3

An Overview of the Treatment Process

When faced with a suicidal patient, the practicing clinician is often left wondering, "What exactly do I do with this patient? How frequently, in what manner, and in what order do I address the myriad presenting problems? What symptoms do I target, and for how long?" Building on the empirical findings reviewed in Chapter 1 and the theoretical foundation provided in Chapter 2, this chapter offers an organizational framework to assist in the weighty task of treating suicidal patients. We have four goals for this chapter. First, we want to provide a clinically accessible summary of treatment tasks (i.e., the *content* of therapy) consistent with existing standards of care and supported by empirical findings. Second, we offer an organizational framework for treatment planning, one that incorporates the various treatment tasks discussed in Chapter 2 and complements the conceptual model offered. Third, we emphasize the varied roles, tasks, demands, and potential limitations of psychotherapy with suicidal patients. And finally, we discuss the complicating role of time and chronicity in treatment planning. Our treatment approach is cognitive-behavioral in the truest sense: cognitive restructuring and skill building go hand in hand. One cannot be done without the other. Skill building is simply a series of behavioral experiments, each providing a critical opportunity for cognitive restructuring and lasting change. Accordingly, the treatment agenda includes a range of cognitive *and* behavioral tasks.

This chapter provides a flexible, comprehensive, and thorough *template* for treatment planning, clinical risk assessment, patient management, and on-

going monitoring. Although the framework offered is most consistent with the theoretical model reviewed in Chapter 2, it is flexible enough to be applied to other theoretical orientations. This is a function of its focus on concrete treatment tasks, as well as the inherent flexibility of cognitive-behavioral theory (e.g., Alford & Beck, 1997). Consistent with the discussion of emerging trends in psychotherapy integration offered by Norcross (1997), the integrative approach described is organized around identifiable problem areas, treatment goals, and related tasks that are uniform across suicidal patients, irrespective of diagnosis (both Axis I and II) and specific symptomatic presentation.

Completing the Clinical Picture: Understanding Severity, Chronicity, and Diagnostic Complexity

Inordinate time constraints in time-limited care demand structure and organization in the treatment process, in planning, in day-to-day application, and in monitoring outcome. In Chapter 2, we discussed six fundamental questions about the patient's suicidality that enable us to articulate the suicidal mode. We wanted to know about the patient's history (i.e., predisposing vulnerabilities), stressors that may have precipitated the suicidal crisis (i.e., triggers), the nature of suicidal thinking (i.e., suicidal belief system), feelings (i.e., affective system), physical symptoms (i.e., physiological system), and suicide-related behaviors (i.e., behavioral system). To complete the treatment planning process, it is critical to think about and be able to answer a few additional probing clinical questions. There are three primary features of the patient's presentation: (1) severity, (2) chronicity, and (3) diagnostic complexity. These characteristic features influence treatment goals, how they are organized and targeted (e.g., what is addressed first, second, third and how much time is devoted to each), and determine the actual duration of treatment itself. The additional questions we need to consider include the following:

- *What is the relative severity of dysfunction or disturbance evidenced by the patient*? In other words, can he or she be managed in outpatient psychotherapy or is a more intensive intervention required first such as hospitalization or day treatment? Is the immediate risk for suicide too high to allow for outpatient treatment? If the patient is at high risk but can be treated on an outpatient basis, do special considerations need to be made such as daily monitoring or a *suicide watch* at home?
- *How chronic is the disturbance? That is, how long has the patient been struggling with suicidality?* How many suicide attempts has he or she made, if any? In other words, we want to make sure we distinguish between ideators, single attempters, and multiple attempters.

- *How complex a behavioral picture is presented?* Is the suicidality compounded by other self-destructive and self-defeating behaviors (e.g., self-mutilation, substance abuse, aggressiveness, and sexual acting out) that will also need to be targeted?
- *How complex is the diagnostic picture presented by the patient in terms of both Axis I and Axis II comorbidity?* In all likelihood, the more complex the behavioral picture, the more complex the diagnostic picture and vice versa.
- *What are the associated domains (i.e., nature) of disturbance?* That is, how is the patient actually impaired? What symptoms, deficient skills, and/or maladaptive personality traits are present?

Depending on the answers to these questions and the patient's suicidal mode, we can start to organize the treatment agenda and determine what goals are important and reasonable within a time-limited framework. From the outset, however, it is critical to recognize that those with severe, complex, and chronic suicidality will most likely require longer-term care. Although the treatment agenda will be the same, it will simply take longer. The duration of care, in most cases, will be complicated by frequent relapses and recurrent crises for those evidencing chronic suicidality. The same organizational framework can be applied but the patient's progression through the various levels of treatment will be slower. As discussed in later chapters, this is a part of the informed consent process that needs to be emphasized when treatment goals are identified, expectations created, and a prospective time line established. This is particularly important for the patient, but it is also an issue for insurance carriers and managed care entities.

Identifying Treatment Components

In accordance with the recent trend in psychotherapy (e.g., Layden, Newman, Freeman, & Morse, 1993; Lerner & Clum, 1990; Linehan, 1993; Linehan et al., 1991; Rudd, Rajab, et al., 1996), suicidality can be viewed as a general construct (see Figure 3.1), with three discernible *domains,* components, or visible manifestations of psychopathology consistent with lower-order factors:

1. Symptoms (i.e., depression, anxiety, hopelessness, suicidal ideation, anger, guilt, panic, etc.).
2. Identifiable skill deficits (i.e., problem solving, emotion regulation, distress tolerance, interpersonal skills, and anger management).
3. Maladaptive personality traits (i.e., consistent with personality disorders as defined by DSM-IV and influencing both self-image and the nature of interpersonal relationships with family and friends).

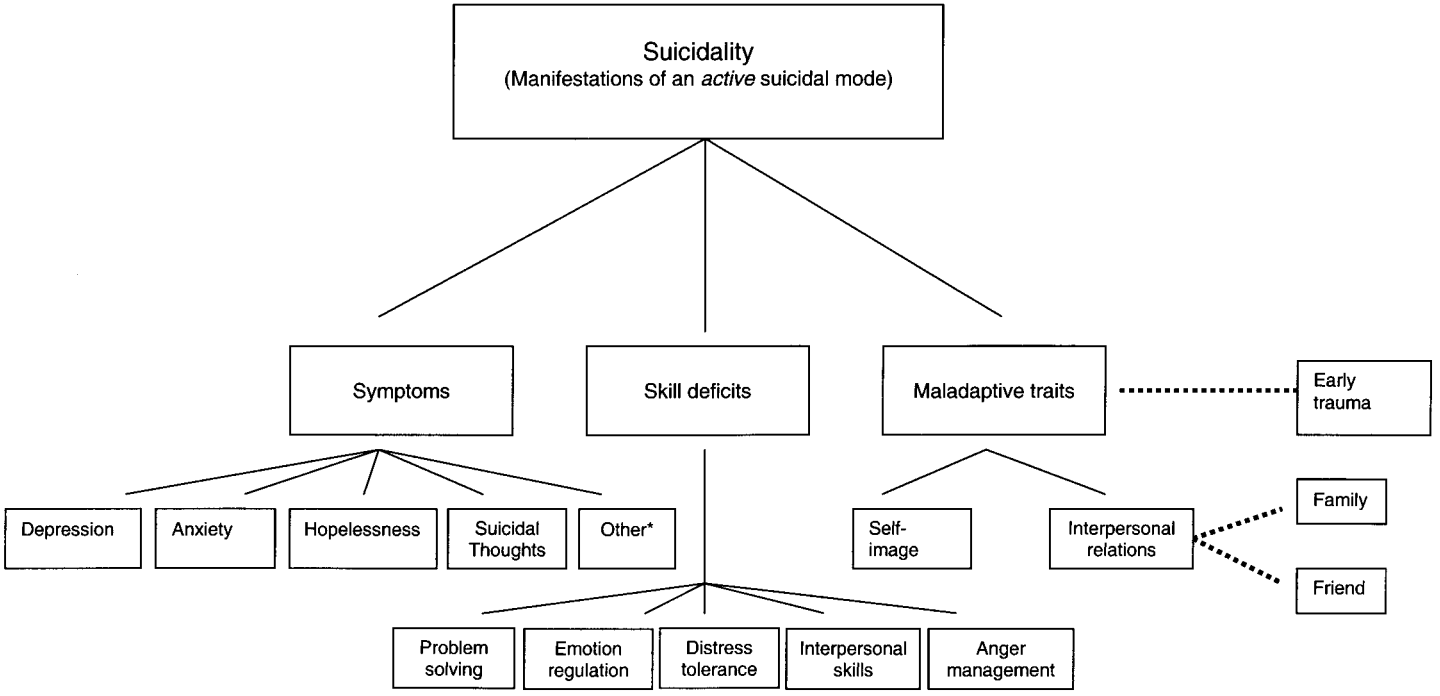

FIGURE 3.1. Conceptualizing dysfunction in suicidality: Higher- and lower-order factors. *Includes guilt, panic, shame, anger, anhedonia, attention/concentration impairment, helplessness, substance abuse, sense of immediacy and urgency, and related behavioral problems such as attempts, self-mutilatory behaviors, high-risk behaviors.

