Treating Suicidal Clients & Self-Harm Behaviors

Assessments, Worksheets & Guides for Interventions and Long-Term Care

Meagan N. Houston, PhD, SAP

"Finally! A hands-on resource which provides practical interventions for the assessment, intervention and management of suicidal and NSSI behavior. Dr. Houston's approach to suicide and NSSI prevention is timely, relevant and culturally sensitive. The level of detail and precision in which this delicate topic is discussed makes it clear why Dr. Houston is an authority on the topic of suicide and NSSI. This gem will benefit neophyte and seasoned clinicians alike!"

Jasmine Ross Burton, PhD
Licensed Psychologist
Essence Psychological Health Services

"Dr. Houston is a consummate professional and presenter, and her years of experience shine in this must-have resource. Working with personality disorders and challenging clients, and managing suicidal issues as well as non-suicidal self-injury on a routine basis, this book will quickly become an indispensable tool."

Daniel J. Fox, PhD
Licensed Psychologist
Award-winning author of *Antisocial, Borderline, Narcissistic & Histrionic Workbook*

"Dr. Houston has graciously and tirelessly given mental health professionals and their clients a priceless, clinical gift. Irrespective of your clientele, clinical setting or academic training, *Treating Suicidal Clients & Self-Harm Behaviors* answers questions, details treatment strategies and provides practical tools. Dr. Houston has thoroughly researched the challenges clinicians face with suicidal and self-harming clients, and provides a comprehensive, one-stop resource. Her book identifies and addresses the fears and inadequacies of clinicians, and empowers them to confidently and compassionately work with these challenging clients. The mental health community and the clients we serve will benefit from Dr. Houston's work for years to come."

Verdi R. Lethermon, PhD
Retired Director, HPD Psychological Services Division

"As a licensed psychologist with over 20 years of experience, I still become a bit nervous when dealing with a client who might be suicidal. Dr. Houston's book provides an excellent roadmap for conducting an in-depth assessment of a potentially suicidal client and then gives very practical information about how to intervene during this type of crisis. I work in a setting where we frequently have clients who express suicidal ideation and I supervise a number of students and interns each year. This book will surely become a favorite reference for my students, as it is clearly written, easy to understand, and has several sections that are directly related to the setting that I am in. It is also wonderful to have an up-to-date book that addresses the complications of suicide and modern technology, such as the impact of social media or working with clients through teletherapy. The checklists and worksheets are very useful and convey information in a way that is helpful for both the clinician and the client. This is the kind of book that I wish that I had available to me as a new clinician; however, I know that even seasoned clinicians can definitely benefit from this comprehensive work."

Nicole Dorsey, PhD
Licensed Psychologist
Training Director, Harris County Juvenile Probation Department, Texas

"Dr. Houston's book is impactful, powerful, and practical. It is easy to understand, with bullet points and clear explanations. She offers many resources and tools to use while working with suicidal and self-harming clients. A useful tool for therapists to use with parents of teenagers who engage in non-suicidal self-harming behaviors or contemplating suicide. Dr. Houston walks readers through assessing for suicide and the post suicidal interview with worksheets and step by step guides. This is a great and useful therapeutic tool."

Susan Beach Barris, PhD
Drug Abuse Program Coordinator

"This is a comprehensive and practical guide for clinicians of all experience levels. Dr. Houston reveals herself to be one of the foremost experts in the assessment and treatment of suicidal and self-harm behavior, both by providing the most up to date resources and tools, as well as offering specific examples of her clinical experience. What I find particularly helpful is the information on safety planning and special populations, the latter of which includes risk checklists for each group. Even more, what is likely the most unique aspect of this book is Dr. Houston's inclusion of technology factors and tools, which is what I am most looking forward to implementing into my own practice. These include mobile apps and web resources, as well as information on cyber-bullying and online communities promoting NSSI behavior. Finally, emphasis on clinician self-care is apparent throughout as necessary component to working with high-risk cases. Whether you are a graduate student, or a seasoned clinician, you will find this workbook a necessary addition to your library."

Scott M. Forbes, PhD
Licensed Psychologist,
Veterans Healthcare Administration

"Dr. Houston provides an excellent overview of assessment for suicidality from all angles. This book is an excellent teaching tool for new clinicians that provides a comprehensive overview of all factors to consider in conducting thorough and extensive evaluations for suicide risk. It also serves as an excellent resource and reference for experienced clinicians who want to make sure they are reviewing all relevant factors in their assessments, even reviewing specific factors related to a variety of special populations, to include LGBT, military vets, college students and more. Dr. Houston provides a comprehensive approach to treating suicidal clients, including ways of managing your own anxieties and concerns along the way!"

Kevin Correia, PhD
Clinical Psychologist

"This workbook takes a practical, well-informed, and nuanced approach to working with clients who engage in suicidal and self-harm behaviors. The worksheets and clinical examples make this a particularly useful guide for trainings. Of note are the several diversity variables and the Internet/social media, and how these may impact our clients' experiences and our treatment choices. Both novice and experienced clinicians will benefit from this resource!"

Cecilia Sun, PhD
University of Houston, Counseling and Psychological Services

"Dr. Houston has written a remarkable workbook for helping professionals of all skill levels. Houston's thoughtfulness regarding clinical responses will bridge traditional academic and experiential learning in a paramount manner, ultimately progressing the prognosis of our clients. This will be my training tool for novice and expert helping professionals alike. This is a significant guide for the helping field."

