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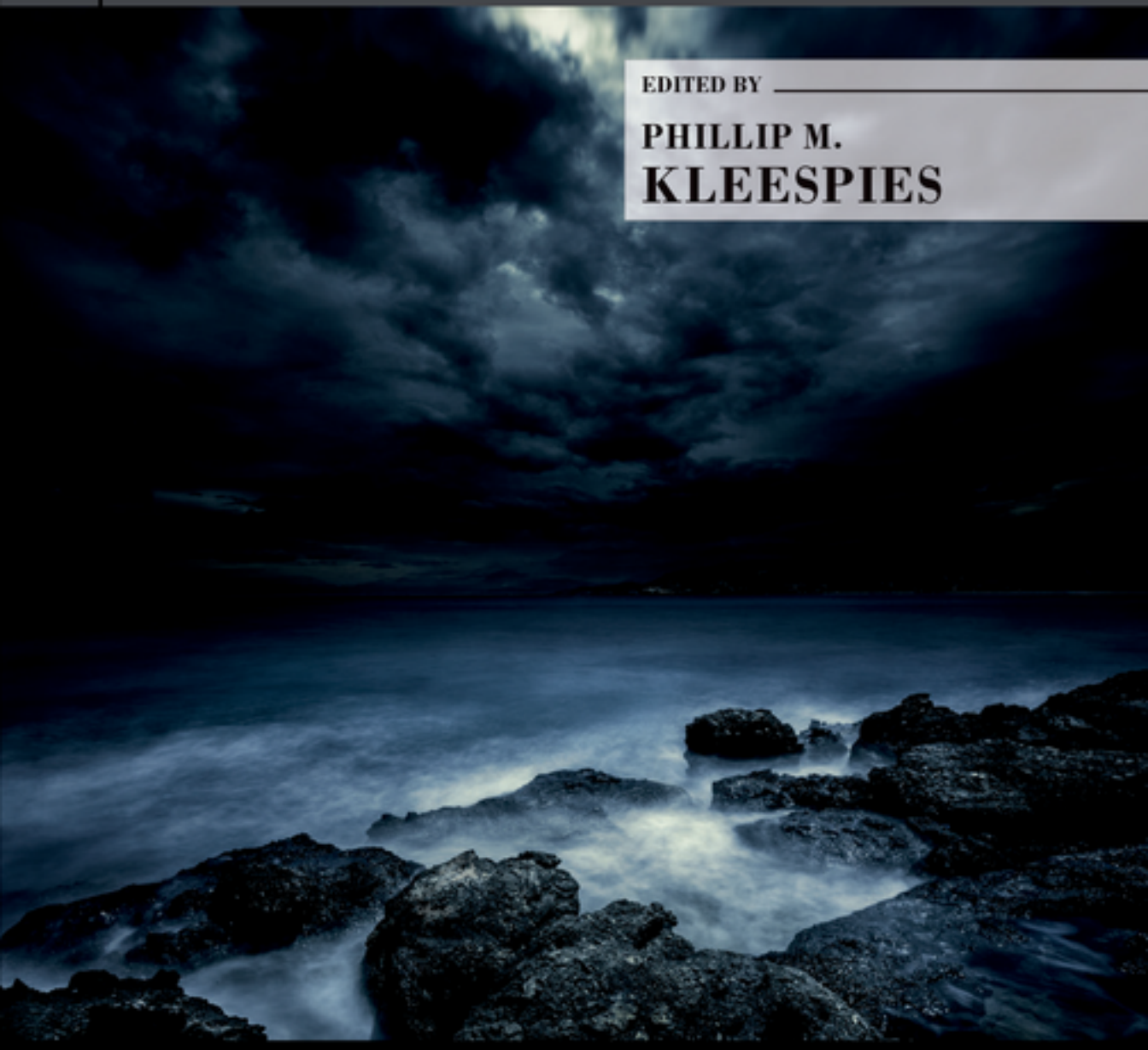

EDITED BY

PHILLIP M. KLEESPIES

The Oxford Handbook *of* BEHAVIORAL EMERGENCIES *and* CRISES

The Oxford Handbook of Behavioral Emergencies and Crises

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Phillip M. Kleespies

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Published in the United States of America by Oxford University Press
198 Madison Avenue, New York, NY 10016, United States of America.

Library of Congress Cataloging-in-Publication Data
Names: Kleespies, Phillip M., editor.
Title: The Oxford handbook of behavioral emergencies and crises / edited by Phillip M. Kleespies.
Other titles: Handbook of behavioral emergencies and crises
Description: Oxford ; New York : Oxford University Press, [2017] | Series: Oxford library of psychology | Includes bibliographical references and index. | Description based on print version record and CIP data provided by publisher; resource not viewed.
Identifiers: LCCN 2016020518 (print) | LCCN 2016018960 (ebook) | ISBN 9780199352739 (ebook) | ISBN 9780199352722 (alk. paper)
Subjects: | MESH: Dangerous Behavior | Emergencies—psychology | Psychotherapy—methods | Crisis Intervention—methods | Suicide—prevention & control | Violence—prevention & control
Classification: LCC RC480.6 (print) | LCC RC480.6 (ebook) | NLM WM 401 | DDC 616.89/025—dc23
LC record available at https://lccn.loc.gov/2016020518

9 8 7 6 5 4 3 2 1

Printed by Sheridan Books, Inc., United States of America

SHORT CONTENTS

OXFORD LIBRARY OF PSYCHOLOGY

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Peter E. Nathan
Editor-in-Chief
Oxford Library of Psychology

ACKNOWLEDGMENTS

I would like to thank Oxford University Press for inviting me to edit this handbook in their Oxford Library of Psychology series. It has been an opportunity to present the most comprehensive coverage, to date, of the area of psychological practice known as behavioral emergencies and crises.

As in all of my work in this area of practice, I am grateful to two groups in particular, the veterans who have sought emotional and mental assistance in the Department of Veterans Affairs Boston Healthcare System during times of great personal turmoil and the psychology interns and post-doctoral fellows whom I've had the privilege to train in emergency room and urgent care settings. As a clinical psychologist in public service, I have had the opportunity to work clinically with men and women in the VA Boston who have served their country, often at great cost to themselves, and who do not have the resources and support that many of us take for granted. I have learned to be a better clinician from observing and attempting to assist them in their struggles to obtain help, stabilize, and rehabilitate themselves. I have also learned a great deal from the questions and issues raised by the interns and fellows whom I have trained that became the impetus for my efforts to improve training in this area of practice.

I am, of course, indebted to the many authors and co-authors who have contributed chapters to this book. Evaluating and managing behavioral emergencies is a complicated and often anxiety-arousing area of service. It warrants having input from a range of mental health professionals who have specialized knowledge and skill in different facets of this work. I feel fortunate to have been able to assemble an outstanding group of contributors with expertise in this field.

I am also grateful to the multidisciplinary staff from nursing, psychiatry, medicine, and social work who, over the years, have been good colleagues in emergency and urgent care services at VA Boston. Training interns and fellows in work with high-risk cases can put demands on the healthcare system. I wish to thank the staff for their patience and assistance in making this training possible.

Finally, I would like to thank my family, particularly my wife, Penelope, for her patience and support during the long hours required to write and edit this book; and thanks as well to my two grandsons, Declan and Otto, who lifted my spirits during times of stress.

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Phillip M. Kleespies

Phillip M. Kleespies, Ph.D., ABPP, has been a pioneer in developing the area of psychological practice known as behavioral emergencies. He was the founding president of the Section on Clinical Emergencies and Crises, a section of the APA Society of Clinical Psychology. His writings and teaching have emphasized acquiring a knowledge base as well as clinical skill in decision making with high-risk patients.

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CONTENTS

SECTION 1

A Framework for Practice and Training

CHAPTER

1 Introduction

Phillip M. Kleespies

Abstract

This book is about behavioral emergencies and the association between interpersonal victimization and subsequent suicidality and/or risk for violence toward others. Section I focuses on the differences between behavioral crises and behavioral emergencies and presents an integrative approach to crisis intervention and emergency intervention. Section II discusses the evaluation of suicide risk, risk of violence, and risk of interpersonal victimization in children and adolescents. Sections III and IV explore behavioral emergencies with adults and the elderly, while Section V deals with certain conditions or behaviors that may either need to be differentiated from a behavioral emergency, or understood as relevant to possibly heightening risk. Section VI describes treatments for patients with recurrent or ongoing risks, and Section VII is devoted to legal, ethical, and psychological risks faced by clinicians who work with patients who might be at risk to themselves or others.

Key Words: behavioral emergencies, interpersonal victimization, suicidality, violence, behavioral crises, crisis intervention, emergency intervention, suicide risk, children, elderly

A 35-year-old man whom you have seen in therapy for depression and anxiety calls you and sounds very distraught. He reports that the preceding night he and his girlfriend had argued and he had grabbed her by the throat and pushed her against the wall. When she slumped to the floor, he came to his senses and felt remorseful about assaulting a woman, something that he had always said he would never do. Several weeks prior to this incident, the patient and his girlfriend had agreed that they would remain friends but that they would start dating other people. His girlfriend had become interested in another man and had started to see him. The patient, however, became intensely jealous. On a night when he knew that his girlfriend had been out with this other man, he had several drinks, took a handgun (which he had a license to carry), and went to her apartment to confront her. When she opened the door, the patient put the gun to his head and asked her if this was what she wanted; i.e., for him to shoot himself. It was then that they argued and the incident noted above (in which he grabbed her) occurred. Although his girlfriend did not sustain any serious physical injury, he does not know if she will seek a restraining order. She told him that he needed to seek help. He fears that what he has done will result in the end of their relationship, and he doesn't know if he can tolerate that.[1]

If you are a mental health clinician, could an incident like this occur in your practice? For most active practitioners, it is probably not beyond belief, and they may have experienced incidents of their own that may have been equally or more intense. How you assess and respond to such a situation can have serious consequences for your patient, for others involved (such as the girlfriend in the case above), for you, and for your practice or clinic. What happens next between the clinician and the patient above could lead to what I have referred to as a *behavioral emergency* (Kleespies, 2009), a circumstance in

which there is serious risk of harm to the patient and/or others, or it could lead to a de-escalation of these risks.

Historically, there has been a lack of agreement about how to define a mental health or behavioral emergency (Munizza et al., 1993). The term *emergency* itself can, of course, have different meanings. In a general sense, it may simply mean an unforeseen circumstance that calls for immediate action or intervention. For the purposes of this book, however, I consider it a *behavioral* emergency when a patient's or client's mental state is such that he or she is at imminent risk of behaving in a way that could result in serious harm or death to self or others.

We typically think of behavioral emergencies as intentional behaviors (as when someone attempts or commits suicide), but there can also be unintentional behavioral emergencies (as when someone's judgement is so impaired that he or she does not know to avoid oncoming traffic). Fortunately, there are only a few situations in clinical practice that meet the definition above. They include (1) suicidal states, (2) states of violence toward another person, (3) circumstances in which a relatively defenseless individual (such as a child or a person with a disability) is at risk of being victimized, and (4) conditions in which, as noted above, an individual's judgement is so impaired that he or she is unable to keep himself or herself safe from harm in the community.

In conceptualizing a *behavioral emergency* as I have above, it should be noted that there has been considerable discussion in the literature about the use of the term *imminent risk*. Typically, a situation of "imminent risk" has been taken to mean that there is risk that the patient will seriously harm or kill himself or herself or others "in the next few minutes, hours, or days" (Pokorny, 1983, p. 249). The discussion arises from the fact that, although there are many known risk factors for suicide, violence, and interpersonal victimization, there are no known *imminent* (or very short-term) risk factors. This state of affairs has resulted, in part, from the fact that patients or clients who are thought to be at imminent risk of harm to themselves or others must typically be excluded or removed from research studies for their own protection or the protection of others. Thus, Simon (2006) has maintained that the term *imminence* defies definition and that there are no validated short-term risk factors that can warn us about when or whether a patient will actually attempt or complete an act like suicide in the immediate future.

While Simon's argument has validity, there is also no doubt that behavioral emergencies occur. Sometimes patients attempt to commit suicide. Sometimes they become violent and attempt to kill others. Sometimes, in a manner of speaking, they "succeed." When, as a result of a mental disorder, a patient seems to be at some risk to self or others, the mental health clinician must attempt to estimate the risk and prevent the acts that appear to be imminent. He or she must decide if the situation is very likely an emergency that requires an emergency response. Ideally, such a decision is made after a thorough evaluation using the available empirical evidence to guide his or her judgement. It should be clear, however, that a statement that a patient is "at imminent risk of harm to self and/or others" is a clinical judgement and not a prediction. As discussed later in this book, the prediction of such low base-rate events as suicide or homicide eludes our current clinical capabilities.

Despite the fact that behavioral emergencies, cumulatively, occur with some frequency in mental health practice (see Chapter 34 of this volume for estimates of incidence), and despite the potentially serious consequences if these emergency situations are mismanaged, the training of most mental health practitioners in evaluating and managing patients or clients at risk continues to be limited. In terms of the assessment and management of suicidal patients, for example, the serious gaps in professional training have been clearly articulated in a report generated by a task force appointed by the American Association of Suicidology (Schmitz et al., 2012). There appear to be similar gaps in the training of psychologists for assessing and managing patients who are potentially violent (see, e.g., Gately & Stabb, 2005; and Guy, Brown, & Poelstra, 1990).

Given the need for improved training in dealing with behavioral emergencies, this book is intended as a handbook mental health clinicians can refer to when seeking information about the evaluation and management of such high-risk cases. In the section that follows, I will describe, for the interested reader, how this book is organized.

The Organizational Structure of This Handbook

There are four guiding ideas that have been influential in the writing and organization of this book. First, an emphasis has been placed on the interrelated aspects of the behavioral emergencies. By this I mean that, not only has there been an emphasis on risk factors that suicidal patients and patients

who are potentially violent may simply have in common, but there has also been an emphasis on shared features or characteristics that may be more causatively related to both the potential for self-directed violence and that for other-directed violence. Moreover, there has also been an emphasis on the links between interpersonal victimization and subsequent suicidality and/or risk for violence toward others. Thus, for example, there is evidence that being physically or sexually abused in childhood contributes to one's risk of subsequent suicidal and/or violent behavior in adolescence and adulthood (Berliner & Elliott, 2002; Kolko, 2002).

Second, a lifespan orientation has been taken in this book. The risk of the behavioral emergencies can vary across the course of an individual's life. Van Dulmen et al. (2013) have provided evidence to that effect in their longitudinal study of associations between violence and suicidality from adolescence into young adulthood. This book, therefore, presents chapters on the evaluation and management of suicide risk, violence risk, and the risk of interpersonal victimization in youths, in adults, and in the elderly.

Third, as it is a handbook of behavioral emergencies and crises, a broad range of emergency and emergency-related topics and issues is presented. At its core, however, the book has been structured around a curriculum for acquiring a knowledge base in this area of practice, as described in previous publications (see, e.g., Kleespies, 2000).

