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MAY 2017 • UPDATE

This special edition of the *Pennsylvania Psychologist Update* focuses on the assessment, management, and treatment of patients at risk to die from suicide. It will also double as a home-study affording you the opportunity to comply with the Act 74 CE requirement. The focus on suicide for this issue is apropos given that May is **Mental Health Awareness Month**.

Get 1 CE credit for this issue! Also available online! Page 18

SPECIAL EDITION—SUICIDE: ASSESSMENT, MANAGEMENT, AND TREATMENT OF AT-RISK PATIENTS

Competence With Suicidal Patients

Helping Good Psychologists Become Even Better

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Dr. Samuel Knapp

The study of suicidal patients is important for several reasons. Most importantly, attempted suicide is the most common type of behavioral emergency that psychologists will face. A successful intervention means that a life is saved; an unsuccessful intervention means that a great human tragedy has occurred.

In addition, Pope and Tabachnick (1993) reported that a patient suicide was the professional event most feared by psychologists. Having a patient die from suicide is an occupational hazard. Nearly half of psychiatrists and perhaps up to 40% of psychologists will have a patient die from suicide sometime during their careers (Gill, 2012). Although skilled psychologists are less likely to have a patient die from suicide, I have known highly competent psychologists who have had patients die from suicide even though they delivered good care.

Treating psychologists are secondary victims of a patient suicide. Often the treating professional will develop an ICD diagnosis such as an adjustment disorder, although some will develop more severe emotional reactions following such a loss (Rothes, Scheerder, Van Audenhove, & Henriques, 2013). Sometimes the treating professionals will enhance the quality of their services and become more vigilant or structured in their approach to subsequent suicidal patients. Other psychotherapists will subsequently provide a lower quality of service because they become over protective, paternalistic, or otherwise overreact whenever a patient expresses a thought of suicide.

My impression, having consulted with many psychologists working with suicidal patients over the years, is that most psychologists provide good or excellent care. At times I have finished a consultation with the impression that this particular psychologist is far more skilled than I would have been under the same circumstances. Nonetheless, the actual data on the competence of psychologists dealing with suicidal patients is meager. A review by Bongar and Sullivan (2013) found that many recent psychology graduates did not believe that they had adequate training in suicide in their doctoral program, presumably learning it on the job or not learning it at all.

Continued on page 7

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

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LIVE A LITTLE LEARN A LOT AT PPA2017!

June 14–17, 2017

Omni Bedford Springs Resort
Bedford, PA

PPA2017 HIGHLIGHTS

WEDNESDAY, JUNE 14

9:00 a.m.–10:00 a.m.

PPA2017: Welcome & Overview

This 1 CE credit opening session is for all attendees and is the perfect way to start your convention attendance at this new venue! Get an overview of what to expect this year, as well as learn about some new continuing education initiatives developed by PPA's Professional Development Committee.

10:30 a.m.–noon

Keynote Address

PPA welcomes all attendees to this year's Keynote Address! Join keynote speaker Barbara Amaya as we delve into Dr. David Rogers's theme of *Striving to Overcome Interpersonal Violence.* Learn more about Ms. Amaya on page 14.

noon–1:30 p.m.

Donor Recognition Lunch Reception

This special reception is available for PPA members who donated to either the Pennsylvania Psychological Foundation (PPF) or the Pennsylvania Political Action Committee (PennPsyPAC) in 2016–2017. We want to take this opportunity to thank these members for their support of these important organizations!

8:00 p.m.–9:00 p.m.

Evening by the Fire

Bring your family and join your colleagues and friends around the fire pit at the Omni Bedford Springs Resort! This is the perfect opportunity to relax and unwind while enjoying s'mores and the beautiful surroundings.

THURSDAY, JUNE 15

11:45 a.m.–12:45 p.m.

Lunch With the State Board of Psychology

This 1 CE workshop includes lunch and features Board members and professional staff as they present on a number of topics, including the role and mission of the Board and recent changes in the licensing law.

1:00 p.m.–2:00 p.m.

Suicidal Patients: Assessment, Management, and Intervention—A Brief Course (Act 74)

Act 74, signed in 2016, requires all psychologists to complete 1 CE credit on suicide prevention per biennium. This requirement will go into effect for the current biennium, meaning that psychologists must complete at least 1 hour of suicide prevention continuing education before November 30, 2017. This workshop meets the requirement for Act 74.

5:00 p.m.–6:00 p.m.

Exhibitor Wine & Cheese Reception

Join your peers and our exhibitors in the exhibit hall for this event on Thursday evening. No tickets are needed to sample food, wine, and other beverages served by our exhibitors at their booths. Afterward, stay for our next event.

6:15 p.m.–8:00 p.m.

PPA Annual Banquet & Awards Dinner

PPA will again be hosting a dinner event at the convention! Join us as we celebrate the recipients of this year's Distinguished Contributions to the Science and Profession of Psychology Award, the Public Service Award, and the Distinguished Service Award. Additional PPA Committee Awards, as well as the Psychologically Healthy Workplace Award, will also be presented this year. We will also use this opportunity to "pass the gavel" from PPA's outgoing president, Dr. David Rogers, to incoming president, Dr. David Zehrung.

The All-Access Pass includes tickets for Lunch With the State Board of Psychology, the Psychology in Pennsylvania Luncheon, and the Annual Banquet & Awards Dinner.

FRIDAY, JUNE 16

8:30 a.m.–10:30 a.m.
Town Hall Plenary Session

This year's Town Hall Plenary Session features student education awards and so much more! Get updates on PPA—where the organization is and the direction in which we will be moving. Interact with leadership and hear from incoming president, Dr. David Zehrung.

10:45 a.m.–12:15 p.m.
Theme Lecture—Situational Awareness

Psychologists are also individuals with private lives. We shop, we visit friends, and we go about our daily routines like so many others. Because of the nature of our work, we might at times feel unsafe, not only in a professional setting but in our private life. This workshop will address a core component of personal safety called "situational awareness." (non-CE workshop)

12:15 p.m.–1:45 p.m.
Psychology in PA Luncheon

This year's luncheon features James Kimmel Jr., JD, a lawyer and lecturer in psychiatry at Yale School of Medicine. Mr. Kimmel will discuss "Beyond Gun Control to Motive Control."

