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A Common Factors Approach to Psychotherapy With Chronically Suicidal Patients: Wrestling With the Angel of Death

Joel Yager and Robert E. Feinstein

Objective: Conducting psychotherapy with chronically suicidal patients challenges clinical decision making and emotional self-management in both trainees and seasoned practitioners. Educators and trainees have noted the need for additional teaching materials in these areas. This article is intended to address these needs. Methods: We review the literature on evidence-based, suicide-oriented psychotherapies; consider commonalities among them; and integrate these findings with observations and suggestions from older professional literature and anecdotal clinical wisdom. Results: Based on these sources, we describe a common factors–based approach for clinicians undertaking the ongoing psychotherapy of chronically suicidal patients, to be practiced within a comprehensive treatment framework that addresses safety planning as well as multimodal interventions including psychosocial and biological approaches. We discuss initial considerations; a checklist of motivations, coping styles, defenses, existential, spiritual, and religious issues, attachments and relationships to be explored in delineating directions to be undertaken in psychotherapy; technical issues for ongoing psychotherapy; perspectives that have been helpful for patients; and coping strategies for countertransference management. Conclusions: Patients are best served by clinicians who focus on the alliance, actively engage chronically suicidal patients and their families, directly confront warning signs, routinely address the many psychological issues mentioned, and carefully attend to their own countertransference reactions and capacities for emotional regulation. Using these strategies, techniques, and tactics, clinicians are better equipped to help chronically suicidal patients reduce suicide-related ideations, plans, and attempts, and, perhaps, completed suicides.

No sharp line exists between acute and chronic suicidality. We consider individuals who experience clinically concerning persistent or repetitively intermittent passive or active suicidal thoughts, suicide planning, and/or occasional, intercurrent suicide attempts (i.e., that are not primarily nonsuicidal self-injurious behaviors) (Meyer et al., 2010) to constitute the “chronically suicidal.” Chronic suicidality is associated with

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an array of psychiatric disorders, personality difficulties, complex stresses and traumas, and social/cultural influences, which weigh against life-sustaining motivations, inhibitions against suicide, and psychological resiliency. Adequate management requires assessing all dimensions that are necessary to formulate appropriate patient-centered treatments, including psychotherapy.

Although certain suicide-specific psychotherapies show promise for reducing suicidal ideation and suicide acts or attempts compared to either treatment as usual or enhanced care as usual (Brown & Jager-Hyman, 2014; Jobes, 2012), no specific therapy has been shown to decrease actual rates of completed suicide (Maltsberger, 2001).

The quality of most psychotherapy studies claiming support for reducing suicidal behavior is very low to low. Many such studies conflate lethal intent with less serious self-injurious behaviors, and only cognitive-behavioral therapy (CBT) and dialectical behavior therapy (DBT) research have yielded at least three independent studies permitting meta-analyses supporting claims for reducing self-harm (Hawton et al., 2016a, 2016b). Suicide-specific therapies include the Collaborative Assessment and Management of Suicidality program (CAMS; Jobes, 2012), cognitive therapy for suicide prevention (Brown et al., 2005), CBT (Slee, Garnefsk, van der Leeden, Arensman, & Spinhoven, 2008), DBT (Linehan et al., 2015), problem-solving therapy (PST; Hatcher, Sharon, Parag, & Collins, 2011), mentalization-based therapy (MBT; Bateman & Fonagy, 1999), and psychodynamic interpersonal therapy (PIT; Guthrie et al., 2001). Transference-focused psychotherapy (TFP) has also reduced suicidality (Clarkin et al., 2001; Doering et al., 2010).