Fourth, chapters in this book are evidence-based or evidence-informed. Statements about how to assess and manage behavioral emergencies have been grounded in the existing empirical evidence to the extent possible.

The book is divided into seven sections. In Section I, "A Framework for Practice and Training," there is this introductory chapter (Chapter 1) plus two other chapters. In Chapter 2, the author/editor examines the differences between behavioral crises and behavioral emergencies and presents an integrative approach to crisis intervention and emergency intervention. Such a perspective is one that can guide the clinician's thinking when attempting to evaluate and manage potential mental health emergencies. In this same chapter, he also presents evidence for viewing the behavioral emergencies (in particular, risk of suicide, risk of violence, and risk of interpersonal victimization) as, at least in certain respects, interrelated. From this perspective, he proposes that there are shared factors that contribute to the genesis of these high-risk behaviors or events. In Chapter 3 of this first section, the author/editor proposes that *naturalistic decision-making* models (as opposed to the *rational or normative* models typically used in scientific undertakings) are a better fit for the, at times, fast moving and dynamic decision-making necessitated by emergency conditions (Kleespies, 2014). He also advocates the use of a stress training model referred to as *Stress Exposure Training* (SET; Driskell & Johnston, 1998) as most appropriate for assisting clinicians in acquiring skill and competence in managing patients under the often stressful conditions that prevail when there is a risk of life-threatening behavior.

Section II, "Behavioral Emergencies with Youth," contains chapters that discuss the evaluation of suicide risk, risk of violence, and risk of interpersonal victimization in children and adolescents. Thus, Chapters 4 and 5, respectively, cover the evaluation of suicide risk and violence risk; while Chapter 6 is concerned with the assessment and prevention of child maltreatment and abuse. The remainder of this section addresses two special topics related to at-risk youth; namely, the problem of aggression and bullying in children and adolescents, and the evaluation and prevention of targeted violence in schools.

Sections III and IV address the topics "Behavioral Emergencies with Adults" and "Behavioral Emergencies with the Elderly," respectively. In the section on behavioral emergencies with adults, Chapters 9, 10, and 11 are chapters that discuss the evaluation and management of suicide risk, risk of violence, and interpersonal victimization in adult patients. The chapters that follow these three are chapters devoted to special emergency-related topics or particular adult populations that are at risk. Thus, Chapters 12 and 13 discuss the evaluation and management of suicide risk in military veterans and the risk of violence in combat veterans. After these chapters, there are chapters devoted to topics such as intimate partner violence (Chapter 14), homicide/suicide (Chapter 15), the assessment and management of victims of sexual violence (Chapter 16), and the assessment and prevention of abuse of persons with disabilities (Chapter 17). Chapter 18 examines the *structured professional judgement* approach to, and the development of, decision-support tools for evaluating the risk of violence; while Chapter 19 deals with interventions in cases of acute agitation. This section ends with chapters on the neurobiological factors in suicide (Chapter 20) and the neurobiological factors in aggression and violence (Chapter 21).

In the section on behavioral emergencies with the elderly (Section IV), Chapter 22 is concerned with the evaluation and management of suicide risk in the elderly; while Chapter 23 addresses the heightened risk of violence in the elderly who are suffering from cognitive and neurological impairments. Chapter 24 provides a discussion of the risks of elder abuse and what feasible measures may be used to try to prevent it. Finally, Chapter 25 discusses the burdens of medical illness as a risk factor for suicide in the elderly, as well as the psychological and ethical issues surrounding the assisted-death controversy.

Section V ("Crises and Conditions Associated with Behavioral Emergencies") is devoted to certain conditions or behaviors that, in clinical practice, may either need to be differentiated from a behavioral emergency, or understood as relevant to possibly heightening risk. Thus, non-suicidal self-injuries (NSSI) have frequently been mistaken for suicide attempts. Chapter 26 is about identifying self-injurious behaviors that the individual has engaged in without suicidal intent and how that person may need to be treated differently from someone who has engaged in suicidal behaviors. In addition, certain medical illnesses and conditions can present with psychological and/or behavioral symptomatology. The patient can appear to be in a behavioral crisis or emergency, and the clinician needs a resource to heighten his or her awareness that there may be an underlying medical condition. This section, therefore, includes chapters on neurological disorders associated with psychological/behavioral problems (Chapter 27) and endocrine disorders associated with psychological/behavioral problems (Chapter 28).

Patients who have a behavioral emergency such as discussed above are not necessarily without future risk once the emergency has passed. Follow-up treatment is frequently needed to reduce the risk of recurrence. In Section VI ("The Treatment of Patients with Recurrent or Ongoing Risk"), the clinician can find treatments that have been found to be effective at reducing such risks. Chapter 29 presents psychopharmacological treatments that have been effective in reducing the risk of recurrent suicidal behavior; while Chapter 30 discusses psychological or behavioral treatments that are empirically supported and have been found to reduce the risk of recurrent violent behavior. In addition, Chapter 31 presents treatments that have been found to be helpful with those who have been traumatized by interpersonal violence.

There are legal, ethical, and psychological risks for the clinician who works with patients who might be at risk of harming themselves or others. In Section VII ("Legal, Ethical, and Psychological Risk Management"), the book therefore includes a chapter on legal and ethical risk management for the clinician (Chapter 32) and a chapter on the clinician's obligations under the often cited "duty to protect" (Chapter 33). Given our limitations in predicting and preventing behavioral emergencies, there continue to be all-too-frequent instances in which patient suicide and/or violence occur. With this in mind, this section includes a chapter (Chapter 34) on the incidence and impact of negative events (i.e., patient suicide or patient violence) and offers suggestions for how clinicians might cope with the emotional aftermath.

In Section VIII, the editor offers his summarizing and concluding remarks about the book in Chapter 35.

Note

1. This case scenario is based on actual events, but changes have been made in the description of the people and of the circumstances to protect the identity of those involved.

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CHAPTER

2 Integrative Perspectives on Behavioral Emergencies and Crises

Phillip M. Kleespies

Abstract

In this chapter, the author discusses two ways in which the area of behavioral emergencies can be viewed as integrative. First, evidence is presented demonstrating how the three major behavioral emergencies (i.e., risks of interpersonal victimization, suicide, and violence) overlap and are interrelated in certain respects. For example, data indicate that those who have been victims of violence have an increased risk of becoming perpetrators of violence and/or victims of suicidal behavior. Second, the author distinguishes between the concepts of crisis and emergency, and then discusses how crises often precede the development of behavioral emergencies, and how crisis intervention techniques can be used to avert a developing emergency. The chapter concludes with a discussion of the decision making involved in determining whether a patient at risk can be treated as an outpatient in crisis or needs to be hospitalized because of imminent risk of suicide or violence.

Key Words: behavioral emergency, crisis, behavioral crisis, suicide, violence, interpersonal victimization, victims of violence, emergency intervention, crisis intervention

As noted in the Introduction, the approach to behavioral emergencies in this volume is an integrative one. It is integrative in two respects. First, it places an emphasis on the linkages or associations among the three behavioral emergencies most frequently encountered by mental health clinicians—suicidality, a potential for violence, and vulnerability to interpersonal victimization. Second, although a distinction has been drawn between a behavioral emergency and a behavioral crisis in previous works by myself and others (see e.g., Callahan, 1998; Kleespies, 1998), it seems clear that human crises are often precipitants to or play a role in the development of an emergency situation. Under such circumstances, crisis intervention techniques can be useful in de-escalating a situation before emergency intervention becomes necessary. In this chapter, I will present a rationale for taking each of these perspectives.

The Interrelated Aspects of the Behavioral Emergencies

The interrelated aspects of the behavioral emergencies have not been a major focus of clinical or research attention until very recently. Rather, as Lutzger and Wyatt (2006) have pointed out, suicide research, violence research, and research on interpersonal victimization have generally been regarded as relatively independent areas of study. These authors have further noted that for more effective clinical service and research, it would be wise to see if one area might inform the other and thereby bring about more effective outcomes. Of course, it practically goes without saying that interpersonal violence leads to interpersonal victimization. It may be less obvious, however, that victimization may be a factor in contributing to a potential for violence, suicide, or revictimization, or that there may be an association between a potential for violence and a potential for suicide. In the

sections that follow, I will summarize several studies that are part of the growing evidence that supports these contentions. Since other authors in this volume will discuss these issues in greater depth, I will only present a few representative studies here.

Interpersonal Victimization as a Factor in Risk of Violence

In a book chapter on child physical abuse, Kolko (2002, p. 32) noted that "one of the most extensively documented clinical consequences in child physical abuse victims is heightened aggression and related externalizing behaviors, including poor anger modulation." Not only does the experience of physical abuse as a child suggest that the individual is at greater risk of future aggression (in the broader sense of that term), but also that he or she is at greater risk of perpetrating intimate partner violence and other forms of domestic violence.

Ehrensaft et al. (2003), for example, conducted a longitudinal, prospective study using a community sample of 543 children. They investigated the relationship between childhood maltreatment, power-assertive punishment in childhood, and exposure to violence between parents on subsequent risk for adult partner violence. The study extended over a 20-year period, and, among other things, the investigators found that physical injury to a child by a caretaker significantly and directly increased the probability that similar violent tactics would be used in the participant's future intimate relationships. Although the development of a conduct disorder in adolescence mediated the effect of child abuse, exposure to violence between parents and power assertive punishment were additional, potent predictors of the perpetration of violence on partners in adolescence and young adulthood.

In a study of violence perpetrated by young adult children against their parents, Browne and Hamilton (1998) had a sample of 469 college students in England complete two questionnaires anonymously. One questionnaire assessed the tactics that they employed (including threats of violence and actual violence) during disagreements; the other examined incidents of violence or maltreatment toward or by the respondent during childhood and adolescence. Overall, the investigators found that 14.5% of the participants reported being violent with their mother and/or father, and 3.8% reported being severely violent with one or both parents. It was found that those who reported being abused or maltreated by their parents when they were children were significantly more likely to have reported that they were subsequently violent toward one or both parents. Moreover, participants who stated that they had been physically abused were significantly more likely to have been severely violent with one or both parents. The authors concluded that violence toward parents is associated with the experience of maltreatment during childhood and that violence toward parents is most often reciprocal to parental violence over time.

In a study of over 800 adults with severe mental illness (recruited from four different states), Swanson et al. (2002) collected self-report data on experiences of physical abuse or sexual abuse before age 16 (early life) and after age 16 (later life). The mean age of the sample was approximately 42 years. The investigators also collected data on social-environmental variables with a scale that measured exposure to community violence. Psychiatric diagnoses were obtained from chart review, and mental and emotional symptomatology, as well substance abuse, were assessed with established psychometric scales. Logistic regression analysis was used to examine the effects on risk of violent behavior associated with victimization and other variables. It was found that those individuals with serious mental disorders who were victimized as adults were significantly more likely to have engaged in violent behavior during the previous year even if they were not victimized as children. Participants who were victimized as both children and later as adults were even more likely to behave violently toward others in the previous year. The authors concluded that repeated abuse into adulthood had a cumulative association with violence. Like the experience of victimization, substance abuse and exposure to community violence were also found to be strongly associated with violent behavior.

Of course, there is the possibility that the potential for violence is genetically transmitted by violence-prone parents to their offspring. To test this hypothesis, Jaffee, Caspi, Moffitt, and Taylor (2004) conducted a longitudinal epidemiological study of 1,116 monozygotic (MZ) and dizygotic (DZ), same-sex, twin pairs. The genetic similarity of MZ twins is twice that of DZ twins; so, if nothing more than genetics influenced behavior, the MZ twins should be at least twice as similar in terms of heritable characteristics.

In this study by Jaffee et al., the twins were part of two consecutive birth cohorts (1994 and 1995),

and the twins and their parents were interviewed at their homes when the children were 5 years old and 7 years old. Child maltreatment was assessed separately for each twin by interviewing the mothers with a standardized clinical interview protocol from a multisite child development project. The children's antisocial behavior was assessed at ages 5 and 7 with standardized aggression and delinquency scales. Compared with children who were not maltreated, physically maltreated children had significantly higher antisocial behavior scores at age 7. Thus, physical maltreatment prospectively predicted antisocial behavior. In addition, physical maltreatment had a dose-response relationship to antisocial outcome—the worse the physical maltreatment, the worse the subsequent antisocial behavior. More to the point, the effects of physical maltreatment remained significant after controlling for the parents' history of antisocial behavior; although genetic factors (with MZ twins compared to DZ twins) accounted for approximately half the association between physical maltreatment and childrens' antisocial behavior, the effect of physical maltreatment on subsequent antisocial behavior continued to be significant after controlling for any genetic transmission of this type of behavior. The authors concluded that approximately half the intergenerational transmission of antisocial behavior in their sample was environmentally transmitted.

Interpersonal Victimization as a Factor in Risk of Suicidal Behavior

Kilpatrick (2005) has suggested that interpersonal victimization can contribute to suicidality. In analyzing the data from a National Survey of Adolescents (Kilpatrick et al., 2003) that involved more than 4,000 interviewees ranging in age from 12 to 17, Kilpatrick (2005) reported that victimization increased the risk of suicide attempts after controlling for depression, posttraumatic stress disorder, and drug use disorders.

Joiner et al. (2007) drew upon a nationwide epidemiological study, the National Comorbidity Survey, to test whether violent physical and sexual abuse would be stronger predictors for the number of lifetime suicide attempts than would molestation and verbal abuse. While controlling for a number of covariates (e.g., age, gender, psychiatric history, etc.), they found that childhood physical and sexual abuse had significant and relatively pronounced associations with lifetime suicide attempts. Moreover, their effects exceeded those for molestation and verbal abuse in this regard. They concluded that childhood physical and violent sexual abuse should be seen as greater risk factors for future suicide attempts than childhood molestation and verbal abuse.

In a retrospective cohort study of over 17,000 adult members of a health maintenance organization (HMO) in California, Dube et al. (2001) examined the relationship between adverse childhood experiences (e.g., emotional, physical, and sexual abuse; household substance abuse, mental illness, and incarceration; parental domestic violence, separation, or divorce) and the risk of suicide attempts. Members of the HMO were mailed an Adverse Childhood Experiences study questionnaire that asked about experiences such as those noted above. The participants were also asked if they had ever attempted suicide, if they had ever been depressed, if they had ever considered themselves to be alcoholic, or if they had ever used street drugs. The investigators found that adverse childhood experiences in any category meant a twofold to fivefold increase in the risk of attempted suicide. As the number of such adverse experiences increased, the risk of attempted suicide during either childhood/adolescence or adulthood increased dramatically. They also noted that there was a strong relationship between adverse childhood experiences and alcohol or illicit substance abuse and depressive disorders, and these problems may partially mediate the relationship between these adverse experiences and suicide attempts.

