Look for exposure to and habituation to pain or suffering through early childhood experiences, trauma, illness, past suicide attempts, etc.

The single best predictor of a future suicide attempt is a recent past attempt. Risk increases as the number of past attempts increases.

Applying the Theory

The Interpersonal or IMV theories and the ASAD help identify who is likely to enter the suicidal crisis state and what to focus on in suicide management and treatment.

Explain the FVT as the way to conceptualize treatments. Goals are to (1) keep patient from going into crisis and (2) lower baseline of distress.

Suicidal Behavior is Cross-Diagnostic

Suicide more common in some disorders, such as bipolar disorder, anorexia, substance abuse and especially if there are co-morbid disorders.

BUT suicide can occur with any mental disorder OR sometimes even in individuals with subclinical presentations of mental disorders.
Substance Abuse

Substance abuse is one of the diagnosis most commonly associated with suicide especially if comorbidities.

Substance Abuse

The data may underestimate the extent to which suicides occur among substance abusers since the coroners have to make a judgment on whether the overdoses with accidental or not.

Nonsuicidal Self-Injury

• The relationship between NSSI and suicidal gestures/behaviors is complex.
• NSSI occurs for many reasons; often patients don’t have a clear sense of why they engage in the behavior.

Nonsuicidal Self-Injury

• But I have known patients who engage in life-threatening behavior, such as a potentially lethal overdose of medication and say they just wanted relief from extreme distress.
• The most common reason for NSSI is escape or relief from extreme emotional distress and feelings of entrapment.

Nonsuicidal Self-Injury?

Non-suicidal self-injury (NSSI) differs from suicide in that there is no intent to die

BUT, it can increase acquired capability of suicide, especially if patients have a large number of attempts, use multiple methods of self-harm, and report less pain when they harm themselves.

Nonsuicidal Self-Injury

While NSSI is usually treated as a behavior distinct from suicidal gestures/behaviors, sometimes it is hard to tell the difference; sometimes patients say the behavior is intended as NSSI, but is potentially lethal; and sometimes patients themselves aren’t clear about their own intent, or don’t honestly disclose their intent to a therapist.
Identifying Plans
If a patient with suicidal ideation reports having no plans at the present, ask them if they EVER had any suicide plans in the past. They may have dormant plans that could be reactivated during periods of stress.

“Impulsive Attempts”
These ideators to attempt patients may
Actually formulate plans very quickly OR
May have had dormant plans that they had not thought about for a while

Moving from Ideation to Attempt
For patients who have ideation, ask them
“On a scale of 1 to 5, what is the likelihood that you will die from suicide, with 5 being the highest likelihood that you will die?”
“What events could occur that could move you closer to the suicide end of the scale?”

Ideators to Attemptors
The movement to a suicidal mode or ASAD may occur quickly.
Sometimes it could occur over a period of hours, sometimes as quickly as half an hour

Ideators and Attempts
Past attempts and detailed plans for future attempts increase the risk of a subsequent suicide attempt
However, a percentage of patients appear to go directly from ideation to attempts

Importance of Questions
Emotions and likelihood of entering into suicidal mode
Secondary or tertiary plans...
Make it easier to identify those who go from ideation to attempt with the apparent intermediary step of having a plan.
Interpersonal Theory and Interviewing

Remember that thwarted belongingness is one of the features that predict suicidal behavior according to the Interpersonal Theory.

Creating a good relationship with the therapist is one social contact that, in and of itself, reduces the risk of suicide.

What do I think about suicide?

- I can understand a person feeling suicidal.
- I have had times that I have thought of suicide myself.
- I have no understanding of how a person could think of killing himself/herself.
- My religion makes it too hard to understand how someone could think of suicide.
- I think more about the people who would be hurt by suicide than I do about the person who might take their life.
- I think of someone I knew who died by suicide.

How do we react when a patient talks about suicide?