Charles Helm, PhD
Correctional Psychologist
Federal Bureau of Prisons

"It is with great pleasure and enthusiasm that I write this endorsement for Dr. Meagan Houston's workbook. Simply put, I found it very informative. She provided wonderful ideas that help professionals maintain their sanity when dealing with suicidal patients. It contains information that can really be useful and it is written in a dynamic, entertaining way. Her workbook highlights her skills and translates state-of-the-art research and knowledge into relevant, accessible, practical gems for the clinical as well as non-clinical. Dr. Houston is always knowledgeable, experienced, entertaining, and engaging and I highly recommend her workbook for trainings/conferences."

CDR Scarlet Lusk-Edwards, RHIA, MPH, PhD
United States Public Health Services, Federal Bureau Of Prisons

"Every good clinician has or does experience some sense of uneasiness or anxiety when thinking about potentially suicidal clients or when dealing with suicidal clients or those who engage in self-injurious behavior. Experience, consultation, and great resources help allay those concerns. Dr. Houston's workbook is one of those references that every clinician should possess--from graduate student to veteran counselor. Dr. Houston has created a thorough, practical guide for professionals of all experience levels. Although assessing suicide risk is extremely unpredictable, use of this workbook can improve clinical judgment and confidence when managing these at-risk clients. From etiology to initial assessment, crisis intervention, and long-term treatment, this workbook includes critical data and useful worksheets to assist mental health professionals in one, comprehensive resource."

Edwina L. Martin, PhD
Licensed Clinical Psychologist

"As a clinician who has experience in the educational and private settings, addressing suicide, suicide prevention, and self-harm behaviors has become a rising hot topic. Within Dr. Houston's workbook she was able to capture the "who, what, when and how" when it comes to identifying and supporting these populations. Dr. Houston also presented the information in a format that is easily applicable, ready to use and able for clinicians to translate across service settings. "

Stephanie S. O'Neal, MA, LPC, LSSP
Licensed Specialist in School Psychology

"*Treating Suicidal Clients & Self-Harm Behaviors* is what the field of mental health needs! Dr. Houston did an extraordinary job at tackling suicide topics from A to Z. Every clinician needs this workbook in their library as it gives great direction on how to handle specific clients."

Patrice Douglas, MFT
Clinical Therapist

"This workbook breaks down suicidality in a way that's easy to understand, along with various techniques that can be applied. I found the various checklists helpful as they broke down each population and specific warning signs in an easy to remember format. It not only explained what to do - but how to do it - with specific questions to ask a client to further and more effectively assess their risk, and the best interventions a therapist can provide for any given specific situation. This is a workbook that is practical for all levels of practitioners!"

Jessica Corey, LPC
Mental Health Clinician

"Dr. Houston's workbook is very beneficial to anyone working in the mental health field. In my role as a chief psychologist in a correctional environment, current and past suicidal behaviors are one of the major risk factors I assess. Dr. Houston's workbook is very concise in describing suicidal risk assessments and she does a great job differentiating between short-term and long-term treatment. She also gives a phenomenal explanation of Non-Suicidal Self-Injury (NSSI). Dr. Houston's workbook is a valuable resource for a novice or senior clinician."

David A. Freeman, PsyD
Clinical Psychologist

"Having been an independent practitioner for almost 25 years and in the field for considerably longer, I rarely find practice manuals interesting. However, Dr. Houston's approach allowed the reader to glean information at their own level of expertise and interest. Dr. Houston structured the material so that the reader is left feeling progressively more knowledgeable and at ease. Finally, structured evaluations that are valid and user friendly."

Vonceil C. Smith, PhD
Clinical Psychologist

"This is a must-have toolkit! The book is a nice mix of scientific literature, theory, and application. In addition to all the practical activities and worksheets, I also appreciate the attention to special populations when working with this important topic."

Summer Rose, PhD
Licensed Psychologist

This book is dedicated to my wonderful and supportive husband, Gabriel U. Bright, and to my amazing parents, Robert Lee and Rosemary Houston. Gabriel, I love you for all that you are and for all that you come with. Mom and Dad, I am me, because you are you. Thank you again for all of your motivating words and unwavering faith! I pray that God continues to guide my path on this journey. That he continues to afford me the opportunity to help those who have chosen this honored and privileged profession of helping others. I hope this workbook will be used to diligently provide effective and professional services to clients in need and to ultimately **just stop one suicide**. If we can do that as mental health professionals, we are fulfilling our purpose!

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about the author

Meagan N. Houston, PhD, SAP, has specialized in providing suicide treatment in a wide variety of settings and populations for over a decade. She has experience in high-risk settings where the application of suicide prevention, assessment, and intervention occurs daily. Dr. Houston treats clients who present with a variety of psychological and behavioral disorders that lend themselves to acute and chronic suicidality. She emphasizes the use of empirically-based approaches when conducting suicide risk assessments.

Dr. Houston is employed full time with the Houston Police Department Psychological Services Division, where she is responsible for providing an array of psychological services to active duty and retired police officers and their family members, in addition to civilian employees and their families. She also provides a variety of training at the Police Academy, including Stress Management, Intermediate Use of Force, and other core classes. In addition, she also maintains a part-time private practice in Houston, Texas, where she provides a wide range of psychological services, national consultation and training to various agencies on suicidal behavior, suicide risk assessment, self-harm behaviors, social media and contagion.

