Suicidality in Clinical Practice: Anxieties and Answers

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This issue of the *Journal of Clinical Psychology: In Session* is devoted to suicidality in clinical practice, with coverage of a broad range of topics. After summarizing some of the problems and recent advances in clinical suicidology, I provide a brief overview of the articles. Included are the more broadly defined issues of risk management and psychotherapy with suicidal individuals, along with more specific topics such as risk assessment, no-suicide contracts, and the risk of suicide with the use of selective serotonin reuptake inhibitors (SSRIs) by children and adolescents. Most of the articles feature case vignettes and provide practitioners with clinical recommendations, and all of the articles have clear and important clinical implications. © 2005 Wiley Periodicals, Inc. J Clin Psychol: In Session 62: 157–159, 2006.

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Regardless of how carefully referrals are screened and how narrowly a specialized clinical practice is focused, questions of suicidality will undoubtedly emerge, sometimes with alarming frequency. Suicide is one of the few topics that almost uniformly trigger anxiety and apprehension in clinicians, whether novice students or seasoned practitioners. And let me add my name to the list, despite the fact that I specialize in the area. Among the topics that generate the most questions in suicidality are methods of risk assessment, risk classification, related clinical decision making, short- and long-term psychotherapy, ongoing risk management for those at chronic risk, identifiable markers of imminent risk, the role of medications, professional liability, malpractice, and the standard of care.

Over the last several decades, the literature in this area has been expanding at a phenomenal rate as a solid empirical foundation to clinical suicidology has been established. This expansion has occurred despite the web of challenges in designing, implementing, and maintaining clinical research with high-risk patients. Nonetheless, many

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questions remain unanswered or even unidentified at this point. Among the most exciting areas emerging in suicidality are warning signs or markers of near-term risk. Ongoing efforts are devoted to differentiating, both conceptually and empirically, the traditional construct of "risk factors" for suicide from the more practical "warning signs," similar to those of heart attack, stroke, and diabetes.

Despite the problems confronted in conducting research with high-risk patients, a number of things can be said about the state of the science in clinical suicidology. We know more now than ever about what works and what does not with suicidal patients. There are greater clarity and precision in our theories and terminology, making it easier to compare, contrast, and metanalyze empirical studies. As a result, our clinical decision making and clinical management are more coherent, with a better understanding of the role of medication in treatment. In short, the emerging standard of care of suicidal patients is founded in science and identifiable core competencies, as are the standards in other areas of clinical practice. Take, for two examples, the recent practice guideline for assessing and managing suicidal patients published by the American Psychiatric Association and the core competencies in suicide risk assessment identified by the American Association for Suicidology.

The primary goals of this issue of *Journal of Clinical Psychology: In Session* are to share what we know, fill in some of the gaps, and answer questions that all practitioners often have about assessing, managing, and treating suicidal patients.

I think you will be pleased with the collection of experts and topics presented. As a starting point, Marsha Linehan and Kate Comtois provide a practice-friendly distillation and synthesis of available empirical findings on psychosocial treatments for suicidal behaviors. Their review is cutting-edge. It represents the latest and best of what we know about psychosocial treatment with this population. At a minimum, their article will help you make treatment choices and recognize the importance of cognitive therapy, dialectical behavior therapy, problem-solving therapy, and interpersonal psychotherapy with suicidal patients. You might also be surprised by the power of simple interventions (such as caring letters). Lanny Berman follows with a wonderfully concise and thorough review of risk management with suicidal patients. If you were looking for an easy to read and understand summary to guide your practice, Lanny has provided one. Lanny gives us a handy summary of points every clinician should consider and respond to when working with suicidal patients. When you read this piece, you will understand better the standard of practice in suicidality and what is routinely expected of every practitioner managing suicidal patients.

Similarly, Craig Bryan and I attempt to synthesize recent advances in risk assessment in an empirically supported model that can be applied in any clinical setting. The model is straightforward and the application simple. Perhaps paramount is our emphasis on differentiating between acute and chronic risk in day to day practice. If you do not already make such a distinction, I hope our article will convince you of the importance of doing so.

The next three articles provide illustrations of several psychotherapeutic approaches to working with suicidal patients. Mark Williams and his colleagues at Oxford provide you with a cutting-edge application of mindfulness-based cognitive therapy for the emergence and persistence of suicidal behavior. Truly unique, this therapeutic approach is quickly establishing itself in the field. Similarly, Thomas Joiner's treatment team at Florida State University apply his interpersonal-psychological theory in psychotherapy with high-risk suicidal patients, with particularly good results. Their approach is promising, with its uncommon elegance and ease of application. Finally, Terry Maltsberger and Igor Weinberg offer a fabulous discussion of contemporary psychoanalytic theory in the assessment and treatment of suicidal patients. I think both newcomers and experienced

psychoanalytic clinicians will find their work helpful and convincing. Those not analytically inclined might be swayed by their penetrating discussion; I know I certainly was. I was also surprised by the considerable overlap between traditional cognitive-behavioral therapy and their approach.

The final two articles provide empirically grounded discussions about high profile issues in suicidality. Michael Bostwick of the Mayo Clinic provides an extraordinary review of the evidence in the ongoing debate about the use of selective serotonin reuptake inhibitors (SSRIs) with children and the potential side effect of suicidal ideation and behavior. This story has received incredible attention in the media, and the actual data have been lost in the shuffle. Michael helps clear the fog with his review, which raises questions about the newly mandated Food and Drug Administration (FDA) "black box" warning. Having participated in the FDA review process, I can attest that Michael has hit the nail on the head here. I would suggest that everyone read his article and take to heart his sensible recommendations when considering the use of medications. In the final article, Mike Mandrusiak, Thomas Joiner, and I offer a critical review of the empirical literature on no-suicide contracts. I think many readers will be surprised by our conclusions. Despite ubiquitous use, no-suicide contracts have practically no empirical support demonstrating their effectiveness or efficacy. Actually, the few available studies addressing clinical outcomes suggest that no-suicide contracts are ineffective as a clinical intervention. We do not leave the reader wanting, though, offering the *Commitment to Treatment Statement* as an alternative for practice.

This practical issue spans the full range in suicidality and provides a plethora of practice suggestions. The contributors have done an exceptional job in translating complex science into practical advice. This issue, I fervently believe, will answer some of your questions and reduce some of your anxiety. More importantly, though, maybe it will result in even more questions and convince you to join those in the trenches conducting clinical research with this high-risk population.