- The alarmist reaction is to focus on fear of the patient dying.
- When a patient expresses any suicidal ideation, an alarmist may overinterpret this statement as meaning that the risk of death is imminent.
- Alarmists may err on the side of adopting intrusive interventions which are clinically contraindicated.

How do I feel about people who think about suicide?

- Judgment
- Sympathy
- Identification
- Rejection

How do we react when a patient talks about suicide?

- A dismissive psychologist may ignore or minimize the patient’s risk of suicide.
- “If you were really going to do this, you would have done it already”
- “If you were really going to do this, you would not be here talking to me about it.”

How do we react when a patient talks about suicide?

- Dismissive psychologists 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.
- A dismissive psychologist may fail to conduct as thorough an evaluation as would be indicated.
Concerned Alertness

- Focusing on the patient’s thoughts, feelings, and lived experience.
- Taking the necessary time to do a thorough evaluation.
- Building rapport with the patient.
- Understanding the underlying factors that sustain the wish to die.
- Inviting the patient to participate in clinically meaningful decisions.

Chronic vs. Acute Suicidal Ideation

- Some patients experience long periods during which they think about suicide every day or nearly every day.
- Such patients may or may not have a history of past suicide attempts.
- For some patients, the first such period occurs in adolescence.
- Suicidal thoughts in young children are rare, but not unknown.
- For other patients, the first episode of thinking about suicide occurs following a loss or setback, or in response to physical pain.

Continuum of Risk

- Passive death wish
- Thoughts of suicide without plan or intent
- Thoughts of suicide with vague or unavailable plan (I would shoot myself, but patient doesn’t have a gun.)
- Thoughts of suicide with plan
- Intent
- Imminent intent

Part Two: Management

Three M’s

- Motivate
- Means
- Monitor

Continuum of Risk

BUT remember that a minority of patients appear to go directly from ideation to attempt without articulating a plan or reporting a plan.
Responses to Suicidal Thoughts
Historically, across all of health care professionals, the most common responses to a patient reporting acute suicidal ideation are:
- Medication
- No-suicide contracts
- Seeking hospitalization
- Send to emergency rooms

Myth One
Myth: When working with suicidal patients, the most important thing is to treat their mental illness and then the suicidal plans will go away
Truth: When working with suicidal patient, it is essential to develop plans to manage the suicide risk in addition to treating the mental illness

Responses to Suicide-2
No suicide contracts— no evidence of effectiveness
Medication— except for bipolar or schizophrenia, no evidence that it reduces short-term risk
Hospitalization— no evidence of long-term benefit
Emergency Rooms— done with discretion depending on patient need

Myth Two
Myth: No-suicide contracts have value
TRUTH: no evidence supports their use

Importance of Management
It keeps patients safe and gives therapy a chance to work.
The specific strategies for management should be informed by data gained during the assessment process.

Ethical Principles of Management
Does the intervention respect patient autonomy?
Yes, sometimes it may be necessary to be more paternalistic for short periods of time, but the general goal is to respect patient decision making.
Motivational Interviewing

Many psychologists have found principles from motivational interviewing to help ambivalent patients.

Get patients to talk about their feelings and goals. Offer opinions only if asked or if given permission (and after patients have expressed their opinions).


Interpersonal Theory and Management

Since thwarted belongingness is a major factor in suicide, management techniques should try to incorporate social connections with the patient.

For example, cooperative and caring relationship with therapist.
Seeking out natural social networks for support.

Management-Motivate

Commitment to Life (Treatment) Agreement

1. Reasons for living
2. Coping: Situations to avoid, situations or people to seek out, ways to self-soothe
Symbols of hope
How to manage distress
3. Crisis response: numbers if needed

Cooperative Work Together

The commitment to life document is a product of active collaboration between the psychotherapists and their patients.

The psychotherapist can make suggestions about reasons for living or soothing activities, but ultimately the patients decide what to put down.

Management-Motivate -2

Unlike no suicide contracts, commitment to life or treatment contracts tell people what to do.