Most traditional treatment approaches have focused on symptoms and personality traits, often struggling to integrate the role of deficient skills in a theoretically coherent manner. The most recent approaches have differed, however, emphasizing the three component parts noted previously (e.g., Linehan, 1993; Rudd, Rajab, et al., 1996). These three domains are the essence of what is targeted via psychotherapy, comprising the *content of treatment.* Consistent with the notion of the suicidal mode, each domain is the observable consequence of an *active mode.*

The emergence of managed care entities in the mental health landscape mandate shorter-term, targeted, and symptom-focused treatment. The suicide-specific approaches that have emerged over the last decade are empirically grounded, with identifiable and quantifiable treatment targets. As a result, they are more easily adapted for short-term treatment. Shorter-term and symptom-focused treatment does not, by any means, suggest less effective treatment. As is evident in our previous discussion of the suicidal mode and the interactive and interdependent nature of the modal systems, the more superficial symptoms are related to associated skill deficits and underlying core personality disturbance. All are a part of an active suicidal mode and targeted to some degree during the course of treatment, regardless of duration, and most often in simultaneous fashion. As is apparent from several of the studies reviewed in Chapter 1, brief treatment *can and does* having lasting impact. The end result is, ideally, more efficient and effective treatment and a more precise understanding and measurement of treatment outcome, both in terms of direct and indirect markers of suicidality (see Chapter 4 for a detailed discussion of direct and indirect markers of suicidality). As noted previously, however, those evidencing severe, complex, and chronic suicidality will require longer-term care. One of the benefits of using the treatment-planning framework offered is that it makes it easier to negotiate with insurance companies for additional sessions. Clinicians will be able to discuss in clear and concrete terms what *has and has not* been accomplished in treatment. They will be able to offer a coherent explanation as to why treatment is going to take considerably longer, that is, that the patient's problems are the result of a complex and chronic diagnostic picture compounded by recurrent, severe episodes of suicidality. In essence, the suicidal mode is more active, stable, and easily accessible.

The content of treatment is more readily *accessible* and *quantifiable* as a result of these suicide-specific approaches (as illustrated in Figure 3.1). We can discuss more clearly and cogently what we are actually doing in therapy, what we are working on specifically, and the types of change we expect to occur. We can articulate where we are in the treatment process (i.e., what *component(s)* of treatment we are targeting). We can also monitor and measure this change over time. As discussed later, this conceptualization has led to the

identification of treatment tasks that provide a foundation for psychotherapeutic integration and a coherent organizational framework for the treatment of suicidality in a managed care environment.

An Overview of the Goals for Each Treatment Component

As summarized previously, empirically based approaches have incorporated three *treatment components* that target (1) symptoms, (2) deficient skills, and (3) maladaptive personality traits. Couched within the theoretical model of the suicidal mode, these three components form the foundation of our treatment approach (see Figure 3.4 for a summary). In other words, the patient's symptoms, deficient skills, and maladaptive traits are the observable consequences of the active suicidal mode, as well as the facilitating modes during periods in which the suicidal mode is inactive. The general goal is not just to deactivate the suicidal mode but to help the patient develop more adaptive modes, making it much more difficult to activate or trigger the suicidal mode in the future. That is, we want to raise the patient's threshold for becoming suicidal. When the patient is no longer highly symptomatic, is making use of improved skills, is more hopeful about the future, has a restructured suicidal belief system, has an improved self-image, and is functioning better in relationships, a new and more adaptive mode has been developed. Adaptive modes need to be accessible during periods of acute stress and crisis. Although each treatment component cuts across multiple systems of the suicidal mode, each has discrete, identifiable goals along with specific treatment targets. As discussed in more detail later, each treatment component is addressed *simultaneously*, with varying degrees of time and intensity depending on the specifics of the clinical situation.

Goals for Symptom Management

The goals for the symptom management component, focus specifically on acute symptomatology and immediate day-to-day functioning. Among the goals are the following:

- Resolve any immediate crisis.
- Reduce suicidality, including diffusing suicidal thoughts and related behaviors.
- Instill a sense of hopefulness regarding both the immediate future and the treatment process.
- Reduce overall symptomatology.

Goals for Skill Building

Goals for the skill-building component revolve around skill identification, development, and refinement. The task, for the most part, is to identify the patient's current level of functioning, associated skill level, and deficient areas to target and to pursue accordingly. Among the goals are the following:

- Identify current skill level across targeted areas of problem solving, emotion regulation, self-monitoring, distress tolerance (i.e., impulsivity), interpersonal assertiveness, and anger management.
- Improve the patient's general level of functioning, that is, return to premorbid level or better.
- Help the patient develop and refine basic skills in the areas identified as deficient.

Goals for Personality Development

The goals for the personality development component are much broader in focus and, accordingly, are likely to be longer term. Specifically, the goals target three areas: self-image disturbance, developmental trauma, and interpersonal functioning including relationships with family and friends. This component targets more enduring psychopathology, and, naturally, it will be a particularly important aspect of treatment for those evidencing chronic suicidality. Among the goals are the following:

- Improve the patient's overall self-image and sense of esteem (e.g., address persistent sense of self-loathing, guilt, shame, hatred, inadequacy, or incompetence).
- Help the patient resolve internal conflicts, developmental trauma, and underlying *core* issues (e.g., early sexual, emotional, or physical abuse).
- Help the patient improve the quality and nature of his or her interpersonal relationships, including those with both family and friends (e.g., improved intimacy as well as accessibility and quality of support).

An Overview of the Steps in Treatment Planning

As illustrated in Figure 3.2, treatment planning can be summarized in five sequential steps. These steps are straightforward and relatively simple. The first step is to complete the initial interview(s) and related history. As a part of this process, initial risk assessment ratings and diagnoses are determined (see Chapters 4 and 5, this volume, for a detailed discussion of each). The second

