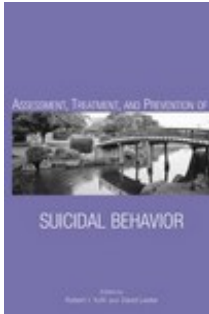


## Assessing and Managing the Deadly Patient

A review of



### **Assessment, Treatment, and Prevention of Suicidal Behavior**

by Robert I. Yufit and David Lester  
Hoboken, NJ: Wiley, 2005. 482 pp. ISBN 0-471-27264-7. \$65.00

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Reviewed by  
**Jerry A. Morris**


In the introduction, Yufit, who has served as a past president of the American Association of Suicidology and is the current associate editor of that association's journal, *Suicide and Life-Threatening Behavior*, and Lester, who has served as past president of the International Association for Suicide Prevention, remind us that suicide and suicide potential are ever-present problems faced by clinicians. They point out that approximately 30,000 people in the United States take their lives each year. Although these suicides are entered into a tracking database, the authors postulate that there may be many suicide deaths that go unclassified and hence unreported. We know that suicide is the eighth leading cause of death in this country and that suicide is second only to accidental death in the 15-19-year-old age range. The author and editors point out that there may be as many as 250,000 nonfatal suicide attempts each year in the United States. They note that about 15% of people who attempt suicide will eventually succeed, with about one third having had previous suicide attempts in their history.


The editors and authors indicate that this attests to the importance of clinicians developing suicide assessment, treatment, prevention skills, and expertise. They indicate that the purpose of the book is to provide a current and comprehensive source of information and guidelines for doing so. The book meets these goals, and it does so in a delightful and clinically useful fashion. The clinician will come away with a comprehensive review of the foundational science, popular theories, usable and refreshingly concise technique summaries, pragmatic assessment overview, and substantive clinical intervention suggestions.

The authors have written and edited a superb, 482-page volume. Contributors include psychologists in independent practice, hospital psychologists, medical school psychologists, university faculty, and even a county district school board

member in Canada. This rich and broad set of authors makes for a well rounded and very useful text, suitable for practicing clinicians who seek to review summaries of pertinent research, theories, and techniques, that also lends itself well to those students who wish to amass foundation knowledge, in the state of science and practice with suicidal patients.

## Assessment

 The first six chapters of the book are focused on screening and assessment for suicide potential. These chapters include extensive reviews of suicide assessment scales, and after the usual material on the reliability, validity, base rates, and general construction weaknesses of suicide scales, some really useful clinical reviews of some specific and promising instruments are provided. Beck's scales—including the Beck Depression Inventory, the Beck Depression Inventory-II, the Beck Anxiety Inventory, the Beck Hopelessness Scale, the Dysfunctional Attitude Scale (Weisman & Beck, 1978), the Scale for Suicidal Ideation (Beck, Kovacs, & Weissman, 1979; Beck & Steer, 1991; Beck, Steer, & Ranieri, 1988), the Suicidal Intent Scale (Beck, Schuyler, & Herman, 1974) and the similar Social Problem-Solving Inventory—Revised (D'Zurilla & Maydeu-Olivares, 1995; D'Zurilla & Nezu, 1990—are reviewed. The authors conclude that empirical evidence is generally supportive of the reliability and validity of these scales. These scales are psychometrically sound, clinically useful, and efficient (many are quite short but powerful, taking only a few minutes to read), and they are deemed useful in assessing suicidal risk and for treatment planning, placement, and clinical decision making. Some scales have good potential for distinguishing between active suicidal desire, preparation stage suicidal risk, and passive suicidal desire. In general, these assessments are based on static predictors of suicide potential and vulnerability factors (dynamic factors) associated with risk of suicide potential. Therefore, the assessment questionnaires and techniques represent excellent ways to efficiently amass key indicator histories and to organize symptoms and data for reports. Every clinician, student, and program supervisor will find the early part of the assessment section of this book invaluable.