No suicide contracts tell people what NOT to do.

Commitment to Life

The activities found useful tend to be those that are active and involve other people (e.g., talking to a friend)

OR that reinforce values (prayer, meditation, religious services)
I Have No Reasons for Living

What did you used to like to do?

If you were not so depressed what would you liked to do?

What reasons for living do other people have?

Commitment to Life-Crisis Plan

Define a crisis— anytime that you doubt that you can control your suicidal urges; 3 X 5 card

1. Do activities—try them again
2. Call Dr. Smith (555-2121). Call National Suicide Hotline
3. Go to EveryTown Emergency Room at 100 Main Street, (555-1223)

Hope

“If your pain were to go away would you still want to kill yourself?”

“No”

“I think I can help you with that”

(Whiteside, 2016)

Ask Patients

“What is the likelihood that you will call if you are in a crisis?”

Commitment to Life Agreement-Soothing Activities

What do you do that reduces your emotional distress?
(Remember Suicidal Mode or ASAD? How to keep emotions under control how to circumvent the hard emotions when they arise.)

Social Ones or involving movement or different senses
Be specific— not “call friend” but “Call John at 555-1212”

Means Restriction

Details of suicide plan and remove guns, medications, etc. away from patient

Patients seldom substitute one means of suicide for another
Myth Three

Myth: If you take away their guns (or pills) they will just find another way to kill themselves

Truth: Taking away guns or medications reduces the likelihood of a completed suicide

Identifying Means

Remember the importance of asking patients with suicidal plans if they have second or third choices for how they will kill themselves.

The goal is to keep them safe during the time-limited suicidal period

Medication

A management strategy for schizophrenia or bipolar disorder

Its effectiveness in reducing short-term suicide risk in other patients is unclear

Increased risk when starting or getting off medication

Management: Monitor

Continue to measure suicidal ideation and plans

Day-to-day check ins or monitoring with patients consent may be indicated for some patients

Hospitalization in extreme cases

Myth Four

Myth: medications will reduce suicidal risk

Truth: except for schizophrenia and bipolar disorder, medications do not appear to reduce suicidal risk in the short run.

“A pill does not remove a gun from the home”
Hospitalizations
Little data guides us on when to use hospitalization or its long-term impact.

Use it when there is no way to ensure the safety of the patient otherwise.

Release from hospital is a high risk period for patients.

Management Techniques
Breaking confidentiality – do so only as a last resort

Involuntary hospitalization – do so only as a last resort

ER: what was your last ER visit like?

Family Involvement
With patient’s permission and if indicated, solicit involvement of family with patient in the form of social support and monitoring.

Rely heavily on patient in managing this.
May need to educate family so that they will not overreact or “support” in punitive or shaming ways

Breaking Confidentiality
Is it absolutely necessary to ensure the safety of the patient?

Are other means available to diffuse the danger?

Myth Five
Myth: No one can stop a patient who really wants to die from suicide

Truth: Although no one can MAKE a patient refrain from suicide, almost all patients are intensively ambivalent and good management and treatment techniques will greatly increase the chance of living

Part Three: Effective Treatments
Evidence-based
Rudd et al. (2015) CBT
Linehan et al. (2015) DBT
Jobes (2016) CAMS

Others may be effective as well
Effective Treatments
Most outcome studies (including studies with medications) exclude patients with suicidal ideation.

Few studies collect data on suicide attempts or completions.

Treatment Is Similar
Good treatment of suicidal patients contains the essential elements of good treatment in general

Relationship, including expressions of empathy
Agreement on goals
Monitoring progress,
Therapeutic humility, etc. (Wampold et al., 2017)

Interpersonal Theory and Treatment
Focus on desire to die:
Acquired capability is slower to respond to interventions.

