# Ethical and Competent Care of Suicidal Patients: Contemporary Challenges, New Developments, and Considerations for Clinical Practice

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Clinical work with suicidal patients has become increasingly challenging in recent years. It is argued that contemporary issues related to working with suicidal patients have come to pose a number of considerable professional and even ethical hazards for psychologists. Among various concerns, these challenges include providing sufficient informed consent, performing competent assessments of suicidal risk, using empirically supported treatments/interventions, and using suitable risk management techniques. In summary, there are many complicated clinical issues related to suicide (e.g., improvements in the standard of care, resistance to changing practices, alterations to models of health care delivery, the role of research, and issues of diversity). Three experts comment on these considerations, emphasizing acute versus chronic suicide risk, the integration of empirical findings, effective documentation, graduate training, maintaining professional competence, perceptions of medical versus mental health care, fears of dealing with suicide risk, suicide myths, and stigma/blame related to suicide. The authors' intention is to raise awareness about various suicide-related ethical concerns. By increasing this awareness, they hope to compel psychologists to improve their clinical practices with suicidal patients, thereby helping to save lives.

*Keywords:* suicide, informed consent, risk assessment, treatment, risk management

## Clinical Work With Suicidal Patients: Emerging Ethical Issues and Professional Challenges

### David A. Jobes

Clinical work with suicidal patients is fraught with professional challenges. Some of these challenges include psychologists' inability to predict behaviors with low base rates (such as suicide attempts and completions), the decision to commit a person to an inpatient setting, intense countertransference issues, and the potential life-or-death implications of treatment (Jobes & Berman, 1993; Jobes & Maltsberger, 1995; Maltsberger & Buie, 1974). Although these concerns continue, additional challenges have recently emerged, which make providing this care even thornier. In this article, I examine various present-day issues that clinicians face with suicidal patients, with an eye to ultimately enhancing the ethical and effective clinical care of suicidal patients. The following fictitious cases capture a sampling of current concerns.

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## Case Examples

A chronically suicidal male 19-year-old with multiple suicide attempts was seen in outpatient psychotherapy for over 3 years. A gun was wrestled away from him by his friends at a party (he had put the weapon to his head and said "bye-bye"). His outpatient psychologist saw him the next morning—the patient completely denied any suicidal thoughts and signed a safety contract. Two days later, he was found hanging in a garage. The parents filed a malpractice lawsuit against the clinician claiming that she had inadequately assessed and treated their son's suicidal risk; his promise to be safe was seen as an inadequate intervention given his long and proven history of lying to adults.

An outpatient psychologist contacted the insurance company of his 20-year-old suicidal patient. The clinician believed that his patient posed an imminent suicide risk, and the patient reluctantly agreed to be hospitalized. However, the insurance representative on the phone asserted that suicidal ideation without any attempt behavior did not meet their criteria for imminent danger. The clinician noted that the patient owned a gun and had threatened to use it. Ultimately, precertification for hospitalization was denied when the clinician admitted that he did not know if the patient had bullets for the gun. The patient severely wounded himself days later and was placed on life support.

A father contacted an outpatient clinical psychologist about his 16-year-old son, who had suffered from severe clinical depression over the past 2 years with frequent suicidal thoughts and two serious overdoses. His son had seen four different psychiatrists and had not responded to a broad range of antidepressants, antipsychotics, and mood stabilizing medications. He had been hospitalized six times, and he ultimately received electroconvulsive therapy. However, the adolescent seemed to be doing worse, and the father was terrified of his son's potential suicide risk. He further noted that his son had never been in any psychotherapy and wondered if that might help.