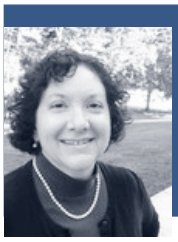
7:30 p.m.–9:00 p.m.
Movie and Q&A Session

Join us for a viewing party of *The Hunting Ground*, a documentary film about the incidence of sexual assault on college campuses in the United States. The film, which features last year's keynote speaker, Diane Rosenfeld, JD, LLM, will be followed by a half-hour discussion, giving you the opportunity to earn 1.5 CE credits. Popcorn and soda will also be provided!

PPF STUDENT AWARDS
Make a donation today!

When a contribution is made to the Pennsylvania Psychological Foundation's (PPF) Student Education Awards fund, 100% of the donation is passed directly to deserving students of psychology who are carefully selected by the PPF Awards Committee. Award recipients have been most grateful for these donations and these awards have helped students to complete the final phases of their doctoral training. Many have gone on to successful careers in clinical practice or teaching.

Each award is $2,000. It would be wonderful to have awards sponsored in full. However, any donation amount is greatly appreciated and will be aggregated with other donations to create a full award.



"As a recipient of a PPF Student Education Award in 2003, I was able to purchase enough copies of a personality measure to successfully complete and defend my dissertation, as well as to graduate in 2004. As a current faculty member at Messiah College, I bring students to present their research posters at the PPA annual convention each June. Thus, PPF's generosity in 2003 provided an opportunity for me to not only support my own research but also set me on a path to support current and future student research."

– Valerie Lemmon, PhD

In 2016, PPF granted six student awards, totaling $12,000. PPF would love to help even more students this year! Can we count on your support? Your donation will make a big difference in the life of a struggling student.

To donate, visit the Foundation page on PPA's website at papsy.org.
Make sure to select PPF Education Award Fund in the Donation Option drop-down menu.

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

Foundation
LEAVING A LEGACY

Check out PPA's Exciting Upcoming Events

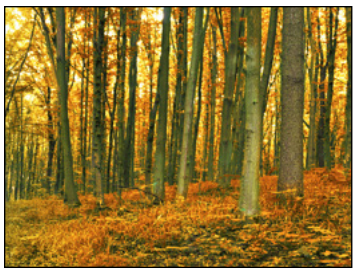
PPA has some great events for our members on the horizon. Hopefully, you can join us for one or more of these exciting CE programs!

Sunday, May 7: Leadership Academy
This invitation-only event educates members about the Pennsylvania Psychological Association and offers great information about becoming a leader within PPA and the field of psychology. It will take place at the PPA office, 5925 Stevenson Avenue, Harrisburg, PA 17112.

Monday, May 8: PPA Advocacy Day
Come to Harrisburg, visit the Capitol Building and help shape mental health policy! At advocacy day, you will receive 1.5 CE credits as we inform attendees about the legislative process and initiatives we are pursuing. This event, which provides you with an opportunity to meet with your local state representative or senator, can't be missed.

Wednesday, May 17, 12:00 p.m. – 1:30 p.m.: PPA Webinar Series – Depression and Cardiovascular Risk in Post-Menopausal Patients
Depressed patients with cardiovascular disease have displayed lower self-care ability in comparison with non-depressed ones. This workshop will address how depression impacts lifestyle choices and health promotion behaviors in the older adult female patient. A conceptual framework for developing collaborative interventions will be examined. This webinar is eligible for 1.5 CE credits.

Wednesday, June 14 – Saturday, June 17: PPA2017 Annual Convention
Visit the gorgeous Omni Bedford Springs Resort for the PPA2017 Annual Convention, where we make it our goal to help you Live a Little and Learn a Lot! At this year's convention we will have many workshops and sessions promoting the theme *Striving to Overcoming Interpersonal Violence*. We hope you join us for PPA's premiere event!



Thursday, October 26 – Friday, October 27: PPA Fall Continuing Education Conference
The deadline for licensure renewal is November 30, 2017. Join us at the Eden Resort in Lancaster, PA, for this two-day opportunity to earn CE credit as you head into the home-stretch for renewing your license!

COMPETENCE WITH SUICIDAL PATIENTS *Continued from page 1*

Most of the data I have found deals with mental health professionals in general and it suggests that a noticeable minority of them received inadequate training in working with suicidal patients. For example, Jahn, Quinnett, and Ries (2016) found that 21% of their sample of psychotherapists who worked with suicidal patients reported that their training and expertise in working with suicidal patients was inadequate. The need for better training among mental health professionals was substantiated in two studies by David Kraus. In both studies, most psychotherapists had limited experience and were either social workers or counselors (less than 20% were psychologists). One of his studies found that about 15% of patients with suicidal inclinations got worse throughout the course of therapy and almost 50% showed no significant improvement (Kraus et al., 2011). Also, psychotherapists' effectiveness with suicidal patients tended to remain stable over time. Those effective with suicidal patients tended to remain effective with suicidal patients over time, while those who performed below average with suicidal patients tended to perform below average over time (Kraus et al., 2016).

Fortunately, psychologists have more extensive training than the other mental health professionals who were so predominant in the aforementioned studies, so I suspect that outcomes for psychologists would be better than those reported by Kraus. Of course, all psychologists, regardless of their level of competence, will want to continue to develop professionally and to improve their skills in dealing with suicidal patients, as they do with other areas of practice. As mentioned previously, these articles in the *Pennsylvania Psychologist Update* are designed to help good psychologists become even better. PPA is also offering one CE credit for those psychologists who read these articles and complete the evaluation questions included in this issue. This CE program will fulfill requirements for education in suicide that is now required as a condition of licensure renewal.

These articles list essential competencies in the assessment, management, and treatment of suicidal patients. One of the articles looks at documentation which is a generic competency that cuts across these modalities. In developing this list of 10 competencies, I have been informed by the work of the American Association of Suicidology (n.d.) and other suicidologists (e.g., Rudd, Cukrowicz, & Bryan, 2008; Cramer et al., 2013). Experienced psychologists can use this list as an informal assessment tool.