Incorporate strategies that help patients feel connected to others or which reduce the perception that they are a burden to others

Remember Suicidal Risk
Be flexible in scheduling—option of more than once a week

Continue management strategies as long as needed

Treatment is Different
Continue to focus on managing suicide

Remember the psychological issues that commonly occur among suicidal patients (isolation, self-disgust, perceived burdensomeness)

Motivate for Treatment
On the average, every suicidal decedent has 6 to 10 persons who are seriously harmed by their death

Service families where member dies from suicide have poorer long-term adjustment than service families where member dies from accidental or natural causes
Survivors
Stigma/Shame: “what kind of wife would allow her husband to . . .?”

Guilt: “If only I had done this, then he would still be alive!”

Monitor Risk
Remember one of the goals of assessment is to provide a baseline by which progress can be measured.

Here the brief suicidal screening instruments may be used for that purpose.

Even one brief question is something

If Treatment Does not Work. .
“If treatment does not work you can always kill yourself.”

Use selectively with very ambivalent patients

Informed Consent
Expectations including expectation that patient will participate fully in treatment including following through with assignments, keeping appointments, discussing issues honestly, presenting concerns as they arise, etc.

Focus of Treatment
Physical illness, pain or disability?
coordinate with health professionals

Social isolation (thwarted belongingness or perceived burdensomeness)
focus on building relationships

Reduce Likelihood of Suicidal Mode
(ASAD)
Reduce baseline of emotional turmoil-

e.g. sleep hygiene if needed, relaxation of cognitive techniques for anxiety, etc.
**Emotional Cascade**

Suicidal mode can be precipitated by one big event OR by several small events where one negative events increases the likelihood that the patient will overreact to a second smaller events, and so on.

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**Insomnia**

More evidence is showing that insomnia is a unique and independent contributor to suicide risk

- Sleep hygiene
- CBT for insomnia
- Medications for short-term sleepiness
- Prazosin (for nightmares)
- Imaginal rehearsal therapy for nightmares

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**“Who Would Care About Me?”**

How would you respond if someone asked you for help?

Have you ever helped anyone else?

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**Promote Protective Factors**

- Strengthen social connections
- Help with positive world views that provide hope
- Self-forgiveness

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**Focus of Treatment**

Factors found in the ASAD

- Emotional pain- e.g., relaxation, mindfulness, cognitive reappraisals
- Sleep hygiene
- Other topics as needed

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**Problems/ Topics in Treatment**

- Nonadherence to treatment
- Attempts During Treatment
- Time or event contingent suicide
- Suicidal blackmail
Nonadherence

Refer back to informed consent agreement
Attempt to discern reasons. Are there good reasons for nonadherence?

If a patient is not benefiting from treatment and there is no reasonable likelihood that they will benefit from treatment, then terminate.

Entrapment

What else can bring relief for the patient?
- Pain management
- Meaningful activity (foster belongingness)
- Reminding patients of their capacity for decision-making

Attempts During Treatment

Attempts are 2 to 3 times more likely to occur than a completed suicide.

1. Patient at a high risk to attempt again
2. Patient may have great shame
3. Reevaluate treatment and crisis plan
4. If necessary, higher level of care

Entrapment

- Be alert to signs of a patient feeling trapped.
- Binary thinking

Attempts During Treatment

When a patient reports any of the following during the course of treatment.

- A suicide attempt
- Non-suicidal self-injury
- An increase in thoughts of suicide
- Behaviors which bring the patient closer to suicide (e.g., handling/counting pills, handling the gun, driving very fast just to see what it feels like, etc.)

Working with Elevated Risk

Behavior Chain Analysis skills are borrowed from DBT. Note that the focus is on the behaviors that preceded the suicide attempt, not on the attempt itself.

- What led up to the incident?
Working with Elevated Risk

- What happened before that (construct reverse behavior chain) to identify precipitants. Sometimes there is a chain of precipitants stretching back over hours or even days.

- Which skills did you use during this time? (Good time to reinforce positive coping behaviors. Patients tend to minimize what they did because they think the skills weren't adequate or successful.)