Recent meta-analyses and metaregression studies involving these therapies concluded that, overall, psychotherapy reduced risk of attempts and self-injurious behaviors by about 7%, with a number needed to treat (NNT) of 15. More fine-grained analyses showed that these psychotherapies were effective for generally reducing suicidal behavior in outpatients but not inpatients, and for patients with borderline personality disorder but not for patients with depression or schizophrenia spectrum disorders (Calati & Courtet, 2016). For self-harming patients with borderline personality disorder, comprehensive DBT-based programs, including individual and group interventions, have reduced both suicide attempts and nonsuicidal self-injuries (Linehan et al., 2015). A “Life Promotion Clinic” devoted to patients at risk of suicide at an Australian university employs several psychotherapies (DBT, CBT, psychodynamic, mindfulness, emotional modulation) almost always accompanied by pharmacotherapy. Diagnoses of their first 238 patients included unipolar depression (65%), posttraumatic stress disorder (PTSD)/trauma and other anxiety disorders (41%), personality disorders (37%), substance use disorder (13%), bipolar depression (7%), psychotic disorders (4%), eating disorders (3%), and assorted others (4%); 44% of patients had more than one diagnosis (Kolves, Arnautovska, Gioannis, & De Leo, 2013). Studies are currently investigating whether brief smartphone apps might reduce suicidal thoughts and behaviors (Franklin et al., 2016).

To study common elements embedded in five empirically based psychotherapies for managing suicidal patients, Weinberg et al. (2010) examined manuals for DBT (Linehan, 1993), MBT (Bateman & Fonagy, 2004), TFP (Clarkin, Yeomans, & Kernberg, 2006), schema-focused therapy (SFT; Young, Kloskso, & Weishaar, 2003), and CBT (Wenzel, Brown, & Beck, 2008). Notably, all but CBT were developed primarily for severe personality disorders. Supporting a common factors perspective (Feinstein, Heiman, & Yager, 2015; Wampold, 2015), these treatments converge around the following recommendations:

- Provide stable treatment frameworks affording consistency with specific patients.
- Attend to affect (psychic pain and anguish).
• Help patients tolerate internal states to reduce impulsivity and emotional dysregulation.
• Help patients better appreciate connections between their emotions and feelings, interpersonal interactions, and behaviors (e.g., to deal with dissociated states).
• Directly address self-destructive and self-defeating behaviors by making them ungratifying.
• Offer increased therapist participation by encouraging problem solving, helping patients gain new perspectives, clarifying, confronting, and actively exploring patients’ psychological states to foster reflectiveness and self-awareness; and support (absent in TFP).
• Increase therapists’ self-awareness of feelings toward patients and ability to manage these feelings.
• Formulate safety plans for managing crises between sessions via alternative coping methods, action plans, and calling on external resources.

Significant differences exist among these approaches. DBT, CBT, and SFT include assignments of homework and explicit behavioral self-monitoring, as well as degrees of therapist self-disclosure. MBT and TFP make much less use of problem solving, advice giving, or personal disclosure. Although both MBT and TFP are based on psychoanalytic theory, transference interpretations as used in TFP are not employed in MBT; the latter assumes deficient mentalization in borderline personality disorder patients, rendering them less capable of making use of interpretations.

TFP ostensibly relies less on common factors and makes no claims for applying this approach to other chronically suicidal patients who do not have borderline personality organization (Kernberg, 1993). Among its several signature features, TFP advocates using formal contracts specifying that, should suicidal behavior occur between sessions, patients are responsible for following the therapists’ instructions to go to a psychiatric emergency room, and that therapists will not engage in “rescue operations” outside psychotherapeutic sessions. Patient refusal to go to an emergency room as instructed may result in termination of therapy. Furthermore, TFP clinicians discuss safety plans with patients and families, advising them that the treatment has a risk of suicide. Families are advised not to consider themselves responsible for the patient’s suicidal behaviors or for rescuing the patient “at any and all times” so that secondary gain opportunities are minimized. Efforts are made to assure that therapists are always physically (and psychologically) safe and legally protected; the dictum is that “the therapist will not be more responsible than the patient himself for keeping the patient alive.”