Previously, she worked in the federal prison system, and she filled the dual roles of Prison Psychologist and Federal Law Enforcement Officer, and she provided a variety of psychological services to both inmates and correctional staff. She frequently conducted training with correctional and executive staff and served as the Mental Health Expert on the Hostage Negotiation Team for several years, working closely with officers and special response teams. She has also provided psychological, psycho-educational, and chemical dependency programs in private practices and college counseling centers, and has provided geropsychological services to nursing homes and rehabilitation facilities.

who this workbook is for and how to use it

One of my first difficult clients cut himself for years and had multiple suicide attempts with lingering suicidal ideation. I had never worked with this kind of client and I was scared. Talk about sink or swim! I thought I was asking the right questions about previous attempts, current ideation, family history . . . all of those things they teach you in class. I was consistent with treatment and I provided structure and boundaries. It was working!

Then, I got "the call." Two days after I'd last seen him, he'd attempted suicide. He'd cut his throat and was in the hospital with 289 stitches . . . on my watch . . . under my care. It was my worst nightmare!

Where did I go wrong? I missed the subtle cues—the ones that may not necessarily be taught in the classroom but that are critical for successful outcomes. Since that time, I have learned to be creative in treating my suicidal and non-suicidal self-injurious (NSSI) clients by personalizing strategies. I've developed a successful suicide risk training program that has saved lives, and I've built an integrated assessment instrument that has become the standard of care for my organization. I've effectively put these principles to work with many at-risk groups, including kids and adolescents, veterans and military personnel, LGBTQI individuals, the elderly, police personnel, and prison populations.

HOW ABOUT YOU? ARE YOU PREPARED? DO YOU HAVE THE BEST TOOLS TO FIGHT THESE BATTLES?

Did you notice the flower on the front cover? Its delicate, looks to be thriving and healthy, but if you look closely, it's not perfect. Subtle changes are happening, that can go unseen if we don't remain vigilant. The presence of suicide and self-harm can also be elusive in the same way, lurking right underneath the surface of what appears to be "normal" and blooming.

Treating suicidal clients and those who engage in self-destructive behaviors is not easy. There is no one right way to do this. Many clinicians feel confused or helpless in the face of the severe behavior or consequences associated with these types of clients. Clinicians become fearful, anxious, uncertain, or overly cautious when treating these clients and at times these feelings can lead to countertransference, negatively affecting treatment. We are not always prepared for the complexity of concerns associated with working with clients who present with suicidal behaviors, and this lack of preparation hinders our ability to provide adequate and effective care to our clients. Working with these types of clients can be intimidating, not only for the fledging practitioner but also for those of us who have continued to provide mental health services to clients who consistently present with suicidal behaviors.

Given the intricacies that affect our clients' choices to live or die, it is difficult to pinpoint just one effective tool or technique that will "fix" this problem. Each client will be in a different place with respect to intensity of suicidal ideation, intention, planning, and even attempting. And clients typically do not fit into nice, neat categories.

This workbook is designed to help clinicians understand the underlying etiology, varying life factors, and mental health concerns that influence suicidal and self-destructive behaviors. It is designed to assist mental health care providers in thinking critically about their clients' presenting concerns and understanding how cultural, environmental, social, and genetic factors play an enormous role in why our clients are thinking, feeling, and behaving in maladaptive ways. This workbook has been created to help you identify those subtle factors that may be key in the prevention of suicide for a client.

As a result of the integral complexity of the presentation of suicide, there are multiple approaches a clinician can use to assess, manage, and treat suicidal clients and clients who engage in NSSI behaviors. This workbook is designed to provide assistance to the treating clinician who may feel impeded, frustrated, or out of options when working with this multifaceted group of clients.

Topics/Areas that will be covered include:

- Discussing suicidality with a client.
- Assessing for suicidal potential.
- Understanding suicide prevention with special populations and the mental health diagnoses that have the highest risk for suicide.
- Using multiple therapeutic approaches, including interpersonal therapy, crisis management, cognitive–behavioral therapy, and dialectical behavioral therapy.

Chapter 1 | Suicide:

What You Need to Know

WHAT IS SUICIDE?

The Centers for Disease Control and Prevention define suicide as "death caused by self-directed injurious behavior with an intent to die as a result of the behavior." The dictionary *Merriam-Webster* defines suicide as "being or performing a deliberate act resulting in the voluntary death of the person who does it" ("Suicide," 2015). No matter the definition, suicide is an occurrence that is preventable, when our clients allow us to help. However, we need to be articulate in our conversations in order to accurately interview, assess, and manage suicidal clients and clients who present with suicidal behavior. We also need to recognize and acknowledge our own fears, anxieties, and possible lack of training in the application of management strategies for these behaviors.

Suicide is a topic that most people view as anxiety-provoking, taboo, and scary. It is a very real topic and, yes, it is frightening, but there are things about suicide that clinicians know that clients are unable to see due to their constricted and, at times, hopeless and helpless worldview. It is a phenomenon that must be addressed candidly and openly and it is an issue that will be found in every clinical and non-clinical setting.

Suicidal behavior can look like many things. It can look like self-destructive behavior (e.g., frequent drug use, driving recklessly, and/or placing oneself in dangerous situations), it can take the form of non-suicidal self-injury and "accidental suicide," or it can present as more blatant self-harm behavior (e.g., cutting, taking medication in excess, or swallowing objects). Suicidal behavior can be impulsive at times or it can be more rational and well planned.

