SUICIDAL IDEATION

BEHAVIORAL DEFINITIONS

1. Recurrent thoughts of or preoccupation with death.
2. Recurrent or ongoing suicidal ideation without any plans.
3. Ongoing suicidal ideation with a specific plan.
4. Recent suicide attempt.
5. History of suicide attempts that required professional or family/friend intervention on some level (e.g., inpatient, safe house, outpatient, supervision).
6. Positive family history of depression and/or a preoccupation with suicidal thoughts.
7. A bleak, hopeless attitude regarding life coupled with recent life events that support this (e.g., divorce, death of a friend or family member, loss of job).
8. Social withdrawal, lethargy, and apathy coupled with expressions of wanting to die.
9. Sudden change from being depressed to upbeat and at peace, while actions indicate the client is "putting his/her house in order" and there has been no genuine resolution of conflict issues.
10. Engages in self-destructive or dangerous behavior (e.g., chronic drug or alcohol abuse; promiscuity, unprotected sex; reckless driving) that appears to invite death.

__. _____
_____

__. _____
_____

__. _____
_____

LONG-TERM GOALS

1. Alleviate the suicidal impulses/ideation and return to the highest level of previous daily functioning.
2. Stabilize the suicidal crisis.
3. Placement in an appropriate level of care to safely address the suicidal crisis.
4. Reestablish a sense of hope for self and the future.
5. Cease the perilous lifestyle and resolve the emotional conflicts that underlie the suicidal pattern.

__. _____
_____

__. _____
_____

__. _____
_____

SHORT-TERM OBJECTIVES

1. State the strength of the suicidal feelings, the frequency of the thoughts, and the detail of the plans. (1, 2, 3, 4)

THERAPEUTIC INTERVENTIONS

1. Assess the client's suicidal risk including the extent of his/her ideation, the presence and feasibility of a plan, past attempts, substance use, availability of means, and family history.
2. Assess and monitor the client's suicidal potential on an ongoing basis.
3. Notify the client's family and significant others of his/her suicidal ideation; ask them to form a 24-hour suicide watch until the crisis subsides.
4. Arrange or conduct psychometric testing to further assess suicidal behavior and/or related conditions (e.g., *The Suicidal Thinking and Behaviors*

Questionnaire; The Beck Hopelessness Scale; The Reasons for Living Scale); evaluate the results for the client's degree of depression and suicide risk.

2. Disclose any history of substance use that may contribute to and complicate the treatment of suicidal ideation. (5)

5. Arrange for a substance abuse evaluation and refer the client for treatment if the evaluation recommends it (see the Substance Use chapter in this *Planner*).

3. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (6, 7, 8, 9)

6. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

7. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

8. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better

	understanding of the client's behavior.
	9. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).
4. Verbalize a promise to contact the therapist or some other emergency helpline if a serious urge to self-harm arises. (10, 11, 12, 13)	10. Elicit a promise from the client that he/she will initiate contact with the therapist or a helpline if the suicidal urge becomes strong and before any self-injurious behavior.
	11. Provide the client with a "crisis card" with emergency help telephone numbers making help available 24 hours a day.
	12. Develop a plan with the client, identifying what he/she will and won't do when experiencing suicidal thoughts or impulses; encourage the client to be open and honest regarding suicidal urges, reassuring him/her regularly of caring concern by therapist and significant others.
	13. Offer to be available to the client through telephone contact if a life-threatening urge develops.
5. Client and/or significant others increase the safety of the home by removing firearms or other	14. Encourage the client and/or significant others to remove firearms or other lethal means to

potentially lethal means to suicide from easy access. (14)

6. Cooperate with hospitalization if the suicidal urge becomes uncontrollable. (15)

7. Participate in a therapy for an identified emotional problem resulting in suicidal thoughts. (16)

8. Cooperate with a referral to a physician for an evaluation for antidepressant medication. (17)

9. Take psychotropic medications as prescribed and report all side effects. (18)

10. Identify life factors that preceded the suicidal ideation. (19, 20, 21)

suicide from easy access; process the client's feelings about this prevention measure.

15. Arrange for hospitalization when the client is judged to be uncontrollably harmful to self; arrange for a hospital legal commitment if necessary to protect the client from harm to himself/herself.

16. Assess whether suicidality is functionally related to an active clinical syndrome (e.g., unipolar or bipolar depression) or personality disorder (e.g., borderline personality disorder); conduct or refer to an evidence-based intervention for the disorder (see, for example, interpersonal therapy for unipolar depression, interpersonal and social rhythm therapy for bipolar depression, or dialectical behavior therapy for borderline personality disorders in appropriate chapters in this *Planner*).

17. Assess the client's need for psychotropic medication and arrange for a prescription, if necessary.

18. Monitor the client for effectiveness, side effects, and compliance with prescribed psychotropic medication; confer with prescribing physician on a regular basis.

19. Explore the client's sources of emotional pain and hopelessness.

20. Encourage the client to express feelings related to his/her suicidal ideation in order to clarify them and increase insight as to the causes for them.

21. Assist the client in becoming aware of life factors that were significant precursors to the beginning of his/her suicidal ideation.