Although a great deal of psychotherapy literature concerning chronic suicidality addresses patients with borderline personality disorder, and although 9% to 10% of these patients eventually do complete suicide (Paris, 2002), borderline personality disorder occurs only in about 3% of the population. In fact, the percentage of chronically suicidal patients meeting criteria for this diagnosis is unknown. The chronically suicidal population that concerns us extends considerably beyond borderline personality disorder per se. Here we offer a common factors–based approach for conducting ongoing psychotherapy with this broader array of chronically suicidal patients.

GETTING STARTED

Initial Encounters

To start, we wish to emphasize that psychotherapy with chronically suicidal patients should be undertaken only in the context of comprehensive treatment for suicidality—after thorough assessments for warning signs (Rudd et al., 2006) that might include the use of valid and reliable assessment tools (Homaifar, Matarazzo, & Wortzel, 2013), multimodal safety planning (Anestis et al., 2016; Betz et al., 2016; Grant & Lusk, 2015; Matarazzo,
Homaifar, & Wortzel, 2014), and suitable biological interventions for alleviating impulsivity, depression, and suicidal preoccupations (Griffiths, Zarate, & Rasimas, 2014). Mindful of this context and of all considerations noted here, several principles can be deduced:

- Because each suicidal patient is unique and no one theoretical model applies to all suicidal patients, considerable variation is necessary in treatment and therapy. Applying models that fit the last suicidal patient to the next one might simply be wrong. (A well-known aphorism states, “All models are wrong, but some are useful.”)
- Clinicians vary considerably in their abilities to handle uncertainties, potential risks, and patients’ and/or their own emotional responses. They differ in moral, philosophical, and personal attitudes; biases; emotional capacities; and technical skills. Faced with patients at serious risk of suicide, clinicians are well served to inventory their strengths, weaknesses, attitudes, and apprehensions regarding the following:
  - Death anxieties: Concerning their own mortality and that of loved ones.
  - Attitudes: Regarding whether individuals ever have the right to take their own lives; that suicide is always wrong regardless of extenuating circumstances; that every measure should be taken to avert every suicide; that some suicides might not be due to psychiatric illness but to existential traps from which no acceptable alternatives seem possible; that some clinicians might believe that some patients might be better off dead or that some patients’ lives are not worth saving.
  - Capacity for compassion: Ability to be fully present without self-protectively “checking out” when patients describe suicidal anguish, ideas, and plans; experiences of compassion fatigue.
  - Risk aversion: Fears of being judged harshly by colleagues, peers, and authorities; culpability; and other adverse personal consequences should the patient suicide. Clinicians whose apprehensions preclude attentive listening to patients can come across as preoccupied and lacking in compassion.
  - Need for control: Because many intrapsychic and environmental aspects of suicidal patients’ lives are beyond any practitioner’s powers to dictate, these patients often particularly distress clinicians who strongly need to be in control.
  - Capacity to confront difficult issues: Some clinicians avoid conducting psychotherapy with chronically suicidal patients fearing that they will inadvertently provoke suicide by saying the wrong thing at the wrong time.
  - Capacity to actively intervene when faced with impending suicidality.
  - Capacity to accept that patients are ultimately responsible for their own actions.
  - Capacity to assess personal counter-transference feelings and use them for patients’ benefit.

Appreciating these difficulties, we offer the several common factors–based recommendations for approaching ongoing psychotherapy with chronically suicidal patients. These recommendations synthesize our own views with those of several scholars and researchers, notably John Maltsberger and colleagues (Maltsberger, 2001; Maltsberger & Buie, 1974; Weinberg et al., 2010), Orbach (2001), Shneidman (1998), Jobes (2012), and Joiner (2007), from whom we liberally borrow. They also incorporate Paulson and Worth’s (2002) findings from 35 patients who overcame periods of severe suicidality during treatment, describing what was most helpful to them during psychotherapy, and findings of Hendin, Haas, Maltsberger, Szanto, and Rabinowicz (2004) and Neimeyer and Pfeffer (1994) summarizing reflections by clinicians who lost patients to...
suicide regarding their possible mistakes in therapy.

