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# Ten Questions to Promote Excellence when Working with Patients with Suicidal Thoughts

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orking with persons who have suicidal thoughts is one of the most common professional stressors experienced by psychologists. PPA data showed that in 2016, 87% of PPA members treated at least one patient who had thoughts of suicide, 23% had a patient attempt suicide while in treatment, and 4% had at least one patient die from suicide (Leitzel & Knapp, 2017). Competent psychologists look for ways to improve the quality of their services to patients who have suicidal thoughts. In this article we present questions that can help psychologists turn a good intervention into an excellent one. As readers may note as they go through this article, the 10 questions have common themes which will be discussed at the end of the article.

The ten questions we pose are:

- 1. What do you think and feel about persons who have suicidal thoughts?
- 2. Are you alert for false deniers?
- 3. Do you ask your patients about back-up plans for suicide?
- 4. Do you ask patients to rate their suicidal risk?
- 5. Do you focus on the relationship?
- 6. Do you review the safety management plan with your patients?
- 7. Do you ask patients how likely they are to follow the safety plan?
- 8. Do you make treatment expectations explicit?
- 9. Do you monitor patient progress?
- 10. Are you alert for binary thinking?

# 1) What Do You Think and Feel about Persons Who Have Thoughts of Suicide?

About 50% of Americans know someone who has died from suicide and many have had family members or close friends who have died from

suicide (Feigelman et al., 2018). Psychologists are not immune from this experience. Also, all Americans have been exposed to media reports of persons who have died from suicide. Writing and presenting about suicide has further sensitized us to the pervasiveness of suicide in our culture. Think of the popular songs in the 1960s such as *Moody River* by Pat Boone, *Patches* by Dickey Lee, *Ode to Billie Joe* by Bobbie Gentry, and others that deal with suicide, as well as books like *The Bell Jar*. These and others illustrate how much suicide has become part of our cultural heritage, even though most of us rarely step back and think about it. Sometimes the popular portrayals of persons with suicidal thoughts are sympathetic; at other times they perpetuate harmful stereotypes.

Reflective psychologists will ask themselves, "What do I think about suicide?" Like other Americans, psychologists may have adopted popular cultural beliefs about people with suicidal thoughts. For example, one stereotype is that people who die by suicide are selfish or cowardly (Joiner, 2010). Being an effective psychologist means becoming aware of these stereotypes and adopting more evidence-based and compassionate attitudes. A careful review of evidence shows that suicidal persons are not cowardly. Many persons who died from suicide have been soldiers, police officers, first responders, or individuals who have endured or witnessed great suffering. Furthermore, it takes considerable effort to overcome the natural tendency toward self-protection that a suicidal act involves. In fact, one of the characteristics of patients who die by suicide is that they have acquired the capability to kill themselves. Usually this acquired capability occurs because of habituation to pain and suffering which has gradually reduced the natural fear of death (Joiner, 2010). This commonly arises when individuals have been



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exposed to suffering through illness or injury, or through exposure to violence as either a victim, witness, or perpetrator.

People with suicidal thoughts do not intend to be selfish. On the contrary, many patients with suicidal thoughts see suicide as an unselfish act because they perceive themselves as a burden on others. They believe that the world would be better off without them. This belief is so common that Joiner (2010) has identified *perceived burdensomeness* as one of the critical characteristics of persons with suicidal thoughts.

Psychologists should also consider their role in preventing the suicide of a patient. Psychologists often report that their treatment of patients with suicidal thoughts can involve great worry and concern. When these worries morph into unproductive rumination or lost sleep, it is a good idea for a psychologist to step back and consider their role and professional limitations.

Every patient ultimately decides whether to live or to die, and no psychologist can assume full responsibility for the life of any patient. On the surface this statement may appear insensitive or even cruel, but we ask our readers to think it through carefully. During the 160+ hours of a week when patients are not in the office of the psychologist, the psychologist has little control over what they do or the events that they will experience. As much as psychologists may wish to prevent a suicide, the state of the field is that we simply do not know enough to prevent all suicides, in the same way that we do not know enough to prevent or cure all mental illnesses.

Ironically, psychologists who remind themselves of their limited control over patients with suicidal thoughts often become more effective in working with those patients. They may find themselves freed to concentrate their attention on quality clinical work, and on understanding and helping the patient to ameliorate the pain that underlies the wish to die.

The feelings of the psychologist are also important. What is it like to be in a room with a suicidal patient? Does it elicit fear? A psychologist may ask, "What consequences

might I face if this patient dies from suicide? Is it possible that I could get sued?" Another psychologist may feel compassion and may ask, "How can I alleviate the suffering of this patient?" Still another psychologist may experience anger toward the patient. A psychologist may ask, "Will this create many more professional demands on my time?" A psychologist may experience any combination of these emotions at different times. A certain amount of fear or anxiety is understandable and perhaps desirable if it helps increase one's attention and alertness. But at a certain level fear becomes unproductive.

Working effectively with patients with suicidal thoughts also requires the ability to tolerate uncertainty. The prediction of suicide is inherently unreliable. No single test or procedure is infallible in detecting who is at risk to attempt suicide. Nonetheless, research and clinical experience have identified steps that psychologists can take to become better at identifying those at risk. Psychologists who have mastered these steps will approach patients with confidence, knowing that most patients who have thoughts of suicide or even past suicide attempts will not die from suicide, and that most will go on to lead productive and meaningful lives.

Knowledgeable psychologists also put the risk of a malpractice lawsuit in perspective. It is true that the death of a patient by suicide is one of the more common causes of malpractice suits against psychologists, but malpractice suits against psychologists are rare and most malpractice suits related to suicide involve the treatment of inpatients (Knapp, Younggren, VandeCreek, Harris, & Martin, 2013).

Psychologists may err by being either alarmist or dismissive when responding to a patient's expressed thoughts of suicide. However, the most competent psychologists will adopt an attitude of *concerned alertness*.

When a patient expresses any suicidal ideation, an alarmist may overinterpret this statement as meaning that the risk of death is imminent, without conducting an evaluation thorough enough to accurately assess the risk. Alarmists may also err on the side of adopting intrusive interventions which are clinically contraindicated. They may overrefer to hospitals or emergency departments or inform the family of the patient about the risk of suicide without first processing that

step directly with the patient. Their behaviors convey a lack of respect for the feelings and wishes of the patients and, paradoxically, risk driving patients away from treatment and increasing the overall risk of suicide.