Brown, Cohen, Johnson, and Smailes (1999) conducted a longitudinal study of the effects of childhood abuse and neglect with a random sample of 776 families over a 17-year period. The sample was drawn from two upstate New York counties in 1975, and the families were seen for follow-up interviews in 1983, 1986, and 1992. Data regarding child maltreatment were obtained from official abuse records (i.e., the New York State Central Registry for Child Abuse and Neglect). Self-reports of child abuse were also included in the study when obtained in the young-adult follow-up interview in 1992. Psychiatric disorders were assessed with the National Institute of Mental Health Diagnostic Interview Schedule for Children. Suicide attempts were reported by the children/adolescents and young adults with details of method, frequency, and associated treatment.

Using logistic regression analyses, the authors found that both dysthymia and major depressive disorder were significantly elevated in those with a history of abuse or neglect. They also found that

suicidal behavior was strongly associated with a history of childhood maltreatment. Certainly, some of the effect of childhood abuse and neglect may have been mediated by depression. The rates of suicidal behavior, however, were without exception highest in those youths who had experienced sexual abuse. Physical abuse also carried an increased risk of suicidal behavior, but sexual abuse clearly carried the greatest risk of depression and suicidal behavior. It was estimated that between 16.5% and 19.5% of suicide attempts in young adults may be related to exposure to child sexual abuse.

Finally, in a study using data from a national youth risk behavior survey, Tomasula, Anderson, Littleton, and Riley-Tillman (2012) investigated the extent to which sexual assault predicted suicide attempts among adolescent students. After controlling for age and stratifying by gender, they found that adolescents with a history of sexual assault were approximately six times more likely to have attempted suicide in the past year when compared with adolescents who had no history of sexual assault. Although both male and female students with a sexual assault history were at greater risk for suicide attempts, male students appeared to be at a greater risk than might be expected. Thus, it was found that male students with a history of sexual assault were nearly 10 times more likely to have attempted suicide in the past year when compared to male students with no history of sexual assault. Moreover, male students with a sexual assault history who attempted suicide were nearly five times more likely to have made a medically serious attempt (defined as needing treatment by a doctor or nurse) when compared to male student suicide attempters who had no history of sexual assault.

Interpersonal Victimization as a Factor in Risk of Revictimization

There has been growing evidence that victims of childhood abuse are not only at greater risk of subsequent violence and/or suicidality, but that they may also be at greater risk of revictimization. Any given incident of victimization is likely to be distressing in itself, but there is also evidence that there can be a nearly linear increase in trauma symptoms with repeated victimizations (Turner, Finkelhor, & Ormrod, 2010).

In a study of lifetime revictimization, Widom, Czaja, and Dutton (2008) used a prospective cohort design of a group of physically and sexually abused and neglected children (with matched controls who had no documented history of abuse) and followed them into adulthood (approximately 40 years of age). The abuse and neglect was court-substantiated and the children were 11 years of age or younger at the time that they first entered the study (1967–1971). Of the original sample of 1575 children, 83% were located and 76% (or 1,196) were reinterviewed during 1989–1995. Of this group of 1,196 interviewees, 93% were located and 75% (or 896) were interviewed again in 2000–2002. A 30-item instrument known as the Lifetime Trauma and Victimization History (Widom, Dutton, Czaja, & DuMont, 2005) was used to gather data on lifetime trauma and victimization history in the context of a structured in-person interview.

In analyzing the data from the 2000–2002 interviewees (896), these investigators found that the individuals who had been abused and/or neglected as children reported a significantly higher number of lifetime victimization experiences. More specifically, the abuse and neglect group versus the control group differed in the number of victimization events in childhood and adulthood, but not in adolescence. The increased risk of revictimization was not across the board; it was associated with only certain types of traumas and victimizations—for example, physical assault and abuse, sexual assault and abuse, kidnapping/stalking, and having a family member or friend who was murdered or who committed suicide. Individuals with documented histories of multiple forms of abuse and neglect reported the highest prevalence of physical assault and abuse, and sexual assault and abuse. The investigators concluded that their results provided strong support for the hypothesis that childhood victimization leads to increased risk for lifetime revictimization. They also reported that the increased risk of revictimization did not apply to all categories of traumas or victimization experiences that they had assessed but rather to what they broadly considered instances involving *interpersonal* violence (physical assault/abuse, sexual assault/abuse, kidnapping/stalking, and murder or suicide of a family member or friend).

In a retrospective study of sexual revictimization, Merrill et al. (1999) surveyed 1887 female US Navy recruits. They selected only those recruits who reported childhood sexual abuse in which there was actual physical contact (but not with a peer) and a comparison sample of those recruits who reported no childhood sexual abuse. The final sample consisted of 1093 women. These women were assessed with the Sexual Events Questionnaire (Finkelhor, 1979) and with five items from the Sexual Experiences Survey (Koss, Koss, & Woodruff, 1991), as well as

with a demographic questionnaire, a scale that assessed how their parents resolved parent–child conflicts, and a screening test for problems with alcohol.

Odds ratios indicated that women who had experienced childhood physical abuse (regardless of whether they had also experienced childhood sexual abuse) were 1.89 times more likely to have subsequently been raped; while women who had experienced childhood sexual abuse (regardless of whether they had experienced childhood physical abuse) were 5.12 times more likely to have subsequently been raped. A hierarchical logistic regression analysis was then used to derive estimates of the independent contributions of childhood physical abuse and childhood sexual abuse to adult rape. In this analysis, childhood sexual abuse remained a significant predictor of adult rape, but childhood physical abuse did not. The authors concluded that childhood sexual abuse was a much stronger predictor of adult rape than childhood physical abuse. Female Navy recruits with a history of childhood sexual abuse, or with a history of childhood sexual abuse and childhood physical abuse, reported prevalence rates of 56% and 65%, respectively. By contrast, female Navy recruits without a childhood history of abuse, or those with only a history of childhood physical abuse, reported a lower rape prevalence of 22% and 25%, respectively.

These investigators also considered whether problems with alcohol and multiple sexual partners might explain the likelihood of adult rape. It was found that women who had experienced childhood sexual abuse had a higher number of sexual partners and more problems with alcohol than did women who had not experienced childhood sexual abuse; however, when differences were controlled between sexually abused and non-abused women in regard to alcohol abuse and the number of sexual partners, the results did not eliminate the significant association between childhood sexual abuse and adult rape. The investigators concluded that, rather than mediating the relation between childhood sexual abuse and rape, alcohol problems and multiple sexual partners appeared to be largely independent risk factors for adult rape.

Violence as a Factor in Risk of Suicide and Vice Versa

For many years, Plutchik and colleagues (e.g., Plutchik, Botsis, & van Praag, 1995) have theorized that violence and suicide reflect an underlying aggressive impulse that is modified by variables that they have referred to as *amplifiers* and *attenuators*. To support their theory, they have cited evidence of the overlap of suicidal and violent behavior in hospitalized psychotic adolescents, in incarcerated juvenile delinquents, and in adult psychiatric inpatients. Plutchik and van Praag (1990) have estimated that one-third of violent individuals have engaged in self-destructive behaviors, and that 10%–20% of self-destructive individuals have engaged in violent behavior.

Hillbrand (1995; 2001) also noted that there may be an overlap between aggression against self and aggression against others. In the study by Hillbrand (1995), he reviewed the records of over 100 male psychiatric patients hospitalized in a maximum security hospital on the basis of insanity acquittals, severe aggressive behavior in other psychiatric hospitals, and the like. These patients were divided into four groups: (1) those with no current or past suicidal behavior; (2) those with no current suicidal behavior but a history of past suicidal behavior; (3) those with current suicidal behavior but no history of past suicidal behavior; and (4) those with current suicidal behavior and a history of past suicidal behavior. The groupings were thought to reflect a continuum of severity or chronicity of suicidal behavior, and the patients' violent behaviors were monitored with a well-established scale completed after any incident of aggression over a three-year period. The findings indicated that group 4 (the group with the most severe or chronic suicidal behavior) engaged in significantly more aggressive acts. Hillbrand concluded that severe and chronic self-destructiveness identified a particularly violent group of individuals. He also noted that a substantial proportion of violent individuals seemed to alternate between aggression against self and aggression against others.

In a study on the relationship of violence to completed suicide, Conner et al. (2001) analyzed data from the 1993 National Mortality Followback Survey, a nationally representative telephone survey with decedents' next of kin. They compared data collected from the next of kin for victims of suicide and accident victims. Informants were asked to rate the decedents violent behavior in the last year of his or her life on a four-point scale from *often* to *never*. Data on alcohol use in the last year of life were also elicited. Multiple logistic regression was used to predict case status—for example, suicide victim versus accident victim. Violent behavior distinguished suicide victims from accident victims, and this finding was not attributable to alcohol use alone. In fact, the association of violence and suicide was stronger

among individuals who did not have a history of alcohol abuse. It was also stronger among younger individuals and among women. The investigators noted that violence in women appeared to confer greater risk for suicide than violence in men. They commented on how intervention strategies that target women who display aggressive behavior are needed. They also were of the opinion that violence prevention and suicide prevention efforts can inform one another and could gain by the collaboration.

In a longitudinal study of associations between violence and suicidality, Van Dulmen et al. (2013) confirmed that violence is a risk factor for suicidal behavior but also found that a history of suicidal behavior is a risk factor for future violence. These investigators used data from the National Longitudinal Study of Adolescent Health in which the adolescents in the study were followed into adulthood. Data collection began in 1994 with an in-school survey of over 90,000 students in grades 7–12, and an in-home interview for a select sample (Wave I). One year later, there was a second wave of interviews (Wave II), followed by a third wave in 2001–2002 (Wave III), and a fourth in 2007–2008 (Wave IV). Interviewees were questioned about incidents of violent behavior and suicidal behavior. The study team then conducted a series of path analysis models with data from Waves II, III, and IV. One of the models included paths from suicidality predicting future (at the next time-point) violence, and another of the models included paths from violence predicting future (at the next time-point) suicidality.

In the first model, suicide attempts in adolescence and early adulthood significantly increased the risk of violence in early and young adulthood, respectively. Likewise, violent behavior in adolescence significantly increased the risk of suicide attempts in early adulthood. The investigators concluded that their study demonstrated that suicidality and violence mutually influence each other across time. Not only was violent behavior associated with increased risk for suicidality, but a history of suicidality increased the risk for future violence. They called for research efforts aimed at a better understanding of why and how suicidality and violence are associated across time.

An Integrated Approach to Crisis Intervention and Emergency Intervention

It is of heuristic value to initially differentiate behavioral emergencies from behavioral crises and then to consider the ways in which they are interrelated. Callahan (2009) has posited that understanding the distinction between *emergency* and *crisis* is often what drives our decision making when a clinical situation confronts us with the need to determine if emergency intervention or crisis intervention is the more appropriate response.

The Distinction Between Behavioral Emergencies and Crises

Mental health clinicians frequently use the terms crisis and emergency interchangeably. Each term also has a variety of meanings in common discourse. An emergency can be any unforeseen set of circumstances that calls for immediate action. You could, for example, have a housing emergency if you discovered that you had overdrawn your bank account, could not pay your rent, and were facing imminent eviction. Moreover, any serious or chronic problem can at times be referred to as a crisis. Someone might say that they are going through a midlife crisis or that their marriage was in a state of crisis.

In a mental health context, some have contended that the use of these terms in poorly defined ways or as synonyms only leads to confusion (Callahan, 2009; Kleespies & Hill, 2011). For the purposes of the current work, I have defined a behavioral emergency (in the *Introduction* to this volume) as meaning that an individual is at imminent risk of behaving in a way that could result in serious harm or death to self or others. Likewise, for the purposes of the current work, I would use the traditional definition of a behavioral crisis as noted in the preceding paragraph. In contrast to an emergency, a crisis does not necessarily imply risk of serious physical harm or life-threatening danger. Some have viewed a behavioral crisis as an emotionally significant event in which there may be a turning point for better or worse. If a crisis takes a turn for the worse, it may be a precipitant for a behavioral emergency. On the other hand, it should be noted that a crisis, in itself, is typically not a sufficient explanation for a behavioral emergency. Suicidal and/or violent states usually involve a number of contributing factors. If, for instance, an adolescent attempts suicide after he is rejected by his girlfriend, in addition to feeling overwhelmed by the loss it is likely that he also has engaged in all-or-nothing thinking about the relationship, has a history of depression and/or substance abuse, has a history of impulsivity, and so forth.

Confusion between the concepts of crisis and emergency is also present at the level of intervention. As Callahan (1998) has noted, many clinicians think that crisis intervention is the appropriate response to a patient who is at risk of suicide

or violence. While resolving a crisis with crisis intervention techniques may decrease lower level risk, when the risk is high, the most appropriate response is an emergency intervention. An emergency intervention typically implies three things: (1) the need for an immediate response to a perceived imminent risk; (2) management to prevent serious harm or death; and (3) resolution of the immediate risk within a single encounter. Crisis intervention, on the other hand, typically implies (1) a response within 24–48 hours; (2) therapeutic intervention to develop or reestablish the ability to cope with the issues causing the crisis; and (3) achievement of a resolution within four to six sessions.

The Interrelated Aspects of Behavioral Emergencies and Crises

Now that we have differentiated crisis and emergency, as well as crisis intervention and emergency intervention, we can consider how they might be brought together in an integrated model such as that proposed by Callahan (2009). As mentioned earlier, a behavioral or emotional crisis is often a contributing (if not a precipitating) factor in the unfolding of a behavioral emergency. When a patient presents in an apparent state of crisis, it is usually wise to also screen the patient for risk of danger to self and/or others. If it appears that the risk is low, the clinician can proceed with evaluating the patient and determining whether he or she is in a crisis. As Callahan (2009) has pointed out, the work here is to be empathic, to engage in active listening, and, through questioning and interacting with the patient, to come to an understanding of how the patient perceives his or her condition and situation. A significant question is whether the patient's condition deviates from his or her baseline level of functioning and thus constitutes an acute episode of crisis. Some patients (e.g., those with borderline personality disorder) lead chaotic lives and are seemingly in a constant state of crisis at their baseline. What they present with is not an acute crisis but a chronic state of crisis, and intervention with them may require an approach such as Linehan's dialectical behavior therapy or DBT (Linehan, 1993).

In assessing a patient in crisis, it is clearly important to gain an understanding of the quality of the patient's preexisting baseline and what coping skills he or she typically has had available. This information will assist the clinician in determining what coping resources might be built upon or enhanced. It also helps in ascertaining what new skills might be encouraged or learned.

According to Aguilera (1998), there are three factors that determine a state of personal equilibrium—perception of events, situational supports, and coping mechanisms. In terms of perception of events, she states (in accord with Lazarus [1994]) that when confronted with a challenging or very demanding state of affairs, the individual engages in a process of appraisal of his or her condition or situation. If achieving the desired outcome is perceived as too difficult or overwhelming, he or she may resort to maladaptive efforts to cope and/or may become anxious and depressed. When feeling inadequate and/or facing a difficult or threatening situation, social support takes on great importance. If the individual can access significant others who can provide support and advice on solving the problem, it can make a big difference in terms of managing the crisis. If the person withdraws or does not have a support network, his or her stress is increased. At times, stress can seem so great that the person loses sight of how he or she has learned to cope with similar situations in the past. If the person can reinstate previous coping strategies or develop new ones, a resolution to the crisis may be at hand.