- Establish and foster a dignified, empathic, respectful therapeutic alliance in which patients feel fully heard, engaged, encouraged to tell their stories and explore deep existential issues, and enabled to get to the heart of the matter. Patients should be assured that discussing chronic suicidality will not lead the clinician to reflexively recommend hospitalization. Maltsberger (2001) emphasizes the value of enabling patients to identify with an “empathic, realistic, and loving therapist,” offering himself or herself as an “auxiliary ego” in a real relationship that does not overemphasize transference, offering a soothing, holding environment in which the therapist, “struggling alongside,” can help patients reality-test. In these relationships, therapists are expected to develop and effectively communicate real (nonerotic) affection for the patient (Maltsberger, 2001; Weinberg et al., 2010). Focusing on the centrality of psychic pain to suicidality, Orbach (2001) stresses an approach that includes “therapeutic empathy with the suicidal wish” in which the therapist nonjudgmentally and empathically “gets” the patient’s pain-producing inner patterns and self-destructive tendencies, shares the patient’s pain burden, and can explore the patient’s most dreadful and frightening inner experiences. These stances, validated by patient feedback (Paulson & Worth, 2002), are intended to increase the patient’s sense of being heard, acknowledged, understood, trusted, and validated, and to decrease the patient’s sense of existential isolation.

- Listen between the lines (with the “third ear”; Reik, 1949) for clues of escalating warning signs, alert to veiled communications, sensitive to all pregnant pauses, silences, allusions, and asides that seem to convey hidden meanings without being explicit or committal. Clinicians should not passively wait for patients to raise all the issues, for example, topics that are obviously being avoided and omitted—the elephants in the room. Clinicians might feel that they walk a tight line between raising sensitive issues without wanting to seem harsh or to provoke further inclinations to suicide. But given the slightest doubt, clinicians should explicitly ask about the patient’s suicidal ideas or plans; better to overask and risk the patient’s admonitions rather than fail to discern a veiled communication in which a patient might be expressing ambivalence or testing whether the clinician is really paying attention and cares enough.

- Don’t take the patient’s death wishes and behaviors personally. Chronic suicidal inclinations constitute coping styles for managing psychic pain, complex and massive psychic traumas, poor attachments, and irreconcilable conflicts, resulting in feeling unloved, misunderstood, alone, and trapped in hopelessness. Such feeling states easily transmute to angry, multidirected rages, for which nearby clinicians can provide convenient lightning rods, easy targets for uncontained fury. But these rages are not about the clinician—unless the clinician has specifically done something to earn them.

- Involve the family in ongoing care, with the patient’s assent in almost all instances. Inform families about patients who are chronically suicidal and at risk, and offer them access. Families should be educated to the fact that clinicians cannot assure around-the-clock safety, and therefore cannot ultimately take responsibility for whether a patient lives or dies or decides to suicide (Gunderson, 2001; Kernberg, 1987). Concurrently, clinicians should be sensitive to complex family dynamics that might complicate treatment.
• Realize that strategies used for clinically urgent, acute suicidal person are typically inappropriate for the chronically suicidal person (Hendin et al., 2004; Schwartz, Flinn, & Slawson, 1974). Even holding “safety first” as a prime consideration, hospitalization is rarely the right thing to do for chronically suicidal patients (unless they become acutely suicidal). Hospitalization might or might not be calming (in fact, hospitalization might be agitating and in other ways counterproductive). Hospitalizing some patients can foster malignant regression, flight from treatment, and resentment of mental health interventions. Furthermore, cycles of repeated hospitalizations with borderline patients might become a destructive game, with stakes and ante being continuously upped—a game which Hendin (1981) called “coercive bondage.” At the same time, partial hospital programs integrated with outpatient and substance abuse treatment and pharmacotherapy can be helpful.

Assessing Patient-Centered Psychotherapy Themes

Initial tasks include engaging patients in exploring salient issues for psychotherapy. The following review of systems offers a systematic checklist for collaborative appraisal. While clinicians should be mindful that all these themes can potentially be pertinent, determining precisely which themes deserve detailed exploration in any given case depends on each patient’s specific circumstances.