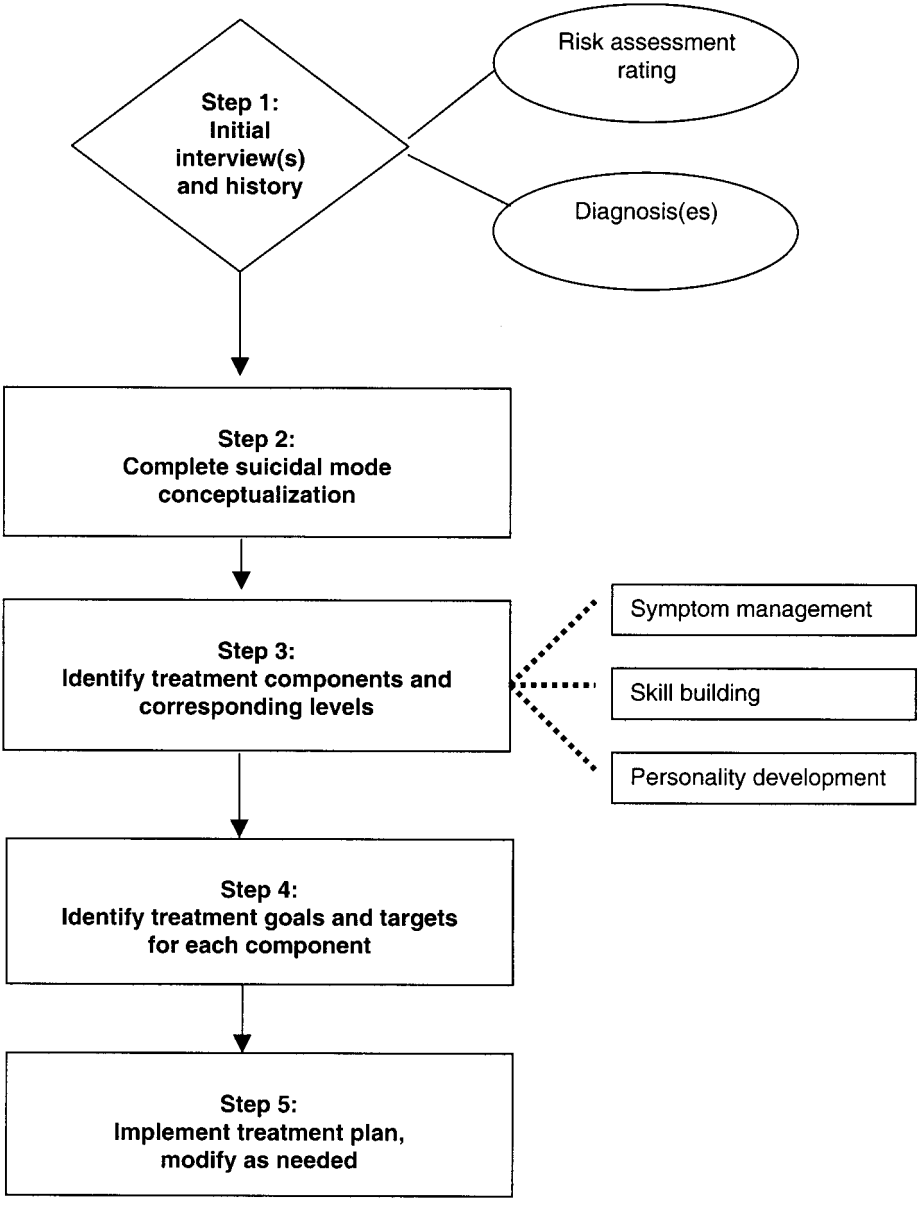

FIGURE 3.2. Treatment planning flowchart.

step is to complete the suicidal mode as reviewed in Chapter 2. This will probably require several interviews. Its completion will assist the clinician in accomplishing step 3: identifying treatment components and assigning corresponding levels, depending on the severity, complexity, and chronicity of the patient's presentation. The next section covers the method for identification and assignment. Once the levels for each treatment component are designated, the corresponding treatment goals and targets in step 4 can be identified using Figure 3.4. Finally, in step 5, the treatment plan is implemented and modified as the patient progresses through the various levels of each treatment component.

The rest of this chapter discusses how to designate levels for each treatment component (step 3), as well as to identify associated goals and corresponding treatment targets (step 4). Later chapters address specific clinical techniques for implementing each component.

Understanding the Treatment Process: Treatment Components and Corresponding Levels

Figure 3.3 summarizes the treatment process. It provides a matrix of treatment components and corresponding levels. As illustrated, the treatment process incorporates three components: (1) symptom management, (2) skill building, and (3) personality development. In addition, each component has corresponding *levels*, indicative of treatment progress within the particular targeted area. The variations in component levels represent therapeutic and individual change and growth over time. Not all suicidal crises are identical. Although Slaikeu (1990) defined crisis as "a temporary state of upset and disorganization, characterized chiefly by an individual's inability to cope with a particular situation using customary methods of problem-solving" (p. 15), the recurrent

	Component:		
Level	**Symptom management**	**Skill building**	**Personality development**
I	Stabilization	Skill acquisition	Personality stabilization
II	Self-management	Skill refinement	Personality modification
III	Utilization	Skill generalization	Personality refinement

FIGURE 3.3. Matrix of treatment components and corresponding levels.

crises experienced by suicidal patient's vary in nature and quality over time. Nor is skill development or enduring personality change in psychotherapy by any means a uniform process. Patients can and will be at varying levels for each component.

Defining the Component Levels

The levels for each of the components are defined as follows:

Symptom Management Component

Level I—symptom management—is characterized by the need for *external* stabilization, that is, direct intervention on the part of the mental health professional (e.g., phone calls, emergency session(s), and hospitalization). Level II—symptom self-management—is characterized by improved skill level on the part of the patient so that direct intervention is no longer necessary, despite acute emotional upset and dysphoria. Level III—symptom utilization—is characterized by effective management of the crisis on the part of the patient but it is coupled with utilization of the crisis for personal growth and change (e.g., recognition and modification of a specific personality trait or identifiable skill deficit).

Skill Building Component

Level I—skill acquisition—is characterized by early experimentation with a new skill. Level II—skill refinement—is characterized by consistent use of the skill and refinement across specific, targeted circumstances (e.g., assertiveness with a specific person in a specific setting such as one's partner or spouse). Level III—skill generalization—is characterized by consistent use (i.e., planned and unplanned) of a skill and application across a broad range of circumstances (e.g., interpersonal assertiveness at home, work, and related settings).

Personality Development Component

Level I—personality stabilization—is characterized by initial skill acquisition that provides for an improved level of day-to-day functioning, with elimination of extreme suicidal, self-mutilatory, and self-destructive behaviors. Level II—personality modification—is characterized by identification and targeting of specific maladaptive traits (e.g., passive-aggressiveness, dependency, avoidance). Level III—personality refinement—is accomplished in concert with crisis utilization and skill generalization. That is, the patient has experi-

enced some basic changes and is making use of available opportunities to further refine and generalize skills, with enhancement of overall level of day-to-day functioning.

The identification of *components* and *levels* in the treatment process provides necessary structure to the organization of assessment and therapeutic tasks. That is, if the clinician knows a given patient's level for each component, the clinician will know what is being targeted in treatment and what is actually happening from session to session. Take, for example, Level I of the symptom management component. At this level, patients are incapable of self-management. The majority of session time will likely be spent on crisis and symptom management, but treatment will also focus on developing the patient's own basic crisis skills, including self-management. This means that the patient is also working on skill acquisition (skill building component, Level I) and initial personality stabilization (personality development component, Level I). Each component is addressed simultaneously. Given the time constraints of treatment, though, one component will consume more time and energy than the others, depending on the specific clinical context. In the example provided previously, the primary focus would be on crisis stabilization, the secondary focus on skill acquisition, and the tertiary focus on personality stabilization. Take, for example, the following sequence in a series of sessions for a patient with a mild, acute episode of suicidality:

- *Session 1:* The patient presents in acute crisis following a squabble with his wife. He is dysphoric, anxious, and experiencing specific suicidal thoughts. The bulk of the session will address the crisis component of treatment, perhaps the entirety of the session. An effort will be made to reduce the patient's manifest anxiety and diffuse the crisis overlay. To some degree, however, skill building will be emphasized (e.g., improving distress tolerance through activity scheduling such as exercise, relaxation training, or listening to music or problem-solving targeting the marital dispute) along with personality development (i.e., allowing for initial skill acquisition to improve day-to-day functioning).
- *Session 2 (the following week):* The patient is no longer acutely dysphoric. The specific suicidal thoughts have subsided. He is, however, continuing to have nonspecific morbid ruminations, as well as a mixture of depressive and anxiety symptoms. Although symptom management will continue to be important, the focus of the session is likely to shift to skill building and, to a lesser degree, personality development.

Using the matrix of treatment components and levels, the clinician can describe in concrete terms where a patient is in the treatment process, exactly what he or she is working on in terms of corresponding treatment targets

(across each component), and what goals lay ahead. This approach is somewhat similar to the use of grade equivalents in identifying reading ability. For example, an eighth-grade level in reading, communicates succinctly whether the child is at the expected level of performance depending on age and education and, if not, the observable deficit. The individual would have a separate grade equivalent for each component of the academic curriculum, be it math, reading, or spelling. Similarly, the patient will have a separate level for each of the three targeted components including symptom management, skill building, and personality development.

In addition, the matrix of treatment components and levels provides a means of communicating this information to other providers and insurance carriers. For example, if we describe a patient as having moved to Level III (utilization) of the symptom management component, Level II of the skill building component, and Level II of the and personality development component, then we know that he or she has:

1. Achieved symptom relief and resolution (e.g., is no longer severely depressed, anxious, angry, hopeless, or actively suicidal). In addition, we communicate that if, in fact, another suicidal crisis does emerge, he or she is capable of effectively managing the crisis without formal intervention of any type.
2. Acquired and can implement a number of new skills (e.g., problem solving, emotion regulation, improved distress tolerance, better interpersonal skills, and more effective anger management) across several targeted circumstances.
3. Modified any number of long-standing maladaptive personality traits (e.g., passive–aggressiveness), improved his or her overall self-image, is more hopeful about the future, and likely resolved some early developmental conflicts that have worked to complicate interpersonal relationships.
4. Made fundamental changes in the identified suicidal belief system (i.e., the notion of cognitive restructuring covered in detail in Chapter 9), a change deemed central to lasting change in the suicidal mode.