Various researchers and associations have developed lists of competency that differ little in substance but rather reflect differences in categorizing or phrasing these competencies. For example, the American Association on Suicide includes "maintain a collaborative, non-adversarial stance" as a core competence. I concur entirely that this is an essential skill, but I would subsume it as part of assessment, management, or treatment, in so far as it is needed to elicit information during the assessment phase, develop collaborative suicide management plans, or conduct effective treatments with the patients.

However, the lists of competencies are only a very small portion of this issue of the *Pennsylvania Psychologist Update*. The articles focus mostly on the areas that I and other suicidologists believe are especially important when implementing these competencies with suicidal patients.

TEN ESSENTIAL COMPETENCIES

ASSESSMENT

1. Elicit suicidal ideation and behavior;
2. Elicit risk and protective factors
3. Make a clinical judgment as to risk; and
4. Integrate assessment data into the management and treatment plans.

MANAGEMENT

5. Set up a monitoring plan for the patient;
6. Motivate the patient for treatment;
7. Implement means restriction counseling; and
8. Create an effective crisis intervention plan.

TREATMENT

9. Develop and implement a treatment plan that addresses the co-existing mental illness while keeping patient safety and management principles in place.

DOCUMENTATION

10. Document assessment, management, and treatment

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Competence in Assessing Suicidal Patients

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Assessments of suicide are difficult in part because no single test or set of questions can definitively predict which patients will die from suicide. Also, the risk of suicide can change over time depending of the life circumstances of the patients. Nonetheless, effective psychologists can make reasonable predictions for individual patients based on existing professional standards. To do so, however, their assessment needs to be "thorough, extensive, and multifaceted" (Jobes et al., 2008, p. 406).

My review of the literature in the assessment of suicide has identified four essential competencies which are to:

1. elicit suicidal ideation and behavior;
2. elicit risk and protective factors;
3. make a clinical judgment as to risk; and
4. integrate assessment data into the patient's management and treatment plans.

Below I review some of the essential information psychologists need to implement the competencies in assessing suicidal risk. I suggest special attention for handling high risk patients who deny suicidal ideation; emphasize the importance of relationship building; encourage following up with questions on suicide plans and past attempts; and, finally I offer cautions on how to use levels of risk charts.

When High Risk Patients Deny Suicidal Risk

Eliciting information about suicidal ideation and behavior appears straightforward as it involves direct questions about thoughts of suicide, past suicide attempts, and future suicide plans. In addition, a good evaluation will elicit information about *fixed (static)* factors related to suicide risk, such as age, gender, race, or personal history;[1] *dynamic (changing)* factors such as stressful events (especially those that weaken an individual's social network), psychological pain, or co-existing mental illnesses;[2] and *protective* factors or factors that reduce the risk of dying from suicide, such as belonging to a strong social support group (e.g., having a supportive marriage, or good friends) or having life-protecting or life-promoting religious or spiritual values.

Although they do not present as high a risk of suicide as patients with active suicidal ideation, they need to be monitored carefully because they may neglect ordinary safety precautions and self-care.

The rule of thumb is to ask every patient about suicidal thoughts (there may be some exceptions to this). For most patients, answering "no" to the question "do you have thoughts of suicide" actually means "no." However, sometimes psychologists will encounter denying patients with such strong risk factors for suicide that the psychologists suspect that their patients may be withholding their suicidal thoughts.

Sometimes suicidal patients will deny such thoughts because they fear the consequences of revealing them. They may fear that they will be put into a hospital, have their firearms removed, or have family members told about their suicidal inclinations. Psychologists can address these fears proactively and explain how suicidal thoughts are usually handled on an outpatient basis with confidentiality intact, and the criteria that they would use when making treatment decisions regarding hospitalizations or breaking confidentiality.

Some patients believe that having suicidal thoughts makes them a coward, immoral, or weak. Psychotherapists can address these concerns by normalizing suicidal thoughts. Psychologists may say, for example, "given all that you have been through, some people think about suicide. Do you ever have those thoughts?" or some other kind of statement that shows that suicidal thoughts are sometimes common reactions to uncommonly painful experiences.

Some patients who accurately deny suicidal thoughts nonetheless wish to die. When asked directly, they may affirm that they would like to go to sleep and never wake up, or that they hope that they get a serious illness and can die. Although they do not present as high a risk of suicide as patients with active suicidal ideation, they need to be monitored carefully because they may neglect ordinary safety precautions and self-care. In addition, sometimes passive thoughts may get transformed into active plans over time.

Finally, psychologists can ask denying patients to take a brief suicide rating scale, such as the Beck Hopelessness Scale or the Beck Suicide Ideation Scale, to inform their judgments. Patients will often reveal information in response to printed questions that they would not otherwise share verbally.

[1]**The fixed or static factors of age, race, gender, etc. may help inform psychologists about the overall risk to the patient. But demographic variables should not be over-valued; any member of any demographic group has a risk to die from suicide.**

[2]**Suicide is more common among patients with anorexia, bipolar disorders, major depression, substance abuse, and schizophrenia. Comorbidities increase the risk of suicide. However, specific diagnoses, in and of themselves, are of limited value when determining suicidal risk because suicide is a transdiagnostic symptom.**

Relationship Building

I emphasize the importance of building good relationships with patients during the assessment process. Psychologists can make better predictions of suicide if they have detailed information about the life circumstances and histories of their patients. Patients will be more likely to open up when they sense that their psychologists care about them. When working with suicidal patients it is important that they feel that they had a chance to tell their story or to be heard. This caring relationship established in the first session facilitates the caring relationship needed for effective treatment. Many patients reported that they refrained from attempting suicide because they knew that their psychotherapists cared about them.

Eliciting Plans for Suicide

The risk of suicide increases when patients have suicidal plans or have had past suicide attempts. If patients have suicidal ideation, but deny suicidal plans, psychologists can ask them if they ever had suicidal plans in the past. Very often patients will respond to questions about suicide plans very literally. They may not currently have a suicide plan and will respond "no" to that question. But in the past they may have had such plans and, under periods of stress, they may retrieve those past plans and act upon them.

If patients reveal one plan for suicide, it may be useful to ask them if they have secondary or back-up plans. It could result in a tragedy if psychologists developed a detailed suicide management plan that includes restricting the means for implementing one suicide plan, but failed to restrict the means for the secondary or tertiary plans that they never knew about.