## A Critique of Contemporary Care of Suicidal Patients

The preceding case examples vividly underscore a few of the many pressing worries related to contemporary care of suicidal patients. It is plain that the clinical landscape of care for suicidal patients has changed dramatically in recent decades (Jobes, 2006). Clinical suicidologists (who specialize in suicide-related research, training, and forensic work) would highlight a number of issues in these case examples that all implicate a core ethical standard for psychologists: *competence* (refer to "Ethical Principles of Psychologists and Code of Conduct," Standard 2.01, Boundaries of Competence; APA, 2002). Competence issues related to suicide tend to haunt contemporary providers. For example, assessments of suicidal risk are commonly inadequate (Coombs et al., 1992), and many clinicians continue to rely on an utterly inadequate intervention for suicide risk—the safety or no-harm contract (Rudd, Mandrusiak, & Joiner, 2006). Moreover, there are now major challenges related to contemporary use of inpatient hospitalization (Salinsky & Loftis, 2007). There is an overreliance on medications, and routine use of newer empirically supported techniques is not common (Linehan, 2007). Given these concerns, experts have argued that contemporary clinical care for suicide risk is largely inadequate, posing considerable professional and ethical challenges for practicing clinicians (Jobes, 2000; Linehan, 2007; Rudd, Mandrusiak, & Joiner, 2006). Let us thus consider some recent developments in the field that may help assure ethical and competent care of suicidal patients.

## Elements of Competent Clinical Care for Suicidal Patients

Fortunately an emerging scholarly literature in clinical suicidology is beginning to provide some remedies for the issues noted earlier (that may also lead to improvements in care). Critically, these new approaches inherently embrace key ethical principles and considerations, thereby enhancing their clinical worth while simultaneously serving to decrease risk and potential malpractice liability therein.

### Sufficient Informed Consent

Clinical challenges posed by suicidal patients can be best addressed from the start by using thorough informed consent (refer to Standard 10.01, Informed Consent to Therapy; APA, 2002). Adequate informed consent with a suicidal patient can be used to structure treatment, disclose prospective risk in an objective manner, and create understanding about treatment ground rules, limits, and boundaries (Jobes, 2006; Rudd et al., 2008; Rudd, Joiner, & Rajab, 2001). New suicide-oriented treatments tend to heavily emphasize structure, and expectations of the patient and clinician are made explicit within time-specific transparent treatment plans (Brown et al., 2005; Jobes, 2006; Linehan, 1993; Rudd et al., 2001).

### Adequate Assessment of Risk

As discussed by various authors (Jobes, 2006; Jobes & Berman, 1993; Joiner, Walker, Rudd, & Jobes, 1999; Maltsberger, 1986; Shea, 1999), the adequate assessment of suicide risk should be a thorough, extensive, and multifaceted activity. Although asking about suicidal ideation is a start, there should be a much more thorough assessment process to allow psychologists to adequately understand the potential for suicidal behavior. For example, among other things, history (e.g., multiple previous suicide attempts; see Rudd & Joiner, 1998), relational aspects of suicide risk (Jobes et al., 2004; Joiner, 2005), cognitive aspects (e.g., hopelessness and suicide-related cognitions; Beck, 1986), and environmental factors (e.g., access to lethal means; Lester, 1989) must be thoroughly explored and documented. There has been a notable and recent shift away from inexact suicide risk factors toward more proximate suicide warning signs (Rudd, Berman, et al., 2006). These warning signs include hopelessness, rage, reckless behavior, a feeling of being trapped, increased alcohol/drug use, social withdrawal, anxiety/agitation, dramatic mood change, and the lack of a sense of purpose in life.

Psychologists also know that there can be limits to purely interview-based clinical judgments (Meehl, 1954), which underscores the obvious value of supplementing our interview assessments with additional assessment tools. In this vein, Barnett and Porter (1998) highlighted the importance of using objective assessment measures to supplement more subjective interviews. For example, instruments, such as the Beck Depression Inventory (Beck, Steer, & Brown, 1996), the Brief Symptom Inventory

(Derogatis & Savitz, 1999), or the Outcome Questionnaire–45 (Lambert et al., 1996), can be used to significantly supplement assessment and add to the medical record. Jobes and Berman (1993) previously advocated the use of the Suicide Status Form, a multipurpose assessment tool that makes assessment an ongoing and well-documented process (refer to Range, 2005, and Goldston, 2000, for reviews of other suicide-specific assessment tools). Similar to informed consent, proper assessment is an explicit ethical expectation of psychologists (refer to Standard 9.02, Use of Assessments; APA, 2002).