Symptom Management Component

Although others have discussed the role of crises in the treatment of suicidal patients (e.g., Layden et al., 1993; Linehan, 1993), they have not offered an organizational framework for conceptualizing and monitoring change in the patient's *crisis experience* over time. Not all crises are the same; their characteristic features and process of resolution can help gauge treatment progress in a more refined manner across episodes. As detailed in both Figures 3.3 and 3.4, the identifiable levels for the symptom management component include: *symptom*

Component:	Symptom management	Skill-building	Personality development
Agenda:	Crisis Intervention and symptom management	Skills	Traits
Goals:	1. Resolve immediate crisis 2. Reduce suicidality 3. Instill hopefulness 4. Symptom reduction	1. Identify current skill level across targeted areas 2. Improve level of functioning, return to premorbid or better 3. Develop or refine basic skills summarized above	1. Improve self-image 2. Resolve internal conflicts, developmental trauma, underlying core issues 3. Improve interpersonal relationships, including family
Therapeutic focus:	Crisis and symptom management	Skill development	Personality development
Levels:	I: Stabilization II: Self-management III: Utilization	I: Skill acquisition II: Skill refinement III: Skill generalization	I: Stabilization II: Modification III: Refinement
Targets:	Symptom relief and crisis resolution: 1. Depression 2. Anxiety 3. Other identifiable symptoms (i.e., anger, guilt, panic, anhedonia, insomnia, attention-concentration impairment) 4. Hopelessness 5. Helplessness 6. Suicidal ideation 7. Suicidal behavior 8. Substance abuse 9. Sense of immediacy and urgency 10. Poor distress tolerance, impulsivity	Skill development: 1. Problem solving: a. Eliminate extreme responding and avoidance b. Develop structured and methodical approach c. Skill acquisition, strengthening, generalization 2. Emotion regulation a. Learn to identify, understand feelings b. Learn to express constructively c. Learn to moderate feelings 3. Self-monitoring a. Awareness (labeling of feelings) b. Understanding (normalize experience) c. Responding (more effective regulation)	Self-Image and Interpersonal Functioning: Cognitive Restructuring 1. Hopeless nature of belief system 2. Identify, explore esteem, and efficacy issues a. Defective, inadequate, incompetent b. Unlovable c. Helpless 2. Identify, explore developmental trauma a. Abuse b. Neglect c. Abandonment 3. Identify, explore conflicts within the family and social systems a. Attachment b. Enmeshment c. Detachment, separation

(continued)

FIGURE 3.4. Treatment planning matrix.

Component:	Symptom management	Skill-building	Personality development
Targets: *(cont.)*	Symptom relief and crisis resolution:	Skill development: 4. Distress tolerance (i.e., impulsivity) a. Raise threshold for reaction b. Lower reactivity (lessen severity) c. Shorten recovery 5. Interpersonal skills a. Assertiveness: address passivity, avoidance, subjugation b. Attentiveness c. Responsiveness 6. Anger management a. Identify, recognize early signs b. Appropriate, constructive expression c. Empathy, acceptance, forgiveness	Self-Image and Interpersonal Functioning: Cognitive Restructuring
Interventions:	Crisis response plan, treatment log, risk assessment, STR, pharmacotherapy	Individual, group psychotherapy, skills training	Individual, group, and/or family therapy
Therapist role:	Active/directive	Collaborative	Reflective/supportive
Process task:	Engagement	Attachment	Separation
Process marker:	Past orientation	Present orientation	Future orientation

FIGURE 3.4. *(cont.)*

stabilization, *symptom self-management*, and *symptom utilization*. A failure to recognize or monitor this qualitative change can result in the loss of subtle but, nonetheless, critical information. Without it, important markers of treatment progress, particularly for those evidencing chronic suicidality, are obscured by the recurrent suicide attempts and related crises common to treatment.

Symptom stabilization is characterized by the need for direct intervention on the part of the mental health professional. As we will discuss in Chapter 7, therapist strategies can include creation of a symptom hierarchy to identify and target the most severe symptoms and creation of a crisis response plan. This plan will involve the introduction of needed skills. *Symptom self-*

management refers to improved skill level on the part of the patient so that direct intervention is no longer necessary. The patient can effectively manage the crisis on his or her own. The final level, *symptom utilization*, refers not only to effective management of the crisis but also to use of the crisis as an opportunity for personal growth and change, consistent with, at a minimum, *skill generalization* and *personality modification* (see discussion of other components later). For example, symptom utilization involves not only effective regulation of emotional upset such as acute anxiety or anger but evidence of skill generalization from one stressor or circumstance to another (e.g., moving from resolving recurrent and predictable interpersonal conflicts with a family member to spontaneous relationship problems at work) consistent with emerging (and it is hoped lasting) personality transformation. Consistent with the definition offered in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994, p. 629), a personality disorder is characterized by inflexible, rigid, and problematic traits, which result in social and/or occupational dysfunction. Accordingly, the manifestation of change in the context of crisis is consistent with identifiable changes in personality structure and organization, despite the fact that they may well be quite minor in magnitude.

Cycling through Components and Levels

Patients cycle through various levels of a given component multiple times during the course of treatment, in all likelihood, exploring and solving similar problems in different ways as they build skills and enhance and modify their self-image and sense of confidence. Actually, for a significant number of suicidal patients it is anticipated that they will experience multiple suicidal crises during the course of treatment and, accordingly, cycle through various levels of each component multiple times. Ideally, each successive crisis would be resolved in a more effective and efficient manner.

Figure 3.5 provides an illustration of a hypothetical patient *cycling* through various levels of the three components over the course of 10 weeks of treatment. As illustrated, the initial trigger (i.e., the precipitant for his presentation to treatment) is a *fight with his wife* in which she threatens divorce. This activates the suicidal mode, the patient becomes markedly dysphoric, anxious, depressed, and actively suicidal (symptom management component, Level I). His problem is compounded by prominent skill deficits that lead to general avoidance, a lack of assertiveness, withdrawal, and reliance on alcohol abuse to regulate his feelings (skill-building component, Level I). The patient sees himself in a negative light, stating that he is *worthless, incompetent, and incapable of making it* (personality development component, Level I). The initial therapeutic intervention is intensive but ultimately effective at deactivating