 There is a wonderful chapter that summarizes and reviews the use of the various forms of the Minnesota Multiphasic Personality Inventory (MMPI) in suicide risk assessment and treatment planning. The book asserts that the research literature leads us to conclude that among the standard psychological tests, only the Rorschach and the MMPI have potential as predictors of suicidal behavior. It is postulated that the prediction of suicide is too complex to be measured reliably by a single variable or combination of indicators on the MMPI or any standard psychological test. It is asserted that empirical investigations into the efficacy of the MMPI in describing suicide attempters from nonattempters, or predicting suicide threateners from actual completed suicides, indicate that the instrument fails to provide valid and reliable markers for practical clinical application with acceptable hit and false-positive rates. Specific scales, code typing, supplemental and derivative scales, and content analysis have

all been disappointing in this regard. However, the book reviews in detail the positive indicators on the MMPI in these regards that can be helpful, along with other measures and techniques for assessing suicide risk. In this way, the book is not only an informative review of the MMPI (MMPI, MMPI-2, and MMPI-A) literature related to this issue, it provides a measured approach to using such data in a balanced and responsible way. Case histories and profile examples are provided. Those who are responsible for determining suicide risk and have MMPI data available will find this part of the book informative and extremely helpful. The supervisor who is charged with attempting to impart skills to students by connecting the scientific literature, proper use of MMPI data, and understandings about related limitations of the will also find the MMPI chapter invaluable.

☞ The Rorschach chapter in the assessment section is very thorough and makes a good research and theoretically linked case for the utility of this instrument in the assessment of suicide risk. Single-sign approaches, including the utility of reviewing color-shading blended responses and transparency or cross-sectional responses, are fully discussed. Suicide constellation approaches (S-CON; Exner & Wylie, 1977), developed to predict a lethal suicide attempt occurring within 60 days after testing, and the Adolescent Suicide Index (Silberg & Armstrong, 1992) are clearly and cogently elucidated. The Riggs Index, which is a composite index including color-shading blended, cross-sectional, transparency, and morbid responses (Fowler, Hilsenroth, & Piers, 2001), has been found to identify the near-lethal groups of suicidal patients. There is some evidence that S-CON and the Riggs Index in combination have incremental validity. The Silberg and Armstrong Adolescent Suicide Index, based on patients who engaged in nonlethal self-injurious behavior before taking the Rorschach, identified as another potentially useful constellation index.

☞ Clinical risk factors for suicide (Bongar, 2002) and the related extensive clinical and research literature noted. These psychological, epidemiological, biological, and cultural variables that can show up in the clinical history, during a mental status exam, and in Rorschach data include: a history of psychopathology, depressive disorder, a history of alcohol/substance abuse, presence of a personality disorder (especially borderline and antisocial personality disorder), and traits and conditions such as a sense of hopelessness or despair, feelings of humiliation or self-hatred, vulnerability to abandonment, feelings of social isolation, and potential for impulsive behavior.

☞ The authors point out that all of our current techniques and tools for assessment in this area are individually weak, inadequate, involving, and have only marginal or minimally acceptable utility for assessing lethality, self-harm, and self-destructive potential. The experienced clinician realizes that a multi-instrument, multitechnique approach involving specific suicide assessment tools with acceptable validity and reliability, standard psychological tests with some theoretical and research-supported utility, clinical experience and

judgment tempered with a thorough understanding of risk factors and red flag indicators amassed with the powerful clinical tools of a social-psychological history and mental status examination are clearly required as a best practice to assessing suicide. Although the naturally fragmented nature of an edited volume with many chapter authors has difficulty sustaining this important and balanced understanding through the various contributions, this core realization is discernable through the combined wisdom of the many and varying authors of this volume. The last chapter in the assessment section, written by Yufit, strikes this balance as it acknowledges that the lack of gold-standard assessment devices forces the clinician to rely heavily on clinical experience, training, and subjective methods.