The clinician can aid the patient in these three areas by assisting the individual in making an accurate appraisal of his or her circumstances; encouraging the person to contact or reach out to potentially supportive people in his or her social environment; and reviewing the individual's past coping resources, working with him or her to develop new ones, and gently confronting maladaptive methods of coping. Work on these issues can continue throughout the course of crisis intervention. The primary goal is to resolve the crisis, but another goal is to promote growth and development so that the individual becomes a better crisis manager or problem solver in the future.

In the course of working with an individual in crisis, the clinician should always be alert to the possibility that the patient may become a risk to self or others. Stress from a variety of sources (e.g., interpersonal conflict/separation/loss, financial reversals, homelessness) can lead to a crisis, and such a crisis can become a risk factor or so-called accelerant for suicidal and/or violent behavior (see, e.g., chapters 9 and 10 of this volume). If it appears that a patient may be considering harm to self or others, an emergency assessment takes priority and emergency intervention may be necessary.

An emergency intervention typically takes place in an immediate, single-session interview.[1] In the

course of this type of interview, the clinician must (1) if necessary, assist the patient in gaining sufficient control of his or her emotions to cooperate with the interview; (2) collaborate with the patient in defining the problem; (3) arrive at an estimate of the level of risk; and (4) provide for appropriate care and treatment. Even after defining the problem(s) and arriving at an estimated level of risk, however, it is not necessarily a black or white decision about how best to intervene. Some clinicians are disposed to hospitalize patients who are at risk because they feel that it is safer, and because they are concerned about liability issues if their judgment not to hospitalize is in error. Yet, many patients who have suicidal ideation or violent ideation can be (and are) managed successfully on an outpatient basis.

In working with patients who are at risk, clinicians need to be guided by a carefully considered estimate of the level of risk and by a weighing of the risks and benefits of each way of proceeding. The level of risk is often determined by a consideration of distal risk factors, proximal risk factors, and protective factors (Kleespies & Hill, 2011). Alternatively (or perhaps concurrently), the clinician might consider the level of risk from the perspective of static (or unchanging) risk factors and dynamic (or modifiable) risk factors. Static risk factors are typically dispositional or historical factors, such as gender, race/ethnicity, a past suicide attempt, or a history of violence. On the other hand, dynamic risk factors are typically clinical or situational factors such as hopelessness, acute depression, or the stress of a financial crisis. Static risk factors may always be there, but variations in the dynamic risk factors may lead the clinician to increase or decrease his or her estimate of risk.

Management of suicide risk on an outpatient basis. Outpatient management of patients considered to be at either mild or moderate risk of suicide has generally been found to be feasible and safe (Rudd, Joiner, & Rajab, 2001; chapter 9 of this volume). Stanley and Brown (2012) have recommended that the management of such patients include a Safety Planning Intervention (SPI). This type of intervention entails the development of a prioritized list of coping strategies and sources of support for use by the patient preceding or during a time when the risk of suicide increases. The listing is developed collaboratively by the clinician and the patient.

An SPI consists of six steps. The first step involves helping the patient to identify and pay attention to warning signs that occur when he or she begins to consider suicide. These warning signs may be thoughts, behaviors, or moods, and they are listed in the safety plan in the patient's own words. In the second step, the patient is asked to identify internal coping strategies that might be used to distract himself or herself from problems. Depending on the patient, activities such as walking, exercising, or reading might lead to a change of focus. If such internal strategies fail or are not feasible, the third step would be to have a list of social contacts, such as visits to a coffee shop or a preferred place of religion. Fourth on the SPI, the patient is to have a list of family and/or friends who could be contacted to talk with and inform that he or she is having thoughts of suicide. If none of the previous strategies are effective, a fifth step is for the patient to have a list of clinicians and/or professional agencies that could be contacted. This list should include contacts that can be reached during nonbusiness hours, such as the National Crisis Hotline (1-800-273-TALK [8255]). Finally, the patient and the clinician should discuss what means the patient might use in a suicide attempt, and then work collaboratively on eliminating or limiting access to such means, particularly the more lethal means such as firearms.

As just described, Stanley and Brown (2012) focused on managing suicidal states by helping the patient to develop coping strategies. Rudd and Joiner (1998), on the other hand, have suggested that the clinician who is working with an outpatient who is at moderate risk might wish to consider the following adjustments: (a) an increase in the outpatient visits and/or the addition of telephone contacts, (b) frequent assessment of suicide risk, (c) recurrent evaluation for hospitalization while the risk continues, (d) 24-hour availability or coverage, (e) reevaluation of the treatment plan as needed, (f) consideration of a medication evaluation or change in regimen, and (g) use of professional consultation as warranted. For patients at mild risk, recurrent evaluation and monitoring of suicide potential may be sufficient.

The decision to hospitalize when suicide risk is high. An emergency intervention such as hospitalization is necessary when the level of risk is considered severe. This type of decision is often preceded by an effort to resolve or reduce a crisis that has precipitated an increase in suicidal intent. There are times when it is possible to achieve such a resolution and have the patient continue in outpatient treatment. Hospitalization is needed, however,

when, as Comstock (1992) has pointed out, it is not possible to establish or reinstate a treatment alliance, when crisis intervention techniques fail, and/or when the patient continues to have intent to commit suicide in the immediate future. There is no evidence that hospitalization ultimately prevents suicide, but it does provide a relatively safer environment during a period of heightened risk. Typically, a one- or two-hour evaluation of a patient who continues to be considered at imminent risk of suicide is sufficient to convince clinicians to hospitalize the patient.

Many patients who require hospitalization for risk of suicide agree to a voluntary admission. They may do so because they have some ambivalence about taking such a final action as suicide. When patients assessed as at imminent risk refuse to be hospitalized, however, the clinician is faced with a decision about involuntary commitment. A decision to hospitalize someone against their will can be difficult because the estimation of suicide risk is not always reliable, and involuntary temporary commitment involves depriving patients of their freedom while possibly creating barriers to effective future treatment (i.e., alienating a patient and damaging the therapeutic alliance; Comstock, 1992). As Kleespies, Deleppo, Gallagher, and Niles (1999) have pointed out, however, it nonetheless remains the clinician's responsibility to decide whether hospitalization is needed to avert a serious risk that the patient will take his or her own life. In the final analysis, the decision to invoke an involuntary temporary commitment and hospitalize the patient should be based on evidence-based risk factors, the clinician's best judgment, and a consideration of the risk–benefit ratio. In making such decisions, it can be helpful to keep in mind that once hospitalization has occurred, resistant patients often gain perspective and begin to perceive the caring aspects and the necessity of the clinician's actions. The door is then open to repairing any damage to the therapeutic alliance that may have occurred.

Options for managing the risk of violence. In a classic paper, Monahan (1993) suggested three levels of intervention for working with the potentially violent patient: (a) intensifying treatment, (b) hardening the target, and (c) incapacitating the patient. When the patient is considered to be at mild-to-moderate risk and has some capacity to modulate or modify his or her behavior, it is possible to intensify treatment as a way of managing risk while the patient remains in the community. *Intensifying treatment* could mean increasing the frequency of therapy sessions, having between-session telephone safety checks with the patient, having the patient enter a more structured outpatient or partial hospitalization program, developing a plan for 24-hour emergency coverage, and making frequent reassessments of the level of risk. Treatment sessions could be focused on ways to reduce the likelihood of violence—for example, increasing insight, teaching anger management techniques, increasing frustration tolerance, improving affect regulation, and so forth.

Hardening the target involves warning the intended victim(s) and/or alerting law enforcement. It makes it possible for the potential victim to take protective measures. Warning the intended victim became known to mental health clinicians as the *duty to warn* following the *Tarasoff* case in California (*Tarasoff v. Regents of University of California*, 1974). Many clinicians do not seem to realize, however, that the same California court reviewed the *Tarasoff* case two years later, vacated the so-called duty to warn ruling, and revised their opinion to what has subsequently been referred to as the *duty to protect* ruling (*Tarasoff v. Regents of University of California*, 1976; Welfel, Werth, & Benjamin, 2009; see chapter 33 of this volume). This revised opinion was that therapists have a broader duty to protect, rather than simply warning, the potential victims of patients or clients who are violent. Warning the individual in question may be one way to protect, but it is not necessarily the only way, and, depending on the circumstances, it may not necessarily be the best way.

Warning the intended victim can be frightening to the individual, or it can elicit retaliatory anger, and, as Borum (2009) has noted, it should be reserved for those times when other interventions have been rejected by the patient or are not feasible given the particular circumstances. If a warning is given, Borum's advice is that the clinician observe caution in reviewing the nature and seriousness of the threat with the intended victim and work with the individual to find sources of assistance as well as other protective measures.

Although Borum's cautionary note about warning the intended victim is well taken, the clinician must also be aware of his or her state's statutes that may regulate what actions a treatment provider is to take in managing a patient's or client's risk of violence (VandeCreek & Knapp, 2000). Some jurisdictions may require that the intended victim be warned.

In situations where the danger of serious harm is great and less restrictive means have failed or would be ineffective, the clinician may need to take steps to incapacitate the patient. *Incapacitating the patient* means using measures that directly decrease the person's ability to act in a violent manner. Such measures may include voluntary or involuntary hospitalization, sedating medication, and physical restraints or seclusion. The use of such means is typically regulated by law and institutional policy. Their use is sometimes necessary to avoid a worse alternative (i.e., the serious harm or death of an intended victim). These actions prevent immediate harm, but they are not a solution to the long-term risk of violence. They may allow, however, for a more complete evaluation and the initiation of treatment that may have longer lasting benefit.

The use of such restrictive measures can be a difficult decision because they are intrusive and involve depriving an individual of personal freedom. As with the suicidal patient, the use of involuntary hospitalization or the use of restraints with the potentially violent patient can damage the patient–clinician relationship. The individual may become angry with the clinician and/or feel betrayed. It may be possible to lessen the risk of such damage if the patient has been informed early in the treatment relationship that there are limits to confidentiality and that, if the patient is considered at imminent risk of seriously harming self or others, the clinician is ethically and often legally obligated to break confidentiality and initiate actions to protect the patient or others who may be at risk from the patient. Should such actions result in damage to the relationship, it can sometimes be repaired once the patient has become more stable.

Options for Managing the Risk of Interpersonal Victimization. If a mental health clinician believes that a patient or client is engaging in child abuse, elder abuse, or abuse of a person who is disabled, in most US jurisdictions the clinician is mandated to report the individual (or, if feasible, have the person report himself or herself) to the relevant state agency (see chapters 6, 17, and 24 of this volume). The laws governing mandated reporting typically do not require a presentation of extensive evidence. The protective services agency to which the clinician reports has the task of conducting a more complete investigation.

Although reporting may be mandated, it has been found that clinicians can have difficulty with these decisions. Zellman and Fair (2002), in a large survey of child abuse reporting behavior, noted that almost 40% of the respondents admitted that, at some point in their career, they had suspected childhood abuse or neglect, but they had decided not to report it. Those who did not report most frequently stated that they exercised discretion about reporting when they felt that there was insufficient evidence that abuse or maltreatment had occurred. What also distinguished them from others in the study was their negative opinion about the ability of the state's protective services staff, whom they saw as overburdened, to deal adequately with the situation. Most of these respondents were experienced in treating cases involving child maltreatment. They felt that reporting would risk termination of treatment and loss of the opportunity that they could provide to reduce the likelihood of further abuse.

In homes where there is child abuse, it has been found that there is an increased probability of partner abuse and vice versa. O'Leary, Slep, and O'Leary (2000) used data from two National Family Violence Surveys and found that when child abuse was present, the conditional probability of partner abuse was 31%. Moreover, when partner abuse was present, the conditional probability of child abuse was also 31%. Notably, arguments over child rearing have been found to be one of the most common precipitants of partner violence (O'Leary & Woodin, 2006).

Therapeutic work with a couple or with a member of a couple in which there is a risk of intimate partner violence can be trying (see chapter 14 of this volume). It is likely that at least one of the partners has problems with anger and aggression as well as issues with power and control. If therapy cannot resolve the problem, and one partner is being victimized, he or she may wish to separate. Unfortunately, there also can be heightened risk in attempting to end a relationship in which violence has been a factor. What may be a crisis in the relationship can quickly become an emergency in which there is a risk of serious harm to the partner who wishes to separate. Estranged wives or partners have been found to be at substantially higher risk of being killed by their partners than wives or partners in an intact relationship (Riggs, Caulfield, & Fair, 2009). Moreover, incidents in which a female partner was killed have been found to be approximately three times as likely as nonfatal assaults to be precipitated by the woman's leaving or attempting to leave a relationship.

During the tense times leading up to and during a separation or divorce, abused partners often seek the counsel of their therapists. The therapist may

be involved in helping the patient or client come to decisions about how and when to terminate the relationship. If there is risk that the other partner may become violent, the patient and the therapist may need to formulate plans for how the potential victim might keep himself or herself safe. (The reader is referred to chapter 14 of this volume for a more detailed discussion of these issues.)

Concluding Remarks

In this chapter, evidence has been presented that supports the contention that there is an interplay among the major behavioral emergencies of suicide risk, risk of violence, and risk of interpersonal victimization. As described, there is research indicating that childhood physical abuse is a contributing or chronic/distal risk factor for the perpetration of intimate partner violence and, more broadly speaking, for the perpetration of violence in adolescence and adulthood. In addition, childhood abuse, but particularly childhood sexual abuse, appears to be a strong chronic/distal risk factor for suicidal behavior. Furthermore, childhood physical and/or sexual abuse seem to be chronic/distal risk factors for revictimization as an adolescent and/or an adult. Finally, there is evidence that violent behavior and suicidal behavior are chronic/distal risk factors for each other.

In my opinion, not only do clinicians need to assess for these risk factors when evaluating patients for either suicide risk or violence risk, but clinicians and researchers need to study these interactions in an effort to understand the possible meaning they may have in terms of the etiology of high-risk behaviors.

In our search for meaning in these findings, Joiner's interpersonal-psychological theory of suicide, for example, might posit that childhood victimization can lead to a sense of thwarted belongingness and/or perceived burdensomeness, as well as habituation to the pain and fear involved in self-harm. The latter can increase the individual's acquired capacity to engage in lethal self-injury (Joiner et al., 2007). Others might suggest that childhood victimization affects self-worth and self-esteem, and these issues mediate suicide risk. In terms of the interrelatedness of suicidality and potential for violence, Hillbrand (1995) has suggested that those who engage in violent behavior and those who engage in suicidal behavior may share such factors or characteristics as impulsivity, anger or hostility, depression, substance abuse, or, particularly in adolescents, modeling behavior. Still others, such as Beck (1999), might take a cognitive perspective and view suicidal individuals and those who are potentially violent as sharing certain cognitive distortions—for example, dichotomous thinking, overgeneralization, catastrophizing, and personalization.