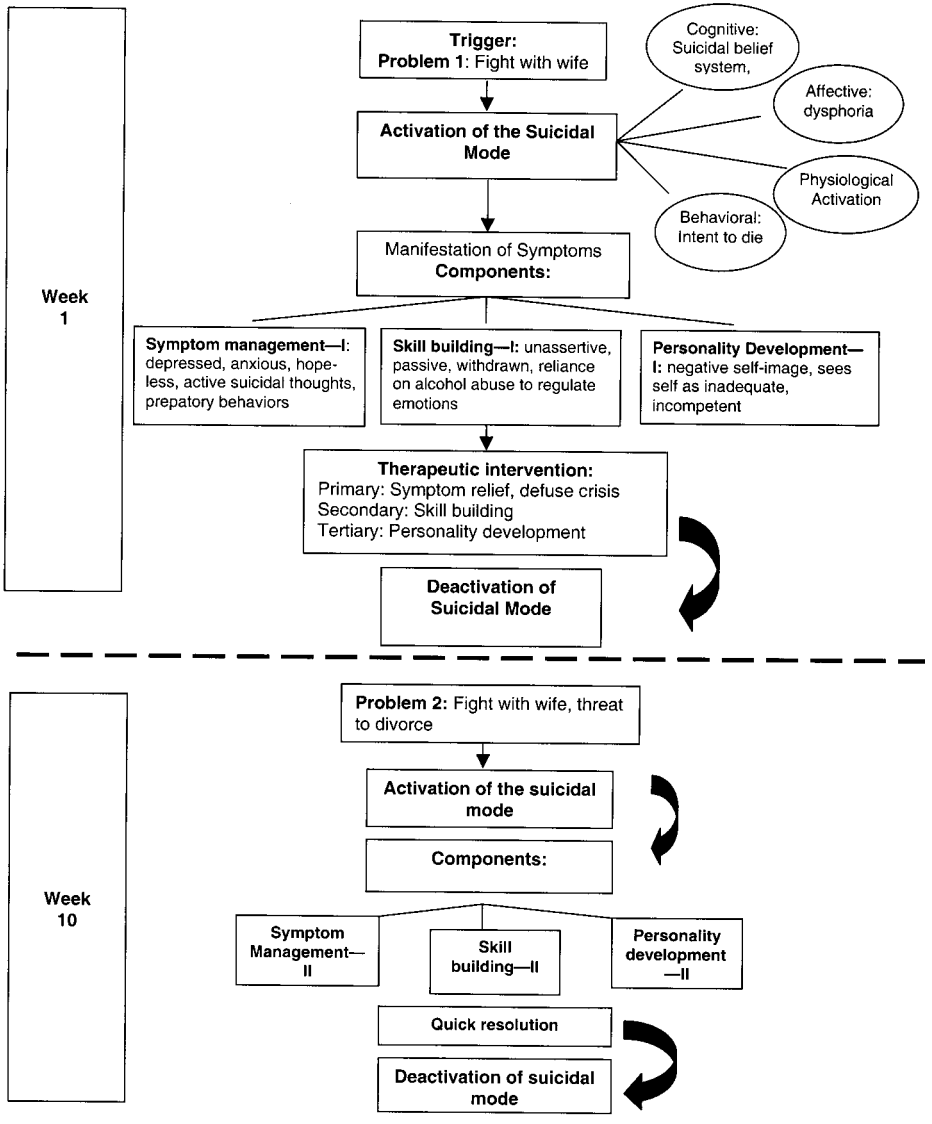

FIGURE 3.5. Illustration of a patient *cycling* through components and levels.

the suicidal mode and returning the patient to a baseline level of functioning that enables him to return to work and meet daily demands.

At week 10 during treatment, the patient again has a fight with his wife, activating the suicidal mode. Given progress in therapy, however, the patient is able to manage the crisis himself, experiences only fleeting dysphoria, and much more effectively regulates his feelings without relying on alcohol (symptom management component, Level II). To do so, he implements use of a number of newly acquired skills. He is much more assertive, and instead of withdrawing, he is active and makes a distinct effort to address a number of long-standing marital problems (skill-building component, Level II). The suicidal crisis is relatively brief and not nearly as intense. He and his wife start concurrent marital therapy. As a result of this process, the patient notes a renewed sense of confidence and capability, a feeling that endures well after the crisis has resolved (personality development component, Level II). As this example demonstrates, the same crisis can and, more than likely will, be experienced differently as treatment progresses, skills develop, and personality change evolves.

The Role of Medications

As discussed early in this book, marked comorbidity and diagnostic complexity are, more often than not, the norm in treating suicidal patients. Severe symptomatology is the natural correlate. Remember, we are seeing patients at their worst, in the midst of a suicidal crisis. One of the primary goals of crisis intervention is symptom remission. Frequently, psychotropic medication will be necessary and advised. Aside from issues of diagnosis, the two primary markers that we have used is the degree of impairment in day-to-day functioning and, of course, the patient's wishes. When patients can no longer function and meet the necessary day-to-day demands, medication is often essential to ensure the stability necessary for continuing outpatient care and ongoing psychotherapy. That is one of the benefits of using subjective ratings in assessing risk and symptom severity; they provide an easy marker by which to gauge the patient's level of functioning, change over time, and ultimately progress. Threshold values can be established that, when crossed, signal the need for a medication consultation. These values can be discussed with the patient, and concrete behavioral correlates can be identified and simply monitored over the course of treatment.

From a purely anecdotal perspective, anywhere from 40 to 60% of the patients with whom we work have had, or are currently taking, medication. Frequently, medication is essential to recovery. At other times, this simply is not the case. Accessing medication consultation is a clinical decision best made by the provider and patient on a case-by-case basis. Consistent with this information, we have generally considered the chronicity of the patient's dis-

turbance, the severity of symptoms, and the diagnostic complexity of the presentation. If medication is a component of treatment, it is important to establish and maintain a working relationship with the psychiatrist or physician prescribing. In most cases, periodic and predictable consultation is critical to effective management and treatment.

Skill-Building Component

The levels identified for the *skill-building* component are consistent with conceptualizations offered by others. Among the specific skill areas covered, self-monitoring, distress tolerance, and emotion regulation are believed to be critical for all suicidal patients and represent *core interventions* that will be standard regardless of the particular clinical presentation. Those making multiple suicide attempts and exhibiting chronic suicidal behavior, in particular, have proven distinctive in this respect (e.g., Linehan, 1993; Rudd, Joiner, & Rajab, 1996). They frequently evidence limited emotional awareness (i.e., poor self-monitoring), experience difficulty in recovering when emotionally upset (i.e., emotion regulation), and are often impulsive when dysphoric (i.e., poor distress tolerance). Consistent with one of the central goals of dialectical behavior therapy (Linehan, 1993), considerable effort is expended to raise the patient's threshold for emotional upset, lower his or her reactivity (i.e., intensity of emotional reaction), and shorten the time necessary for recovery. As is evident, there is a clear interrelationship between self-monitoring ability, emotion regulation, and distress tolerance. Essentially, it is posited that the more emotionally aware patients are, the more effectively they will regulate emotion, the greater their tolerance for distress, and the less they manifest impulsivity. Specific skill development in psychotherapy is assumed to progress in a fairly predictable fashion, particularly with suicidal patients, from acquisition to refinement and ultimately generalization across situations and circumstances (e.g., Layden et al., 1993; Linehan, 1993; Nezu et al., 1989). *Skill acquisition* is simply experimentation with a newly identified skill (e.g., assertiveness or problem solving). *Skill refinement* is characterized by consistent use of the skill and refinement across specific, targeted circumstances (e.g., assertiveness with a specific individual such as one's boss in a specific setting such as work). Finally, *skill generalization* is characterized by consistent use of a skill (i.e., planned and unplanned) and application across a broad range of circumstances (e.g., interpersonal assertiveness at home, work, and leisure activities). Skill generalization is confirmation that the skill has been adequately developed, is useful and, most important, accessible when needed.

Of critical importance for skill building is a consistent and methodical approach, regardless of the skill being targeted. A consistent approach will not only help motivate the patient but will also facilitate the process of skill acqui-

sition, refinement, and generalization across various settings. The following steps are suggested:

1. Identify specific skill deficits for the patient and keeping a running log (i.e., self-monitoring either through a journal or daily record of some type).
2. Place the deficit in context, both developmentally and with respect to current functioning (i.e., help the patient recognize and understand the origin of the deficit and implications for day-to-day activities).
3. Identify and explore the potentially recurrent nature of the problem or deficit (i.e., chronicity) over time. Help the patient recognize that the skill deficit probably appears with some regularity. It is particularly important to help patients recognize that the deficit is present much of the time, not just during periods of acute crisis.
4. Identify and address the disadvantages of the deficit(s) (e.g., emotionally, interpersonally, financially, and self-image) to facilitate motivation for change. This can be done easily using a daily journal.
5. Remediate the deficit using a blend of indirect (e.g., education and information) and direct techniques (e.g., role playing and behavioral rehearsal).

Personality Development Component

The personality agenda integrates issues of self-image, interpersonal functioning, and developmental trauma (see Figure 3.4). As detailed in Chapter 2, the principal defining feature of the patient's belief system is hopelessness, a variable which has been consistently linked to suicidality, from ideation to completions (see Weishaar, 1996, for review). Personality trait targets have most consistently revolved around self-image disturbance (i.e., seeing self as defective, inadequate, helpless, and unlovable), developmental trauma and abuse, and interpersonal dysfunction with problems of attachment, enmeshment, and separation, all cloaked within a veil of hopelessness (e.g., Freeman & Reinecke, 1993; Layden et al., 1993; Linehan, 1993). The approaches to addressing personality dysfunction cover a broad range of therapeutic orientations and techniques, with the common feature being the requisite need for long-term contact and a strong therapeutic relationship.