☞ The concept of the vital balance, first illuminated by Karl Menninger (1967), is used by Yufit to draw attention to the assessment of coping ability and vulnerability to stress that is so essential in suicide assessment. The issues considered essential for coping and the subcomponents of resiliency and buoyancy are discussed. Resiliency, or the needed flexibility to maximize adaptation to change and coping with stress, is related to having cognitive flexibility, optimism, and hopefulness. Having the ability to bounce back, or buoyancy, is also stressed. Clinicians assessing suicide risk potential are encouraged to assess this vital balance of resiliency and buoyancy in the context of the patient's vulnerability to stress and his or her coping skills. Yufit reminds the clinician that the most frequent legal action in our profession is related to alleged failure to reasonably protect the patient from harming him-or herself (Bongar, 1991). Drafts of clinical suicide assessment checklists (with weighted items) are presented by Yufit and offered in full draft in the book.

## Treatment

☞ Chapters 7-14 of the book are concerned with the treatment of suicidality and are led by a chapter on classical systems of psychotherapy and their views about the origins and treatment of suicidal behavior. This section of the book is a delightful, brief-but- concise review of several major theories and techniques relevant to the treatment of suicide (crisis theory, psychoanalysis, cognitive-behavioral therapy, voice therapy, dialectical behavior therapy, family therapy for older people, group therapy, suicide prevention, and emergency contracts). The various authors provide well-written, research-informed, and condensed reviews of the theoretical etiology of suicidal behavior, goals of therapy, core interventions and techniques, and a general overview of each method. Although the advanced practitioner in any given technique will find the summary introductory, the amalgam of all the noteworthy theories and techniques in a parsimonious and useful summary is a helpful review for the seasoned clinician and a wonderful teaching aid and review for the supervisor, program director, intern, or resident. The authors give the clinician a review of the body of theory and knowledge that is held as core, important, and explanatory for treating the suicidal patient. This core elucidates major theoretical views of suicidal behavior. These etiological views

include suicide emerging from guilt over death wishes toward others and identification with a suicidal parent as the consequence of irrational beliefs generating negative emotions and a downward behavioral spiral with loss of hope (reinforced by dissolving interpersonal relationships that drive the victim's growing negativity and despair), and learned helplessness conditioned by blocked avenues of escape and painful experiences. Whether he or she uses dialectical behavior therapy, transactional analysis, reality therapy, existential therapy, cognitive therapy, client-centered therapy, psychoanalysis, behavioral therapy, others, the clinician needs to know how colleagues and treatment team members conceptualize the problem, and he or she must understand that many patients relate to one or another explanations of their problems with differential allegiance.

Specific skills related to crisis intervention are covered in some detail. A conceptualization of the patient's mind-set (that they are faced with an unsolvable problem, view the problem as continuous, viewing suicide as the only solution or that their situation is hopeless, embrace suicide as ego-syntonic, abandonment of problem-solving options, and intense psychological pain that is believed to be resolved by personal death) is juxtaposed against the clinician's functions of rapid assessment, radical availability, and ability to reassure, calm, relax, and restore hope. Collateral consultation and education with family and significant others are seen as essential components of crisis intervention. Through joining the family and core relational system, being radically available and maximally supportive, and linking the patient with vital community resources, the clinician demonstrates competence in handling a suicidal crisis and instilling hope and confidence in the patient and their family. Many clinicians who simply transfer the responsibility for crises to the hospital emergency room or the local community mental health center need to read this chapter and ask themselves what they are communicating to their patient about their caring, involvement, and dependability and the patient's ability to have confidence in them and to attach hope to therapy and treatment plan.

Antisucide contracts have not been established as scientifically valid interventions at this time, even though the majority of clinicians seem to favor them. The authors review these no-suicide contracts as popular clinical tools and provide dos and don'ts and sample contracts.

These chapters not only educate the reader on the generally accepted conceptualization of suicidal ideas, urges, and acting out, they refresh the clinician about their options for treatment. These chapters remind the clinician of the constructs useful for treatment plans, progress notes, explanations for managed care gate-keepers and reviewers, and necessary conceptualizations and professional terminology essential for demonstrating competent conceptualization of a case and the provision of a treatment that is up to community standards. Certainly, this section of the book will have utility in the continuing education and risk-management programs facilities treating individuals with serious and persistent

mental illness.