When a patient expresses any suicidal ideation, a dismissive psychologist may ignore or minimize the patient's risk of suicide. They may adopt the attitude of, "If you were really going to do this, you would have done it already" or "If you were really going to do this, you would not be here talking to me about it." Because of this attitude, the psychologist may fail to conduct as thorough an evaluation as would be indicated. They may not, for example, consider notifying other members of the family when clinically indicated to do so, fail to take steps to restrict access to the means of dying from suicide, or fail to develop a careful crisis intervention plan for the patient. Their attitudes and behaviors minimize the very real concern and pain of their patients, causing patients to feel less connected to their psychologists and more likely to drop out of treatment. However, psychologists who demonstrate concerned alertness will take the necessary time to do a thorough evaluation, build rapport with the patient, invite the patient to participate in clinically meaningful decisions, consider clinically relevant management strategies, focus treatment on the underlying factors that sustain the suicidal ideation, and so on.

#### 2) Are You Alert for False Deniers?

It is common for a patient to withhold information about suicidal ideation from their psychologist. About 75% of patients who died from suicide had denied such thoughts in their last meeting with a health care professional (Berman, 2018). It is possible that some of those suicidal decedents did not have suicidal thoughts at their last encounter. However, it is likely that many did have suicidal thoughts but simply decided not to tell their health care professional about it.

We recommend that psychologists screen all mental health patients over the age of 12 for suicidal risk, although there may be exceptions based on unusual circumstances. In most mental health settings, most patients screened will deny thoughts of suicide. Of the patients who deny such thoughts, most are *true deniers*. That is, they truly do not

have thoughts of suicide. A smaller number are *false deniers*, patients who have thoughts of suicide, but deny such thoughts to their treating psychologist when asked. It can be difficult to distinguish between true deniers and false deniers. Because of the importance of identifying patients who have suicidal thoughts, it is worth stepping back and reviewing screening and assessment steps.

We recommend that the screening involve both a written question and a verbal question. The written question can be a simple one, such as the question on suicide found in the PHQ-9.¹ Regardless of how the patient responds to the written question, it is recommended that the psychologist also ask a verbal question as well such as "Have you ever had thoughts of suicide?" Psychologists can modify the wording based on their own preferences or style of interviewing.

For example, one of the authors (BES) typically asks patients a series of questions: "Do you sometimes find yourself thinking about dying?" "Do you sometimes wish you were dead?""Do you sometimes think about taking your life?" If any of these are answered in the affirmative, he follows up with questions that help establish the degree of risk.

When patients are asked both verbally and in writing, some patients will acknowledge suicidal thoughts in one form, but not the other. The reasons for this discrepancy aren't entirely clear. It may be simply that the question was asked twice, but it is also possible that some patients feel shame at having suicidal thoughts and are more willing to open up on paper than in person. Nonetheless, the two-question strategy may identify some patients with suicidal thoughts who would not be identified by one question alone.

Despite this step, some patients with suicidal thoughts will still fail to acknowledge them in response to either written or verbal questions. The reasons may vary. Some may feel shame at having such thoughts and have internalized prejudices that suicidal persons are weak or selfish. Others may fear that the psychologist will try to hospitalize them or share personal information without their

consent. Some may believe it is sinful to have suicidal thoughts.<sup>2</sup> Still others may believe that treatments do not work or that they personally are not worth the time and effort of the psychologist. Some patients have a mixture of these reasons or there may be other reasons not identified above.

Psychologists can take several steps proactively in consideration of these concerns. For example, during the informed consent process when discussing exceptions to confidentiality, psychologists can emphasize that they very seldom would reveal patient information without the consent of the patient and only do so if it seemed like the only way to save a life. The preferred approach is to work cooperatively with the patient.

Also, psychologists have steps that they can take in the interview to increase the likelihood that a patient will open-up. First, they can normalize having thoughts of suicide (Shea, 2011). If a patient has gone through an especially difficult time or stressful experience, the psychologist can say, "Wow! That is a lot you have been through. Some people going through all those experiences might have thoughts of harming themselves. Have you ever had those thoughts?"

Some patients believe that having suicidal thoughts is a sign of weakness. If patients are struggling to share painful emotions, it is appropriate for psychologists to recognize the courage that it took for them to share those thoughts. Psychologists can validate the patient's thoughts and feelings and tell the patient that they have enough strength and courage to acknowledge these problems and to commit themselves to doing something about them.

A final consideration for identifying false deniers is to consider the timing of asking questions about suicide. If patients have acknowledged suicidal thoughts on the written questionnaire, psychologists can ask directly about those thoughts at the start of treatment. However, if patients did not acknowledge suicidal thoughts on the patient questionnaire, then psychologists can start the interview by asking more general information about their

well-being and life circumstances and then, as the interview goes on and more rapport is built, can ask about suicidal thoughts later in the interview.

#### 3) Do You Ask Your Patients about Back-Up Plans for Suicide?

Good psychologists will ask patients with suicidal thoughts about their plans for suicide including the method that they intend to use. If patients intend to kill themselves by taking an overdose of medications, for example, then the psychologist could take steps to restrict their access to lethal amounts of medication. They may talk to the prescribing physicians and ask them to limit the amount of medication to a non-lethal dose or have a family check on the supply of prescription and non-prescription medications in the house.

Death by firearms is the most common method of a completed suicide, so it is indicated to ask all patients with suicidal thoughts if they have access to firearms and, if so, to take steps to remove or immobilize those firearms. It may mean using gun locks, removing ammunition from the household, or even removing the guns entirely from the household.

These restrictive methods are effective in preventing suicides. Means restrictions (or means safety) interventions are part of a comprehensive safety plan for patients. Some mistakenly believe that if suicidal persons have one means of dying from suicide removed, they will simply find another way to kill themselves. This theory is not empirically supported, however (Anestis et al., 2018). Most suicide attempts occur during a suicidal crisis, or a period of intense feeling of dysphoria that can sometimes arise in a matter of hours or even minutes. These suicidal crises are time-limited, so the goal is to keep the patients safe during this relatively brief suicidal crisis. Of course, the patient could always look up lethal doses of non-prescription medication on the internet and drive to the drug store and purchase them. But patients in a suicidal crisis

<sup>1.</sup> That question is "Have you had thoughts that you would be better off dead or of hurting yourself in some way for at least several days in the last two weeks?" See http://www.bmedreport.com/archives/14638

<sup>2.</sup> This may be especially common among Muslim patients for whom suicide represents a terrible sin. For such patients it may be prudent to begin with indirect questions such as, "Do you ever feel tired of living?" or "Do you ever wish God would take you home?"

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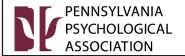


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are seldom thinking through things clearly, and during the time that it would take them to develop and act on an alternative plan, the crisis may have passed.