*Empirically Supported Treatments*

Marsha Linehan (1998) has long been a passionate advocate for increased suicide treatment research and has noted recent progress in this domain (Linehan, 2007). As discussed by Rudd, Joiner, Jobes, and King (1999), empirically informed treatment guidelines can be readily used to improve clinical practice with suicidal patients. Work in this area has sometimes been contentious because long-standing treatment techniques (e.g., safety contracts) and routine interventions (e.g., hospitalization and medications) are now being challenged in various professional forums to the chagrin of advocates of these approaches.

Some contemporary changes in practice have been driven by previously unforeseen factors. For example, inpatient hospitalization has long been the standard intervention for suicidal persons (a practice that can be traced back to the asylum movement of the European enlightenment). However, recent economic forces have significantly changed this practice as lengths of inpatient hospital stays have plummeted since the 1990s—with stays now typically lasting 3 or 4 days (Olfson, Gameroff, Marcus, Greenberg, & Shaffer, 2005). It is also becoming increasingly difficult to obtain insurance precertifications for admissions; repeated short-term hospitalizations (e.g., 10, 15, 20 times in 2 years) may be problematic and over time might make matters worse for the patient (Jobes, 2006). Undoubtedly, there is a role for inpatient care, but innovative and cost-sensitive models of intensive outpatient and inpatient treatments are needed to adequately respond to the range of suicide risk that exists (Lineberry, Bostwick, Rudd, & Jobes, 2007).

In relation to outpatient care, Rudd, Mandrusiak, and Joiner (2006) thoughtfully critiqued the routine use of no-suicide safety contracts. They noted that such verbal or written promises of prospective safety represent an inadequate response to outpatient suicidal risk. Such contracts, as typically extracted, are not about safety, nor are they contractual in any legal sense. Indeed, in malpractice litigation, safety contracts may actually work against the clinician's defense. Fortunately, there are sensible alternatives to no-suicide contracts. Rudd et al. (2001) proposed the use of a written commitment to intervention and the related use of a crisis response plan. Brown et al. (2005) advocated the use of a safety plan. Critically, these approaches use coping action plans—what patients will do versus what they will not do (the typical focus of no-harm contracts). Moreover, a crisis response plan can be collaboratively developed with the patient in anticipation of future suicidal crises to help the patient cope differently through self-soothing, appropriate outreach/support, and new adaptive skills (Jobes, 2006). Brown et al.'s innovative work underscores the importance of developing new cognitive and behavioral skills for

averting a future suicide attempt. For example, use of a *hope box* and rehearsal of newly acquired coping skills are central to their 10-session suicide-specific cognitive psychotherapy treatment. Many of these techniques are akin to cognitive–behavioral coping techniques used in dialectical behavior therapy (Linehan, 1993). These behaviorally activating, cognitive coping, grounding techniques provide a suicidal patient with a critical new repertoire for coping and self-soothing; there is also clear recourse for directly obtaining professional help if a patient's coping efforts do not work.

It is surprising to many in the field that there is virtually no empirical support for purely biological treatments of suicidal risk. As Linehan (2007) has recently discussed, the research so far shows that psychosocial interventions are most effective for treating suicidal ideation and behaviors. Yet, medications are still widely used and may well be the primary treatment response for suicidal people. Beyond considerations of suicide risk, it is interesting to note that although medications appear to work for many patients, they do not work for many others, and length of treatment is an important consideration (e.g., Rush et al., 2006). Indeed, some even fundamentally challenge the whole notion of biological depressions, arguing that evidence for the value of medications is weak (Leventhal & Martell, 2005). Whatever the case, if medications are to be effective, they must be taken reliably, and therapeutic doses must be present in the bloodstream. However, one look at the medication compliance literature shows that many patients do not fill their prescriptions, do not take medication reliably, and do not reach therapeutic dose levels in their blood (Dwyer, Levy, & Meander, 1986; Haynes, McKibbon, & Kanani, 1996; Horowitz & Horowitz, 1993). Although medications are obviously an important part of the contemporary treatment, the empirical data suggest that a medication-only approach to suicide risk is so far unfounded.

Thus, a competent psychologist should be aware of the increased emphasis on intensive outpatient treatment, crisis response planning, and the explicit development of coping techniques that may render suicidal coping obsolete over time (Brown et al., 2005; Jobes, 2006; Linehan, 1993; Rudd et al., 2001). Embracing these approaches is consistent with the spirit of professional ethics in psychology and complies with explicit ethical expectations of professional competence that should be informed by the scientific and professional knowledge of the field (refer to Standard 2.01, Boundaries of Competence; APA, 2002).