Motivations

To what extent do the patient’s suicidal motivations address the following needs? (Bryan, Rudd, & Wertenberger, 2013; Joiner, 2007):

• Escape from otherwise inescapable, insufferable feelings and thoughts, for example, psychic pain and anguish related to feelings of frustration, rage, vengefulness, hopelessness, terror, guilt, shame, self-hatred, entrapment, numb emptiness, detachment from life, already being dead, being socially isolated and alienated, burdening others, ineffectiveness, dependence and/or incompetence, powerlessness, significant losses, defective, failing, psychological weak, and chronic physical pain.

• Escape from otherwise inescapable, insufferable current and anticipated situations, for example, getting away from others to prevent being hurt further, preventing oneself from hurting or killing others, avoiding realistic or unrealistic dreadful events or outcomes such as progressive medical illness (such as amyotrophic lateral sclerosis, Huntington’s disease, frontotemporal dementia, prolonged painful deaths via malignancies), other interpersonal crises, and fears the patient would have to face and confront if he or she stayed alive.

• Achieve desired feelings, thoughts, and outcomes, for example, gratification through expressing rage, taking revenge, relief and atonement through self-punishment, communicating desperation, getting attention and help, aiding others, shocking or impressing others, making others understand. What is the patient attempting to communicate directly and indirectly via suicide-related messages?

• Reduce inner conflict by conforming to one’s local culture and core beliefs, which might privilege suicide over acknowledging psychological deficits or weakness, support a “machismo” or heroic script, and/or advocate protecting others through one’s own death (Braswell & Kushner, 2012).

Identifiable overt and hidden contingencies, subtle triggers, and barely evident stimuli...
Factors Clinicians Should Identify and Explore

**Coping and defense.**
- Protective factors and strengths, including reasons the patient might still have for continuing to live and how these might be reinforced. Studies show that therapeutic attention to strengthening reasons for living may help avert suicide, for example, via increasing coping skills, religious beliefs, social support, and connections (Bagge, Lamis, Nadorff, & Osman, 2014; Bakhiyi, Calati, Guillaume, & Courtet, 2016).
- Ambivalent attitudes and courage regarding suicide, their sources, and whether the patient is trying to become progressively more fearless about death and suicide to desensitize and work up to the act.
- Quality of life: If the patient isn’t experiencing unbearable suffering, why is there a need to die at this point?
- Personality characteristics (e.g., narcissism, need for control, impulsivity, dependency) and psychological deficits contributing to suicidality, failing psychological defenses, and whether the patient experiences splits in the self or dissociative states.
- Complex or massive psychic traumas contributing to suicidality.
- Are there patterns of substance use/abuse?
- Imagined methods of suicide, personal meanings these methods hold, and possible safety measures regarding guns and other lethal means.

**Existential, spiritual, and religious issues.**
- Whether the patient has (or lost) a sense of meaning and purpose in life; feels attached to life, repulsed by life, or already dead; is grappling with spiritual or religious issues or loss of faith; sees himself or herself as a fallen or cursed individual; fantasizes joining loved ones in an afterlife; or desires to see God as quickly as possible. Might new or modified religious/spiritual beliefs offer alternatives to suicide? Spirituality-focused mindfulness and meditation approaches (Birnbaum & Birnbaum, 2004) and logotherapy-based approaches emphasizing dignity, choice, and personal meaning have been anecdotally helpful in treating nonpsychotic suicidal patients (Schulenberg, Hutzell, Nassif, & Rogina, 2008).