Nonetheless, some patients have secondary or tertiary suicide plans and psychologists will not learn about these plans unless they ask. It will not be sufficient to develop a safety plan for one means of suicide without having a safety plan for the secondary or tertiary means of suicide. Therefore, we recommend that psychologists ask all patients with suicidal plans if they have secondary or tertiary plans for killing themselves, or if they had other plans in the past which have temporarily become dormant. Psychologists can ask, "If that does not work, have you thought of other ways that you would kill yourself?" and "Did you ever in the past have other plans for killing yourself?"

## 4) Do You Ask Patients to Rate Their Suicidal Risk?

A good assessment of patients with suicidal thoughts includes gathering information on their suicidal thoughts, including their frequency, intensity and duration; any past suicide attempts including when they occurred, what precipitated them, and the methods used; and any plans for future attempts. It can also be clinically indicated to ask patients, on a scale of 1 to 5 (with five being the highest risk), what is the likelihood that they will die from suicide or the likelihood that they will attempt suicide again. Evidence suggests that this simple statement helps predict future suicide attempts. For example, Czyz, Horwitz, and King (2016) found that adolescents who predicted that they would eventually die from suicide using a similar scale were more likely to attempt suicide in the future than adolescents who made no such prediction, even when other risk factors were controlled.

If patients say that they believe that they will die from suicide, then it becomes an opportunity to discuss what factors led them to make this prediction. If patients say that they do not believe that they would die from suicide, it becomes an opportunity to discuss the protective factors that lead them to this

conclusion. With all patients it can also be productive to ask what factors might change that would increase or decrease the risk of suicide.

#### 5) Do You Focus in the Relationship?

Joiner (2010) proposes three essential elements in a patient's thinking and experience which are critical in determining risk for suicide. Two of these, acquired capability and perceived burdensomeness have been discussed above (See item 1.) The third factor is thwarted belongingness. Patients who lack a sense of belonging or connection with others are more likely to have thoughts of suicide, and to act on those thoughts. Patients who decide to act on their thoughts of suicide often take steps to break any remaining sense of belonging or connectedness with others, either in actions, or in thought. For example, patients who are in an imminent suicidal crisis may convince themselves that no one cares, or that the one remaining significant relationship is irrevocably broken. Psychologists working with a patient in a suicidal crisis may forget the importance of the psychotherapy relationship or may overlook the power of verbalizing connection with a patient. Yet for some patients, connection with a psychologist can be the critical factor which keeps the patient alive. In a suicidal crisis, it is important to overtly express caring for the patient.

The psychotherapeutic relationship is an important element in effective psychotherapy (Wampold et al., 2017). This is no different when working with patients who have suicidal thoughts. When asked why they did not kill themselves, many patients say it is because their psychotherapist cared about them (Montross-Thomas et al., 2014). Few things are as strong and powerful as the opportunity to tell one's story and to be heard. Sometimes alarmist psychologists will want to argue with patients about the desirability of suicide or automatically or immediately refer the patient to a hospital or notify family members. While each of those interventions may be indicated in some cases, they should seldom be the first steps in dealing with patients with suicidal thoughts. By listening closely to patients and accepting their pain and fears, psychologists can create an environment in which patients are more willing to share suicidal thoughts. They work collaboratively with the patient to develop meaningful treatment goals

and strategies. One of the goals of the first interview is give patients a chance to tell their stories and to feel that they were heard. By listening carefully to patients, psychologists will learn more about their life history, their interpretations of events, and perspectives on how to develop an effective treatment program. Although the professional may be an expert on mental health in general, "only the patient can be the expert of his or her own individual experience" (Michel, 2011, p. 9).

It is a good idea to ask patients to think carefully through any decision to kill themselves. After all, this decision cannot be reversed. It can be a powerful intervention to remind a patient that if she does not die today, she can still make that choice at a future time. It is appropriate to ask a patient to review assumptions they hold that make it appear that suicide is a reasonable option. It is appropriate to remind patients of the pain that they will cause to survivors and the fact that most people who survive a suicide attempt never attempt again and go on to lead productive and meaningful lives.

Psychologists should ask these questions to help patients reflect on their experiences and interpretations. Asking questions, however, should not morph into an argument wherein the psychologist gives a reason for living and the patient responds vigorously with reasons for dying. Psychologists will never win that argument. However, paradoxically, the mere fact of listening to the patients carefully and trying to understand their feelings can reduce those very suicidal urges. Instead of berating patients into believing that their life has meaning, a psychologist who listens is providing the emotional connection that, in and of itself, gives meaning to life

Validation of a patient's feelings, thoughts, and experiences is critical in establishing and maintaining connection, and can be tremendously comforting (Linehan, 2014). It can be difficult to think of validating a patient's thoughts of suicide. Psychologists who are familiar with the principles of validation will recognize the difference between validating the patient's thoughts, feelings, and experiences versus agreeing with the patient's intentions or actions. Validation involves acknowledging that the patient's experienced pain and desire for relief are understandable. It

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does not mean agreeing with a plan to end one's life.

#### 6) Did You Review the Safety Management Plan with Your Patients?

Effective treatment of patients with suicidal thoughts requires the development of a safety plan. It is not sufficient for psychologists to treat the patient's mental illness; they must also ensure the immediate safety of the patient. Such safety plans may include a crisis response plan and a treatment agreement in which the parameters of treatment are made explicit. In contrast to a "no-suicide contract" which simply tells patients that they cannot attempt suicide, a safety agreement is written cooperatively with patients and includes steps that they can take to reduce their distress (Rudd et al., 2006). These agreements are intended to be useful documents that patients can refer to in their daily lives. Psychologists can give patients a copy of the agreement that they can refer to during times that they experience suicidal thoughts.

These agreements may include, among other things, writing down the patient's reasons for living. Often patients will focus on values ("to follow the teachings of Jesus"), or relationships ("to see my grandchildren grow up"). Writing these reasons down can remind patients of what is important to them at a time when there is a risk that their emotions and suicidal urges could get out of control.

The safety plan could also include warning signs or indicators that the patient is doing poorly psychologically. Warning signs can be unique for every patient and often they include symptoms such as sadness, anxiety, agitation, loneliness, insomnia, nightmares, ruminations and, of course, suicidal thoughts.

The agreement can also may specify steps that a patient can take to reduce negative emotions. Activities could include talking with friends, going for walks, listening to music, and so on. Preferable activities involve interactions with others or involve movement such as walking or traveling to a restaurant.

Finally, the safety plan should include crisis numbers to call if the emotion-disrupting

activities do not provide sufficient relief. It could include the number of a local crisis intervention agency, the number for the National Suicide Prevention Hotline (1-800-273-8255), and the number to reach their psychologist in time of crises. Going to an emergency room should be the last resort when other options have failed, or the patient has a medical issue that needs immediate attention.