*Appropriate Risk Management*

Finally, if clinicians adequately assess suicide risk, have a suicide-specific treatment plan, consult with colleagues, and document their work, the prospect of being successfully sued for malpractice is significantly reduced (Berman, Jobes, & Silverman, 2006; Jobes, 2006; Jobes & Berman, 1993). In summary, if psychologists use (a) thorough informed consent, (b) adequate assessment of suicide risk, and (c) empirically informed outpatient suicide-specific treatments (with the appropriate use of medication and hospitalization), we can be relatively assured that we are a part of developing a whole new standard of care where managing suicide risk is synonymous with working in the best interest of the patient. The essential roles of professional consultation—with knowledgeable colleagues and attorneys when indicated—and of

thorough, contemporaneous documentation assure that potential risks have been well managed.

## Conclusion and Remaining Challenges

Suicide has been a leading sentinel event for many years in American health care settings (The Joint Commission, 2007), and the threat of losing a patient to suicide is seen as the most threatening professional concern (Pope & Tabachnik, 1993). It is, therefore, incumbent on ethical psychologists to extend their boundaries of competency to be able to appropriately and effectively assess and treat suicidal patients. Although there has been headway in efforts to improve clinical care for suicidal patients, many unresolved issues, challenges, and ongoing dilemmas remain. For example, how do psychologists go about raising the overall standard of clinical care of our field? How do we realistically help clinicians work in novel and competent ways when there is often a tremendous reluctance among some to change familiar practices? How can we change models of health care delivery for suicidal patients when such models are often driven by short-term economic incentives? What role does research play and where should we focus our investigations? Can we better appreciate issues of diversity that may affect the care of suicidal subgroups?

If psychologists are able to address these professional challenges in the years to come, we honor the ethical principles and standards of our field, we improve our clinical practices, and we potentially save the lives of patients who might otherwise be lost to suicide. The invited commentaries that follow address these and other important ethical issues and concerns relevant to the effective identification, assessment, and treatment of suicidal patients.

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# Commentaries

## The Fluid Nature of Suicide Risk: Implications for Clinical Practice

### M. David Rudd

Jobes did a wonderful job of identifying and discussing a broad range of ethical and professional challenges in working with suicidal patients, issues that fall at the forefront for many in clinical practice. Among the issues identified, he noted the problem of adequate assessment of risk, with mention of the confusion in differentiating between risk factors and warning sign, and the emerging (and converging) evidence about the unique status of multiple attempters. Both of these issues relate to the broader problem of appropriately understanding, differentiating, assessing, and responding to the variable or "fluid nature of suicide risk" (Rudd, 2006, p. 358).

The primary characteristic that distinguishes between suicide warning signs and suicide risk factors is proximity (Rudd et al., 2006) to either a suicide attempt or a suicide. As with other conditions, like heart attack and stroke, warning signs connote imminent risk, risk that is evident over the next few minutes, hours, or days. In contrast, risk factors are related to what can best be described as lifetime risk, with the time periods covered in the extant literature ranging anywhere from a year to several decades (cf. Rudd, Joiner, & Rajab, 2004). Research on multiple attempter status has converged with rare uniformity in findings across age

and gender, with those engaging in multiple suicide attempts manifesting more severe psychopathology (both diagnoses and related symptom constellations), elevated suicide intent, and greater interpersonal disruptions and impairment in daily living (Forman, Berk, Henriques, Brown, & Beck, 2004; Rudd, Joiner, & Rajab, 1996). It has also been discovered that the suicidal crises of multiple attempters carry unique parameters, with crises being more enduring when the individual is exposed to external stressors, but with intent being relatively constant regardless of experienced stress. In short, those with a history of multiple suicide attempts exhibit elevated suicide intent without external stressors, along with being more vulnerable to significant exacerbation when stress does emerge.

It is true that many single suicide attempters are multiple attempters in waiting; that is, they simply have not yet had time to make multiple attempts. Henriques, Wenzel, Brown, and Beck (2005) found that suicide attempters' reactions to surviving can meaningfully differentiate those likely to make subsequent attempts. A simple question (along the lines of "How do you feel about surviving your suicide attempt?") proved significant in differentiating those who made subsequent attempts. Those likely to make additional attempts offered more frequent responses expressing regret about surviving.