**Attachments and relationships.**
- The nature and quality of the patient’s attachment patterns.
- The extent to which significant others in the patient’s life are aware of suicidal thinking, their reactions to such discussion, and whether they should be included in therapy. Acknowledging that such invitations can always be rejected, might reaching out to others (including those from whom the patient has been estranged) reduce isolation and improve chances for wanting to live? What “unfinished business” regarding significant others remains to be considered? If the patient declines to have others involved, reasons for refusal should be explored.
- Whether the patient has considered who among his or her significant others might need emotional and other types of support following a completed suicide, and how that support could be provided.
- Fantasies of how the suicide will affect surviving relatives, children, unborn generations, friends, and acquaintances.
- Explicit or implicit pressures, challenges, or taunts by others urging the patient to suicide.
- Fantasies regarding who is likely to find the dead body, how gory or decomposed it might be, and what should, or will, happen to the remains. Such
explorations can reduce any glamour that might be attached to suicide fantasies by evoking much less appealing images of carnage and biological decay.

- Fantasies of being present in an afterlife to witness how survivors are reacting to the death, who will attend their funeral, and what they are likely to say.

**STRUCTURING PSYCHOTHERAPY FOR THE CHRONICALLY SUICIDAL PATIENT**

In this section, several phases are identified for conducting psychotherapy with chronically suicidal patients.

**Initial Phase**

Orbach (2001) describes the initial phase as one of “healing contact ... establishing compassionate attachment including empathy with the suicidal wish.” The very act of “being there,” bearing existential witness and listening empathically, thereby helping decrease the patient’s sense of alienation and social isolation, might be suicide averting, at least for a time. Our common factor approach includes assessing the issues described in detail in the previous section, offering the patient initial formulations of diagnoses, problems, and treatment approaches, and aiming toward mutually agreed upon understandings, plans, and goals. The therapeutic contract includes safety planning and a statement of expectations that treatment could be long term, will be outpatient based (relying on emergency rooms, intensive outpatient, or inpatient treatments only if suicidality becomes acute), will involve others, and will as necessary be multimodal.

**Working Through**

This phase consists of detailed explorations of the motivations, coping and defense issues, existential, spiritual and religious issues, and attachments and relationships identified as salient. Discussions cover the pain, beliefs, dynamics, losses, traumas, relationships, and all past experiences that have made things worse and where therapeutic interventions might make things better.

Also discussed are fears, conflicts, and convictions that must be progressively faced and confronted. If present, substance abuse issues impeding progress must be managed. Paulson and Worth’s (2002) patients described these functions as allowing themselves to feel, acknowledge, and resolve pain, helplessness, and despair; recognizing and facing fears; and understanding suicidal behaviors.

**Changing the Inner World**

These processes involve working through losses, stresses, and various traumas; restoring losses by finding alternative acceptable coping styles, defenses, and solutions; reframing the narrative; expanding the amounts of reflective thought and inhibitory space between suicidal triggers and impulsive action; filling in gaps and capacities where deficits exist; and accepting some degree of ambivalence. What alternative explanations, substitutions, or accommodations are conceivable? The patient’s strengths are explored, fostered, and put to creative use. Paulson and Worth’s (2002) patients described the importance of developing capacities for better distinguishing thoughts, feelings, and behaviors; accepting responsibility for and owning their behaviors and roles in creating their own pain; breaking self-destructive patterns; developing new patterns of coping; learning to reject unrealistic expectations of others; learning to effectively express anger; realizing the need for boundaries; developing connections to God; resolving unfinished business with family members; and reclaiming their power to make choices. Deeper transformations, in which individuals find potential “gifts” or sources of unexpected growth and resilience hidden in extreme suffering, are occasional dramatic accomplishments.
Through such experiences individuals might be able, for the first time, to be completely honest with certain others or to change their lives entirely (Orbach, 2001).

**Termination**

If and when the patient has responded sufficiently for treatment to wind down, termination should not be abrupt. Weaning is preferred, and clinicians should always leave the door open, should future needs require.