## Special Issues


— The third part of the book deals with special issues such as easing the legacy of suicide, suicide in the schools, colleges and suicide, and suicide and terrorism. Lester (2005) indicates that suicide is a socially undesirable act with serious negative consequences for the survivors (Calhoun, Selby, & Selby, 1982). Survivors experience issues of guilt, receive less social support, and feel urges to try to understand the loved one's death. They are susceptible to powerful and often disruptive negative emotions that must be managed. Many have to deal with the trauma of finding the deceased and carrying that memory. Family members are sometimes exhausted by a long period of consideration of suicide as a means of adaptation to emotional turmoil, ill health, or depression, and many families seek postevent therapy. The treating clinician is reminded that postsuicide care for the survivors is clinically important, ethically necessary, and morally conscientious.


— Leenaars, Lester, and Wenckstern point out that we have long known that up to 30% of youth experience some sort of psychopathology or maladjustment (Glidewell & Swallow, 1969) and that only a very small number of these children and adolescents get help with their problems (Kazdin, 1990). Strong imitation and triggering effects after suicide have been identified in the literature. This has necessitated postevent control for suggestibility in schools (Leenaars, 1985; Martin, 1998). In this part of the book, the authors indicate that prevention programs—including peer helpers, dissemination of current knowledge, school crisis teams, counseling, postevent debriefings, student evaluation and individual programming, and managing the attitudes and behaviors of school leaders and officials—are important parts of the expert clinician's armamentarium. They make the point that the local clinician has a responsibility to assist the schools in their suicide prevention and preparedness, response to suicide threats, postsuicide adaptation, and staff training. An excellent chapter describing the necessary knowledge, skills, and interventions is provided for the community clinician.


— A chapter on helping college students who may be suicidal provides an excellent resource for those psychologists offering clinical services on or near campuses. Research indicates that suicide is less common on campuses than in the general population but that we now understand that older students, and particularly older female students, are the most susceptible individuals (Silverman, Meyer, Sloane, Raffel, & Pratt, 1997). The book provides epidemiological data about various aspects of suicide, suicide risk, and risk of otherwise acting out on college campuses. It has an extensive section on intervention using various techniques and models. A final chapter on suicide and terrorism is provided. This chapter is of little value to the clinician but offers a timely analysis of the various theoretical and multicultural explanations of terrorist suicidal acts. With all the clinician-helpful chapters, this chapter, although interesting reading, is quite out of place with the rest of the book. The editors did a great job of

organizing and putting together a book that is very useful to clinicians and student clinicians, but this chapter takes a wrong turn. It leaves one wishing for a big finish useful to the clinician caring for the dangerous patient. Perhaps a final chapter on duty to warn, ethical issues, involuntary hospitalization, and other complex issues facing the clinician would have been more appropriate.

## Summary



 In all, with the noted exception above, this is an essential book for the active clinician's shelf. It is an able review of the literature regarding the assessment and treatment of suicidal patients, and is well grounded in the major theories of the origins and treatments of these patients. The book has utility for clinicians, program directors, supervisors, interns, and residents. Clinicians who must meet the ethical and professional requirements to delineate the foundations on which they make decisions about holding, placing, and treating patients that they think are a danger to themselves will appreciate the generally accepted, scientifically based, and theoretically sound indicators provided in the questionnaire, MMPA, and Rorschach chapters of the assessment section of this book. Yufit's clinical checklists are helpful interview guides and ways of tabulating data.

 Community mental health centers, general hospital emergency rooms, and crisis- team directors of psychology will find this text an invaluable addition to their continuing and professional education programs. Assigned readings, Internet-assisted learning, and scheduled workshops can be developed using this work. Psychologist supervisors of treatment teams, interns, and residents will find this book an invaluable instrument, useful in the clinical supervision process. Clinicians wishing to do program evaluation and research scientists new to this area of study will find this book a valuable survey of the state of knowledge about the perceived origins of suicidal thinking and behavior and the literature related to suicide.

 Yufit and Lester have produced a work that will be valued by clinicians and trainers for some time to come. It will predictably survive to second and future editions in which research and techniques can be updated. Clinicians will likely become dependent on Yufit and Lester's updates well into the future.

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