The identified levels for the *personality development* component are also consistent with other conceptualizations of personality change but more specific in nature (e.g., Beck, Freeman, & Associates, 1990). *Personality stabilization* is characterized by *initial* skill acquisition that allows the patient an improved level of day-to-day functioning with elimination of extreme suicidal, self-mutilatory, and self-destructive behaviors, along with noticeable sympto-

m remission. *Personality modification* is characterized by identification and specific targeting of maladaptive traits (e.g., passive–aggressiveness, avoidance, and dependency) while the patient attempts to refine targeted skills and engage in self-management of crises. Finally, *personality refinement* is accomplished in concert with crisis utilization and skill generalization. In other words, the patient has experienced some fundamental and enduring changes, having acquired some targeted skills and applied them with success. He or she is making use of each available opportunity to further refine and generalize skills. The net result is fewer and less severe crises, less intense symptomatology, and improved day-to-day functioning (i.e., both socially and occupationally), ideally, with limited (if any) *active* support on the part of the clinician.

Specific treatment targets from different components are routinely addressed simultaneously, although those from other than the primary component targeted naturally consume less time during sessions (see Figure 3.4). During the symptom management component, for example, not only will acute symptomatology, suicidality, and hopelessness be the focus of intervention, but also their successful resolution will assist in skill building and self-image/personality development.

Variation in Therapist Role

Each component demands variation in the role orientation of the therapist, ranging from directive to collaborative to reflective. The identified treatment components are also hierarchical in nature, that is, in terms of the amount of time devoted to particular agenda items (i.e., targets) during treatment sessions. Specifically, in the symptom management component of treatment, a disproportionate amount of time is spent with crisis intervention tasks, depending on the patient's day-to-day stressors, symptom severity, and individual skill level. Naturally, the role orientation of the clinician is more directive during this beginning component given the crisis intervention nature of treatment.

As the patient establishes an adequate skill repertoire, crises resolve more quickly and effectively, active symptomatology is less of a concern, with a disproportionate shift in time available to address specific skill deficits and target more enduring issues of self-image, interpersonal functioning, and related developmental trauma. Accordingly, a collaborative orientation predominates. As individual skill level develops further, the majority of time in treatment is spent on the longer-term issues noted previously, with limited time devoted to skill refinement and even less time to symptom management and crisis intervention. There is a natural shift in the therapeutic role orientation, taking on more a reflective and supportive position, although active collaboration continues.

A Clinical Example of Acute Suicidality: The Case of Mr. E

The organizational framework offered can be applied easily across the full spectrum of those presenting with suicidality, from the most severe chronic individuals to those presenting with a first attempt. In each case, the primary goal is simply to identify the appropriate components and levels, and focus treatment efforts accordingly.

Background of Case

The patient, a 23-year-old single male, requested evaluation following his arrest for public disturbance and intoxication. Apparently, he was arrested after an argument with his girlfriend in which he "threatened to kill himself." He reported no current suicidal thoughts, stating that they "lasted only a few days" following the breakup of the relationship. The thoughts were described as nonspecific with Mr. E stating, "I never thought how I'd do it." He reported no intent, no actual attempt, and no prepatory behaviors of any type. He also reported no previous suicidal crises and no prior mental health care. The patient described no prominent symptomatology, only brief depression and anxiety "that lasted a few days," consistent with an adjustment disorder with mixed emotional features. He did note episodic alcohol abuse over the last month, stating that he was "drunk" at the time of his arrest but had had nothing to drink since, adding that he "has only been drunk three times in my life." The patient stated that he was in his final year of college, was a "straight A student," and was "planning on getting married" when the relationship abruptly ended. He reported that he "relied heavily" on his girlfriend for support and that "she was the first serious relationship" in which he had been involved. He noted that for the most part, he felt "indecisive" and "had a hard time doing things for himself." He reported occasional problems "controlling anger," stating that he would "yell and make threats." He reported only a few friends and social activities outside of his relationship with his girlfriend but described very "strong attachments" in those few cases.

Initial Treatment Plan

SYMPTOM MANAGEMENT COMPONENT, LEVEL II (SELF-MANAGEMENT)

The patient is no longer actively suicidal or in acute crisis. He did not make an attempt but noted nonspecific suicidal thoughts and voiced a threat. The symptoms resolved spontaneously without formal mental health intervention. The patient is currently functioning adequately and hopeful about any ongoing

treatment. He is currently capable of managing day-to-day activities with no symptomatic problems. This is consistent with his report of no significant problems prior to the current relationship. The majority of the patient's therapy will focus on targeted skill building and personality development as his symptoms have resolved.

SKILL-BUILDING COMPONENT, LEVEL I (ACQUISITION)

The patient possesses limited skills and would require skill training targeting specifically improved self-monitoring (i.e., self-awareness), emotion regulation, distress tolerance, and anger management. Problem solving would be integrated but would likely be secondary to the above given the impulsive nature of his suicidal crisis. The suicidal crises highlighted what, in all likelihood, was a long-standing skill deficit(s). Prior evidence of a problem was probably more subtle and less visible but likely will become more apparent as treatment progresses.

PERSONALITY DEVELOPMENT COMPONENT, LEVEL II (MODIFICATION)

The patient does not present in any acute crisis and notes that this is his first mental health evaluation. Prior to his current presentation, he appears to have adjusted and adapted fairly well (e.g., college grades, no previous problems). However, he does evidence some maladaptive personality traits that would be the focus of ongoing work. Personality components that would naturally be woven into ongoing interventions would include (1) poor self-image, (2) lack of confidence, and (3) marked in dependency in relationships.

Mr. E presents a symptomatic picture evidencing spontaneous resolution and requiring no acute intervention and no specific symptom management. Essentially, his suicidal crisis appeared to be the function of limited skills (i.e., self-monitoring, emotion regulation, distress tolerance, and anger management) and related personality dysfunction (i.e., prominent dependency). In his case it may well be that targeted intervention can result in lasting change.

The case of Mr. E. can be summarized with relative ease using the treatment planning matrix. Each treatment component can be understood in terms of specific treatment goals and targets. The treatment planning matrix is an excellent tool for summarizing the treatment process and treatment components; identify corresponding goals and targets; translating the treatment agenda to the patient, fellow clinicians, and insurance administrators; and monitoring treatment progress and the process of individual change.

Monitoring the Treatment Process

Essentially, the treatment process (i.e., movement through the levels of each treatment component) can be accurately gauged and monitored by the content (i.e., treatment agenda and associated assessment and treatment targets or tasks) of therapy, not its duration. The important point with respect to this conceptual and organizational framework is that an individual successfully treated for suicidal behavior will transition through the same component levels (treatment process), regardless of the duration of treatment. He or she will address the same treatment agenda(s) and specific target areas, simply in a different time frame and potentially by a different mechanism of action (i.e., the specific psychotherapeutic model employed). Where the patient is in the treatment process can be addressed rather simply: What do you spend the majority of your session time discussing and targeting?

The organizational framework offered provides a means of more clearly articulating where a patient is in the treatment process. Each patient can be placed within the treatment process by describing both components and corresponding levels. This translates into a clearly articulated treatment agenda with respect to active symptomatology being targeted, particular skills being developed, and enduring personality traits being explored.

Figure 3.6 provides a worksheet for monitoring treatment components and levels. It is recommended that the worksheet be completed at various points during the treatment process, specifically at intake, during periodic planned reviews (e.g., when a treatment *update* is requested by an insurance carrier), when referred to another provider, and at treatment completion or termination. It is particularly important if termination is unplanned. For example, if a patient abruptly discontinues treatment (i.e., voluntary withdrawal), it is critical to log the patient's progress to date and level of functioning when he or she withdrew from treatment. Completion of the component and level worksheet provides a clear and concise summary of the patient's level of functioning at any one point in time. All the clinician needs to do is to circle the levels for each treatment component. There is also room for relevant clinical notes. As illustrated, it provides a fairly concise means of addressing current level of functioning, severity of psychopathology, and related treatment goals in comprehensive fashion.

Process Tasks and Markers

As detailed in Figures 3.4 and Figure 3.7, the clinician and patient move through a process of engagement, attachment, and separation not only in each individual session but also throughout ongoing treatment. The clinician can

Treatment point (circle one):	Intake assessment Periodic review, No. of sessions ____ Transition or referral Termination, planned Termination, unplanned (e.g., abrupt discontinuation)
Symptom management component (circle one): Current target(s):	Level I: Symptom stabilization Level II: Symptom self-management Level III: Symptom utilization
Skill building component (circle one): Current target(s):	Level I: Skill acquisition Level II: Skill refinement Level III: Skill generalization
Personality development (circle one): Current target(s):	Level I: Personality stabilization Level II: Personality modification Level III: Personality refinement
Notes:	

FIGURE 3.6. Treatment component and level worksheet. From *Treating Suicidal Behavior: An Effective, Time-Limited Approach* by M. David Rudd, Thomas Joiner, and M. Hasan Rajab. Copyright 2001 by The Guilford Press. Permission to reproduce this figure is granted to purchasers of this book for personal use only (see copyright page for details).