**ONGOING CLINICAL DETERMINATIONS**

During the course of psychotherapy, clinicians can anticipate having to frequently consider the following issues:

- The amount of exploration versus support the patient can tolerate and how much the clinician should extend a helping hand. These may depend on the extents to which the patient’s suicidal struggles result from deficits (e.g., of psychic energy related to mood disorder, personality, and defensive structures) versus resolvable avoided conflicts and the patient’s capacities to productively persevere by searching within for answers. Depressed suicidal patients who lack capacities often experience a clinician’s unwillingness to provide support and direction as withholding and rejecting; they not infrequently deteriorate.
- The patient’s tendencies and likely directions of distorting the clinician’s words. Anticipating such sensitivities, clinicians can attempt to better frame and time their communications to minimize misunderstandings.
- The extent to which the clinician can speak bluntly without being adversely confrontational and destructively provocative. The best approach is likely to be tactful directness. For example, in attempting to decrease patients’ senses of existential isolation and to foster trust, Orbach (2001) asks patients to convince him that suicide is the correct and only course. He does not ask this question cynically or disparagingly reject what the patient says out of hand. Nor does he ever denote or connote agreement with suicidal intentions. Primarily, he aims to establish empathic connections “coupled with an uncompromised confrontation of self-destructiveness.”
- As examples of tactful directness, over the years we have stumbled upon styles of phrasing difficult questions or posing statements which seem to have helped some chronically suicidal patients, and which, to our knowledge, have never caused adverse effects. Some come from colleagues, some from our own wise supervisors, and some we have originated. None are meant to be used glibly or callously; all are intended as hooks to deepen engagement and discussion. Their therapeutic value depends on the clinician’s artful timing and delivery and the patient’s character, mood, and receptivity at the moment. While some might seem irreverent, these statements sometimes manage to penetrate patients’ fixed ideas regarding self-destruction and foster out-of-the-box considerations:
  - “I can only do my best to help you while you’re alive. I’m very bad at helping dead people.”
  - “From everything we can tell, suicide is final; there are no do-overs.”
  - “If you’re so intent on being dead, how come you aren’t?”
  - “I can never take away your ability to kill yourself. Ultimately, if you really want to kill yourself, you will. All I can do is my best to be with you, help you think things through, deal with awful feelings, and hopefully improve your situation.”
  - “My job isn’t to keep you alive, since I really can’t; my job is to help you make the best choices for yourself, and that’s hopefully to stay alive.”
“Are you coming for treatment just for me to serve as witness to your misery before you die? Is my job to explain you to your survivors?”

“Why do you seem to be looking so hard into what I say for excuses to justify killing yourself? I have no intention of saying anything for you to use as an excuse to suicide.”

“Just because I say I fully understand your wish to die doesn’t mean I agree that you should kill yourself.”

“Whenever you feel an impulse to kill yourself, please stop and ask yourself, ‘What would Dr. [insert your name here] say at this moment?’”

In response to chronically suicidal patient rages against the clinician for being insensitive or inept, insensitive: “Look, you don’t even know me well enough to hate me that much. Who am I taking the rap for? God? Your parents? If you need to blame someone or something, put the blame where it belongs. I’m on your side.”

“Hey, I’m a limited resource. If you keep attacking me, you’ll use me up, and I’m not sure you’ll be able to find an easy replacement. I can probably be of more use to you if I’m alive and well.”

**SELF-MANAGEMENT STRATEGIES FOR CLINICIANS COPING WITH CHRONICALLY SUICIDAL PATIENTS**

Clinicians frequently think about their perplexing suicidal patients after hours, mulling over ways to better understand and treat them. Too often these patients also evoke feelings of fury, worry, and/or despair. Countertransference reactions, many described by Maltsberger and Buie (1974), based on frustration, exasperation, and burnout, take various forms of fight, flight, and withdrawal stress responses. “Fight” responses include feelings toward the patient of hate, rage, irritability, callousness, contempt, rejection, including fantasies of killing—or being killed by—the patient. Fight responses might also include fantasies of breaking boundaries to rescue the patient from his or her plight. “Flight” responses include fantasies of running away or escaping; the patient dying in an accident; and wishing to not return calls or cancel appointments; and experiencing preoccupying fears that anticipate utter disasters resulting from treatment failure and losing this patient. “Withdrawal” responses include undue feelings that the patient is hopeless combined with resignation to failure and to simply give up, dissociatively checking out during sessions. Such feelings may be generated by feeling tormented by the patient as well as resenting and fearing the burden of unending responsibilities for the patient’s entire lifetime. Clinicians who act out countertransference reactions can precipitate suicide attempts in patients who experience these as rejections (Paulson & Worth, 2002; Weinberg et al., 2010). Some clinicians might focus on simply delaying the dreaded inevitable, doing whatever they believe might stave off suicide during their watch, pacifying the patient as necessary to assure that the patient will live another day—or until the next provider assumes responsibility.