Well-developed safety plans, however, are only effective if patients understand them and know how to use them. Safety plans will be remembered better if patients are involved in developing them and the patients and psychologists go over them together to ensure that the patient understands how to use them. When a patient participates in creating a safety plan, the patient is more likely to embrace and use it. We recommend against using prewritten or boilerplate safety plans. Such plans do not take into consideration the specific needs and interests of the patient and patients are unlikely to buy into them.

# 7) Do You Ask Patients How Likely They Are to Follow the Safety Plan?

It can be clinically indicated to ask patients, on a scale of 1 to 5, how likely they would be to follow through with the safety plan. This simple question gives patients and psychologists an opportunity to evaluate the quality of the plan. If a patient says that they believe that they are unlikely to follow through with the plan, then it becomes an opportunity to discuss the limitations of the plan and how to improve it.

Some patients may believe that the plan is fine, but they do not believe that they are worth saving or do not want to be a bother to their psychologist. One psychiatrist talks with patients about "the lies that depression tells" (William Hernz, M.D., personal communication). These lies can include a belief that the patient is a burden to others, including family, friends, and the psychologist. It can include the belief that the patient's life has no value, that the patient has failed in life, or that others don't want to be connected with them.

If patients do not believe they are worth saving, then it can be prudent to review the impact that their suicide will have on others. The average person who dies by suicide leaves 5 to 10 persons who are extremely hurt by the event. Some of the people who are hurt may

be unrelated to the patient. For example, a patient who dies by jumping in front of a train causes trauma to the train operator and others. Patients have told us that thinking about the pain they may cause to other people who are unrelated helped them remain alive. It may be worth informing or reminding patients that their suicide will increase the likelihood that other members of the family or other members of their social circle will die by suicide

A suicide will harm a family more than a death by other causes. When compared to families where a member died by natural causes, families where a patient died by suicide had poorer postmortem adjustment. They have worse mental health and physical health (Spillane et al., 2017). In addition to the grief of losing a loved one, they had to deal with the guilt that they might have missed an opportunity to save their loved one or had contributed to the decedent's suicide. In addition, the family must deal with the social stigma involved with suicides. One could imagine the neighbors saying to themselves, "What kind of husband (wife, father, mother, etc.) would allow their family member to become suicidal?"

# 8) Did You Make Treatment Expectations Explicit?

Perhaps the most common reason for treatment failure is the patient's failure to adhere to treatment. At the extreme it may mean failing to keep appointments, but it can also mean failing to complete home-work assignments, completing them haphazardly, or failing to engage fully in treatment.

It is prudent to address non-compliance issues as part of the informed consent process. Some of the issues to be addressed include the expectation that patients will keep appointments or reschedule missed appointments promptly, complete home-work assignments, and most importantly be open about their thoughts and feelings. If patients are not complying with treatment, then it is prudent to explore the reasons why. Noncompliance should be dealt with early in treatment.

Sometimes a patient's reasons for not completing homework may be legitimate. Years ago, I (SJK) had one patient who was noncompliant with completing homework assignments. I later learned that he was functionally illiterate and too embarrassed to tell me that. At other times noncompliance may occur because patients did not see the

connection between the assignment and their treatment goals, or perhaps they were too demoralized to see the value in completing the assignment. The initial reaction to noncompliance should not be to blame or shame the patient, but to use it to better understand the patient and, if necessary, to revise the intervention to make it more appropriate to their needs.

#### 9) Do You Monitor Patient Progress?

One of the goals of the initial assessment is to get a baseline of functioning. Monitoring progress means monitoring the overall progress in treatment and monitoring the risk of suicide. Often this is done by a simple question at each session, such as "Tell me the frequency, strength, and duration of the suicidal thoughts you have had in the last week (or since we last met)?" This is a better question than just, "Do you feel suicidal?" which only asks about their present suicidal thoughts and may not capture the suicidal thoughts that they have had in the last week.

Another option is to repeat the question asked on the intake, "On a scale of one to five (with five being the highest risk), what is the likelihood that you will kill yourself?" This question can be asked over a period of weeks and the psychologists will have a number to record in the record. One advantage of monitoring progress is that it gives patients a chance to see how much their suicidality is decreasing. If patients go through a period of demoralization, then their psychologists can show them the ratings over time and the overall trend toward improvement.

If the patient has especially strong suicidal thoughts or risk factors, it may be prudent to get sources of information other than the patient's self-report such as reports from the patient's family or loved ones. The progress of patients can be measured by a formal questionnaire. Psychotherapists might give their patients a simple questionnaire such as the Beck Depression Inventory at the start of treatment to get an objective score on their response to treatment.

Whatever method is used, we urge psychologists to be vigilant about monitoring progress. It is true that some patients get worse before they get better. However, early response is a good prognostic sign and a lack of early progress should be grounds for concern and a

reason to involve the patient in a reevaluation of the treatment plan.

# Question Ten: Are You Alert for Binary Thinking?

Like all-or-nothing thinking, binary thinking occurs when a patient believes that only two options exist in a given situation. Worse, one of the options may be unacceptable or may not be viable. If the other option is suicide, the patient has created his or her own trap. For example, if the patient says, "If the doctor can't cure my chronic pain, I will kill myself," then the patient creates a binary choice in which one choice is not viable, leaving suicide as the only remaining option. The same is true for the patient who says, "If my girlfriend breaks up with me, I will kill myself."

The way out of the trap is to work with the patient to generate a range of options. When we recognize binary thinking, we start by validating the patient's pain and the patient's perception of being trapped. We can then begin to ask questions to help the patient generate a range of options. For example, the patient may be asked what level of pain is tolerable. Then the psychologist can work with the patient to develop a better pain management plan, perhaps including the patient's physician in the process. In the second instance, the patient has limited control over his or her girlfriend's choice to remain in the relationship. But the psychologist can help the patient plan to talk with the girlfriend or recognize other important relationships and reasons for remaining alive.

## What Do These Ten Questions Have in Common?

Several themes emerge in the 10 questions that we have identified to improve the treatment of patients with suicidal thoughts. These questions attempt to increase the self-reflection of the psychologist, maximize patient involvement in treatment, and to make implicit assumptions about treatment explicit.