IMPULSIVE SUICIDE

An impulsive suicide often involves the combination of a precipitating event, diminished coping ability, and feelings of helplessness, hopelessness, shame, guilt, burdensomeness, and feeling trapped. A precipitating event can include issues such as notice of a terminal illness, death of a loved one, loss of a job or financial stability, the break-up of a relationship, failing grades, or rejection. These events, typically, can make the risk of suicidal behavior imminent in the upcoming hours, days, weeks, or months. These events are typically sudden and involve crisis types of reactions. Drugs and alcohol are typically involved when a suicide is impulsive, as these substances lower inhibition, increase impulsivity, and compromise rational thinking and decision-making capabilities. Impulsive suicides are seldom accompanied by the classic warning signs, such as prior suicide attempts, diagnosed mental illness, or drug and/or alcohol abuse. The act is sudden and unrehearsed, and is thus especially more common among adolescents and young adults, who are already biologically primed to be more impulsive.

Clinical studies about impulsive suicide have varied, but some common characteristics of those who complete this type of suicide have indicated the following:

- **Gender**: Typically male.
- **Age**: Adolescents are at increased risk.
- **Emotional immaturity**: There is a diminished ability to think through consequences.
- **Mental illness**: Increased prevalence for psychosis and alcohol and/or drug abuse, but not for depression.
- **Method**: Considered medically severe. Jumping into a body of water or throwing oneself into oncoming traffic from a certain height (jumping off an overpass into traffic) are highly correlated with impulsive suicides.
- **Other factors**: A history of aggressive behavior or of previous impulsive suicidal behaviors (cutting, other self-destructive behaviors, and a history of poor decision making).

RATIONAL SUICIDE

Rational suicide has been defined as suicide in which there is a reasonable choice to die by a terminally ill person; it is also the ending of one's life for considered reasons as opposed to emotional or psychological reasons. Those who support rational suicide argue that there is a need to respect an individual's autonomy, meaning their right to be their own person or being able to act according to their own beliefs or desires without interference from others. The "right to die" is often viewed as an expression of the most extreme form of autonomy, which is the right to choose the time and manner of one's own death. Another view that supports the concept of rational suicide involves the ability of an individual to make a rational assessment of the utility or "benefit" that is gained by ending their life. Proponents of this view argue that suicide can provide escape and freedom from painful and hopeless disease. This view emphasizes the importance of quality of life rather than "just living."

Physician-assisted suicide describes the process of facilitating a patient's death by providing the necessary means and/or information to enable the client to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose while being aware that the client may commit suicide). This type of suicide is usually reserved for individuals who are currently living with terminal illnesses that are progressive and debilitating. As of September 2015, physician-assisted suicide is legal in California, Montana, Oregon, Vermont, and Washington State.

COMMON ELEMENTS OF SUICIDE

A common **purpose** of suicide is to seek a **solution**. Those who are contemplating suicide usually feel as if they have exhausted all possibilities when attempting to solve problems. Typically, suicide is conjured when experiencing a stressful situation for which they have no coping ability or when attempting to navigate a situation that is out of their control.

A common **emotion** in suicide is **hopelessness** or **helplessness**. Research demonstrates that hopelessness and helplessness are typically accompanied by feelings of shame, guilt, burdensomeness, inability to cope, and intermittent insomnia. This combination of symptoms can increase one's suicide risk, and the imminence of suicidal behavior should be assessed when these elements are present. These symptoms are also prevalent in most mental health diagnoses, including depressive disorders, anxiety disorders, bipolar disorders, psychotic disorders, eating disorders, trauma and other related stressor disorders, obsessive–compulsive disorders, and even substance-related mental health disorders.

A common **stressor** in suicide is a **frustrated psychological need**. Frustrated psychological needs vary and are subjective. These needs could include the need for belongingness, financial needs, relationship needs, esteem needs, or safety needs. These needs are typically not being met and most individuals feel as if there are road blocks and other factors, out of their control, impeding the satiation of these needs. The intensity of this frustration varies for each individual and in relation to the most recent issue or precipitating event.

A common **goal** of suicide is **cessation of consciousness**. When suicide is being contemplated, individuals are typically seeking peace, homeostasis, and psychological and emotional congruence. They are seeking to end their existence in order to cease experiencing psychological and emotional pain.

A common **stimulus** (or information input) in suicide is **intolerable psychological pain**. This type of pain is, again, subjective, similarly to frustrated psychological needs. Intolerable psychological pain refers to the inability to attain symptom relief from everyday functioning. This pain has been described as chronic and pervasive and is typically severe in intensity. It can be caused by various factors, including relationships, self-loathing and self-worth distortions, and feeling as if there is no end or logical solution to managing the pain.

A common **internal attitude** in suicide is **ambivalence**. Ambivalence refers to the indecisiveness that accompanies suicidal behavior at times. Ambivalence is a **good** thing! When our clients remain ambivalent, they are uncertain about suicide and are more willing to discuss the issue. It becomes problematic when our clients move away from ambivalence and move closer to a sense of resolve about suicide. When resolve occurs, our clients do not typically give any indicators or warning signs about suicidal ideation or potential attempts.

The common **cognitive state** in suicide is **constriction**. When our clients are contemplating suicide, they tend to view the world through a narrow lens and begin experiencing "tunnel vision" about their current situation. Feelings of hopelessness and helplessness begin to manifest themselves cognitively when this type of thinking occurs. Clients may view prior efforts as useless and future orientation as futile. This is why it is so important to instill hope and provide alternatives to the various situations clients experience.

The common **action** in suicide is **escape**. When our clients are contemplating suicide, many of them are seeking to escape, flee, avoid, and/or seek a resolution to the problem they are experiencing. They want to be free of their current situation and are desperate to end their psychological, emotional, and at times physical pain.