Getting information about past attempts is important for planning suicide management strategies and interventions. An increase in the amount of detail suggests that greater thought or preparation has gone into the plans. Highly detailed plans may include a how (e.g., with an overdose of a specific type of pill), where (e.g., in my bedroom so I can just go to sleep), and when (e.g., on Tuesday afternoon when no one is around to stop me). In addition, some patients may have rehearsed their attempts. For example, a patient who wants to shoot himself with a gun may have put the gun into his hand and placed it against his head for practice.

Past suicide attempts increase the risk of future suicide attempts, especially if they are recent. Psychologists can ask patients about the situations that led to the attempts and how they felt about surviving them. Expressing relief at surviving is a good prognostic sign. Often patients have had several past attempts. If so, it may not be productive to go into detail about every suicide attempt. However, it may be productive to ask them about the most recent attempt, and the most serious suicide attempt in terms of lethality.

Do Not Overvalue Levels of Risk Formulae

Many books or articles on suicide will present formulae to determine levels of risk. For example, based upon various factors, the risk of suicide could be considered immediate (hospitalization is recommended), serious (a safety management plan and close monitoring of the patient is required); moderate (a safety management plan and ordinary sequence of psychotherapy should be sufficient); or low (no identifiable suicide risk; regular outpatient psychotherapy only).

Although such ratings of risks may have some value, they also have limitations. First, the levels may give professionals a false sense of certainty because the suicidality of patients can sometimes change rapidly. This points to the importance of continually monitoring suicide risk. Also, no rating system can accurately capture the risk for many patients. For some patients, one single factor, such as a severe functional limitation, may have a salience that a predetermined formula could not capture.

I do not discourage psychologists from using these charts. I only suggest that they use them wisely and recognize their limitations. Whereas the assessment, management, and treatment of a suicidal patient could be considered a movie; the levels of risk chart provide only a snapshot of the patient's status at one point in time.

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Competence in Managing Suicidal Patients

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Competent psychologists will work with their suicidal patients to develop effective management plans to reduce their risk of suicide. It is a mistake to assume that treating the predisposing mental illness of a patient is sufficient to diffuse the immediate threat of suicide (Weissberg, 2011). Instead, regardless of the patients' diagnoses, psychologists should develop and implement plans to reduce the immediate risk of suicide until treatment has a chance to become effective.

My review of the literature on the management of suicide has identified four core competencies which are to know how to:

1. set up a monitoring plan for the patient;
2. motivate the patient for treatment;
3. implement means restriction counseling; and
4. create an effective crisis intervention plan.

Below, I review essential information for psychologists who are developing suicide management plans. I urge psychologists to keep overarching ethical principles in mind such as respecting patient autonomy, beneficence (promoting the well-being of patients), and non-maleficence (avoiding harming patients). The fear of a patient suicide may cause some psychologists to suspend their normal good clinical judgment and forget the importance of these overarching ethical principles. As Dr. John Lemoncelli has stated, "some psychologists will take off their psychotherapist hat and put on a helmet" (Personal Communication, February 13, 2017). I will look at how these overarching ethical principles are especially relevant to means restriction counseling, hospitalizations, medication referrals, treatment agreements, and other safety precautions.

Means Restriction and Beneficence

Psychologists acting out of beneficence will engage in means restriction counseling with their patients. Means restriction counseling means working collaboratively with the patients or their significant others to restrict patient access to the means of suicide. Evidence suggests that means restrictions can save lives. Access to firearms is a special concern because those who attempt to die by shooting themselves are more likely to complete the attempt (Anestis, 2016). Some critics may argue that taking or removing the weapons from patients will only cause them to find other ways to kill themselves. However, data does not support this assumption. Stroebe (2013) found that removing access to firearms reduces the rate of completed suicide attempts.

Hospitalizations and Respect for Patient Autonomy, Beneficence, and Non-maleficence

Some professionals may, perhaps out of a fear of a patient suicide, recommend options that they mistakenly believe will reduce their potential legal liability, but which risk delivering less-than-adequate care for their patients. For example, health-care professionals often respond to suicidal threats by hospitalizing the patients. I have hospitalized suicidal patients and I believe that I saved the lives of some patients by doing so. However, such decisions need to be made carefully with the acknowledgement that these hospitalizations may have limitations and risks to them. Hospitals do provide a safe environment at least temporarily and an opportunity for the patients to start on medication. On the other hand, hospital stays are typically short and little psychotherapy occurs in hospitals. The risk of suicide is especially high immediately following discharge from a hospital. In addition, some patients feel stigmatized by going into a psychiatric hospital. Also, the hospitalization itself may cause additional burdens in arranging for child care, taking time off work, or paying for the hospital bill. From the standpoint of beneficence, hospitals are sometimes indicated, but the advantages are often short-lived and they may be clinically contraindicated for some patients.

[A]ny immediate benefit of an involuntary psychiatric hospitalization needs to be balanced against potential harm in the long run.

The issues become even more problematic when considering involuntary psychiatric hospitalizations. Pennsylvania permits an involuntary psychiatric hospitalization if a patient has attempted suicide or taken steps to further a suicide attempt in the last 30 days. Nonetheless, involuntary psychiatric hospitalizations usurp the patients' right to control their own treatment and can only be justified if there is an immediate threat to their safety, and there is no other less intrusive way to diffuse the threat. Also, any immediate benefit of an involuntary psychiatric hospitalization needs to be balanced against potential harm in the long run. For some patients, hospitalizations represent great humiliation and, if the hospitalization is involuntary, it means losing the right to own firearms. If the hospitalization is done against the will of the patient it may disrupt the treatment relationship. Consequently, patients who are released may decide

not to cooperate with (or even attend) therapy in the future, thus putting their long-term safety at even greater risk. Therefore, I recommend the use of involuntary psychiatric hospitalizations with great caution.

Referral for Medications and Beneficence

Competent psychologists will promote the well-being of their patients by referring them for medications when it is clinically indicated to do so. But, except for schizophrenia and bipolar disorders, little evidence supports the value of medications in reducing the risk of suicide in the short-term. A pill does not quickly change suicidal thoughts, increase social contacts, or remove a gun from the home of a suicidal patient. Psychologists should keep all safety plans in effect whether or not the patient is on medication, and not lift them until there is sufficient justification for doing so. Simply starting on medication by itself adds very little to patient safety.