Psychologists can increase their self-reflection by asking themselves about their attitudes and feelings when working with patients who have suicidal thoughts. They can also use feedback on patient progress to reflect on the benefits of treatment and the need, if any, to modify treatment. Patient autonomy is increased by having patients involved in the treatment as much as possible by, for example,

helping create the safety plan and eliciting their opinions about their perceptions of their own risk of suicide, the likelihood that they would use the safety plan, and so on. A final theme is that the psychologist tries to be as transparent as possible concerning the steps involved in psychotherapy including importance of adhering to the treatment protocol. These perspectives are consistent over all ethical principles and have evidence to support their effectiveness.

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# School Shooters: Who Are They and How Can

**They Be Identified?** 

Peter Langman, PhD

Friday, March 8, 2019 8:30 AM - 4:00 PM

### Milton Hershey School - Purcell Friendship Hall

**Registration Cost: \$149.00** (Includes morning coffee, a copy of Dr. Langman's newest book, *School Shooters: Understanding High School, College, and Adult Perpetrators*, and lunch)

**6 Continuing Education Credits** 

#### School Shooters: Who Are They and How Can They Be Identified?

Ever since the attack at Columbine High School in 1999, school safety has been a national concern. The ongoing occurrence of school shootings is a critical issue for those in positions to assist with maintaining safety and well-being of those in school settings. Knowing the warning signs of impending violence is essential for identifying potential perpetrators before there is a mass attack. Best practices regarding threat assessment and the prevention of school shootings will be discussed. Special thanks to WellSpan Philhaven for support of our speaker and Milton Hershey School for hosting this event!

#### Who Should Attend?

This workshop is open to psychologists, educators, school administrators, public safety officers, mental health professionals and anyone who has an interest in the subject. All are welcome!

#### Speaker:

Dr. Peter Langman is a psychologist whose research on school shooters has received international recognition. His first book, *Why Kids Kill: Inside the Minds of School Shooters*, was named an Outstanding Academic Title. His work has been cited in congressional testimony on Capitol Hill and he has been interviewed by the New York Times, The Today Show, 20/20, Nightline, Fox, CNN, the BBC, and over 350 other news outlets in the USA, Canada, South America, Europe, Asia, Australia, and the Middle East. After the Sandy Hook attack, the CEO of the American Psychological Association presented Dr. Langman's recommendations on school safety to President Obama.

Registration is available online at www.papsy.org

#### **Agenda**

8:00 AM - Registration and Coffee

8:25 AM - Welcome and Introduction

8:30 AM - Misconceptions and Stereotypes

Three Psychological Types of Shooters

10:00 AM - BREAK

10:15 AM - Body-Related Issues and Damaged Masculinity

Social Failures and Their Impact

11:45 AM - Lunch

12:45 PM - Threat Assessment, Lessons Learned from Arapahoe High School

Leakage, Threats, Attack-Related Behavior

2:15 PM - BREAK

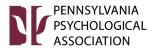
2:30 PM - Common Themes in School Shooters' Writings

Group Activity: Review Writing Samples

4:00 PM - Closing







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# A Psychologist's Journey to Understand Suicide

#### Brett E. Schur, Ph.D. Independent Practice, Bryn Mawr, PA

I've been practicing almost 30 years. Three of my patients have died by suicide. I've been told that I have a reputation for working with patients who have chronic suicidal ideation. That's not something I set out to do. Rather it feels like that part of the work has found me and followed me. In this article I describe the work I have done with a few patients who struggled with suicidal thoughts, including one who died by suicide. The lessons I learned along the way reflect the points in our companion article, *Ten Questions to Promote Excellence*. The themes in this article include:

- 1. Feelings about losing someone to suicide;
- 2. Alarmist and dismissive stances vs. concerned alertness;
- 3. The power of therapeutic relationship and maintaining boundaries;
- 4. Questions of self-disclosure;
- 5. Remaining alert for signs of a change in acuity of suicidal ideation;
- 6. The importance of collaboration and support; and
- 7. What it means to walk in the shoes of a patient.

#### Recognizing Our Feelings about Loss and Suicide

The journey began when I was 14 years old. I learned then that my father's death three years earlier was a suicide, not an auto accident or a heart attack as I had been told. I had been 10 years old; my parents were divorcing. My father's parents divorced when he was young, and he said he would never be a weekend father as his father had been. He told me he wanted to take me to another city and raise me (but not my younger siblings). But that was 1969 and there was little chance a father could get custody of a child. So instead he took me and ran away to Europe for three months. When he realized that was unsustainable, he brought me home to my mother, then took his life.

The feelings I had were complicated by the delay in learning the nature of my father's death. Initially, my feelings were about the loss. The details of his death weren't a factor, since I didn't have accurate information about it. It took a few years for me to realize that I was embarrassed. Although I certainly didn't have any feelings of responsibility for it, I also didn't want people to know about it.

Despite this, my life after my father's death worked out pretty well. I think this helped me through the later experience of loss when a patient died by suicide. It made it easier to go on working, because when someone dies by any means, our own journey continues.

#### On Becoming an Alarmist

As discussed in the companion article, when working with suicidal patients, one should avoid taking an alarmist stance, overreacting to every indication of suicidal risk. The other pole, a dismissive attitude, is just as problematic. The goal is to adopt a position of concerned alertness.

I had the experience of the alarmist stance during my first external training practicum. I was placed at an alcohol treatment facility in a small town about an hour away. One of our faculty worked part-time as the psychologist in the facility. On days when the psychologist was not on premises, I had responsibility to assess the mental status of newly admitted patients. If there was a question about safety, I was to call the psychologist and review my findings with him. Four times during the year, patients were admitted who had suicidal ideation and were unwilling to contract for safety. All four times, I recommended transfer to an inpatient psychiatric facility, which meant tying up a staff person for most of a day. The director of the facility became increasingly irritated. She was obligated to follow the psychologist's decision and my supervisor felt he had to back up his student. In retrospect, I doubt a skilled clinician would have hospitalized any of the four patients, but I understood that my job was to err on the side of safety.

#### Learning the Dismissive Stance

My graduate program had one course cross-listed with the law school and co-taught by a professor from the Psychology Department and the Law School. For the psychology students, the course was our ethics class. The Psychology professor introduced us to Thomas Szasz. He suggested that suicide is a rational decision which an individual has a right to make without interference. It was eye-opening to consider what it would mean to choose not to intervene with a patient who declared intent to die by suicide. Yet it was also a lesson in the limits of taking responsibility for another person's decisions.