The common **interpersonal act** in suicide is **communication of intention**. Many completed suicides and attempted suicides communicate pain, agony, and desperation. Whether this communication involves writing a suicide note, writing another text, verbal communication, or behavioral communication, the sender is attempting to express intolerable inner psychic turmoil to a receiver.

The common **consistency** in suicide is a history of **unhealthy lifelong coping patterns**. Most clients who present with suicidal ideation, intent, or a plan typically report a history of poor coping skills and becoming easily overwhelmed. They present with poor distress tolerance skills and poor emotion regulation skills.

Chapter 2 | Identifying At-Risk Clients:

DSM-5® Diagnoses at Increased Suicide Risk

A new feature of the DSM-5 is a specific section labeled "Suicide Risk," which is included for select diagnoses. This emphasizes that individuals with these disorders may be at an increased risk for suicidal ideation, intent, or planning.

SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS AND SUICIDE

When working with clients who present with schizophrenia or other psychotic disorders, it is important to remember that these individuals, while not always dangerous, may present with suicidal ideation, intent, or planning. These ideas may be influenced by delusional content, feelings of paranoia, feelings of grandiosity, or feelings of invincibility. When an individual is experiencing actively psychotic symptoms, the risk for suicide increases, as cognitive and affective impairment influence the person's behavior.

When inquiring about suicidal ideation, intent, or planning with an actively psychotic individual, it is first important to remain calm and aware of their presentation. Are they agitated, restless, paranoid, or distrustful? If the client is presenting as agitated, it is most important that you first attempt to contact another clinician (if possible) and that you **do not** touch the client or physically approach the client. Continue to use your active listening skills and remain proactive in managing your safety. You can attempt to engage the client in deep breathing or other de-escalation techniques.

It is also important to assess for the presence of auditory and/or visual hallucinations and to inquire about the details of these hallucinations. Such details are important, because you want to know whether the client is experiencing derogatory and/or command hallucinations that are encouraging the client to harm him/herself or others, or whether the visual hallucination is dangerous or prompting of harmful behaviors.

Disorders with increased suicide risk

- Schizophrenia
- Schizoaffective Disorder (bipolar or depressive type)
- Substance-/Medication-Induced Psychotic Disorder
- Psychotic Disorder Due to Another Medical Condition

Schizophrenia and Suicide Risk

- Research has indicated that 20–40% of individuals diagnosed with schizophrenia attempt suicide.
- Clients may act impulsively and without warning. During a psychotic episode, a client can present with unpredictable and sporadic behavior. This behavior cannot always be predicted or anticipated. It is important to keep this information in mind when conducting a suicide risk assessment (SRA) or engaging in treatment with an actively psychotic patient.
- Clients may be influenced by hallucinations and/or delusions. The client may be experiencing derogatory and/or command auditory hallucinations, or other hallucinations (tactile, visual, and/or olfactory) that sway their actions and behavior. The delusions may also cause sporadic and dangerous behavior.
- Depersonalization can also occur. This causes loss of reality; thus, during a psychotic episode, the client may not recognize that their behaviors are dangerous or life threatening.
- Cognitive disruptions may affect decision making.
- Paranoid ideation may influence behavior.
- Non-compliance with treatment increases suicide risk. The treatment of this disorder can be overwhelming for clients, as it involves a variety of methods including psychotropic medication management, intensive outpatient and/or inpatient treatment, and case management.
- There may be mood disorder symptoms (symptoms of depression, anxiety, agitation, irritation, frustration, or being easily overwhelmed).
- There may be a lack of family or social support. Most individuals diagnosed with a psychotic disorder have difficulty establishing and/or maintaining relationships with others. They are typically estranged from their family and friends and can be ostracized from their communities. The stigma associated with psychotic disorders also plays a role in seeking help and discussing their symptoms with others. The stigma associated with this disorder is also reported to increase suicide risk, as many feel helpless and hopeless and also experience clinical levels of other mood disorder symptoms.

Clinician Safety Measures

- Position yourself closest to the nearest exit (e.g., door, entry way, hallway, window).
- Remain cognizant of any object in your office that may be used as a weapon against you and/or used by the client against him/herself (e.g., scissors, pens, pencils, staplers).
- Continue to remain calm and use a low and even tone when discussing provocative topics with the client.
- Do not use patronizing language or present as aggressive toward the client.
- Attempt to inform colleagues about the client prior to client's arrival. Do not provide treatment to the client when alone in the office.
- Contact law enforcement authorities when warranted—for example, if the client remains non-compliant or aggressive, or continues to refuse treatment or hospitalization.
- Remain empathic with the client when they are presenting with paranoid or delusional content.

Other Characteristics of Schizophrenia

- The client may demonstrate flat affect, inappropriate affect, (e.g., laughing when telling a traumatizing story or being angry when discussing a seemingly benign event).
- Depersonalization or derealization, which may be present, is an abnormal sense of self-awareness. It can consist of a reality or detachment within the self regarding one's mind or body, or being a detached observer of oneself. Patients feel they have changed and that the world has become vague, dreamlike, less real, or lacking in significance.
- Anxiety and phobias may be present.
- During a psychotic episode an individual may present with poor decision making, poor reality-testing, and poor problem-solving ability.
- Client may demonstrate aggression or hostility.
- Non-compliance with treatment is common with this diagnosis. Many individuals who suffer from a psychotic disorder are typically non-compliant with treatment, including psychotropic medication management, case management, and/or individual therapy.
- The onset of psychotic symptoms typically occurs during the late teens to mid-thirties.