Treatment Agreements, Respect for Patient Autonomy and Beneficence

Some psychotherapists have been taught to use no-suicide contracts with patients. Although the exact content of these contracts may vary slightly, these are generally pre-written agreements that the patients sign promising that they will not attempt suicide. No evidence supports their effectiveness in reducing suicide attempts (Edwards & Sachman, 2010). Indeed, psychotherapists who pressure patients to sign them can impede treatment. Some patients see psychotherapists who push these contracts as insensitive, and they may interpret this behavior as an indication that the psychotherapists care more about protecting themselves from liability and less about caring for the patient. In addition, aggressive promoting of no-suicide contracts risks violating respect for patient decision making. Nonetheless, some psychologists will offer a middle ground in which they offer a no-suicide contract, but use it only as a vehicle of discussion without being pushy or intrusive. This avoids some of the ethical and clinical problems usually associated with no-suicide contracts but I think psychologists can do even better if they consider the alternative described below.

It is possible to offer a positive alternative to no-suicide contracts such as a commitment to life or commitment to treatment document that involves the patient in the creation of said document (respects patient autonomy), and is designed to benefit them (promotes beneficence; Rudd, Madrusiak, & Joiner, 2006). Unlike a no-suicide contract that simply tells patients what they cannot do, a commitment to life agreement offers patients options and solutions to their problems (Jobes et al., 2008).

Psychologists should keep all safety plans in effect whether or not the patient is on medication, and not lift them until there is sufficient justification for doing so.

The commitment to life agreement could include a list of reasons for living, helpful suggestions for the patient to follow between sessions, a list of situations or individuals to avoid (because they increase the likelihood of dysphoria or suicidal ideation), a list of situations or individuals to seek out (because they appear to increase their sense of well-being), and ways to handle crises.

Addressing potential crises is especially important. A good commitment to treatment document will prepare patients for the possibility that they may have a strong increase in suicidal thoughts, and it will provide concrete steps for patients to follow when such thoughts arise. In creating this document together, patient and psychologist can review the activities, strategies, or persons that the patient has found helpful in stabilizing their mood in the past, or activities, strategies, or persons to avoid. For example, Simon et al. (2016) found that most depressed and suicidal patients could reduce distress by talking with peers, exercising, or doing things with others (although a minority of patients found that these activities were harmful). Of course, no two patients are identical, and patients need to identify what helps them. The commitment to life document could also contain crisis intervention information such as the psychologist's emergency number or the number of a suicide prevention hotline such as the National Suicide Prevention Lifeline Number (1-800 273-TALK).

Breaking Confidentiality and Respecting Patient Autonomy and Beneficence

Pennsylvania psychologists may break confidentiality of patients who are an immediate threat to harm themselves or others (49 PA Code 41.61, Principle 5 (b)). If it is necessary to involve other family members or friends in a safety plan, then it would be important to solicit the consent of the patient if possible. If patients refuse to allow psychologists to engage their family or friends in the safety plan, then it may be useful to find out the reasons for their refusal and try to negotiate some compromise. Perhaps they have good reasons for withholding this information. Sometimes notifying families can substantially harm the patient. Although most families are responsive and caring for their loved ones during this time, a few families have a high degree of pathology and may respond in a way that increases the risk of suicide. Even well-meaning families may respond in paternalistic or unproductive ways that increase the stress on the patient. Psychologists should remember the general rule to avoid interventions that risk harming the patient (non-maleficence).

If family members or friends are involved, then the process should include more than just telling them,

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COMPETENCE IN MANAGING SUICIDAL PATIENTS

Continued from page 11

"Your loved one is suicidal and watch them over the weekend, please." Instead it usually requires educating family members or friends on what they specifically can do to be helpful, and what they specifically need to avoid doing. Meaningful patient input is essential in this process and the parameters of family and friend involvement can be negotiated and modified in the future if needed. The American Foundation for Suicide Prevention (https://afsp.org/our-work/education/) offers some useful educational materials that psychologists can use to supplement their discussions.

If patients refuse to consent and disclosure is essential to protect the patient, then respecting patient autonomy (not telling the family) appears to conflict with beneficence (doing things to promote or protect patient well-being). If psychologists believe that it is necessary to inform the family to protect the patient, then they may have beneficence (engaging the family or friends) temporarily trump respect for patient autonomy (not engaging the family or friends). However, an effort should be made to minimize harm to the offended moral principle. In such situations, psychologists can still try to involve patients in the decision as much as possible by reviewing with patients what would be said to their family or friends (and modifying it according the wishes of the patients if appropriate). Also, psychologists can offer to have patients tell their families directly or allow the patients to be present when the psychologist tells them. Even if patients completely refuse to cooperate, psychologists should inform the patients who is being notified, why, and the general nature of the information that will be shared. The information shared should be the minimum necessary to fulfill the purpose of the disclosure.

Even if patients completely refuse to cooperate, psychologists should inform the patients who is being notified, why, and the general nature of the information that will be shared.

Because of their potential to reduce trust in the psychologist, disclosures without the consent of patients should be done rarely and only when it is essential to save the life of patients and no other options to ensure their safety can be found.

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Competence in Treating Suicidal Patients

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

My review of the literature shows that the core competency for interventions with suicidal patients is the ability to develop and implement a treatment plan that addresses the co-existing mental illness while keeping patient safety and management practices in place. It is beyond the scope of this article to describe all the elements that are necessary for the effective treatment of suicidal patients. However, effectiveness as a psychotherapist in general does not necessarily ensure effectiveness as a psychotherapist with suicidal patients. Kraus et al. (2011) found that some psychotherapists who had good outcomes in other domains of treatment did poorly when working with suicidal patients. Good psychologists will know both how to address the specific diagnoses of their patients and how to address the unique factors found in suicidal patients.

Intervention Factors Unique to Suicidal Patients

Some of the same qualities with effective psychotherapy in general also apply to psychotherapy with suicidal patients. That is, effective psychotherapists will respect patient autonomy as it applies to agreement on the goals and processes of treatment; will develop a good working alliance; and will strive to convey empathy and understanding. However, effective psychotherapists also need to address unique factors associated with suicidal risk.