#### Learning to Exercise Concerned alertness

I came to Philadelphia for a pre-doctoral internship at Temple University Hospital. On the first day of the internship, each intern was assigned a number of outpatients transferred from the previous intern class. One patient had been receiving services in the clinic for several years. Each year she became attached to her therapist and was upset when the therapist left. Each year, she had a suicide attempt in the late summer or early fall, just after her therapist left. This year was no different. Maggie<sup>1</sup> was admitted to the hospital with cardiac symptoms. She called me to say that she had taken an overdose of medication while she was in the hospital; she asked me to promise not to tell her other doctors. I told her that I was going to have to let her doctor know what she had done. There seemed to be clear ambivalence on her part. She was genuinely distressed with her difficult life, poverty and a husband who was both medically fragile and emotionally and physically abusive. On the other hand, Maggie valued the relationship with a therapist who cared and who listened non-judgmentally. So, the suicidal behavior was both an expression of her distress and a test of whether the new therapist cared.

<sup>1.</sup> All the patient names used in this article are pseudonyms.

# A PSYCHOLOGIST'S JOURNEY TO UNDERSTAND SUICIDE Continued from page 9

Other patients that year presented with suicidal ideation. Some presented a serious risk of suicide. A dismissive position wasn't going to work. But neither would an alarmist stance. In this year, I learned much more about using the therapeutic relationship in the service of the growing health of the patient. I helped Maggie prepare for the coming transition at the end of my internship year. There were other patients who struggled with suicidal ideation; one needed to be hospitalized involuntarily. And there were chances to help psychiatric residents learn about believing the trauma in their patients' histories.

#### **A Supportive Community**

Susan was a patient in a clinic where I was working part-time. She had grown up with a mother who was chronically suicidal. She described coming home from middle school, never knowing whether her mother had attempted suicide that day. Susan was unhappy in her marriage, but she felt trapped. As she became increasingly suicidal, I encouraged her to accept a voluntary hospital admission. She regretted it; it was humiliating and did nothing to help. But she hung in there with therapy. I was worried. I offered two, sometimes three sessions a week. It helped that I had a pretty good working relationship with her treating psychiatrist and I talked about her regularly in my peer consultation group. Eventually she left her marriage. Although she was glad she had left, her depression didn't improve. She complained about the stress in her job. I recommended that she take a medical leave of absence. There was some improvement in her depression. The most helpful thing about the leave of absence was hearing how much she had been missed and needed while she was out. But one stressful day at work, she threw her keys on the desk and walked out. Her boss had apparently had enough. She was told that leaving her keys and walking out constituted a resignation, which had not been her intent. A lawyer told her that her employer would likely win a legal challenge. With her permission, I spoke with human resources, asking that the "resignation" be turned into a disability leave. They refused.

Susan's suicidal ideation escalated with her unemployment. We were doing frequent, sometimes daily telephone check-ins. I had contact with her adult daughter (with permission), who was worried about her. There was an involuntary hospitalization. Initiating that meant driving to the crisis center, completing paperwork, waiting for the county advocate to approve it, then driving the signed documents to the police department. It did add to my sense of professionalism that the crisis center staff said that they tend to support a treating psychologist who knows a patient well. After that hospitalization, things didn't get any better. One day I started getting a series of increasingly frantic phone calls from her daughter. Susan was missing. Susan was found Monday morning. She had taken her life in the parking lot of the building where she had previously worked. It was likely that I was the last person she had spoken with, assuring me that she was safe during a Saturday telephone check-in.

I was stunned and I think I processed the loss a little bit at a time. I worried about mistakes I had made, especially about having been lax about boundaries with Susan. I found myself focusing on small details, like the fact that Susan died by the same means as my father. I found myself suddenly certain that I had told Susan about my father and that she had purposely chosen that method. In retrospect, I realize that I did

no such thing. I spent some time talking with her treating psychiatrist. I also got support from a peer in my consultation group, and from other colleagues. One colleague suggested that I speak with PPA staff person Sam Knapp. All these consultations were helpful.

Susan's story comes back to me at times, sometimes suddenly and unexpectedly. Last year, I was invited to participate on a panel of psychologists who have lost a patient to suicide. The panel organizer encouraged me to tie my experience with Susan to the loss of my father. Despite preparatory discussions, I was flooded with sadness during the actual presentation.

#### **Heeding A Message**

I worked with Diane for about 2½ years. She was a young doctoral candidate who was disabled with a painful medical condition. She was also chronically depressed with periods of suicidal ideation. She had numerous psychiatric hospital admissions, always voluntary, as she tried to find the cocktail of medications which would bring her relief.

As Diane's medical condition became worse and her pain became more intractable, her suicidal ideation became more chronic. A student of philosophy, she wanted me to affirm that sometimes a decision to die is a rational choice. I was reluctant to do so, afraid of where such a discussion might lead. But Diane always denied imminent intent to harm herself and I didn't see her as having acquired capability. (I hadn't heard that as a named concept yet.) Further, when things got bad, Diane sought hospitalization, searching for relief rather than escape.

One day I picked up a phone message, "Please tell my parents I'm sorry." No name, no caller ID, and the voice was faint, but I thought it was Diane. It was the middle of the afternoon and I had a couple more appointments. I wasn't sure what to do. During a break, I called a colleague, who offered only ambiguous guidance. I was distracted but finished two appointments. I probably shouldn't have. I drove to her home. Her car was there, the lights were out, and no one answered the door. I called the police department's non-emergency number. The dispatcher suggested that an officer could be dispatched for a "wellcheck." The police officer who responded was a kind man, probably in his 50s. He seemed comfortable dealing with a psychiatric emergency. He banged on the door and walked around the house. No response. We discussed our options. He could force the door. If she was home, it would be a good thing. If she wasn't, we would have egg on our faces and there would be damage to repair. He got the landlord's contact information from the Township Building, but the landlord couldn't be reached. I asked what would happen if I told him I believed the patient was suicidal. He told me that if I said those words, he would be forced to enter the house. We looked around again. It was dark by this time. As he shined his flashlight into the living room, the cat jumped up to investigate, pushing back the curtain enough to see the keys on the table, confirming that Diane as home. The police officer said that the fire department had a new tool which would allow entry with minimal damage. Unfortunately, it was fire department policy that every call was answered in force. Three fire trucks showed up in full emergency mode for a job that could have been done quietly by one person. Now all the neighbors were watching. The door was opened, and the officer entered the house, instructing me to wait outside. Diane was inside, unconscious, with empty pill bottles by her bedside.

I called Diane's parents to let them know she was in ICU. I also called

her primary care physician. The physician was stunned. She had seen Diane that day and Diane's depression seemed better. She gave no indication of being suicidal. In fact, Diane had asked for and received a flu shot about two hours before she took a nearly fatal overdose of pain and anxiolytic medication. It took a week or so for Diane to recover medically. She moved away shortly after that, and after a couple of years she was married to a man who had been a friend for many years. She sent me Christmas cards with updates for several years. She said that she had found happiness, in spite of her pain. It also seemed that she had also found more effective treatment for her pain.