Schizoaffective Disorder and Suicide Risk

- Presence of a major depressive episode or manic episode increases suicide risk.
- There may be hallucinations and/or delusions, particularly if these symptoms are derogatory and/or commanding in nature.
- Social isolation also increases suicide risk, as lack of social support has been correlated with increased risk. Given the intensity, severity, and frequency of their psychotic episodes, these individuals typically have difficulty establishing and/or maintaining relationships with others. There are also feelings of shame and guilt that are associated with this diagnosis, and this leads to isolating behaviors and remaining withdrawn.
- Suicide risk is increased due to impulsivity and poor decision making related to symptoms of schizophrenia, and these symptoms are often exacerbated by the presence of mood disorder symptoms.
- Those with this diagnosis are often non-compliant with their treatment regimen, specifically during an active psychotic episode.
- Increased occurrence of suicidal ideation occurs as a result of the combination of psychotic and mood disorder symptoms.

Individuals who have received this diagnosis are experiencing the symptoms of psychosis in addition to mood disorder symptoms. These mood disorder symptoms can include manic, hypomanic, mixed, and/or depressive symptoms. This mood disorder component exacerbates psychotic symptoms and can increase suicide risk. When working with these clients, it is important to thoroughly assess the presence of psychotic and mood symptoms, as this diagnosis is often misdiagnosed as a mood disorder with psychotic features (e.g., major depressive disorder with psychotic features). This is important because these two diagnoses are treated and managed differently.

When assessing for suicide risk, it is very important to attend to the intensity and duration of the psychotic and mood disorder symptoms. The likelihood of suicide increases during a

depressive episode, wherein the client is experiencing feelings of hopelessness, helplessness, guilt, shame, worthlessness, loneliness, and sadness. During these episodes, suicidal ideation and/or morbid ideation can occur. The client may also be isolating him/herself from others and may be withdrawn. This may further diminish social support, creating an increased suicide risk.

Working with these clients involves patience, empathy, diagnostic skill, clinical competence, and knowledge of the available resources in your community (hospitals, psychiatry services, indigent services, etc.). You should also practice the clinician safety measures listed in the section on schizophrenia.

Other Characteristics of Schizoaffective Disorder

- There is an increased risk for developing a major depressive disorder or bipolar disorder symptoms following actively psychotic phases.
- There may be co-morbid substance-related disorders, including alcohol use disorder, cocaine use disorder, opioid use disorder, and/or amphetamine use disorder.
- Onset of symptoms typically occurs during the late teens to early adulthood (ages 16–30).
- This disorder is often misdiagnosed as bipolar disorder with psychotic features or major depressive disorder with psychotic features. This misdiagnosis increases risk for suicide and other socio-environmental risks, as the above-mentioned disorders involve a different type of treatment planning when compared to schizoaffective disorder.

Psychotic Episode Due to Another Medical Condition and Suicide Risk

- The chronicity of the medical condition could increase suicide risk. The medical condition could be terminal in nature and/or progressive (e.g., HIV, Huntington's disease, multiple sclerosis, or Parkinson's disease).
- The presence of mood disorder symptoms (including depressive and anxiety symptoms) can also cause elevated suicide risk.
- After a while, chronic pain becomes debilitating, draining a person's energy and diminishing their motivation. These individuals sometimes attempt to limit social contact with others in an effort to reduce stress and to decrease energy expenditure. Eventually, many people with chronic pain develop depression-like symptoms: lack of interpersonal interaction, difficulty concentrating on simple tasks, and the desire to simplify their life as much as possible, which often manifests as seeking isolation and quiet.
- Sleeping often makes the pain less intrusive, and that combined with the exhaustion that pain induces causes some pain sufferers to develop hypersomnia; alternatively, at times, pain can have the opposite effect and may cause intermittent insomnia. The combination of the above issues may increase risk for suicide.
- Impaired decision-making ability may increase suicide risk.
- Unpredictable nature of onset of symptoms increases suicide risk.
- Access to medical care may be limited or nonexistent to clients; thus, the medical condition may go untreated and worsen, possibly increasing suicide risk.

It is important to understand the medical condition causing the psychotic symptoms when working with your client. The medical condition could be terminal or progressive and this could increase suicide risk. It is also important to remain aware about the use of medications

associated with the medical condition, as interaction effects could influence the presence, frequency, or intensity of suicidal ideation, intent, or planning. The concept of "rule-outs" (a term commonly used in outpatient care to eliminate a suspected condition or disease as the cause of the client's symptoms) should be practiced when managing this condition, and it is always important to consult with other health professionals to provide the most adequate care.

Other Characteristics of Psychotic Disorder Due to Another Medical Condition

- Treatment for the medical condition could include the use of innumerable medications and other treatments (e.g., chemotherapy, radiation, or interferon treatment). Psychotic symptoms could be side effects of certain treatments or medications. Additionally, interaction effects between the various medications may cause the development of acute psychotic symptoms.
- The medical condition may cause delusions and hallucinations.
- The client may experience transient or recurrent psychotic episodes.
- Psychotic symptoms may be contingent upon the course of the medical condition.
- The onset of symptoms typically occurs within older age groups due to the likelihood of such individuals developing conditions and/or the likelihood of their pre-existing medical conditions worsening.