Unfortunately, there is little research on programs specifically designed to reduce suicidal behavior. Those evidence-based programs include cognitive behavior therapy for depression (Rudd et al., 2015), dialectical behavior therapy for borderline personality disorder (Linehan et al., 2015), the Collaborative Assessment and Management of Suicide (CAMS; Jobes, 2016), a transtheoretical approach to suicidal management. Given this limited research I recommend that psychologists use the interventions that they believe will be most helpful considering the diagnosis and presenting problems of their patients, but modify them to account for the suicidal behavior.

Regardless of the treatments used, I recommend that psychologists pay special attention to informed consent... and ensure that the treatment addresses the unique needs of their patients.

Regardless of the treatments used, I recommend that psychologists pay special attention to informed consent, seek consultation when appropriate, monitor their patients' suicidal ideation and treatment progress, be prepared to handle suicidal crises, and ensure that the treatment addresses the unique needs of their patients. Finally, I have a few comments about special issues that may arise when patients have serious personality disorders.

Informed Consent

Psychotherapists will be more effective if they take the time to orient patients into the process of psychotherapy. This requires psychologists to honestly address the important issues in psychotherapy ahead of time including what they expect of their patients. Although psychologists can use the informed consent (or psychotherapy orientation) process to generate hopefulness with their patients, psychologists also need to inform patients that effective psychotherapy requires them to be conscientious about keeping appointments, and being open and honest about their feelings. Although psychologists will take efforts to reduce discomfort in psychotherapy, effective psychotherapy often involves the discussion of upsetting events.

Consultation and Collaboration

When treating a patient at risk to die from suicide, psychotherapists should seek consultation if they are uncertain how to proceed. Consultation could include conversations with objective professionals who have no relationship to the patient, but it could also involve conversations with other treating professionals who can provide information or perspective on how to handle their mutual patients. In addition, the benefit of the conversation can be bidirectional as well. The treating psychologists can also give the other health care professionals information about their patients that will help them provide a better quality of care as well. For example, it is possible that psychologists can advocate for a reevaluation of patients who suffer from chronic pain, but who have not adequately communicated the extent of the pain to their health care providers.

Monitoring Patient Suicidal Ideation and Progress

It is good to monitor one's work, especially when patients have life endangering features. This may require asking patients about their suicidal ideation, their perceptions of the process of therapy, whether they perceive they are getting better, and whether psychotherapy needs to be changed in any way to help them progress.

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COMPETENCE IN TREATING SUICIDAL PATIENTS

Continued from page 13

It can sometimes be useful to have additional sources of information about suicidal ideation besides the self-reports of the patients. This could mean getting, with the consent of patients, input from family members, close friends, or other health-care professionals treating the patients. Also, psychologists can use a brief suicide screening instrument to supplement a patient's self-report of suicidal ideation (it could be the same instrument that the psychotherapist used during the initial evaluation of the patient).

Monitoring suicidal thoughts is especially important. This may mean keeping some of the suicidal management precautions in place during the early parts of psychotherapy or as long as needed. As the risk of suicide decreases, the amount of time spent on managing suicidal thoughts can similarly decrease.

Some suicidal patients will need more psychotherapy than the traditional one psychotherapy hour per week. Also, I have known psychologists who have wisely instructed suicidal patients to call into their offices between appointments just to let the psychotherapists know how they are doing. Sometimes a call back is required; often it is not. In any event, patients often appreciate the concern showed for them. Many patients have said that the concern expressed by their psychotherapists was the factor that kept them alive during their worst moments.

Handing Crises

Some suicidal patients will develop a crisis during psychotherapy and may need access to services after hours. As noted in the article on suicide management, psychologists should address the potential for crises in the management plan. Ideally, the crisis plan will circumvent any suicide attempt, but some patients will nonetheless attempt suicide while they are in psychotherapy. Because suicide attempts are 10 to 25 times more common than completed suicides, psychologists are far more likely to see a patient after a suicide attempt than to have a patient die from suicide. A suicide attempt by a patient already in treatment is a serious issue and an indication that psychotherapy has not been sufficient in some way. It is important for the psychologists and patients to review the procedures and process of psychotherapy. However, it is possible that psychotherapy can be modified and made effective.

Tailor the Treatments to the Patient

Effective psychotherapy addresses the drivers of suicide that are unique to the patient, such as their diagnosis and transdiagnostic factors. Although patients with depression have a high risk of suicide, suicide risk is not confined to any one diagnosis. Risks are especially elevated with patients who have bipolar disorder, schizophrenia, anorexia, or substance abuse diagnoses. The risks increase even higher when patients have co-morbid diagnoses.

The transdiagnostic factors related to suicide could include social isolation, perceived burdensomeness, hopelessness, adjustment to medical conditions, non-suicidal self-injury, emotional pain. or other factors that make life seem intolerable. Ideally, psychologists will identify these factors and make them the targets for the treatment plan. A general rule of thumb is that any activity that involves meaningful interactions with other people can be helpful. Sometimes couples or family therapy may be indicated. Other psychologists will encourage their patients to get involved in social activities such as volunteer work. Even relatively minor or simple activities, such as calling a relative or talking to a friend can reduce social isolation.

Monitoring suicidal thoughts is especially important. This may mean keeping some of the suicidal management precautions in place during the early parts of psychotherapy or as long as needed.

For some patients, suicidal thoughts are associated with thoughts of worthlessness or spiritual waste. As noted in the article on suicide assessment, some patients refrain from acting on suicidal thoughts because they have *life protecting religious values* that prohibit them from harming themselves. Other

patients will strive to improve the quality of their lives because they have *life promoting religious values* that urge them to forgive themselves, get involved in helping others, and lead a meaningful life. Although most religions have life protecting and life promoting doctrines, suicidal patients often selectively interpret their traditions to reinforce beliefs that support self-harm or self-hatred.

Psychologists may discuss religion or spirituality and if patients want to discuss it and it is relevant to their treatment needs, psychologists may address religious and spiritual issues in psychotherapy. Effective psychotherapists should be aware of the competencies needed for religious interventions (Vieten et al., 2016) including the need to focus on the relevance to the clinical issues of the patients, respecting patients' worldviews, and allowing patients' input into when, if, how, and how much to integrate religion into psychotherapy.