It is important for clinicians to recognize and integrate these latest findings into daily practice. It is particularly important to recognize that there are both acute and chronic features to suicidal crises. It appears that the most accurate and efficient way to differentiate acute and chronic aspects of risk is by considering the attempt status of the individual being evaluated. In other words, those with a history of multiple suicide attempts need to be considered at enduring or chronic risk for suicide; assessment practices and chart entries need to reflect this distinction (cf. Joiner, Walker, Rudd, & Jobes, 1999). Perhaps the easiest way to translate enduring or chronic suicide risk is that those having made multiple attempts are more vulnerable to experience another suicidal crisis in the future. It takes less to trigger such a crisis, and there is evidence that, for many, suicide intent endures at higher levels on a daily basis regardless of external stressors (Forman et al., 2004; Rudd et al., 1996).

Perhaps the primary implication for those in clinical practice is that every time a suicidal patient is evaluated, an assessment should be made of attempt status. For those experiencing suicidal ideation with no previous history of attempts or for those making a single attempt, the risk assessment is focused on acute risk. In contrast, though, those with a history of multiple suicide attempts require some discussion of chronic suicide risk. This is a simple acknowledgement of current empirical findings along with the reality that suicidal crises come and go, that some aspects of risk are enduring, and that all patients have different levels of vulnerability to experience another suicidal crisis in the future. All crises have a beginning and an end, but what we know is that those with a history of multiple attempts are at significantly greater risk (more vulnerable) to experience a subsequent crisis and suicide attempt or eventual death by suicide. Accordingly, a section is needed in the clinical chart that clearly identifies chronic risk.

It is easiest to understand how this distinction translates to a chart entry by considering those hospitalized for suicidality. Eventually, the crisis subsides, and the patients are discharged. For multiple attempters, a chart entry saying "no suicide risk" at

discharge is simply inaccurate. The reality is that these patients are not evidencing any acute risk, but they definitely manifest enduring or chronic risk. Chart entries making this distinction between acute and chronic risk should appropriately note that the symptoms and stressors that precipitated the admission have resolved adequately to warrant discharge. However, for multiple attempters, a range of known variables leave a patient vulnerable for future crisis episodes, with those factors being appropriately targeted by ongoing treatment. For example, such risk factors include the following: Axis I and II diagnoses (along with comorbidity); persistent and recurrent symptoms of depression, anxiety, and hopelessness; a history of unresolved trauma or abuse; substance dependence; a fragmented and strained social support system; among a host of others. These entries can be brief, with the goal of efficiently conveying the rationale for clinical decision making. What follows is an example of a brief discharge note (it is not entirely comprehensive but provides a general idea of how these entries might look).

### Discharge Suicide Risk Assessment Summary

Over the course of the patient's admission (see intake and subsequent entries), all presenting symptoms have resolved to within normal limits, including depression, anxiety, and hopelessness. Naturally, there has been no alcohol use. The patient also reports no current suicide ideation, intent, or associated plans. There is no evidence of acute risk that would prevent discharge. There are chronic risk factors that need to be addressed following discharge, that is, factors that increase the patient's vulnerability, including a past history of multiple suicide attempts, unresolved trauma secondary to sexual abuse, recurrent major depressive episodes with some anxiety overlay, episodic substance abuse, and persistent relationship problems. The most appropriate mechanism to address these issues is ongoing outpatient psychotherapy and medications. The patient has been scheduled for immediate follow-up care, with her psychiatrist and psychologist (dates and times of appointments provided). Treatment compliance has been an issue in the past and has been discussed. The patient reported a commitment to treatment and will again discuss compliance issues with her outpatient providers. A crisis response plan was also reviewed, and the patient is aware of available emergency services (and has made use of them in the past).