Most likely, there are many factors involved in and many paths that can lead to suicide and/or violence. The interactions between interpersonal victimization and suicidality or the potential for violence may eventually yield some additional insights into how an individual might move along such a pathway. Nonetheless, the findings noted suggest that a more integrated approach to suicide and violence risk-assessment and prevention may prove fruitful.

In this chapter, I have also distinguished between crises and behavioral emergencies (as well as between crisis intervention and emergency intervention). I have done so in an effort to reduce confusion about terminology and to demonstrate how the distinction between crisis and emergency frequently guides our thinking when we are confronted with patients in acute emotional distress. I have also discussed how crises can be precipitants for behavioral emergencies, and how, if a patient in crisis can have his or her state of equilibrium restored, an emergency situation may be avoided. In an integrated model of crisis intervention and emergency intervention, as just noted, if a crisis can be resolved, an emergency may be averted, but the clinician needs to remain alert to the possibility that a life-threatening situation may develop. If that occurs, he or she must be prepared to intervene on an emergency basis. I have further discussed the management of the levels of suicide risk, violence risk, and the risk of interpersonal victimization up to and including high or serious risk in which emergency measures are needed.

Note

1. For an example of an emergency interview, see Kleespies and Richmond (2009).

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CHAPTER

3

Training for Decision Making under the Stress of Emergency Conditions

Phillip M. Kleespies

Abstract

When under time or procedure pressure, people change their decision-making strategies. They may accelerate information processing and filter the information they will process. In this chapter, the author presents several models for decision making under pressure and compares them to more traditional models. The naturalistic decision-making models are proposed as more appropriate for decision making when working with high-risk patients under emergency conditions. Given that it is often stressful for clinicians to evaluate and manage patients or clients who are considered at acute risk to themselves or others, the author presents a model for training to reduce stress that is based on Meichenbaum's stress inoculation training. The chapter concludes with a discussion of the training for skill development and competence in dealing with behavioral emergencies that is consistent with the recommendations of the APA Task Force on the Assessment of Competence in Professional Psychology.

Key Words: decision making, decision making under stress, naturalistic decision-making models, behavioral emergencies, stress training, skill development with behavioral emergencies, competence with behavioral emergencies

As noted in the Introduction to this volume, this book is intended to be a handbook to which mental health clinicians can refer when they wish to acquire information about the evaluation and management of behavioral emergencies. In that sense, it is primarily devoted to the domain of knowledge, as in the knowledge, skill, and attitude (KSA) model that supports competency-based professional training (Baartman & Bruijn, 2011). Kleespies (2014) has addressed the issue of acquiring skill in this area of practice, and I will discuss that domain of the KSA model in this chapter. We will cover three major topics: (1) models for decision making under the stress of dealing with behavioral emergencies; (2) *stress* training, or a model for training to reduce the stress involved in managing behavioral emergencies; and (3) training for skill development and competence with *experience near* and actual behavioral emergencies.

Models for Decision Making under Stress

People change their decision-making strategies based on the task they are confronting. Payne, Bettman, and Johnson (1988) have shown that under increased time pressure, individuals will accelerate their information processing, filter what information they will process, and change the method that they use for decision making. Among the mental health disciplines, clinical and counseling psychologists have often been trained in the scientist-practitioner or Boulder model (Jones & Mehr, 2007). This model calls for an integration of science and practice such that the practitioner is directed by empirical data and scientific methods for the resolution of clinical issues. Through scientific inquiry, he or she is also to contribute to the development and enhancement of practice. In this model, Jones and Mehr have pointed out that the first role of the scientist-practitioner is that of a researcher.

The decision-making model of the scientist or researcher, however, is typically one in which the individual is very deliberative and analytical. Yet, this type of approach is not necessarily one that is best suited for the dynamic and fast-paced circumstances that can accompany the evaluation and management of behavioral emergencies, or even for the give-and-take of emotionally charged psychotherapy sessions. There is a need for a decision-making model for clinicians who must deal with patients or clients who are at high risk for harm to themselves or others, about whom information may be incomplete, whose emotional state may be highly charged, for whom the best course of action may be uncertain, and with whom there is time pressure to arrive at a decision. In this section, I will briefly discuss three broad categories of theoretical models for decision making (Polic, 2009; Shaban, 2005)—*rational* and *normative* models, *descriptive* models, and *naturalistic decision-making* models—with the intent of arriving at a model appropriate for dealing with behavioral emergency conditions.

Rational and Normative Models for Decision Making

In a rational model of decision making, the decision maker conducts a systematic, organized information search, considers all alternatives, generates a large set of options, compares the options, and selects the course of action that is most likely to lead to an optimal outcome (Driskell & Johnston, 1998). There is an assumption of a clearly defined problem and an impartial and fully rational decision maker.

Normative models are rational decision-making procedures that are based on probabilities. The Bayesian inference model (or Bayes theorem for judgments), perhaps the best known of these models, presents an analysis of all possible choices and their associated risks. The risks, however, are assigned weights and each choice is assigned a probability. By weighing risks and probabilities, the option with the highest utility for the decision maker can be determined (Shaban, 2005).

In the past, rational and normative models were considered ideal. They were the preferred models of the scientist or of those responsible for allocating financial resources. Deviations from the ideal were seen as a breakdown in the decision-making process (Janis & Mann, 1977). More recently, however, the limitations of these models for certain tasks has become evident. First, as it takes a relatively long time to elucidate all the options and come to a judgment, these models are best used for long-range planning rather than for the fast-paced decision making that may be needed in an emergency. Second, under dynamic and changing circumstances, when decisions must be made with incomplete knowledge, the requirements for complete quantification in a rational model cannot be adequately fulfilled. Finally, it has been demonstrated that in actual practice human decision making does not occur according to the processes described in rational models (Kahneman, Slovic, & Tversky, 1982). This latter point gave rise to interest in decision-making models that attempt to describe how people actually arrive at decisions.

Descriptive Models of Decision Making

Psychologists such as Simon (1957) and Tversky and Kahneman (1974) challenged the notion that people attempt to evaluate all available response choices as called for in rational models of decision making. Simon proposed a concept of *bounded* or limited rationality to describe typical human decision making. From this perspective, the individual considers only as many alternatives as needed to find one that satisfies him or her. From a somewhat different perspective, Tversky and Kahneman proposed that, under conditions of uncertainty, people frequently rely on a limited number of heuristic principles (or strategies) to reduce complex decision-making tasks to simpler judgmental operations. They provided empirical support for their proposal in numerous studies in which they demonstrated that when conditions were uncertain, not only relatively naïve subjects but also experienced researchers tended to abandon probabilities, such as the base rates of events or the sample size of groups, and they based their decisions on heuristics (or rules of thumb). An example of such a rule of thumb might be what they have referred to as *representativeness* (or having characteristics similar to those attributed to certain groups of people or things) (see Kahneman et al., 1982, for other examples).

In his book *Thinking, Fast and Slow*, Kahneman (2011) has placed the heuristics model within a larger, two-system framework for thinking and decision making. What he refers to as System 1 consists of thinking and perceiving that occurs automatically and quickly, without great effort. This is the system by which we recognize objects, perceive causality, and think intuitively. Heuristics, or rules of thumb, are a part of this system. On the other hand, System 2 consists of thinking that involves effortful mental activity and includes critical thought and analysis. Much of the time, System 2 runs in *low-effort mode,*

but it is activated when tasks or events are encountered that require analytical and logical reasoning. The dominance of one or the other system, at any particular time, may be determined by the demands of the situation, by the preference of the individual, or by the degree of emotional involvement in the outcome of events.

Naturalistic Decision-Making Models

Although descriptive models approach the process of decision making in everyday life more closely than rational models, they nonetheless tend to be based on evidence from laboratory studies. As such, they fail to take into account the context that can accompany decision making in the real world where the decision maker may confront many different pressures. As a result, decision researchers and theorists began to question how experienced decision makers (i.e., those who worked in dynamic, uncertain, and fast-moving natural environments, and who were good at what they did) went about assessing situations and making decisions. This direction of theory and research is more consistent with the decision making that often occurs when evaluating and managing behavioral emergencies or situations in which a patient or client is at acute risk of suicide and/or violence. Several naturalistic decision-making (NDM) models have been proposed and I will briefly describe them here.

The recognition-primed decision model. Klein (2009) proposed the recognition-primed decision (RPD) model to explain how experienced decision makers can identify a situation and generate a course of action without needing to consider multiple options. He theorized that, in many situations, such a decision maker identifies the particular situation as similar to situations that he or she has experienced in the past and recognizes a typical course of action. When confronted with a situation for which he or she has no immediate match, the experienced decision maker searches for features of the situation whereby he or she might place it into a known category. If this *feature matching* effort fails, the decision maker tries to mentally synthesize relevant features into a new causal explanation of the situation. The more experienced the decision makers, the more likely they are able to have a mental match for the situation or be able to match features and have a feasible course of action.

The RPD model asserts that experience and expertise with a task can allow a decision maker to find a plausible option as one of the first (if not the first) considered. Time pressure need not have a negative effect on performance because the experienced decision maker uses pattern recognition, which can occur very quickly. Klein (2009) has cited various studies in support of his model. Two examples follow.

Randel, Pugh, Reed, Schuler, and Wyman (1994) studied electronic warfare technicians while they were performing a simulated task. They found that 93% of the decisions involved non-comparative deliberations in keeping with the RPD model. Only 2 of 38 decisions were found to involve comparisons between options. In a second study, Calderwood, Klein, and Crandall (1988) investigated the quality of chess moves by chess masters and Class B chess players under tournament conditions (2.6 minutes per move) and blitz conditions (6 seconds per move). Under the extreme stress of blitz chess, it was found that the rate of blunders increased for the Class B players (from 11% to 25%) but not for the chess masters, whose blunder rate remained essentially unchanged at 7% to 8%. The authors contended that the more experienced chess masters had a greater range of, and/or more easily accessible, matches to the chess board configurations.

The recognition/metacognition model. The recognition/metacognition (R/M) model (like the RPD model just discussed) posits that the experienced decision maker utilizes an initial level of pattern recognition, but it goes on to posit that pattern recognition activates schemas (or mental structures) related to past situations with similar elements (Cohen, Freeman, & Thompson, 2009). These schemas are said to be under metacognitive control and can be critiqued for problems with the recognitional schemas. Critiquing can identify problems such as missing key elements, contradictory elements, and faulty or doubtful assumptions. The critiquing process can lead to additional information retrieval and a reinterpretation of cues to bring about a more satisfactory situation model for decision making.

The R/M model attempts to include critical thinking in addition to recognition priming as part of the process utilized by experienced decision makers. It posits that proficient decision makers work with developing situation scenarios in which they go through a mental investigation of gaps and conflicts that may require modifications to the pattern that has been recognized. Cohen et al. have presented some evidence that these critiquing or critical thinking skills can be enhanced through training. In a small study, R/M trained participants

considered significantly more factors in their evaluation of a battle scenario than a control group. They also placed greater value on the factors that more experienced senior officers valued.

The situation awareness model. Many errors that are said to be due to poor decision making are attributable to the situation awareness portion of the decision-making process. Given an individual's perception of the situation, he or she may make a correct decision, but there can be a problem with the perception. The situation awareness (SA) model of Endsley (2009) gives particular attention to accurate perception of the particular situation. It has three levels: (1) perceiving critical factors in the environment; (2) understanding what those factors mean; and (3) understanding what is likely to happen with a changing situation in the future.

Similar to the RPD and R/M models, the experienced decision maker in the SA model makes use of long-term memory stores of schemata or mental models (i.e., mental representations of similar situations or events) to aid in understanding the current situation and in making a decision about a course of action. In effect, they look for a best fit between characteristics of the situation and the characteristics of known categories of events. Of course, the decision maker needs to be careful not to become too automatic in responding because he or she could be susceptible to missing novel aspects of the situation.

The hypervigilant strategy. As previously noted, in many settings, decisions must be made under time pressure with incomplete, ambiguous, and/or conflicting information. Under these conditions, decision makers must conduct a less-than-exhaustive information search, do an accelerated evaluation of the data, consider a limited number of alternatives, and come to a rapid closure on a decision. Johnston, Driskell, and Salas (1997) referred to this type of decision-making process as a *hypervigilant* decision-making strategy. They contrasted it with a *vigilant* strategy by which they meant a rational-analytic approach, as described earlier. They contended that, in comparison to the vigilant approach, a hypervigilant strategy does not represent a defect in the decision-making process, but rather an adaptive response given the time-limited nature of the task.

Johnston et al. put their theory to the test with a naturalistic task. They had 90 US Navy enlisted personnel from a technical training school perform a computer-based simulation in which they had to monitor a radar screen for threats to their ship. Numerous unidentified contacts or potential threats popped up on the screen. The participants were initially trained in either a vigilant or a hypervigilant decision-making strategy. The task was to access three information fields or menus to classify the type of craft that had appeared, whether it was civilian or military, and whether its intentions were hostile or peaceful. They were told to work as quickly as they could so that they could identify the other ship and either engage it as hostile or clear it for safe contact with their ship. The researchers also manipulated stress levels with auditory distractions, task load, and time pressure.

The findings indicated that those who used a hypervigilant decision-making strategy made a significantly greater number of accurate target identifications. Performance was degraded under high-stress conditions for both types of strategies, but those using a vigilant strategy still performed significantly worse than those using a hypervigilant strategy. It was concluded that the *best-fit* pattern for decision making is likely to be dependent on the nature of the task demands. Under some conditions (e.g., time pressure, incomplete information), a hypervigilant approach can be the more effective strategy.

Naturalistic Decision Making in Behavioral Emergencies

Several of the NDM models for expert decision makers clearly have common ground. The RPD model, the R/M model, and the SA model all take experience and long-term memory storage as crucial to recognition in the present of similar patterns, situations, or events from the past. In most cases, this type of recognition enables the individual to make relatively quick decisions about a course of action when there is time pressure to do so. The R/M model stresses critiquing the fit of the pattern to a greater extent than either the RPD model or the SA model, while the SA model puts a greater emphasis on awareness of the current situation than the other two. The hypervigilant strategy describes how, in naturalistic task settings with time pressure, it is necessary to rapidly evaluate the limited information that can be gathered. It does not, however, invoke experience, long-term memory storage, and pattern recognition as important to the development of decision-making expertise.

I contend that the NDM models of decision making are crucial for understanding what must be learned to acquire the skills necessary to become competent in the evaluation and management of

behavioral emergencies. When a clinician works with patients who may be at risk for suicide and/or violence, lives can be in the balance, and the time for evaluating and managing the situation can be very limited. It is important that the clinician have good situational awareness (e.g., be aware of the patient's demeanor and behavior, as well as the resources available to cope with the patient's behavior should problems escalate). He or she needs to rapidly gather and analyze the information that can be obtained in a limited period of time. Because time is limited, the focus must be on gathering information that is essential to the decision at hand, calling upon past experiences (or be recognition-primed) in evaluating the patient's condition and deciding if something preventive needs to be done. With recognition schema that seem to be a good fit, the clinician needs to be able to critique the schema to detect gaps or inconsistencies. In Kahneman's (2011) terms, the clinician needs to learn to recognize situations in which mistakes or biases are likely and try to avoid them, particularly when the stakes are high.