- Which additional skills could you have used?
- What got in the way of using those skills?
- I notice that you didn't call me the night you were counting your pills. Why not? Would it have been helpful to call?

- Which skills can we add to your repertoire? (Patient may name additional skills. This can also be an opportunity for therapist to introduce a new skill, e.g. a new mindfulness technique.)

- The Learning Trial Model

Time/Event Contingent Suicide

- If such and such happens, then I will kill myself.
- Do not overvalue the link between the event and suicidal inclinations— they may be suicidal outside of the event
- Establish your parameters for intervention
- Are there implications for the treatment relationship?
Suicidal Blackmail

“If you do not take my phone calls every day, allow me to intrude on your personal life, let me skip payments for services (etc.), I just might kill myself.”

Do not agree to anything that is clinically contraindicated.

Quality Enhancement Strategies

These are a series of procedures designed to reduce legal risks to the psychologists by improving the quality of services the patients receive.

Many of these reiterate themes already identified in previous slides.

Ethical Foundations of Quality Enhancement Strategies

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Evidence Base for Quality Enhancement Strategies

Consultation: look at diagnosis, treatment choice, relationship quality

Empower Collaboration: agreement on treatment goal, legitimate patient preferences

Redundant Protection: routine monitoring of patient progress

Quality Enhancing Strategies

As the legal risks, the possibility of treatment failure, or patient complexity increases, the greater the level of attention should be given to quality enhancing strategies.
Consultation
Beneficence/nonmaleficence
addresses stress and isolation
Competent Community--

Empowered Collaboration
Empowered collaboration builds upon informed consent and attempts to maximize patient involvement in all essential elements of treatment
The patient becomes more actively involved in the process of psychotherapy. Greater commitment leads to better outcomes.

Consultation
Technique oriented information
Emotional reactions (countertransference)
Reduction of emotional turmoil
Thinking through solution together

Empowered Collaboration
Empowering psychologists respect a patient's autonomy and decision making skills about the goals of treatment, process of treatment, and life choices.
Examples of tough decisions and ambivalent patients

Empowered Collaboration
Respect for Patient Autonomy
Evidence based relationship-agreement on treatment goal
accommodation to reasonable preferences

Application of Empowered Collaboration
Because of the importance of empowered collaboration, psychologists should be reluctant to overturn patient preferences for
Involving family members in treatment
Choice of treatment goals
Documentation: Legal Purposes

Beneficence/Nonmaleficence

Required by insurers, State Board of Psychology, APA Ethics Code, etc.

A record of treatment for future providers

Useful risk management tool

What Should be Recorded?

Record the information obtained about risk including patient responses to questions, background especially related to risk factors, and scores on screening instruments.

The thinking process used to integrate this information, including cost/benefit analysis of major decisions

Documentation: Quality Enhancing

Dialogue with self and patient regarding process and goals of treatment

Means to identify pertinent clinical issues

Procedure to document progress

Monitoring Progress

Beneficence/Nonmaleficence

Additional source of information for a difficult patient

Routine procedure with high risk patients

Routine and Risk-Focused Documentation

As the level of risk increases, the detail and specification of documentation should increase.

Most patients are routine and the documentation is mundane.

Suicidal patients should trigger more detailed documentation.

Application of Monitoring

Include data on patient progress (see “four session rule” below)

Also, include scores on screening instrument in the record.
Four Session Rule

Always monitor progress and be vigilant if progress has not occurred by the fourth session

Then Prompt List
1. rethink diagnosis and goals- do you need a consultation
2. discuss issues with patients
3. are there second sources of data to explore?

Prompt List- Additional Reflections

Do YOU think you and the patient have a good working relationship?
Is your assessment of the patient adequate?:
Are there unresolved ethical issues?
Do unresolved clinical issues impede treatment?
What does your System I say about the patient? System II?


Thank You!!

Questions?

References


2. discuss issues with patients
occurred by the fourth session
Always monitor progress and be vigilant if progress has not

References-2


References-3
References- 4


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