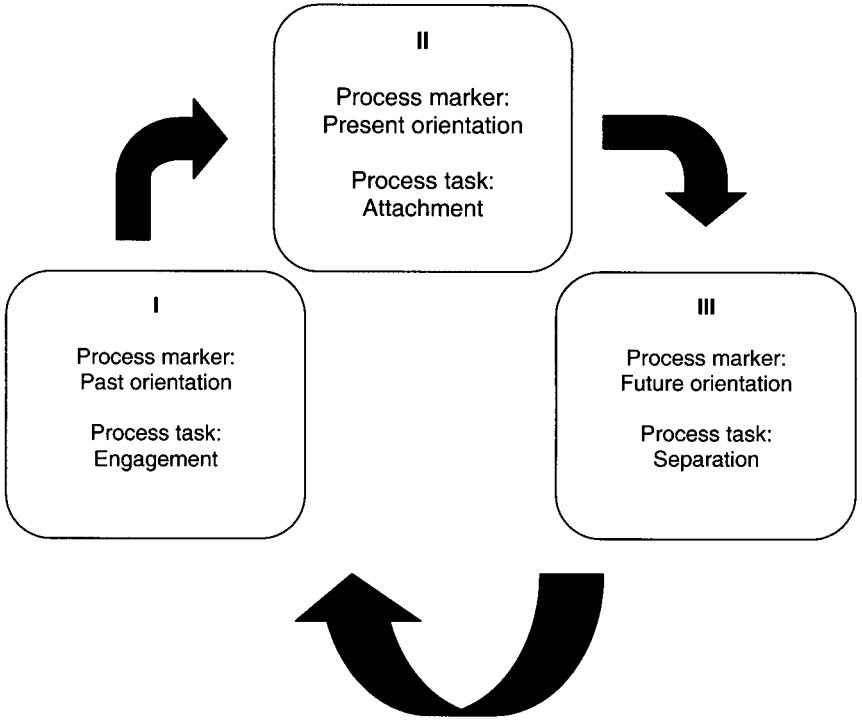

FIGURE 3.7. The treatment process: Stages and characteristics.

monitor this process by attending to *content markers* during and across sessions. Specifically, in the symptom management component of treatment, the majority of the content of a session or sessions will be past oriented as the patient addresses recent or remote emotionally painful issues (the majority of session time spent addressing the ending of relationship, job loss, financial problems, etc.). In the skill building component of treatment, the focus shifts to current functioning, with an emphasis on identifiable skill deficits. Although historical and developmental issues are addressed, the majority of time is likely to be spent on current skill building. Similarly, in the personality development component of treatment the focus shifts to future goals, integrating developmental trauma and previous interpersonal conflicts. Although ideally the patient will have improved his or her level of awareness and understanding for developmental issues that are relevant and targeted identifiable skill deficits, the focus of treatment is likely to revolve around improving self-image and interpersonal functioning through *future* activities, not a perpetual rehashing of old problems.

As is the case across the course of treatment, each individual session mimics the process of engagement, attachment, and separation. Again, the actual content of therapy allows for monitoring of process. For example, early in session, the patient will discuss past issues (e.g., past week functioning and homework assignment(s)), will eventually transition to current functioning and related agenda items, and ultimately will establish an agenda for the coming days, weeks, or month(s). Essentially, each session models the skill of appropriate attachment–separation (i.e., independent functioning) in relationships. This is one of the primary benefits of applying the proposed organizational framework, an improved ability to identify and monitor what are, often, subtle skills and process markers that can be lost in the psychotherapeutic milieu. Such skills are, nonetheless, *critical* to treatment success and important indirect markers of treatment outcome. A clinical example illustrates this process.

The Case of Ms. D, to be discussed in detail later, provides a good example of process variables in treatment. Upon initial presentation, Ms. D discussed in great detail *past* relationships and *past* failures.

THERAPIST: Please tell me about your *current* relationship(s).

MS. D: I'll never have a good relationship with a man, none of them have ever worked out. They've all been failures [past orientation]. The first one ended after only a year, the second one lasted five years, and look what happened to this last one! I've always been a loser in relationships and always will be. I couldn't make one work if my life depended on it.

After facilitating the process of initial *engagement*, however, Ms. D was more open and amenable to discussing her *current* level of functioning, with an identifiable move into the *attachment* phase (i.e., for this initial session). She described current symptomatology in great detail, including suicidal thoughts and behaviors and depressive symptoms, as well as her current drinking pattern. After a thorough evaluation and assessment, the session ended with Ms. D discussing her plans for the immediate future and active participation in treatment, consistent with the *separation* phase (and future orientation).

THERAPIST: Let's discuss and review your plans for the next several weeks.

MS. D: Well, I've got an appointment with you next week and I'll see the psychiatrist tomorrow about medication. Then, I guess, I'll be coming in every week for the next couple of months [future orientation]. Didn't we agree to work on my ability to tolerate feeling bad first, like when I cut myself. I'm feeling OK about doing this, maybe it'll work [hopefulness consistent with future orientation].

Provocations and Resistance in the Therapeutic Relationship: How a Clear Organizational Framework Helps

The conceptual and organizational framework offered allows the therapist to specifically target relationship skills that are manifest in the therapy process. As Rudd et al. (1995) and Rudd and Joiner (1998a) have discussed, help negation (including provocations and resistance) in treatment for suicidality is a serious concern, one that requires a compassionate and sensitive approach to transference–countertransference problems. Framing these somewhat abstract concepts as relationship *skills* has numerous advantages in treatment, allowing them to be discussed with the patient in a meaningful and understandable way from the outset.

1. It externalizes the problem to some degree, labeling it as a skill rather than an individual defect of some type.
2. It makes it conceptually easier to grasp and discuss, translating it into a concrete task.
3. It provides a means for monitoring and gauging progress over time. Chapter 9 provides a detailed discussion of the therapeutic relationship.

Quantifying Change: How to Measure and Monitor Change in Treatment

Measuring change in the treatment of suicidal behavior depends on a range of factors. First, it is essential to use a standard nomenclature for distinguishing what is suicidal and what is self-multilatory and self-destructive. Without such a nomenclature, treatment progress is almost impossible to gauge and monitor. Second, it is important to distinguish between direct and indirect markers of suicidality. Third, it is essential to distinguish between acute and chronic variables in the suicidal process. If these factors are addressed, a general and useful framework can be established and maintained to monitor the progress of the suicidal patient.

In terms of nomenclature, we recommend that the one proposed by O'Carroll et al. (1996) and reviewed in Chapter 1 be universally adopted. Without question, it represents the best the field of clinical suicidology has to offer. It clearly differentiates between suicide attempts and instrumental suicidal behavior, something critical to accurate risk assessment and effective treatment. The notion of direct and indirect markers of suicidality in treatment outcome is a concept that, surprisingly, has not been previously addressed. It is critical to distinguish between the two, particularly given that as direct

markers of suicidality improve acute risk wanes, whereas indirect markers might well endure for years.

Direct markers are fairly straightforward and include suicidal ideation (frequency, intensity, duration, and specificity) and suicidal behaviors (attempts and instrumental behaviors). Indirect markers range from symptomatic variables (e.g., hopelessness, depression, anxiety, impulsivity, and anger) to individual characteristics (e.g., attributional style, cognitive rigidity, and problem-solving ability) to personality traits (i.e., in accordance with DSM-IV). Direct and indirect markers of suicidality can be monitored and assessed in a number of ways. Of importance, however, is the need to balance and integrate subjective and objective measures using available psychometric instruments during the course of treatment. Distinguishing between direct and indirect makers of suicidality allows the clinician to differentiate between acute and chronic variables in the suicidal process. Consistent with the conceptual and organizational framework offered, clearly articulating chronic variables helps establish reasonable expectations regarding the treatment process and outcome, facilitates more accurate risk assessment, and lends itself to a reasonable standard of care.