Effective charting can be accomplished in an efficient fashion, with the primary goal of communicating the rationale behind the clinical decision. As Jobes noted, adequate risk assessment is a fairly broad topic, but it is critical for practicing clinicians to routinely consider and differentiate between acute elements of risk and those that indicate enduring or chronic vulnerability for suicide. In addition to charting, clinical practice is clearly improved when a patient transitions from an inpatient to an outpatient setting if information flow is unimpeded. More specifically, copies of the discharge summary, suicide risk assessment, and crisis response plan should all routinely make their way from the inpatient service to the outpatient provider. Exactly how this is accomplished can vary considerably. Regardless, though, the flow of information from the inpatient to the outpatient side of practice is critical, particularly in light of some of the more recent data regarding escalation of suicide risk following discharge from inpatient facilities, indicating markedly high risk in the first week following discharge (cf. Troister, Links, & Cutcliffe, 2008). Speculation has been that poor coordination and communication between the in-patient facility and outpatient provider, coupled with delays in scheduling, escalate suicide risk following discharge.

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# Professional Competence When Working With Suicidal Clients

## James C. Overholser

In this article, David Jobes has provided a thoughtful discussion on clinical work with suicidal clients. For many years, Jobes has published important scholarly reviews, empirical studies, and clinical guidelines to help improve work with suicidal patients. In this article, Jobes refers to competence as a central construct that guides ethical action. Competence is especially important when working with suicidal clients because of the risk of injury or death to the client, as well as the professional liability risks that could be incurred by the treating professional (Overholser, 1995).

As noted here by Jobes, many clinicians rely on assessment procedures that are deemed inadequate. The assessment of suicide risk is a complicated skill that requires a range of tools (Bisconer & Gross, 2007). Furthermore, Jobes noted that many therapeutic intervention strategies are not adequately designed to help the suicidal client and simply rely on short-term hospitalization, psychotropic medications, and a no-suicide contract. There are clear limitations to each of these intervention strategies. I agree with Jobes that psychologists should be encouraged to learn about the wealth of strategies available to guide a clinical assessment and psychological treatment of suicidal clients.

A critical issue in graduate training involves helping students to develop an adequate level of competence in various psychological skills. Professional competence can include several central

components, such as factual knowledge, general clinical skills, specific intervention skills, clinical judgment, and professional demeanor (Overholser & Fine, 1994). Most important, competence requires the integration of knowledge and skills (Epstein & Hundert, 2002). When working with suicidal clients, the psychologist should have certain skills that are specific to understanding and reducing suicide risk. The specific skills are still being negotiated. However, the required skills are likely to be relevant to graduate students as well as the core faculty who provide the graduate training. Several recent reports have helped to improve the assessment of competency skills and behaviors (Kaslow et al., 2007). However, the field needs to go beyond assessment strategies and ensure that an adequate level of clinical competence is demonstrated by the teaching faculty.

Professional skills and competencies are developed during graduate training, predoctoral internship, and the early postdoctoral years. Training usually requires background reading, academic course work, supervised experience, and the opportunity to work with clients who are struggling with suicidal thoughts. As they progress through their training, graduate students are expected to develop basic competence in numerous skills (Association of Directors of Psychology Training Clinics Practicum Competencies Workgroup, Council of Chairs of Training Councils Practicum Competencies Workgroup, Hatcher, & Lassiter, 2005; Hatcher, & Lassiter, 2007). Although most graduate training programs recognize the importance of suicide prevention, few programs (35%–40%) provide formal training in the assessment and treatment of suicidal clients (Bongar & Harmatz, 1989, 1991).

Even when it has been firmly established, competence does not last forever (Barnett, Doll, Younggren, & Rubin, 2007). Competence is maintained by participating in (a) continuing education activities, (b) ongoing clinical service with clients, and (c) peer consultation when needed. It seems likely that all three activities are needed to maintain an adequate degree of professional competence. However, these specific activities do not include some of the most common tasks pursued in the ivory tower of academia: involvement with research projects, writing professional papers, or supervision of work completed by students. Although these academic chores drive the scholarship process, they do not help to maintain the clinical skills that are involved in the clinical assessment and treatment of suicidal clients. Competence derives from a combination of formal training and clinical experience (Barnett et al., 2007). Academic psychologists are often competent to conduct research investigations, but these research skills do not automatically translate into competent clinical skills.