The Impact of Stress on Decision Making

Not only do we, as clinicians, need to have models for decision making under stress (as described earlier), but we also need to be able to cope with stress to minimize its potentially negative impact on our decision making. I should note that, when I speak of stress, I am referring to the cognitive-appraisal model of stress offered by Richard Lazarus (1994). In this model, stress is not something that is solely induced by events in the environment, nor is it solely a response in the individual. Rather, stress involves an interaction between the person or group and the environment, where the demands of the situation are appraised as taxing or exceeding the coping resources available to deal with them. The individual, therefore, feels distressed and under pressure to find a way to cope, meet the demands, and relieve the distress. In this model, it is the perception and assessment of his or her ability to manage the situation that can lead to stress, particularly if the person doubts that he or she has the resources to cope with or control the unfolding events.

I believe it is self-evident that dealing with behavioral emergencies can be stressful, but there is also evidence from various surveys that supports that opinion. Pope and Tabachnick (1993), in a national survey of psychologists, found that 97% of the respondents reported being afraid of losing a patient to suicide. In a survey of nearly 300 recently graduated, former psychology interns, Kleespies, Penk, and Forsyth (1993) found that 97% of the sample had had a patient or patients with suicidal ideation or behavior during their training years, and that there was a dose-response increase in the emotional impact on the intern as a function of the increasing severity of the patient's suicidal behavior (i.e., from suicide ideation to suicide attempt to suicide completion). Rodolfa, Kraft, and Reilley (1988) surveyed staff and psychology trainees at 12 counseling centers and 14 VA medical centers. Participants rated 19 client behaviors and 24 therapist experiences in terms of how stressful they were. The two client behaviors that were ranked as most stressful were client–clinician violence and a suicide attempt by a client. In that national survey by Pope and Tabachnick (1993), 89% of the psychologists reported experiencing episodes in which they were afraid that a patient might attack a third party. There is also evidence in the literature indicating that clinicians who treat victims of interpersonal violence (e.g., victims of assault, rape, or torture) over a prolonged period of time may suffer negative effects that have been termed *vicarious trauma* (McCann & Pearlman, 1990) and *secondary traumatic stress* (Figley, 1995).

Of course, one can question whether stress can actually have a negative effect on decision making, and theorists such as Hammond (2000) have done so. As noted earlier, it has been found that people adapt and change their decision-making strategies to simpler operations depending on the intensity of the task and the time demands. These more abbreviated operations (e.g., the naturalistic decision-making strategies) have been found to be more effective under conditions of task and time pressure than lengthier, more complex rational strategies—at least with decision makers who are expert in their field. It seems feasible, therefore, that for some people (particularly those who are expert at what they do) performance might improve under stressful conditions rather than be degraded. The question remains, however, whether stress has a deleterious effect on the decision making of those who are not so expert or who are new at a particular task or in a particular field.

The study of chess players mentioned earlier in this chapter (Calderwood et al., 1988) has relevance in regard to this question. As noted in that study, the "blunder" rate of the more expert chess masters was essentially unchanged under the time pressure of "blitz" conditions (i.e., 6 seconds per move) as compared to tournament conditions (i.e., 2.6 minutes

per move). The blunder rate of the less expert players, however, increased significantly under so-called blitz conditions.

In another laboratory study, LeBlanc, MacDonald, McArthur, King, and Lepine (2005) had flight paramedics from two levels of certification participate in either a low-stress or high-stress study condition. In the high-stress condition, the participants were in a simulated ambulance with an adult-sized mannequin on a stretcher. The mannequin was programmed to replicate many human physiologic functions, such as heart rate, pulse in limbs, breath sounds, and so forth. The paramedics had to diagnose and manage respiratory failure, including doing a tracheal intubation. They then completed an anxiety inventory and were required to complete a set of drug dosage problems. Those in the low-stress condition completed a study questionnaire and then completed the anxiety inventory and the set of drug dosage problems. Those in the high-stress condition reported a significantly higher level of anxiety and did significantly worse on solving the drug dosage problems. The investigators concluded that when paramedics had to calculate drug dosages after experiencing a highly stressful situation, their performance was impaired.

Several studies have examined issues pertinent to decision making under stressful, real-life conditions. In a case control study, Gawande, Studdert, Orav, Brennan, and Zinner (2003) investigated the occurrence of an adverse medical event (i.e., when a foreign body such as a gauze swab or an instrument is accidentally left in the body of a patient following surgery). Although such events are statistically rare, the investigators found that the probability of such an event was eight times more likely when the operation was performed under emergency conditions and three times more likely when the operation involved an unexpected change in procedure. They attributed these increased risks to the abandonment of routine procedures and to the time pressure that exists during an emergency operation.

In an example of the effects of *production pressure* on decision making, Gaba, Howard, and Jump (1994) conducted an anonymous survey of anesthesiologists in California. They defined production pressure as "overt and covert pressures and incentives on personnel to place production, not safety, as their primary priority" (p. 488). Survey respondents reported internal pressure to work agreeably with surgeons and to try to avoid delaying surgical cases. They also, however, reported overt pressure from surgeons and hospital administrators to proceed with cases instead of canceling them and to hasten anesthetic procedures. Nearly half (49%) of the respondents had observed an anesthesiologist pressured to administer anesthesia in what they considered an unsafe fashion; 31% had seen patients undergoing surgery with significant contraindications for either the surgery or the anesthesia; 34% had observed a colleague perform anesthesia on a patient for whom anesthesia had just been refused or canceled for safety reasons by another anesthesiologist. The authors concluded that production pressure from internal and external sources was perceived by survey participants as having resulted in, at least in some cases, decisions to proceed with anesthesia under unsafe conditions.

The Stress of Behavioral Emergencies and *Stress* Training

Evaluating and managing patients or clients who may be acutely suicidal or potentially violent, or at great risk of becoming a victim of violence, can be stress-inducing in and of itself; but, as we have seen earlier, it may not be the only source of stress for the clinician. It has been said that patients typically don't schedule a time to have an emergency or crisis. These events can, and often do, occur at very difficult times—for example, when the clinician has other distressed or agitated patients waiting to be seen, when other staff are being kept from their duties to see if their assistance may be needed, or when normal clinic activities are being disrupted to cope with such an emergency situation. Unfortunately, the mental health disciplines have generally not made training in this area of practice a routine and integrated part of their educational process (see, e.g., Schmitz et al., 2012), and they have clearly not made consistent efforts to assist clinicians in dealing with the stress that can accompany work with high-risk patients or clients (Kleespies & Ponce, 2009).

Although it might seem obvious, it is nonetheless reasonable to ask if training and/or experience with the evaluation of behavioral emergencies actually makes a difference in the management of patients. A recent study by Teo, Holly, Leary, and McNiel (2012) has provided some relevant information on this issue. As part of a larger study, these investigators examined whether unstructured violence risk assessments completed by experienced attending psychiatrists were more accurate than those completed by psychiatric residents. Using a retrospective case control design, the research team selected 151 patients from four locked psychiatric units of a county hospital who had physically assaulted staff during the years 2003–2008. They also selected an

equal number of nonviolent patients matched for psychiatric inpatient unit and month of admission. On admission to these units, physicians rated each patient on a four-point assault precaution checklist that ranged from zero (no clinical indication for violence precautions) to three (strong intent is present or unable to control impulses). It was found that the clinical assessments by attending psychiatrists had a moderate degree of predictive validity, while those completed by residents were no better than chance. The violence risk assessments by the attending psychiatrists were significantly more accurate than the risk assessments by residents. The investigators concluded that less training and experience is associated with less accurate violence risk assessment.

There have been several recent efforts to provide models or programs for training in the behavioral emergencies or in a particular type of behavioral emergency. The books by Kleespies (1998, 2009) were organized as a proposed curriculum for teaching about behavioral emergencies and related topics. Two publications by McNiel and his colleagues (McNiel, Chamberlain, et al., 2008; McNiel, Fordwood, et al., 2008) have reported on a study in which they provided a 5-hour workshop for a group of psychiatry residents and psychology interns on evidence-based assessment and management of the risk of violence and risk of suicide. A comparison group attended a 3-hour workshop on the application of evidence-based medicine to psychiatry that was not focused on risk assessment for violence or suicide. The investigators found that, immediately after the training, the study group participants were able to identify the evidence-based variables that pertain to violence risk and suicide risk in a more systematic way. They were also able to be more explicit about the significance of risk and protective factors when they developed plans for intervention to reduce risk. In relation to the comparison group, the training group's improvements were described as substantial. Further, the risk assessment training was associated with increased confidence in risk assessment skill.

With a focus more exclusively on training in suicide risk assessment, Oordt, Jobes, Fonseca, and Schmidt (2009) also demonstrated that training in a workshop format with an empirically based assessment and treatment approach to suicidal patients could significantly impact the confidence, as well as a number of the suicide care practices, of US Air Force mental health professionals, both post-training and at the 6-month follow-up. Further, those who have been concerned with training in the evaluation and management of suicidal patients have developed what they consider to be core competencies needed to become clinicians capable of working with individuals at risk for suicide (Rudd, Cukrowicz, & Bryan, 2008; Suicide Prevention Resource center, 2006). There are eight sections that include competencies related to the clinician's attitude and approach to the suicidal patient, the clinician's understanding of suicide, the ability to collect accurate assessment information, the ability to formulate risk, the ability to develop a treatment and services plan, the ability to manage the care of a suicidal patient, the ability to document the assessment, formulation, plan, and so on, and the ability to understand legal and ethical issues related to suicidality.

There have been at least two workshop-type programs that have been developed for teaching content consistent with these core competencies. One is a 6-hour program titled *Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals* (AMSR; Suicide Prevention Resource Center, 2011), and the other is a 16-hour program called *Recognizing and Responding to Suicide Risk* (RRSR; American Association of Suicidology, 2011).

Jacobson, Osteen, Jones, and Berman (2012) have published an outcome study using the RRSR. In this study, 452 participants in RRSR training workshops were assessed at three points (pretest, post-test, and at the 4-month follow-up). The assessments included a variety of measures related to attitudes toward suicide prevention, confidence in working with clients at risk of suicide, and changes in clinical practice behaviors. The results suggested that training in this workshop format could improve clinicians' attitudes toward working with suicidal patients, their confidence about doing so, and their clinical practice skills as measured by their response to suicidal client vignettes both post-test and at the 4-month follow-up. The practice skills assessed were the ability to identify risk and protective factors, the ability to make a formulation of risk, and the ability to make a management plan in response to the risk. One limitation of the study was the lack of opportunity to observe actual clinical practice and behavior in the assessment and management of actual suicidal patients.

These workshops appear to be informative, useful, and well constructed. Pisani, Cross, and Gould (2011), however, conducted a rather sobering review of the results of participating in workshops. The following three criteria were included in the review: (a) the target audience was primarily mental health professionals; (b) the program's

educational objectives targeted clinical competence in the assessment and management of suicide risk; and (c) there was at least one peer-reviewed article that described or evaluated the training or explicated the clinical model. Twelve workshops met these criteria (including the AMSR and the RRSR). The investigators gave a cross-program description of the objectives and methods of the workshops. They also reviewed the training qualification and the feedback for the trainers who delivered the workshops, and they reviewed published studies about training outcomes (the study noted previously by Jacobson et al., 2012, was not available for this 2011 review). They found that research was very limited in terms of documenting real-world outcomes for those mental health clinicians who participated in these workshops. The available studies indicated that clinical knowledge and attitudes improved with the workshop training (at least during the relatively brief period of follow-up); and one study (McNiel, Fordwood, et al., 2008) found some evidence of improved clinical skill. Most importantly, however, the investigators found no evidence of improved real-life clinical care for suicidal patients.

Clearly, acquiring knowledge about suicide risk and violence risk, improving one's ability to do a formulation of the risk, and having practice in risk evaluation and management under the controlled conditions of a workshop can be a very valuable training experience. As I have contended earlier, however, it is only when the clinician confronts real-life conditions that he or she can ultimately learn to deal with the challenges of these high-stake situations in which there is risk of suicide or violence to others. Real-life emergencies are situations that are often stressful in themselves, but there can also be many other associated stressors (e.g., time pressure, other concurrent demands on the clinician, the needs of other patients). That is why it is important to have not only training but also what has been referred to as *stress* training (Driskell & Johnston, 1998).

Stress training has its roots in the stress inoculation training (SIT) of Donald Meichenbaum (1985, 2007). Meichenbaum's position is that the object of stress management training is not to eliminate stress "but to encourage clients to view stressful events as problems-to-be-solved rather than as personal threats. The goal is to make clients better problem solvers to deal with future stressful events as they might arise" (Meichenbaum, 1985, p. 30). In addition to helping people be better problem solvers, however, he has also emphasized learning techniques designed to relieve distress and foster emotion regulation. As he has stated, "Rather than conceiving their stressors as being overwhelming, uncontrollable, unpredictable, debilitating, and hopeless, the SIT trainer helps clients develop a sense of 'learned resourcefulness'" (Meichenbaum, 2007, p. 513).

The SIT model has three phases: (1) a *conceptualization phase*; (2) a *skills acquisition and rehearsal phase*; and (3) an *application and follow-through phase*. In the conceptualization phase, the focus is on attaining a better understanding of the nature of stress, its effect on emotion and performance, and on re-conceptualizing it into transactional or cognitive-appraisal terms. The skills acquisition and rehearsal phase centers on developing and rehearsing a variety of coping skills, primarily through imaginal and behavioral rehearsal. Finally, the application and follow-through phase focuses on transitioning from the imaginal and behavioral rehearsal to graded in-vivo or real-life exposure to stressors.

Although it has been applied with some professional groups, the SIT model was originally developed as a clinical treatment program for individuals who had difficulty dealing with problems such as physical pain, anger, and phobic responses. It has retained an association with treatment for clinical conditions. In an effort to extend stress training beyond the clinical domain, Johnston and Cannon-Bowers (1996) have developed a modification of the SIT model (i.e., stress exposure training, or SET) to be used in training professionals who must perform tasks under high-stress conditions.

As presented by Driskell and Johnston (1998), the SET model has three objectives. The first is to convey knowledge of the stressful task and environment. This objective is based on the assumption that stress is reduced by giving an individual information about what to expect in performing under stressful conditions. The second objective is to emphasize skill development. This involves training people in the behavioral and cognitive skills needed to perform the task or tasks effectively under stress. The third objective is to build confidence in the ability to perform under stress. This can only be achieved when the person in training experiences success or task mastery under actual stressful conditions.

Consistent with these objectives, the SET approach has three stages: (1) an initial stage in which information is provided about the importance of stress training and what stressors are likely to be encountered; (2) a skills training phase in which cognitive and behavioral skills for performing the task or tasks under stress are acquired; and (3) a final

stage of applying and practicing the acquired skills under conditions that increasingly approximate the potentially stressful environment or circumstances.