Special Considerations With Serious Personality Disorders

A minority of patients have serious personality disorders which may also include suicidal ideation or attempts. Psychotherapists who work with such patients should use therapies that have been specifically developed for such patients. Dialectical behavior therapy, for instance, has proven useful. Often these protocols have specific instructions on how to deal with suicidal behavior. Fortunately, these psychotherapies have had good outcomes, although such treatments are time-intensive and demanding on both psychologists and patients.

Many patients with serious personality disorders have chronic thoughts of suicide. Such thoughts need to be addressed in some form in psychotherapy. Effective psychologists will be able to discern when to simply monitor such thoughts, and when to take the thoughts more literally. Psychotherapists make a mistake if they assume that patients with serious personality disorders never die from suicide.

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Documentation: The Tenth Competency When Working With Suicidal Patients

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

The tenth competency that cuts across all modalities is to document the assessment, management, and treatment of suicidal patients. Documentation serves several purposes. It fulfills legal requirements or requirements of insurers. Documentation helps remind professionals of the events that occurred during psychotherapy. It also provides a record for other current or future treatment professionals who need to understand what happened in psychotherapy. The creation of the documentation itself can be a form of self-reflection. Finally, it is a very effective form of risk management. As psychologists know, the general rule in courts is that "if it is not written down, it did not happen." Conversely, if it is written down, then it did happen. This final purpose of records is especially salient in the minds of psychologists who deal with high risk suicidal patients. In such cases, it could be said that the service is only as good as its documentation.

If a patient dies from suicide or suffers seriously from a failed suicide attempt, the family or surviving patient may question the level of care provided by the psychologist and initiate a malpractice suit. The suicide of a patient is a profound tragedy. However, I see no value in complicating that tragedy by having an unwarranted lawsuit against a psychologist who acted conscientiously and competently. I have known mental health professionals who delivered good care, but nonetheless had to defend themselves in a malpractice suit because they failed to document services adequately.

The general rule is that any subsequent health care professional should be able to look at the notes and have a general idea how the treating psychologist reached a diagnosis, formulated and implemented the management and treatment plans, and made important decisions. The reasons for any major decision made in psychotherapy should be noted. As noted by Knapp and Gavazzi (2017), the best risk management strategies are "to provide *and document* good treatment" (italics added).

Notes with suicidal patients differ from notes taken with non-suicidal patients in psychotherapy due to the detail involved. The notes should contain the information that psychologists gathered in determining suicide risk, such as patient responses to questions about suicide; risk (fixed and changing) and protective factors; and the results of the screening instrument. In addition, the documentation should describe management strategies (commitment to life documents, efforts at means restriction, etc.), and the intervention.

One common flaw in documentation for suicidal patients is using vague terms that do not have agreed-upon meanings. Terms should be described clearly so that a reader could understand what the psychologists were thinking. For example, the word "suicidal gesture" is open to multiple interpretations and psychologists should not use it unless they define what they mean by it (Heilbron et al., 2010). Similarly, the word "manipulate" confuses readers. Does it mean that the patient deliberately took a non-lethal dose of medication, engaged in non-suicidal self-injury, or expected to be interrupted in the suicide attempt? It is better to describe the events in behavioral terms rather than to use the ill-defined word "manipulate."

In any event, documentation should be as transparent as possible, especially when psychologists must make difficult decisions. Psychologist who treat suicidal patients often need to balance the advantages and disadvantages of possible interventions. For example, psychologists may have to decide whether to recommend hospitalization, or whether to break confidentiality to notify a family member of the suicidal intentions of their patients. Often these are not easy decisions and the treating psychologist must determine if the benefits of the hospitalization, for example, outweigh its risks.

I have known mental health professionals who delivered good care, but nonetheless had to defend themselves in a malpractice suit because they failed to document services adequately.

If a suicidal patient suffered harm and the treatment decisions were ever reviewed by a court, psychologists would not be liable just because their decisions, in hindsight, were wrong. Instead, psychotherapists will be held liable if they deviated from good standards of care and this deviation was directly related to the harm to the patient. Ideally, the treating psychologist will have gathered sufficient information to make a good decision and would rely on more sources of information than just the self-report of the patient. Ideally, this information would include a detailed social history of the patient, an opportunity to review past treatment records, and conversations with family members or other treatment providers, etc. However, ideal conditions do not always exist.

Suicidal crises often occur quickly with new patients and psychologists do not have the opportunity or time to gather this information.

Psychologists would not be held liable for making a decision that appeared reasonable given the information that psychologists had at the time. Good documentation gives psychologists the opportunity to memorialize what they knew and how they used this knowledge to make their decisions. Most courts understand the difficulties in treating suicidal outpatients, and successful malpractice cases for outpatient suicides are infrequent, in contrast to inpatient settings where successful malpractice cases for suicides are more common.

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How Are CPT Codes Made and Reimbursement Levels Determined?

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

The American Medical Association develops the Current Procedural Terminology (CPT) Codes to ensure a common parlance and unitary language for describing services and procedures by physicians and other health-care professionals. AMA published and copyrighted the CPT manual. A panel of the AMA (the Editorial Panel) creates the CPT Codes, although it solicits advice from advisory panels. The process is tightly controlled with strict restrictions against lobbying (unsolicited communications) concerning the codes.

Although the Editorial Committee recommends the CPT Codes, another committee within AMA, the Relative Value Update Committee (RUC; rhymes with truck), recommends Medicare fees for the CPT codes to the Centers for Medicare and Medicaid Services (CMS). The RUC bases its recommendations on surveys conducted by affected organizations on the relative work effort involved with the procedure. Its secret adoption process allows no public comment period or consumer input. All participants must follow strict standards of confidentiality and the AMA will remove violators from the process. Although CMS has the ultimate authority over the relative value, it almost always accepts all RUC recommendations.

Medicare payments are based on the Resource Based Relative Value Scale (RBRVS) which consists of three factors: work product, practice expenses, and professional liability. Work product involves the time, technical skill, and mental effort required to perform a certain procedure. For physicians, work product consists of 48%, practice expenses consist of 47%, and professional liability insurance consists of 4% of the RBRVS. For psychologists, work product is almost 70% of the RBVS and professional liability is around 1%. Because the portion of practice expenses for psychologists is so much lower than physicians, minor changes in the work product calculation can have a larger impact on reimbursement rates.