#### **Permission To Die**

Sally was in her 40s. She described a history of repeated childhood abuse, including sexual abuse by a treating pediatrician. She selfinjured in ways that seemed to recreate her childhood abuse. She was chronically suicidal and skilled at engaging a therapist in directions that weren't helpful. Sally believed that she was bad, a quality she believed to be inherent in every cell of her body, just like being female exists in every cell of the body. I got drawn into debates about what it means to be bad, whether being bad was relative or absolute and whether it was remediable. She had a career in the medical field, was well respected in her hospital and was responsible for saving many lives. But that didn't change her belief that she was bad. It seemed like therapy was going nowhere. There was a period when Sally's suicidal thoughts rose to a crisis level. She called me one day and it seemed clear she intended to end her life. I called the crisis center nearest her home. They informed me there was nothing they or I could do, since the phone call from Sally had been across state lines. They suggested that if Sally repeated her suicidal statements in my office, then I would be able to act here in Pennsylvania.

My next appointment with Sally was three days later. We had daily phone contact in the interim. I was not reassured by the phone calls. Sally was scheduled for an evening appointment. I called the local police department serving my office and let them know that I had a potential emergency brewing. Sally came to the appointment and it was clear she intended to die. She asked me repeatedly to tell her it was okay for her to die. She refused voluntary hospitalization. She pleaded her case that sometimes emotional pain is too great to endure. She grew frustrated that I wouldn't give her my blessing to end her life. It was especially frightening that Sally intended to kill herself by driving her small car into a much larger oncoming vehicle, in the belief that she would die, and the other driver would be uninjured.

The second office in my suite was vacant but furnished. Sometimes Sally used the room when she didn't feel safe to leave at the end of an appointment. I let her into the spare office and without tipping my hand, I called the police. She was transported to the crisis center. I followed in my car to complete an affidavit for an evaluation for involuntary hospitalization. Sally was interviewed by the Crisis Center psychiatrist and released that night, having convinced him that she was not imminently suicidal. When I next saw Sally, she admitted that she had in fact intended to kill herself that night. She said that she understood why I took the action I had, but she was hurt and angry that I had been distant and unsupportive once the police arrived. I explained that I was trying to stay out of the way and not interfere with the police. And I hadn't seen her in the crisis center because I didn't think that was permitted. Sally saw

me a couple more times, but it was clear that she had disengaged. She stopped scheduling appointments and didn't respond to phone calls.

One of the dangers of making the choice to seek involuntary hospitalization for patients is that they will be so angry that they will not return to treatment. Sally had dropped out of treatment, in contrast to Susan who was angry but continued in treatment. The therapeutic alliance with Susan was sufficient to carry us through the crisis of hospitalization. The outcome was different with Sally.

#### Self-disclosure in Psychotherapy

A therapist should be cautious about self-disclosure in therapy. Selfdisclosure should always be in the service of the therapy and should not occur when doing so detracts from the therapy or makes the therapy more about the therapist than about the patient. I met Brandon about a year after he returned from his last deployment to Iraq. He was having flashbacks and he was angry too often. His marriage was shaky, and he couldn't connect with a teenage stepson who was far from following Brandon's warrior model. From the outset he questioned how therapy could help and whether he should even be talking about such things with an outsider who had never served. In the first session, Brandon talked about how lost he had been after his father's suicide and how it had contributed to his journey to becoming a warrior. I made the decision at the end of the first session to disclose my own father's death by suicide at about the same age that Brandon's father had died. When Brandon returned, he told me that my disclosure was key to his decision to give therapy a try. Up to that point, he was convinced that I could never understand his experience and that I would never be able to connect with him. We went on to work together off and on for a few vears.

#### Lessons Learned

Some of these experiences have touched me more deeply than others. It has indeed been a journey of learning, and of understanding. The deepest understanding has been about my own reactions and my own emotions. Along with that has been a deepening understanding of the lives, experiences, and feelings of those I sit with in the therapy office.

When I look, back, what I tend to see is my lack of skill. But when I share these experiences with colleagues, they see the lack of guidance I had available to me, and the ways I have incorporated what I learned into my daily practice. I am embarrassed by the poor boundaries early on. I heard many times that I was good with chronically suicidal people and that some community referral sources directed such patients to me. That was something I didn't want to hear, although I was also proud of it. In retrospect, much of what I was doing was consistent with the principals of the recovery movement and of the Interpersonal Theory for managing suicidal patients.

Key lessons have been about the importance of the therapeutic alliance, especially when a patient has thoughts of suicide. I have learned that the therapeutic alliance is helped, not harmed by maintaining firm and gentle boundaries. I have learned that alarmist behavior doesn't keep patients alive any more than being dismissive of a patient's distress and risk-level. I have refined my skills in maintaining concerned alertness.

I also learned about the dangers of making the decision to seek

## A PSYCHOLOGIST'S JOURNEY TO UNDERSTAND SUICIDE Continued from page 11

involuntary hospitalization. Some patients will be angry but will return to therapy to work through the disruption to the therapeutic relationship. For others, like Sally, the relationship is beyond repair.

Most importantly, I have learned how little control we have over the decisions our patients make. We can be persistent and plant seeds of hope for change and a better life. However, we cannot prevent all suicides. Sometimes, our patients will act on their need to escape pain and discomfort. The best we can do is to be present for them and apply our knowledge and our skills to minimize risk.

#### Sharing my Learning

I worked for a few years in a residential treatment center. That was both an opportunity for more training (a broader introduction to the skills training component of Dialectical Behavioral Therapy, for example), and a chance to see that I was in fact skilled in this area. Suicidal crises were common in this program which treated the most intensely high-risk patients, and in fact there were deaths. Past experiences with patients

who struggle with suicidal ideation helped me to sit with patients as they struggled with their traumas, sense of being trapped, and wish for escape by any means. Part of my role in the facility was to help case managers and other staff to learn to work with such high-risk patients, and to help them cope when a suicide attempt or a death occurred. I shared my own experiences and offered consultation about boundaries, about the central role of the therapeutic alliance in preventing suicide, and about concerned alertness versus the polar stances of alarmist and dismissive attitudes.

In the past couple of years, I have become more active in PPA leadership. As I described above, I had the opportunity to share some of my experiences and the lessons learned as a member of a panel at the 2018 Annual PPA Convention. More recently, I have had the opportunity to co-present some of these lessons with Dr. Sam Knapp, who had helped me through the aftermath of a client suicide 18 years earlier. I will continue to share my learning, to help colleagues, including younger psychologists learn lessons that will increase the chances a patient with suicidal ideation will live, avoid some of the pitfalls, and perhaps learn from my mistakes and my successes. I will continue to share what I have learned because none of us can do this work alone.