I have proposed that this three-phase model (with modifications) be used as a guide for training clinicians to deal with behavioral emergencies (Kleespies, 2014). Thus, there is a phase 1 in which information is provided about what stressors may be involved when a behavioral emergency arises; the clinician-in-training also learns, through lectures, readings, and/or workshops, about suicide risk, violence risk, and the risk of interpersonal victimization. Such preparatory information can begin to lessen the buildup of stress by clarifying misconceptions, reducing fear of the unknown, and increasing the clinician-in-training's understanding of this area of practice. It can provide a preview of the stressful events and make them less unfamiliar.

Phase 2 consists of cognitive and behavioral skills training through case conferences in which high-risk situations are discussed and/or through scenario-based training in which potentially stress-inducing clinical situations are presented and used for mental practice in making decisions about high-risk patients (see Kleespies, 2014, for some suggested scenarios). As noted by Meichenbaum (1985), it is in this phase that the clinician-in-training can rehearse attempts at how to cope and receive feedback on these exercises, as well as hear how others might have responded.

In phase 2, there are also certain stress training strategies that can begin to be integrated into the training process (Driskell & Johnston, 1998). *Mental practice* or *mental simulation* is most consistent with the scenario-based training previously noted. It refers to cognitive rehearsal without actually performing the task. It is a technique by which the mind creates a mental representation of a cognitive skill or a motor skill with the intent to mentally practice and enhance performance. In a meta-review of studies of mental simulation, van Meer and Theunissen (2009), concluded that "the general effectiveness of MS (mental simulation) for both motor and cognitive tasks has been established beyond reasonable doubt" (p. 104). Of course, it should not be used instead of actual practice, but it can be an excellent training adjunct. There is a debate in the literature about whether mental practice is as effective with *open skills* as with *closed skills,* where an open skill requires one to improvise and be reactive to changes while a closed skill is without much interference from external influences. With open skills, the investigators suggest reducing complexity and practicing components of the task. Behavioral emergencies certainly require *open skills*. A clinician-in-training might think through and mentally practice how he or she would respond in a scenario in which a patient was feeling hopeless and expressing suicidal thoughts, or in a scenario in which a patient was feeling disrespected, angry, and having an urge to become violent to others.

In complex situations, where there are often competing demands, it can be crucial to learn *prioritization skills*. If there is time pressure and/or high stakes, the clinician may need to think through what is most important to deal with or accomplish first. Time and attention cannot be devoted to low priority tasks when one may lose the opportunity to deal with more critical issues. In scenario-based training with behavioral emergencies, he or she can mentally rehearse how multiple tasks or multiple patients might be prioritized in terms of the urgency of each person's condition.

Phase 3 involves applying and practicing skills under conditions that increasingly approximate the potentially stressful task or situation. With suicidal or potentially violent patients, applying and practicing evaluation and management skills is best initiated under close, on-site supervision. In fact, it can be an excellent learning experience if a more senior clinician or supervisor initially has the trainee or intern observe him or her doing an evaluation. On a subsequent case or two, they can switch and let the trainee or intern take the lead in the interview or evaluation while the supervisor is there to inquire further, if needed, or to assist in managing the case. In cases that follow, the trainee can do the evaluation more independently, with a supervisory consultation before the case is completed and before the management plan is decided on. In this way, the clinician-in-training can have a gradated experience leading to increasing mastery and autonomy.

This graduated approach allows the clinician-in-training to become more familiar with the stressors he or she may face with patients who are at risk without feeling overwhelmed. It also gradually builds confidence, and it is less likely than immediate exposure to an intensely stressful situation (without guidance or support) to interfere with learning and mastery of the task.

In this phase 3, the trainee or intern can practice additional stress training strategies. Thus, he or she can work on increasing his or her cognitive control while being involved with actual cases. Control can be improved by recognizing when thoughts irrelevant to the task or emotions occur, replacing

them with task-focused cognitions. Attention can be consciously directed to task-relevant issues and away from distractions. The clinician can also employ physiological control strategies like relaxation through deep breathing exercises. The use of relaxation techniques is based on the premise that relaxation and stress are incompatible. If someone is relaxed, he or she is less likely to experience the negative reactions brought on by stress.

Overlearning has also been found to be a good training procedure for dealing with high-stress situations. The term refers to deliberate overtraining of a task beyond the level of proficiency. It is training to the point where aspects of the task become automatic and require less attention. Since stress can restrict attention in a negative way, making certain tasks automatic can compensate, to some degree, for the effects of stress. Of course, with overlearning and multiple experiences, the clinician-in-training also develops a store of memories or schemata of behavioral emergencies—for example, becoming more recognition-primed to understand a high-risk situation and quickly decide on a course of action to manage it.

Although this model for stress exposure training with behavioral emergencies has been presented in three phases, it should be noted that these phases are not intended to be strictly sequential. Clearly, the clinician-in-training can be acquiring a knowledge base in behavioral emergencies while simultaneously learning cognitive and behavioral skills through participation in case discussions and scenario-based training. Likewise, one can be learning cognitive and behavioral skills in simulated clinical scenarios while beginning to engage in the application of skills by doing evaluations with close supervisory monitoring. The model is presented in phases to emphasize the importance of taking a gradated approach to acquiring the skills needed to evaluate and arrive at decisions with high-risk patients under what are often stressful conditions. The three-phase model is also consistent with the position that a clinician-in-training is not fully competent until those skills learned in more controlled settings are put to the test in real-life situations with real-life consequences that can be life-threatening.

Training for Decision Making and Competence in Behavioral Emergencies

It is certainly possible that a clinician can know a great deal about risk and protective factors for suicide or violence, yet still lack skill in interacting and assisting patients who are suicidal or potentially violent. This possibility prompted Bongar, Lomax, and Harmatz (1992) to comment that "knowledge of risk factors and the capacity to respond in an effective way to those patients who present as an imminent risk of suicide may be independent areas of clinical competence" (pp. 262–263). This statement by Bongar et al. highlights my position (as noted previously) that making good decisions in high-stake situations in which a patient is at risk of suicide or violence to others, and in which there may be many associated stressors, is something that is only fully mastered under real-life conditions. As noted in the book by Kleespies (2014), this does not in any way negate the value of lectures, courses, workshops, discussions of past cases, or discussions of hypothetical case vignettes. These are all important methods by which mental health professionals learn about and, in some instances, practice the assessment and management of behavioral emergencies. They are methods that clearly help to prepare clinicians for actually dealing with patients or clients who are at acute risk of harm to themselves or others, and they do so under calm, controlled conditions that allow them to contemplate their decisions and actions without the stress of dealing with consequences if there is an error in judgment. However, these methods cannot provide the type of training that experience with actual patients in emergency situations can. Moreover, they are often discrete episodes of learning rather than extended experience that might be more likely to lead to recognition-priming and allow for greater mastery.

The APA Task Force on the Assessment of Competence in Professional Psychology (2006, October) has attempted to provide a conceptual framework for thinking about competence in the practice of psychology. They embrace a definition of professional competence that was proposed for the medical profession but which is felt to also be relevant for professional psychology. Within this definition, competence is "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (Epstein & Hundert, 2002, p. 227). There is clearly an emphasis in this definition on *the habitual judicious use of knowledge, skills, and abilities in daily practice* as integral to achieving competence in professional functioning.

While recommending that there be a culture shift in psychology toward placing a high value on the assessment of competence, the APA Task Force also acknowledges that there have been many

problems arriving at a consensus about what constitutes competence and how to assess competence and competencies. It emphasizes, however, that assessment should reflect fidelity to actual practice—for example, evaluating as closely as possible the actual behaviors that the clinician must perform in practice.

The Task Force goes on to state that there are *competencies* that are elements of *competence*. Competencies are conceptualized as clusters of integrated knowledge, skills, and abilities that enable an individual to fully perform a task. They are divided into foundational competencies and functional competencies. Foundational competencies have to do with scientific knowledge, scientific methods, knowledge of ethical and legal standards, and so forth. They form the building blocks of what psychologists do. Functional competencies, on the other hand, have to do with assessment, diagnosis, intervention, consultation, and so on. They reflect the knowledge, skills, and attitudes needed to actually perform the work of a professional psychologist. In my opinion, the assessment and management of behavioral emergencies is a functional competency, essential to the development of overall competence for practicing psychologists.

In assessing functional competencies, the Task Force has suggested the development of reliable methods that use case vignettes, video- or audiotapes of patient–practitioner interactions, written work samples, and/or live patient–client situations. These methods are time intensive, labor intensive, and can be costly. Nonetheless, the Task Force's emphasis is on devising assessment methods that are *experience near.*

Experience near is a term used by the Task Force to describe the degree to which a task or measure reflects the actual behaviors the clinician must perform in practice. Thus, an assessment or training technique that involves the evaluation of a clinician while assessing a simulated patient is more experience near (i.e., closer to an actual experience with a patient) than having the clinician take a multiple-choice exam assessing his or her knowledge of a particular clinical condition. While a multiple-choice exam may be a good way to assess someone's knowledge base, evaluating a clinician while he or she assesses a simulated patient is a way to assess the individual's clinical skills.

In regard to becoming competent in the assessment and management of behavioral emergencies (i.e. assessing and managing patients/clients who are at high risk of suicide or violence or both), I have contended that the training itself, let alone the assessment of competence, is best accomplished in real-life encounters with actual patients/clients at risk where the practitioner can have not only training, but the stress training discussed earlier in this chapter. In the pages that follow, I present a model for such a training program.

Training to evaluate and manage behavioral emergencies can be carried out using the three categories recommended in the APA Task Force (2006) report—knowledge, skill, and attitude. Such training also seems compatible with the stress exposure model (SET) for training.

A Knowledge Base for Behavioral Emergencies

In terms of a knowledge base, this volume can serve that purpose. The book starts with an overview of behavioral emergencies and then gives a framework for practice and training. These introductory chapters are followed by sections on (1) behavioral emergencies in youth (including chapters on the assessment and management of suicide risk, violence risk, and risk of victimization in children and adolescents); (2) behavioral emergencies in adults (including chapters on the assessment and management of suicide risk, violence risk, and risk of victimization in adults); and (3) behavioral emergencies in the elderly (including chapters on the assessment and management of suicide risk, violence risk, and risk of victimization in the elderly). These core sections are then followed by chapters covering (1) conditions that are either frequently associated with behavioral emergencies or need to be distinguished from behavioral emergencies (as, for example, non-suicidal self-injury, alcohol and drug-related issues, and neurological and endocrine disorders with behavioral manifestations); (2) the treatment of patients with ongoing or recurrent risk of suicide, violence, or interpersonal victimization (including psychological/behavioral treatment and psychopharmacological treatment); and (3) the legal, ethical, and psychological risks for the clinician who works with behavioral emergency cases.

A Supervisory Model for Teaching Skill and Attitude

As noted by Kleespies (1998, 2009), applying a knowledge base in practice with good supervision leads to skill development and clinical competency. When a patient or client is thought to be on the verge of suicide or violence, or of becoming a victim of violence, the situation can be stressful for the

seasoned professional, let alone for those who are in training and less confident of their clinical abilities and status. When it comes to stressful clinical events, some working in the field have felt that clinicians-in-training have a protective advantage over professionals in that they work under the direction of a supervisor and can process events in an organized program (Brown, 1987). Rodolfa, Kraft, and Reilley (1988), however, found that patients' suicidal statements, patients' suicide attempts, and patients' attacks on the therapist were all rated as moderately to highly stressful by both professional psychologists and psychologists-in-training. Kleespies et al. (1993) also found evidence that the negative emotional impact of patients' suicidal behavior on psychologists-in-training may be as great or greater than that on professional psychologists. It seems clear that those who are first learning to cope with such difficult emergency situations need considerable instruction and support to reduce their level of stress.

A mentor model for learning under such conditions seems advisable. In this model, an experienced clinician and an intern or trainee are paired in settings where patients or clients at risk are evaluated. The intern or trainee has the opportunity to observe and work closely with the more seasoned professional who has been successfully engaged in this type of clinical work. The pressure of more complete clinical responsibility is only gradually assumed by the trainee, and anxiety is kept at manageable levels. In this model, it is important for the supervisor to be aware of the balance between support and intern responsibility, and to shift the balance appropriately over time to promote the more independent functioning of the clinician-in-training.

As recommended in the SET approach, the clinician-in-training, in working with a mentor, has the opportunity to begin applying and practicing the skills that he or she has acquired through lectures, workshops, mental practice with case vignettes, and observation. With this gradated approach, the stress inoculation discussed by Meichenbaum (2007) can begin to occur. As Meichenbaum noted, stress in these situations is never completely eliminated, but the objective of stress training is to assist the clinician in viewing these scenarios as problems that they have the skills to solve. Constructive attitudes develop from these experiences of mastery.

Clearly, there have been instances in which relatively inexperienced trainees have been placed in the front lines, so to speak, dealing with behavioral emergencies with little direct supervisory support. Under such circumstances, emergency and crisis work is often seen as trying and burdensome. Good support and supervision, however, can go a long way toward preventing a negative viewpoint and aiding in the development of a sense of competence in dealing with emotionally charged cases. Long ago, Barlow (1974) observed that psychology interns responded initially to emergency department duty with moderate to severe anxiety. He further observed that within about three months, a second response of increased clinical confidence began to emerge. This sense of competence was described by interns as one of the more important developments in their training.

A Model Program for Training in Emergency Psychological Services

Training in the evaluation and management of behavioral emergencies can occur in a number of different settings—an emergency room (ER), an urgent care clinic (UCC), a medical center that has a psychiatric consultation/liaison team, an acute inpatient psychiatry unit, or at a community-based walk-in clinic that occasionally sees patients who are suicidal or potentially violent. An ER is a very medical setting, but Covino (1989) found that the majority of psychiatric patients seen in a hospital ER had complaints that fell well within the competence of psychologists to evaluate and provide immediate management. Moreover, with good collaboration from the nursing and medical staff, complications can be minimized.

In the model program presented by Kleespies (2014) for psychology interns and/or postdoctoral fellows, the intern or fellow is on call to consult on cases in the ER or UCC on a morning or afternoon shift 1 day a week for 4–6 months. These consultations and evaluations take place under the supervision of a staff member (or mentor) who is experienced in this work and who coordinates the training experience. Interns may have three 4-month major rotations or two 6-month major rotations. During one of their major rotations (e.g., at a general mental health clinic or substance abuse treatment program) each intern in the internship program participates in consulting on cases in the ER or in a UCC where patients present with mental health or psychiatric problems or crises.

Given that it is important to prepare interns for the experience and to help them develop a knowledge base, the experience should have a lecture series that begins with a good orientation to the setting and to the types of patients and conditions that are likely to be encountered. The lecture series is one

in which different staff or faculty with expertise on particular topics may be asked to provide lectures. The series might include topics such as the emergency interview, evaluating and managing suicide risk, evaluating and managing the risk of violence, alcohol and drug abuse problems, neurological disorders that may present as behavioral or psychological problems, and so forth.