Accordingly, clinicians should be constantly checking themselves: What countertransference feelings can be identified? How are they expressed in session? How are they impacting the therapy? To better understand and deal with what they are experiencing, whether activated by personal issues and/or via projective identifications resonating with their patients, clinicians are obliged to objectively inventory and reflect on their internal states. To what extent has the clinician managed to deal with personal anxieties about death and suicide? To what extent is the clinician riddled with anticipatory guilt and shame, overriding sense of responsibility for an anticipated bad outcome, and excessive concerns about being socially judged?
Effective management of the clinician’s own emotional reactions requires both practical instrumental (information gathering, skill building) and emotion-focused (emotional self-regulation) coping strategies; many strategies include elements of both. First and foremost, clinicians should seek out formal or peer supervision and/or personal therapy in which to explore and manage their reactions.

Practical coping strategies include getting an informational framework by seeking specialized training (Sockalingam, Flett, & Bergmans, 2010): learning as much as possible about suicidal warning signs, safety planning, and other suicide-mitigation strategies, as well as the techniques associated with suicide-ameliorating psychotherapies. Clinicians should also meticulously record their risk assessment, case formulation, and treatments, to document their ongoing high-quality care.

Emotion-focused strategies embrace various stress-reduction strategies, including the use of effective self-talk, affirmations, aphorisms, and mantras that clinicians find helpful in allaying their anxieties and sustaining resilience. These activities aim at generating compassionate objectivity—the ability to feel but to let the feelings go and to not bear excessive personal responsibility or guilt for what the clinician cannot control. We, our colleagues, and our supervisors have occasionally found the following examples of self-talk to be helpful:

- “Some cases will turn out bad regardless of what you do and how good you are.”
- “Dealing with patient suicide turns rookies into veterans; it is part of professional development.”
- “Don’t respond to the patient’s sadism or masochism with your own sadism or masochism.”
- “I can only help patients want to stay alive, but I can’t actually keep them all alive. Since I can’t be with them 24/7, I can’t do much if patients determined to die deliberately hide their plans from me.”
- “I’ve done whatever is possible about alerting, forewarning, and preparing this family.”
- “Although suicide is the most frequent cause for lawsuits against psychiatrists, such suits are rarely successful when the clinician has done a good job of documenting high-quality care.”
- “At the end of the day, I can look myself in the mirror and honestly say, ‘I’ve done whatever I could. I don’t think I could have done this any better.’”

**DISCUSSION**

Challenges of conducting ongoing psychotherapy with chronically suicidal patients can tax the professional and personal capacities of even highly experienced clinicians. Built on evidence-based psychotherapies for addressing suicidal individuals, contributions of thoughtful clinician-scholars, and our own experiences, we have distilled recommendations for a common factors approach for psychotherapy with this population. Essential components are alliance building, communicating with families, being actively involved with patients, extending multiple resources, making thorough and nonavoidant inquiries about an extensive range of psychological and existential issues, staying close with the patient’s concerns to work through amenable issues, having a considerable degree of self-knowledge on the part of clinicians, and undertaking constant monitoring and management of the clinician’s own emotional reactions. Such psychotherapies should be undertaken only when nested into comprehensive treatment packages, including safety planning and multimodal treatments, and utilizing medications as indicated.

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