Sadly, some psychologists develop expertise in suicide assessment and intervention but then fail to remain active in the frontline delivery of clinical service. This is understandable because there are numerous demands on professional time. Administrative meetings, research reports, and classroom instruction frequently intrude into the busy day of an academic psychologist (Conway, 1988). Only a small percentage of academic psychologists remain active in the direct provision of clinical services (Clement, 1988). Unfortunately, some experts in the field allow their expertise to erode. One perspective on maintaining an adequate level of competence derives from the clinical recredentialing process. For example, I have had staff privileges at a local hospital for 10 years, and these privileges have allowed me to provide clinical services to clients in the hospital's outpatient clinic. To renew my staff privileges every

2 years, hospital administrators required that I provide documentation about my education and experience. If I had not provided a certain type of therapy (e.g., cognitive therapy) or if I had not worked with a specific type of high-risk client (e.g., suicidal clients) during the past 2 years, it would have been assumed that my skills were no longer sharp, and I would have lost those privileges. As noted long ago (Dubin, 1972), professional knowledge becomes obsolete within 7 years of graduation. It also seems likely that our professional skills become weak if not used on a regular basis.

There is a risk of confusing competence with confidence (Stewart et al., 2000). It seems that many academic psychologists write, publish, and speak on topics related to psychological assessment and psychotherapy, while not continuing to work in frontlines clinical practice. Academic psychologists risk developing an authoritarian style and may even publish clinical guidelines without applying them in their own work. I have met too many psychologists who supervise clinical work without serving as therapists themselves because they believe that they still have the competence to tell others how therapy should be conducted. I worry that their unsupported confidence could aggravate the ever-present gap between the scientist and the practitioner. It seems likely that competence for working with suicidal clients is best restricted to psychologists who pursue the ideals of the scientist–practitioner model (Overholser, 2007). Effective work with suicidal clients seems to require the ongoing integration of the science and practice of psychology. Psychologists who work primarily in clinics or hospitals can integrate science and practice by remaining informed about current research findings and using the published literature to guide their own clinical work (Wolf, 2007). Ambitious clinicians can even use single-case methodology to track client symptoms as reported before, during, and after the start of treatment in order to monitor the effectiveness of the intervention (Borckardt et al., 2008).

Thus, I agree with Jobes that professional competence is a central construct that helps to develop and guide the ethical management of suicidal crises. However, I fear that Jobes has overlooked a critical component required for professional competence. I have argued that competence in clinical skills is likely to be deficient if a psychologist has not provided clinical services to clients within the past 2 years. It seems that many who are considered experts are teaching the next generation of clinicians and writing the authoritative texts in the field even though they have failed to maintain their own competence in the clinical skills required for effective psychological treatment. Furthermore, I strongly encourage psychologists who work with suicidal clients to develop and maintain an adequate level of competence in evidence-based practices relevant to the clinical assessment and psychological treatment of suicidal clients.

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# Concrete Suggestions to Improve Care for Suicidal Patients and the Implications of Their Limits

## Thomas E. Joiner Jr.

A clinician sees a vulnerable and ill patient several times over the course of a few weeks; unfortunately, the patient dies. If the clinician is a cardiologist, people's reactions—indeed, the reactions of the cardiologist himself or herself—are likely to be of a distinctly different character than if the clinician is a psychologist and the patient has died by suicide.

Why is this? In both cases, the clinicians are seeing patients facing grave illnesses—in the case of the cardiologist, heart disease, and, in the case of the psychologist, recurrent major depressive disorder (to choose one example)—and, in both cases, the illnesses were grave enough that they resulted in death, even though the clinicians did nothing wrong and everything right. For both the psychologist and the cardiologist, clinical technique, although effective and in some cases lifesaving, has limits. The nature and consequences of these limits are fairly well understood in the case of the cardiologist. Are they as well understood in the case of the psychologist?

My answer involves a kind of paradox. No, the limits in the case of the psychologist are not as well understood as they should be, and concrete things can and should be done to redress this problem. However, in a sense, the limits should not be as comprehensible, because the psychologist's tool is, in part, the human relationship, the depths and vicissitudes of which include inherently intractable features. In this last point inheres a kind of tragedy in the classical sense.