Treatment Withdrawal and Noncompliance

Treatment withdrawal is a fairly common problem with this population, with withdrawal rates of 30% or more across most studies (e.g., Rudd, Joiner, & Rajab, 1995). This is not particularly surprising given that suicidality is, at one level, about ambivalence. The ambivalence about whether to live or die naturally plays out in the course of therapy. In our study, we found that those who withdrew likely did so not because they had recovered and experienced symptom remission but because of prominent personality disturbance that made the intimacy of the therapeutic relationship untenable for many reasons.

Treatment withdrawal can be minimized if adequate informed consent procedures are followed from the very beginning. Being specific and detailed not only will help patients answer questions about issues of *commitment to treatment* but also will help them resolve ambivalence about living. The procedures covered in Chapter 7 provide a framework to ensure that the patient has an adequate understanding and reasonable expectations about the treatment process. If compliance becomes an issue, it needs to be made the primary agenda item until effectively resolved. Otherwise, it can derail treatment, potentially creating a conflictual environment that may only serve to exacerbate the patient's suicidality. Chapter 9 provides a detailed discussion of addressing resistance and noncompliance, couching it within the rubric of the therapeutic relationship.

When patients abruptly terminate or withdraw from treatment, follow-up

of some sort is strongly encouraged. We have had considerable success with patients returning to treatment (or at least continuing treatment elsewhere) by simply contacting the patient either by phone or letter (sometimes both) to discuss the reasons for termination and what he or she plans on doing in the immediate future. Sometimes the patient will cite financial problems or time constraints, but, more likely, abrupt withdrawals are secondary to a problem in the therapeutic relationship. We recommend a telephone call for patients who have been in treatment for more that one or two sessions. If the clinician is unable to contact the patient, a simple follow-up letter is best (see Figure 3.8).

Regardless of the circumstances, it is important to *close* a patient's clinical chart with some indication that the closure has been discussed with the patient or an effort has been made to contact him or her to do so. If a patient is unwilling to continue in treatment, it is important to provide other alternatives (i.e., referral to other resources in the local community). The clinician should always document the circumstances surrounding withdrawal, termination, or referral to another provider. In addition, when abrupt termination has occurred, the clinician should always document efforts to contact the patient (either by phone or letter) to coordinate ongoing care. If a letter was sent, the clinician should include a copy in the chart.

Ensuring Treatment Fidelity

Although treatment fidelity is always a concern, the hallmark of this book is its flexibility. It is designed for the practitioner, regardless of setting. The procedures discussed and the framework provided can be implemented anywhere, whether a clinician is operating solo or in a large clinic or hospital. Treatment fidelity is less of an issue for the solo practitioner. For those work-

Dear _____:

It has been a few weeks since your last appointment. Given that I haven't heard from you (or have been unsuccessful in reaching you by phone), I simply wanted to touch base to see if all was well. If you'd like, you can give me a call at XXX-XXXX to discuss your plans for future treatment. If you have any questions, concerns, or simply need a referral of any type please let me know and we'll get it arranged. Again, I hope all is going well and I look forward to hearing from you.

Sincerely,

FIGURE 3.8. Follow-up letter.

ing in settings with a greater number of clinicians and more resources, treatment fidelity becomes a concern, particularly if a group(s) component is integrated. In these cases, the easiest way to ensure treatment fidelity is by incorporating treatment team meetings with a regular review of procedures, training sessions, and periodic review and discussion of videotaped sessions.

Termination: When, Why, and How

Ideally, termination occurs when patient and therapist agree that the treatment goals have been accomplished. As is evident, treatment of suicidal patients, and particularly chronically suicidal patients, is neither that clear nor that simple. Others have written in some detail about the role of provocation and acting out in the treatment process (see Newman, 1997, for review). In addition, the importance of ensuring that a patient's ongoing treatment needs have been addressed has been stressed by clinicians and researchers alike (e.g., Simon, 1987; Stromberg et al., 1988). The treatment of suicidal patients has been characterized by relatively high withdrawal rates, with those abruptly stopping treatment often continuing to experience marked symptomatology and continued high risk (Rudd et al., 1995).

The organizational framework allows for relatively straightforward assessment of the treatment process, along with markers of acute and chronic risk. Accordingly, it provides some structure and guidance to potential termination issues. Barnett (1998) has offered a number of recommendations regarding appropriate termination. Among them is the need to be specific and clear about expectations from the outset, something facilitated by the framework summarized in Figure 3.4. Moreover, it provides a means of identifying and clearly articulating the need for continued treatment, and in what specific areas. Finally, use of the organizational framework provided allows for clear documentation of the overall clinical picture, treatment goals and targets, accompanying rationale, and monitoring change and progress. As Barnett (1998) noted about termination, "plan for it, prepare for it, and process it" (p. 22). We would add one additional caveat: Simply organize the entire process in a manner meaningful and understandable to patients.

Interpersonal Process Groups and Booster Sessions

As we discuss in Chapter 10, psychoeducational groups can be helpful in skill building. Traditional process groups can also play an important adjunctive role in the treatment process. They can provide the patient an interpersonal outlet to complement ongoing individual therapy. However, it is important that these groups use the same theoretical framework (i.e., the suicidal mode)

to complement rather than conflict with ongoing individual work. We have most frequently used the process-oriented groups as an open-ended group to which the patient has access *after* individual treatment is completed. Some clinicians believe that the group is most appropriate only after completing individual treatment; we tend to fall into this category given our reliance on concurrent psychoeducational and problem-solving groups (see Chapter 10). It is recommended that the patient *not* participate in any more than one group activity while simultaneously involved in individual treatment. It can simply be overwhelming to the patient in many ways—emotional, financial, and practical. In the past, we have had patients involved in the psychoeducational group first, followed by the problem-solving group. We have found the process group most helpful as a supportive resource *after* individual treatment is completed. If the process group is accessed after treatment has been completed, it essentially serves the role of *booster sessions*, helping the patient to sharpen skills, provide support, or simply target a specific problem before it escalates.

The Role of the Treatment Team

This book is designed to be flexible. The treatment model can be implemented in a broad range of settings from the sole practitioner to the large group practice. In many settings, such as those with limited resources, the development and use of a treatment team will not be possible. However, if the necessary support is in place, it can facilitate treatment provided by multiple providers within the same institution. The integration of a group component or complement in a particular setting will be enhanced by the development of a treatment team. The treatment team consists of all clinicians treating suicidality in a setting who refer to the group(s). As noted previously, it is recommended that the patient *not* participate in more than one group activity at a time. For those patients involved in individual treatment, it is most effective is to have the patient first complete a psychoeducational group in order to establish basic knowledge and understanding, followed by the problem-solving group, and finally the process group as an ongoing supportive resource. A rotational schedule needs to be established for coherency and coordination in the treatment process.

If the groups are rotational (e.g., on a quarterly schedule), the group leader can rotate among staff. We have found it most effective and appropriate to have the group leader serve as the team leader, a position that rotates as the groups rotates (e.g., quarterly). If a process group is used in any capacity, it is necessary to have the facilitator's tenure considerably longer (e.g., a year) in duration. If an ongoing process group is in place, the facilitator should not be the team leader given that most patients will likely have completed individual treatment. Moreover, the process group facilitator will have a longer tenure

than do the facilitators of the quarterly psychoeducational or problem-solving groups. The team can meet monthly with a specific goal of reviewing all patients' progress, addressing both group and individual issues. The treatment team serves many functions including the following:

- Informing individual clinicians of patients participation in group and issues that are relevant to individual therapy.
- Providing a mechanism for discussion and consultation about difficult cases, particularly those not evidencing progress.
- Support for clinical staff.
- Education and training for staff.
- Staff supervision needs, if appropriate.

In short, use of a treatment team is highly recommended. Actually, without it, treatment of more than one or two highly suicidal patients can be risky and a potentially serious emotional drain on the clinician.

The Need for Long-Term Care in a Time-Limited World

Treating suicidality often times requires considerable time and energy, frequently more time than provided by the insurance carrier. The framework provided here is specific and detailed. Accordingly, we hope it will make it easier for the clinician to make the argument for more enduring care. We have found that if a specific, logical, and detailed argument addressing the patient's risk factors and treatment needs is provided in an understandable format, it is well received. Although the duration of treatment is, without question, more limited now than ever before, we believe we have provided an approach that will make arguments for longer-term care much more effective.

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