# In Memoriam Dr. Kimberly (Kim) Castner

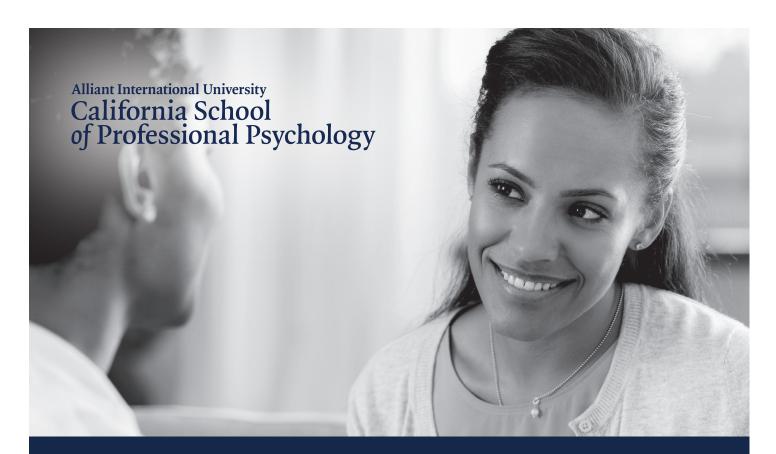
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December 26, 2018

https://www.legacy.com/obituaries/pottsmerc/obituary.aspx?n=kimberly-castner&pid=191191372

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**Learning objectives:** The articles in this issue will enable readers to (a) assess and explain current issues in professional psychology and (b) describe and act on new developments in Pennsylvania that affect the provision of psychological servicess.

1.	About	of Americans	have k	nown	someone	who
	has died from suicide.					
	a. 10%					
	b 30%					

- c. 50%
- d. 70%

- 2. The term acquired capability refers to
  - a. The acquired ability of psychologists to help patients who have thoughts of suicide
  - b. The gradual habituation of patients to pain and a reduction of their fear of death
  - c. The capabilities of reducing suicidal thoughts that patients acquire over the course of the treatment
- 3. Which statement best represents the attitudes of the authors toward patients who have thoughts of suicide?
  - a. The patient ultimately makes the decision whether to live or die
  - b. The psychologist ultimately makes the decision whether the patient will live or die
  - c. The decision to live or die is best made by qualified ethicists who consider different philosophical traditions
  - d. The family's role in determining whether the patient should live or die has historically been overemphasized
- Most malpractice suits following a patient suicide occur when the patient was treated in an in-patient facility.
   True
   False
- 5. A psychologist who thinks, "if this patient were suicidal, she would have already killed herself" is likely adopting an attitude called \_\_\_\_\_\_
  - a. dismissive
  - b. alarmist
  - c. concerned alertness
- 6. About \_\_\_\_\_ of patients who died from suicide had denied suicidal ideation in their last appointment with a health care professional.
  - a. 25%
  - b. 50%
  - c. 75%
  - d. 90%
- 7. Patients who have suicidal thoughts, but deny them, may do so because they
  - a. Feel ashamed of the thoughts
  - b. Do not believe treatment can help
  - c. Believe that thoughts of suicide are a sign of weakness
  - d. All of the above

8. When patients have plans to use a gun to kill themselves, it does no good to remove access to the gun, because the patients will only find other ways to kill themselves.

True

False

- 9. Effective safety plans for patients with suicidal thoughts may include
  - a. A list of warning signs
  - b. A set of activities that are likely to reduce negative emotions
  - c. Phone numbers to call in the event of a crisis
  - d. All the above
- 10. Monitoring suicide risk could involve
  - a. Asking patients at every session about their suicidality
  - b. Soliciting perspectives from friends and family members
  - c. Having patients take a brief screening instrument concerning suicidality
  - d. All the above

11. Patients who respond well early in treatment tend to have better outcomes

True

False

- 12. Many of the questions about suicide have a common theme of
  - a. Giving the highest priority to the professional wisdom of the psychologist
  - b. Involving patients in the decision making as much as clinically indicated
  - c. Strictly enforcing safety plans, whether or not the patient agrees to them
  - d. Protecting patient confidentiality at all cost



## **Continuing Education Answer Sheet**

The Pennsylvania Psychologist, February 2019

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
- 4r. I F
- 5. a b c d
- **6.** a b c o
- 7. a b c d
- **8.** T F **9.** a b c
- **10.** a b c c
- **11.** T F
- **12.** a b c d

#### **Satisfaction Rating**

Overall, I found this issue of the Pennsylvania Psychologist:

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 \_\_\_

Please print clearly.

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# 2019 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2018, we are looking to expand these options—we hope you'll join us for one or more of these programs!

#### Calendar

The following programs are being offered either through cosponsorship or solely by PPA.

#### February 11-12, 2019

PBI - Parenting Coordination Trainings Philadelphia, Mechanicsburg, Pittsburgh, Webcast

#### March 8, 2019

Preventing School Shootings Milton Hershey School Hershey, PA

#### April 4-5, 2019

PPA Spring Continuing Education Conference Holiday Inn Grantville Grantville, PA

#### April 6, 2019

PPA's Day of Self-Reflection Holiday Inn Grantville Grantville, PA

#### April 6, 2019

ECP Day Holiday Inn Grantville Grantville, PA

#### June 19-22, 2019

PPA2019 - PPA's Annual Convention Sheraton Station Square Pittsburgh, PA



## Home Study CE Courses

#### **Act 74 CE Programs**

Older Adults at Risk to Die From Suicide: Assessment Management and Treatment—1 CE

Assessment, Management, and Treatment of Suicidal Patients (Extended)–3 CEs

Essential Competencies When Working with Suicidal Patients—1 CE

Patients at Risk to Die From Suicide: Assessment, Management, and Intervention (Webinar)–1 CE

#### **Act 31 CE Programs**

Pennsylvania Child Abuse Recognition and Reporting—3 CE Version

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

#### General

Record Keeping for Psychologists in Pennsylvania—1 CE Introduction to Telepsychology, Part 1, 2, and 3 (Webinar)—1 CE each

Introduction to Ethical Decision Making\*–3 CEs

Competence, Advertising, Informed Consent, and Other Professional Issues\*–3 CEs

The New Confidentiality 2018\*-3 CEs

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

For a full listing of our home studies, download our catalog here, or visit our online store.



For CE programs sponsored by the Pennsylvania Psychological Association, visit papsy.org.

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