The American Psychological Association (APA) has a representative on both the RUC and the CPT Health Care Professional Advisory Committees. Representatives from APA are bound by the very strict standards of confidentiality concerning their participation in the process. Participation in the process should not be interpreted to mean agreement with the recommendations concerning CPT Codes or payments were accepted.

CE Questions for This Issue

The articles selected for 1 CE credit in this issue of the *Pennsylvania Psychologist Update* are sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. The regulations of the Pennsylvania State Board of Psychology permit psychologists to earn up to 15 credits per renewal period through home study continuing education. If you have more than 30 continuing education credits for this renewal period you may carry over up to 10 credits of continuing education into the next renewal period.

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Learning objective: The articles in this issue will enable readers to identify special considerations needed to implement the core competencies in the assessment, management, and treatment of suicidal patients.

Competence With Suicidal Patients

1. The most common professional fear of psychologists, according to Pope and Tabachnick (1993) is that psychologists will:
   a. Have a patient die from suicide
   b. Be the subject of a malpractice suite
   c. Be the subject of a licensing board complaint
   d. Accidentally break the confidentiality of a patient

2. According to Kraus et al (2011), most psychotherapists in his study had:
   a. Suicidal patients who got much better
   b. Suicidal patients who got worse or stayed the same
   c. Suicidal patients who got worse over time
   d. An equal number of suicidal patients who got worse, got better, and stayed the same

Competence in Assessing Suicide

3. When assessing suicidal risk, the authors recommend that psychologists consider:
   a. Static (fixed) factors such as the age or history of the patient
   b. Dynamic (changing) factors such as whether the patient has a weak social network
   c. Protective factors such as a religious belief that prohibits suicide
   d. All of the above

4. The authors state that some suicidal patients will deny suicidal ideation because they:
   a. Feel shame at having such thoughts
   b. Have narcissistic personality disorders
   c. Feel deep resentment at being asked this personal question
   d. All of the above

5. The limitations of levels of risk charts are that they may:
   a. Give clinicians a false sense of security
   b. Reflect risk at only one point in time
   c. Involve decision trees or formulae that fail to capture the drivers for any one individual patient
   d. All of the above

Competence in Managing Suicide

6. Data shows that restricting access to firearms can reduce the risk of death for suicidal patients who plan to kill themselves with firearms.
   True
   False

7. When encountering patients who deny suicide risk, but seem at high risk for suicide, the author recommends that psychologists consider:
   a. That the patients have sociopathic qualities
   b. Confronting them directly with the cowardly refusal to acknowledge what they are thinking
   c. Asking them about passive death or passive suicide ideation
   d. All of the above

8. At the end of the first interview with a suicidal patient, the author believes that it is important that psychologists had:
   a. Clearly identified the ICD diagnosis for the patient and have a copy of the notes of any past health-care professionals.
   b. Developed a checklist where they can enumerate all of the risk and protective factors, even if the interview takes several hours to complete.
   c. Given patients a sense that they had a chance to tell their story and that the psychologist cared about them.
   d. All of the above

Competence in Treating Suicidal Patients

9. Kraus et al (2011) found that effectiveness as a psychotherapist in general is not necessarily associated with effectiveness in working with suicidal patients.
   True
   False

10. Research has revealed only a few psychological treatments that have been empirically proven effective specifically in reducing suicidal behavior.
    True
    False

11. The ways to monitor the patient's suicidal ideation could include:
    a. Asking patients if they are having suicidal thoughts
    b. Giving patients brief screening instruments that measure suicidal ideation
    c. Asking for the input of relatives or others in the patients' natural social network
    d. All of the above

12. A suicide attempt by a patient in treatment :
    a. Means that therapy has been a failure and a referral is absolutely required
    b. Is so common that they are not a cause for unusual concern or attention
    c. Is a cause for concern and suggests a need to re-evaluate the patient's treatment plan
    d. Should be the basis for the unilateral termination of the patient

Documentation: The Tenth Competency

13. According to Knapp and Gavazzi, the best risk management strategy is to provide and document good treatment.
    True
    False

Continuing Education Answer Sheet

The Pennsylvania Psychologist Update, May 2017

Please circle the letter corresponding to the correct answer for each question.

1.	a	b	c	d
2.	a	b	c	d
3.	a	b	c	d
4.	a	b	c	d
5.	a	b	c	d
6.	T	F		
7.	a	b	c	d
8.	a	b	c	d
9.	T	F		
10.	T	F		
11.	a	b	c	d
12.	a	b	c	d
13.	T	F		

Satisfaction Rating

Overall, I found this issue of the *Pennsylvania Psychologist Update:*

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

Comments or suggestions for future issues _____

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October 26–27, 2017
2017 Fall Continuing Education & Ethics Conference
Eden Resort & Conference Center, Lancaster, PA

Webinars and Home Studies

Check out our new Online Learning Portal at papsy.bizvision.com!

Podcasts

Podcasts for CE credit by Dr. John Gavazzi are available on papsy.org.

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit papsy.org.

Registration materials and further conference information are available at papsy.org.

Home Study CE Courses

Pennsylvania Child Abuse Recognition and Reporting: 2017 (Act 31 Approved)
2 CE Credits

Medicare's 2016 Physician Quality Reporting System (PQRS)
1 CE Credit

The Assessment, Management, and Treatment of Suicidal Patients (approved for Act 74)
1 CE Credit / 3 CE Credits

*Ethical Practice Is Multicultural Practice**
3 CE Credits

*Introduction to Ethical Decision Making**
3 CE Credits

Staying Focused in the Age of Distraction: How Mindfulness, Prayer, and Meditation Can Help You Pay Attention to What Really Matters
5 CE Credits

*Competence, Advertising, Informed Consent, and Other Professional Issues**
3 CE Credits

*Ethics and Professional Growth**
3 CE Credits

*Foundations of Ethical Practice**
6 CE Credits

*Ethics and Boundaries**
3 CE Credits

Readings in Multiculturalism
4 CE Credits

*Pennsylvania's Psychology Licensing Law, Regulations, and Ethics**
6 CE Credits

***This program qualifies for 3 contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.**

For all Home Study CE Courses above contact:
Judy Smith, (717) 510-6343, judy@papsy.org.