## Let's Do Obvious and Concrete Things Better and Also Accept the Tragic Aspects of Our Work

Cardiologists are not afraid of hearts and blood and the like—it would be absurd if they were. It would be absurd too if psychologists (and other mental health professionals) were afraid of the topic of suicidal behavior. Alas, many are. Indeed, it has been reported that over half of training clinics do not provide service to suicidal patients (Bongar & Harmatz, 1989) for fear of being sued and of other problems associated with patients' suicidal behavior. Suicide is fearsome, but it is appalling that mental health professionals have not fully trained this fear out of themselves.

We need to train ourselves and each other better, and not on particularly complex things either. For instance, we should freely ask about whether people have suicidal thoughts or plans—the idea that doing so is iatrogenic is highly uninformed (Gould et al., 2005). Straightforward frameworks for asking about suicide risk are widely available, learnable, and trainable; see, for example, the lethality assessment guidelines of the National Suicide Prevention Lifeline, which administers 1-800-273-TALK (Joiner et al., 2007) or the Collaborative Assessment and Management of Suicidality framework (Jobes, 2006).

As another example, although I am aware of no systematic data on the issue, I and many others working in the field of suicidal behavior routinely encounter myths like the following: patients who talk about suicide are just talking, they won't actually do it; patients who have been suicidal for years won't die by suicide, they would have already done it by now; and patients with borderline personality disorder are only gesturing suicide, they won't actually do it. Psychologists should quash these myths—they are false and disrespectful, not to mention lethal. One way to counteract these myths is to promote the warning signs for suicide developed by the American Association of Suicidology and available on its Web site (www.suicidology.org). Initial research on the beneficial effects of these warning signs has been encouraging (e.g., Van Orden et al., 2006). Another way to counteract these myths is to see mental disorders as they are; for instance, many mental health professionals view borderline personality disorder as including hopeless chronicity and the tendency to merely gesture suicide. Hopeless chronicity is demonstrably false. Patients with borderline personality disorder do get better. A persuasive study found that 34.5% of a sample of borderline patients met the criteria for remission at 2 years, 49.4% at 4 years, 68.6% at 6 years, and 73.5% over the entire follow-up. Only around 6% of those who remitted then experienced a recurrence (Zanarini, Frankenburg,

Hennen, & Silk, 2003). The claim of merely gesturing is false too, tragically so, given that approximately 10% of patients with borderline personality disorder end up dying from their suicidal gestures (comparable to the rate for patients with mood disorders)—and this has been known for many years (Gunderson, 1984).

In another, related example, psychologists should understand that suicidal behavior is a complication of mental disorders and should insist that mental disorders are common, nothing to be ashamed of, and treatable. The claim that cancer is common, nothing to be ashamed of, and treatable is so taken for granted that its emphasis seems unneeded today. However, mere decades ago, this was not the case—cancer was misunderstood and was stigmatized to the extreme, arguably even more so than mental disorders are today.

Psychologists can make dramatic progress on the destigmatization, public awareness and education, and therapeutics of mental disorders and their lethal complications through suicide, as the example of cancer shows. The example of cancer is also instructive in that progress involved (and continues to involve) the culmination of the slow labors of theoretical development and synthesis, and of empirical analysis, all within the traditions of biomedical and other sciences. Substantial progress on something as complex as mental disorders and suicidal behavior will require science—psychological science (including but not just neuroscience).

Even given such progress, tragedies in the form of deaths by suicide will occur. A similar truth applies, of course, in disciplines like cardiology and oncology, but for psychologists, there is an additional layer of complexity. Cardiologists' and oncologists' techniques are imperfect and limited; thus, they will occasionally fail, and deaths will ensue. The same is true for psychologists. Deaths in fields like cardiology and oncology, however, are routinely attributed—by practitioners and survivors alike—to factors external to the practitioner: the limits of technique and the power of the illness. In large part, deaths should be similarly attributed in cases of suicide of those under the care of psychologists (given treatment that meets or exceeds the standard of care).

The difference is that, in the case of the psychologist, the practitioner is in part the technique; the technique is in part the practitioner. The limits of technique, therefore, take on an intimate and personal quality. It is tragic that the practitioner cannot prevent all deaths by suicide. To proceed nevertheless and to risk the personal toll of a patient's suicide armed with the latest scientifically informed techniques, saves lives and, therefore, involves tragedy's antidotes—courage, compassion, pity, and honor.

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