BIPOLAR AND RELATED DISORDERS AND SUICIDE

Bipolar disorder is a mood disorder that involves high "highs" and low "lows." Individuals with this diagnosis experience manic, depressed, and mixed mood disorder symptoms. During a manic episode, clients are typically non-compliant with medication use and therapy approaches. Several of the medications used to treat this diagnosis are administered in high doses and have unpleasant side effects. Those diagnosed with this disorder also tend to enjoy manic phases, in which they feel creative, outgoing, charismatic, grandiose, and motivated; have an increased energy level; and experience an expansive or elevated mood.

These individuals may present as grandiose, feel indestructible, take dangerous risks, use illicit substances, and require minimal sleep. These risky behaviors can include compulsive gambling, risky investing, or spending without regard for one's true financial state (e.g., buying a car when you can't possibly make the payments). Clients may also engage in high-risk behaviors that may be hypersexual, such as making inappropriate sexual advances; spending a great deal of money on phone sex, being involved with internet pornography, or hiring prostitutes; or having affairs. This combination of symptoms increases suicide risk, as cognitive and affective functioning are compromised. "Accidental suicide" is possible due to the impulsive and risky behaviors and as a result of the intensity of manic symptoms.

When conducting a suicide risk assessment (SRA), the individuals adamantly deny any current suicidal ideation, intent, or plan and may present with a flight of ideas and/or with rapid or pressured speech. They may report an elevated or expansive mood and thus it is critical to thoroughly assess their behavior and to obtain observable information from those familiar with them about any drastic or dangerous changes in behavior. They may be resistant to feedback or lack insight about their mood state.

It is also possible for these clients to be experiencing actively psychotic symptoms during a manic and/or depressive episode. This makes it pertinent to assess for any auditory and/or visual hallucinations.

Depressive episodes are typically moderate to severe. The intensity of these symptoms increases the likelihood of suicidal ideation, intent, and planning. However, clients tend to be more amenable to psychotropic medication management and are more compliant in treatment while in this state.

Disorders with increased suicide risk

- Bipolar I Disorder
- Bipolar II Disorder
- Cyclothymic Disorder

Bipolar and Related Disorders and Suicide Risk

- There is a 15% rate of suicide among individuals with bipolar disorder. This rate is about 30 times higher than that of the general population.
- As in the general population, women attempt suicide more often than do men.
- Contrary to the general population, women are more likely to complete their attempt; thus, the rate for suicide deaths is slightly higher for women than for men who have been diagnosed with bipolar disorder. There are several theories about the reason for this statistic, for example: (1) This diagnosis causes tremendous relationship difficulty and those diagnosed with this disorder typically have a limited social support system. Research indicates that social interactions are more important to women than to men and thus lack of these relationships places women at an increased risk for completed suicides. (2) Research has indicated that women tend to be diagnosed with bipolar disorder more often than men and thus may be overrepresented within this group. (3) Women tend to use more lethal means then men when experiencing a manic episode (e.g., use of a firearm, jumping from a bridge, hanging).
- Individuals diagnosed with bipolar disorder are twice as likely to commit suicide as those suffering from major depression alone.
- Research has demonstrated that individuals become suicidal during bipolar depressive episodes and/or rapid-cycling bipolar disorder.
- When suffering from psychotic symptoms of delusions and hallucinations during a bipolar episode, clients are more susceptible to suicide attempts
- At least 50% of people with bipolar disorder experience suicidal ideation.

Other Characteristics of Bipolar I Disorder

- Many individuals diagnosed with bipolar disorder remain non-compliant with or resistant to treatment, specifically psychotropic medication management.
- 90% of individuals experience recurrent episodes of mania.
- 60% of manic episodes occur immediately before a depressive episode.
- The onset of these symptoms can occur throughout one's lifetime.
- Clients may become physically assaultive or aggressive during a manic episode, specifically if psychotic or paranoid symptoms are present.
- There are detrimental consequences to behavior.
- Clients may experience poor judgment.
- Clients may experience rapid mood shifts.

- Clients may have unpredictable behavior, including indulging excessively in high-risk behaviors.
- Clients may experience loss of insight and objectivity.

Bipolar II Disorder and Suicide Risk

- Impulsivity is present, which increases suicide risk.
- Severity and duration of depressive symptoms increase suicide risk.
- The presence of a substance use disorder increases suicide risk.
- Medication non-compliance also contributes to an increased risk.

Clients diagnosed with bipolar II disorder are at an increased suicide risk as a result of the duration and intensity of their depressive symptoms. Many clients who have been diagnosed with this disorder report intense feelings of helplessness, hopelessness, worthlessness, guilt, shame, and loneliness as well as intermittent insomnia. These symptoms often lead to more frequent and enduring periods of suicidal and/or morbid ideation. Clients often report feeling as if they have no purpose and question their existence. Once their depressive symptoms decrease and are reported to be milder in severity, they are better able to manage these ideations and are not as likely to act on these thoughts.

Hypomania differs from mania in that individuals typically "enjoy" the feelings associated with a manic episode, whereas a hypomanic episode is not pleasant. Clients typically report being easily agitated, irritated, frustrated, and provoked to anger. They report periods of restlessness, intrusive ideation, rumination, and racing thoughts. They may report excessive energy and cleaning tirelessly. They typically isolate themselves from others, become withdrawn, and have a limited social support network.

Other Characteristics of Bipolar II Disorder

- Clients tend to report a heightened sense of creativity.
- The onset of symptoms typically occurs in the mid-twenties.
- The onset of this disorder typically begins with a depressive episode.
- 5–15% of individuals with this disorder experience multiple mood episodes.