11. Increase communication with significant others, resulting in a feeling of understanding, empathy, and being attended to. (22, 23, 24)

22. Probe the client's feelings of despair related to his/her conflicted family relationships.

23. Hold family therapy sessions to promote communication of the client's feelings of sadness, hurt, and anger.

24. Meet with significant others to assess their understanding of the causes for the client's distress.

12. Identify how previous attempts to solve interpersonal problems have failed, leading to feelings of abject loneliness and rejection. (25, 26)

25. Encourage the client to share feelings of grief related to broken close relationships.

26. Review with the client previous problem-solving attempts and discuss new alternatives that are available.

13. Learn and implement problem-solving and decision-making skills. (27, 28)

27. Use a Problem-Solving Therapy approach (see *Problem-Solving Therapy* by D'Zurilla and Nezu under Unipolar Depression) involving psychoeducation, modeling, and role-playing to teach client personal problem-solving skills (i.e., defining a problem specifically, generating possible solutions, evaluating the pros and cons of each solution, selecting and implementing a plan of action, evaluating the efficacy of the plan, accepting or revising the plan); role-play application of the problem-solving skill to a real life issue (or assign "Applying Problem-Solving to Interpersonal Conflict" in the *Adult*

	Psychotherapy Homework Planner by Jongsma).
	28. Encourage in the client the development of a positive problem orientation in which problems and solving them are viewed as a natural part of life and not something to be despaired, approached passively, or avoided.
14. Reestablish a consistent eating and sleeping pattern. (29)	29. Encourage normal eating and sleeping patterns by the client and monitor his/her compliance.
15. Commit to the use of coping strategies for suicidal urges. (30)	30. Assist the client in developing coping strategies for suicidal ideation (e.g., more physical exercise, less internal focus, increased social involvement, more expression of feelings, and contact with therapist).
16. Identify the positive aspects, relationships, and achievements in his/her life. (31, 32)	31. Ask the client to write a list of positive aspects of his/her life (or assign "What's Good About Me and My Life" in the *Adult Psychotherapy Homework Planner* by Jongsma).
	32. Review with the client the success he/she has had and the sources of love and concern that exist in his/her life.
17. Learn and implement behavioral strategies designed to increase engagement in rewarding activities. (33, 34)	33. Engage the client in "behavioral activation," increasing his/her activity level and contact with sources of reward, while identifying processes that inhibit activation (see *Behavioral Activation for Depression* by Martell, Dimidjian, and Herman-Dunn under Unipolar Depression in Appendix B; or assign "Identify and Schedule Pleasant Activities" in the *Adult Psychotherapy Homework*

Planner by Jongsma); use behavioral techniques such as instruction, rehearsal, role-playing, or role reversal, as needed, to facilitate activity in the client's daily life; reinforce success.

34. Assist the client in developing skills that increase the likelihood of deriving pleasure from behavioral activation (e.g., assertiveness skills, developing an exercise plan, less internal/more external focus, increased social involvement); reinforce success.

18. Identify and replace negative thinking patterns that mediate feelings of hopelessness and helplessness. (35, 36, 37, 38)

35. Assist the client in developing an awareness of the cognitive messages that reinforce hopelessness and helplessness.

36. Assist the client in identifying, challenging, and changing biased cognition, allowing for a more realistic perspective conducive to hope (or assign "Journal of Distorted, Negative Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma).

37. Address underlying assumptions to self-talk that may be contributing to biases (e.g., beliefs about self-worthlessness, hopelessness).

38. Ask the client to keep a daily record of self-defeating thoughts (thoughts of hopelessness, helplessness, worthlessness, catastrophizing, negatively predicting the future, etc.); challenge each thought for accuracy, then replace each dysfunctional thought with one that is positive and self-enhancing; review;

	reward successes; problem-solve obstacles toward positive cognitive change.
19. Verbalize the devastating effects that suicide can have on significant others. (39)	39. Assist the client in reviewing the effects that the client's suicide would have on loved ones (or assign "The Aftermath of Suicide" in the *Adult Psychotherapy Homework Planner* by Jongsma).
20. Verbalize a feeling of support that results from spiritual faith. (40, 41)	40. Explore the client's spiritual belief system as to it being a source of acceptance and peace (or assign "My History of Spirituality" in the *Adult Psychotherapy Homework Planner* by Jongsma).
	41. Arrange for the client's spiritual leader to meet with and support the client.
__. _____	__. _____
_____	_____
__. _____	__. _____
_____	_____
__. _____	__. _____
_____	_____

DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	296.xx	Bipolar I Disorder
	300.4	Dysthymic Disorder
	296.2x	Major Depressive Disorder, Single Episode
	296.3x	Major Depressive Disorder, Recurrent
	296.89	Bipolar II Disorder
	_____	_____
	_____	_____

Axis II:	301.83	Borderline Personality Disorder
	_____	_____
	_____	_____

Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
296.xx	F31.xx	Bipolar I Disorder
300.4	F34.1	Persistent Depressive Disorder
296.2x	F32.x	Major Depressive Disorder, Single Episode
296.3x	F33.x	Major Depressive Disorder, Recurrent Episode
296.89	F31.81	Bipolar II Disorder
301.83	F60.3	Borderline Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.