Cyclothymic Disorder and Suicide Risk

- Recent onset of mixed states and the recent onset of mania or depression increase risk for suicide.
- Rapid cycling involves feelings of hopelessness, helplessness, and being easily overwhelmed.
- Severe anxiety often develops due to the sporadic nature of this disorder.
- An inability to attain treatment (e.g., as a result of a lack of insurance or a lack of medical care) can affect the condition, for example by leading to non-compliance and/or lack of insight into the severity of the condition (by the client).
- The presence of panic attacks increases suicide risk, as this can be a debilitating symptom.
- Pronounced agitation increases suicide risk.
- Severe insomnia increases suicide risk.
- Recent alcohol abuse increases suicide risk.

- Loss of pleasure in normally pleasurable activities (e.g., eating, socializing, or sex) may also increase risk.
- Recent or anticipated loss of a job, loss of a personal relationship, financial loss, or criminal or legal proceedings may increase the likelihood of a suicide attempt.
- Acute psychosis, especially featuring command hallucinations, paranoid fears of punishment, or delusional guilt, may increase risk.
- Co-morbid substance use disorder diagnosis may increase suicide risk.

Clients diagnosed with cyclothymic disorder often report pervasive feelings of helplessness and hopelessness as a result of the unpredictable nature and difficulty of managing this diagnosis. They describe feeling as if these symptoms are out of their control, and some clients even develop symptoms of agoraphobia and panic. Individuals who develop these two specifiers are at times isolated, are withdrawn, have limited social support networks, avoid interactions with others, or plan activities around the panic attack. This causes an increase in suicide risk, and the presence of panic and agoraphobic symptoms should be assessed when working with these clients. Helplessness and hopelessness are pervasive symptoms of this disorder, increasing the risk for suicide.

Other Characteristics of Cyclothymic Disorder

- Symptoms typically begin in early adolescence or early adult life.
- Individuals diagnosed with cyclothymic disorder have a 15–50% chance of developing bipolar I disorder or bipolar II disorder.
- In children, the mean onset of these symptoms is 6.5 years of age.

DEPRESSIVE DISORDERS AND SUICIDE

Major depressive disorder is the one diagnosis most commonly associated with suicidal ideation, intent, and planning. Research has indicated that undiagnosed depression has been the primary factor related to suicide attempts in various populations, including the elderly (aged 65+), college students, and adolescents. Untreated depression can lead to the development of other mental health disorders such as substance use disorders, anxiety disorders, and even eating disorders. Symptoms of major depressive disorder are typically pervasive and chronic and vary from mild to severe. The symptoms of feelings of burdensomeness, worthlessness, hopelessness, helplessness, and intermittent insomnia are highly correlated with attempted and completed suicides.

Depression can cause a constricted world-view and an inability on the part of the client to objectively understand and manage their condition. The symptoms of depression respond well to psychotropic medication management and psychotherapeutic treatment.

When working with depressed clients, it is important to frequently assess for the presence of suicidal ideation. It is also important to monitor your clients' affective and cognitive state upon the introduction of psychotropic medication management. Research has indicated that, as energy and motivation return, your client may continue to experience those key depressive symptoms (hopelessness, helplessness, worthlessness, burdensomeness) that make a suicide attempt more likely.

Disruptive Mood Dysregulation Disorder (DMDD) and Suicide Risk

- A new disorder in the DSM 5 that is specific for children.
- Impulsive behavior increases suicide risk.

- Affectively labile, as moods are unpredictable and fleeting. This sudden fluctuation of mood shifts causes an increased risk for impulsivity and acting out, and possibly an increase in suicide risk.
- These children may be using illicit substances in order to self-medicate and thus the presence of a substance use disorder diagnosis may increase suicide risk.
- Lack of a social support network may increase risk.

When working with children who are experiencing any type of mood disorder diagnosis, suicide risk should be frequently monitored. Disruptive mood dysregulation disorder is a new diagnosis in the DSM-5 and helps to categorize children who display chronic agitation, irritation, and frustration. The chronicity of these disruptive mood states differentiates this diagnosis from the episodic presentation of children diagnosed with bipolar disorder. Children who present with this diagnosis typically have a limited social support network as they have strained relationships with friends, family members, teachers, daycare workers, clergy people, and others with whom they have contact. These children are typically impulsive and irrational and have a limited worldview, which increases their risk for suicide. These children may also use illicit substances (cocaine, alcohol, marijuana, etc.), which will aggravate this condition and impair cognitive functioning and decision making.

The DSM-5 has been very specific as to how we diagnose this disorder. These specifics have been clearly delineated in order to avoid misdiagnosis of this disorder.

Bipolar Disorder versus DMDD

Bipolar Disorder	DMDD
Lifelong episodic illness	Severe, non-episodic irritability: It is persistent and present over the months
Discrete mood episodes of mania and depression	Does not develop bipolar disorder
During a manic episode, the mood must be accompanied by cognitive, behavioral, and physical symptoms that are different from the child's usual baseline	Severe outbursts, rage, and tantrums
Elevated or expansive mood and grandiosity	Elevated or expansive mood and grandiosity not present
Less irritability than in DMDD (DSM-5)	Cannot be first diagnosed before age 6 or after age 18
Can be diagnosed at any age, but rare in childhood	Not associated with psychosis
Peak onset in the twenties and thirties	
Psychosis may be present	

Oppositional Defiant Disorder versus DMDD

Oppositional Defiant Disorder	DMDD
Disruptive behavior	Depressive disorder
Irritability is a common factor but not required for a diagnosis	Mood expression significantly abnormal
Pattern of defiant and resistive behavior toward authority figures	Impacts the environment and associates with dangerous behavior