Concurrent with the orientation and lectures, the participating interns can begin their experience in the ER or UCC by sitting in and observing the supervising psychologist as he or she does at least two evaluations. The patient is, of course, asked for verbal consent to allow the intern to observe for training purposes.[1] After two or three evaluations and the opportunity to read his or her mentor's written reports, the intern is usually ready to begin doing one or two evaluations, with the mentor observing and contributing as appropriate. Subsequently, the intern is typically ready to become more autonomous in doing evaluations, but the mentoring psychologist is always present in the ER, UCC, or walk-in clinic for consultation or assistance with difficult situations or decisions. Moreover, each case is discussed with the supervisor before a final decision is made about the disposition or plan for management and follow-up. Two to three days after the intern has been on-call, there is a wrap-up and supervision meeting where each of the cases seen that week are reviewed with the supervising psychologist. If two or three interns have been on-call, this supervision can be held in a group session. Through this process of close supervision and increasing autonomy, the intern develops a sense of being able to master the stresses and problems presented by work with patients who are at acute risk to themselves or others. They also begin to acquire a reservoir of experiences that they will be able to call upon in the future.

A Model for Assessing Competence in Evaluating and Managing Behavioral Emergencies

When a clinician-in-training has completed training in an area of practice such as behavioral emergencies, assessing whether the individual is competent to practice independently is not a simple matter. As the APA Task Force on the Assessment of Competence in Professional Psychology (2006, October) indicated, assessment models for competence should have validity, feasibility, and fidelity to actual practice. Validity, of course, refers to whether the assessment measures the competency it purports to measure. Feasibility refers to practical issues such as the resources, cost, expertise, and the time needed to develop and maintain the assessment. Finally, as noted earlier in this chapter, fidelity refers to the degree to which the assessment reflects the actual behaviors that the clinician performs in practice.

If we are interested in measuring knowledge that a trainee has acquired, we typically look to multiple-choice, essay, and short-answer questions as measurements. If we are interested in measuring professional decision making, the APA Task Force seems to support the use of case-based oral examinations. This type of exam has been used extensively in specialty certification programs, such as with the American Board of Professional Psychology (ABPP) certification. Case materials are presented in the form of written vignettes, videotapes, audiotapes, the clinician's own reports, or live patient–clinician interactions. The clinician must explain his or her actions and decisions about assessment, diagnosis, treatment, and/or case management. Examiners then question the clinician about those decisions. This approach to assessment requires standardization of case materials (e.g., the video- or audiotape of an interaction that replicates a professional interaction), in addition to guidance for and training of the examiners to ensure inter-rater reliability.

In keeping with such a case-based model, McNiel and colleagues (McNiel, Hung, Cramer, Hall, & Binder, 2011) and Hung and colleagues (Hung et al., 2012) have made strides toward developing an approach to evaluating competence in assessing and managing risk of violence and/or suicide. Working within an OSCE framework, the investigators trained advanced psychiatry residents (third and fourth year residents) and psychology postdoctoral fellows to be standardized (simulated) patients and had them follow a script based on a clinical vignette of a young adult patient presenting to an emergency room. The script included the patient's chief complaint, history of present illness, psychiatric, medical, and psychosocial histories, and mental status examination findings. The subjects (or clinicians-in-training) were less advanced psychiatry residents (first and second year residents) and psychology predoctoral interns who initially had a 5-hour workshop on risk assessment for violence and suicide. Faculty members were trained as observers. Each OSCE team consisted of a clinician-in-training, a standardized patient, and a faculty member.

After receiving a brief description of the presenting problem, the clinician-in-training was asked to perform a violence risk assessment or a suicide risk

assessment of the standardized patient. He or she interviewed the simulated patient and was asked to discuss what additional information he or she might seek if this were a real situation. The clinician-in-training was also asked to write a progress note and give an oral summary of the assessment and plan regarding the patient's risk.

To assess competence, the investigators developed two instruments: the Competency Assessment Instrument for Violence (CAI-V) and the Competency Assessment Instrument for Suicide Risk (CAI-S). These instruments were created based on literature reviews and input received from focus groups with mental health faculty at multiple sites in a large academic psychiatry department. The CAI-V and CAI-S consist of checklists of 31 and 30 components, respectively, on violence risk assessment and suicide risk assessment, including areas such as interviewing and data collection, case formulation and presentation, treatment planning, and documentation. In separate studies, the CAI-V and the CAI-S were found to have good internal consistency reliability (a = 0.93 and a = 0.94, respectively) and good inter-rater reliability (intra-class correlation coefficient [ICC] = 0.93 and ICC = 0.94, respectively).

After the clinician-in-training interviewed the standardized patient and discussed the case, the faculty observer rated the competence of the clinician's performance using CAI-V or CAI-S, as the case might be. For purposes of data analysis, the clinicians-in-training were divided into those at a senior level (second year residents who had 6 months of supervised inpatient psychiatry experience) and those at a junior level (first year residents). The mean scores on the CAI-V and on the CAI-S were significantly higher for the senior level clinicians-in-training. In addition, the global rating of the overall quality of the violence risk assessments and of the suicide risk assessments were significantly higher for the senior level learners. The risk assessments by senior learners were also significantly more likely to be rated as competent by the faculty examiners than the risk assessments by junior learners.

The investigators in these two studies noted that the CAI-V and the CAI-S had concurrent validity in that senior learners performed better than junior learners in the context of an OSCE. They further found that both learners and faculty expressed satisfaction with this method of assessment and that the CAI-V, CAI-S, and the OSCE provided helpful structure for feedback and supervision concerning violence risk and suicide risk assessment and management.

In terms of limitations of these assessment methods, the researchers have mentioned the cost of having faculty serve as examiners in an OSCE. In that regard, they suggest the possibility of having the simulated patient also be the person rating the clinician-in-training. They note that a second limitation is that simulated patients may not show the range of problems comparable to actual patients in high-risk, clinical situations. They comment that future research could investigate the applicability of these measures in clinical supervision with actual cases.

The author concurs that it is unlikely that simulated patients will show the range of problems that an actual patient in a state of crisis might present. The limitations of cost and of having a simulated patient mentioned by McNiel and his colleagues might be addressed in a setting such as an ER or a UCC using the mentor model of supervision discussed earlier in this chapter. The supervisor (again with the patient's permission) could be an observer of an actual evaluation with a patient who presents with a question of suicide risk or risk of violence. Immediately following the evaluation, he or she could evaluate the competence of the clinician-in-training by completing an instrument such as the CAI-S or the CAI-V. One drawback to assessing competence with actual patient interviews is that it is not possible to have a standardized patient.

Concluding Remarks

There is a great deal to be learned from naturalistic decision-making models regarding how best to approach the decision making-process when dealing with behavioral emergencies. In an acute clinical situation involving questions of risk to self or others, the task demands typically do not permit the painstaking approach of the rational and normative models of decision making. In fact, as we have seen, efforts to apply such models in time-limited, dynamic, and rapidly shifting circumstances can lead to poorer performance (Johnston et al., 1997). In some sense, we can take something from each of the NDM models that we have discussed in this chapter (recognition-primed model, recognition/metacognition model, situation awareness model, and the hypervigilant strategy) and find that it applies well to the evaluation and management of behavioral emergencies.

As I have also noted, we not only need models for decision making in behavioral emergencies, we also need to be able to cope with the attendant stress of emergency circumstances to minimize

its potentially negative effect on decision making. Thus, I endorse a training model for this work (such as the stress exposure training model) that emphasizes the development of resources for coping with stress. In addition, and in accord with the APA Task Force on the Assessment of Competence in Professional Psychology, I contend that training for competence in behavioral emergencies (and competence itself) is ultimately achieved through a process that includes the development of a knowledge base, as well as through a gradated approach to acquiring skill, that culminates in well supervised, real-life encounters with actual patients who are at risk to themselves or others.

Note

1. In medical teaching facilities, when patients initially enter the health-care system, they are typically informed that teaching is an integral function of the particular health-care system and that care may be provided by clinicians-in-training under the supervision of a staff member. If they object to treatment or to involvement in treatment by a clinician in training, treatment is provided only by a fully credentialed staff member.

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SECTION 2

Behavioral Emergencies with Youth

CHAPTER 4

The Evaluation and Management of Suicide Risk in Adolescents in the Context of Interpersonal Violence

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Abstract

In this chapter, risk factors for suicidal ideation and behavior are reviewed, including sociodemographics, prior suicidal behavior, nonsuicidal self-injury, depression, anxiety, substance use, family factors, physical and sexual abuse, sexual orientation, and access to firearms. Special emphasis is placed on the intersection of suicidality and interpersonal violence in terms of reciprocal risk. A review of the core areas to address in the acutely suicidal adolescent or the adolescent who has recently attempted suicide is also provided. Clinical questions regarding the adolescent's current emotional state, suicidal ideation/intent, reasons for suicidality, access to means, and capability of the environment to keep the adolescent safe are suggested. The chapter concludes with a discussion of safety planning.

Key Words: suicide, suicidal ideation, attempted suicide, interpersonal violence, adolescent

Suicide incidence increases markedly in the late teenage years and continues to rise until the early twenties. Suicide represents the third leading cause of death for 10- to 24-year-olds (National Center for Injury Prevention and Control [NCIPC], 2014) and is the second leading cause of death for 15- to 24-year-olds (McIntosh & Drapeau, 2014). Suicide attempts are defined as any intentional, nonfatal self-injury, regardless of medical lethality, if intent to die was indicated (O'Carroll et al., 1996). Nationally, the most recent results from the Youth Risk Behavior Surveillance Survey (YRBSS) of youth in Grades 9 through 12 found that 16% of students reported seriously considering suicide, 13% reported creating a plan to kill themselves, and 8% reported trying to kill themselves in the 12 months preceding the survey (Kann et al., 2014).

Interpersonal violence (assault or homicide), the third leading cause of death among 15- to 24-year-olds and fourth leading cause of death for 10- to 14-year-olds (McIntosh & Drapeau, 2014; NCIPC, 2014), is defined as "the intentional use of physical force or power, threatened or actual, against another person or against a group or community that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p. 5). Interpersonal violence is divided into intimate partner violence (between current or former romantic partners), which is also referred to as dating violence (Centers for Disease Control and Prevention [CDC], 2012b), and peer nonpartner violence (e.g., fights at school, gang violence; CDC, 2012a). Many researchers and clinicians further differentiate bullying (which is defined as having a power differential) from other forms of peer violence. Nationally, 10.3% of adolescents endorse dating violence (being slapped, hit, or physically hurt on purpose) at the hands of a partner, with females (13%) endorsing higher rates of dating violence victimization than males (7.4%; Kann et al., 2014). Almost

a quarter of adolescents surveyed endorse past-year peer physical fights (Kann et al., 2014), and 20% to 30% endorse past-year peer bullying (CDC, 2012c). Interpersonal violence, in all forms, is a significant risk factor for suicidality.

Accumulating evidence suggests strong links between dating violence and suicidality among adolescents. Adolescents who reported dating violence victimization had 3 times the odds of having attempted suicide within the timeframe of the abuse (CDC, 2006). Other studies (Silverman, Raj, Mucci, & Hathaway, 2001) suggest that adolescent female victims of dating violence are 6 to 8 times more likely to think about and attempt suicide than those who have not experienced dating violence. Among girls, experiencing dating violence at baseline was associated with suicidality at a one-year follow-up (Roberts, Klein, & Fisher, 2003), even after controlling for prior dating violence and other potential confounders. In a community sample of Latino youth 11 to 13 years of age, dating violence victimization among boys was associated with a history of suicidal ideation (Yan, Howard, Beck, Sattuck, & Hallmark-Kerr, 2010). Other studies show that both physical dating violence victimization and perpetration increased the odds of suicide ideation.

Peer violence is also strongly associated with risk of suicidality. For instance, adolescents reporting a past-year physical fight and weapon carriage have a higher likelihood of reporting past-year suicidal ideation and suicide attempts (Stack, 2014; van Geel, Vedder, & Tanilon, 2014). Studies suggest that there is a direct correlation between increasing frequency of physical peer victimization and rates of suicide ideation and suicide attempts (Kaminski & Fang, 2009; Turner et al., 2012). Interestingly, it is not just victimization that correlates with suicidality and suicide attempts. Mere exposure to violence—witnessing peer violence in the community—also correlates with higher rates of suicidal ideation (Lambert, Copeland-Linder, & Ialongo, 2008). Increased aggressiveness—for example, being a perpetrator of peer violence—predicts future suicidal behavior as well, particularly for girls (Juon & Ensminger, 1997; O'Donnell, Stueve, & Wilson-Simmons, 2005).

Reviews of the literature (e.g., Kim and Leventhal, 2008) suggest that adolescent perpetrators and victims of bullying are at increased risk for suicidal behavior. In a sample of 208 Swedish adolescents, any kind of bullying (victim, perpetrator, both) was associated with a history of suicide attempts (Ivarsson, Broberg, Arvidsson, & Gillberg, 2005). Likewise, Kim, Leventhal, Koh, and Boyce (2009) prospectively used a peer nomination design to study bullying and risk for suicide in a sample of 1,655 Korean seventh and eighth graders. Adolescent perpetrators and victims of bullying were at increased risk for suicidal ideation and attempts compared to adolescents not involved in any form of bullying. In addition, high school students who report being bullying victims *and* perpetrators are at higher risk of suicidal behavior than those who are only victimized or only bullied (Roland, 2002; Hepburn, Azrael, Molnar, & Miller, 2012).

Cyberbullying (i.e., bullying that takes place using electronic technology such as mobile phones and social media) is increasingly common. Confirming earlier single-site studies (e.g., Hinduja & Patchin, 2010), a recent meta analysis showed that cyberbullying is more highly correlated with both suicidal ideation and attempts than in-person bullying (van Geel et al., 2014). (See Chapter 7 of this volume by Samantha Pflum, Peter Goldblum, Joyce Chu, and Bruce Bongar for more information on bullying and suicide risk.)

Dating violence, peer violence, and suicidality tend to "cluster" in adolescents (Bossarte, Simon, & Swahn, 2008). Polyvictimization (e.g., experiencing a combination of peer and dating violence, sexual assault, and adverse childhood experiences such as child abuse) also predicts significantly higher rates of suicidal ideation (Turner, Finkelhor, Shattuck, & Hamby, 2012).

In this chapter, risk factors for suicidal ideation and behavior, including interpersonal violence, are reviewed. These background variables set the stage for the assessment of suicidal risk. Whenever possible, special emphasis is placed on the intersection of suicidality and interpersonal violence, both in terms of reciprocal risk as well as management.

Risk Factors for Suicidal Behavior

Sociodemographic factors related to suicidal behavior and their overlap with interpersonal violence are reviewed in the following.

Sex

Sex differences among 13- to 24-year-olds who die by suicide are pronounced (CDC NCIPC, 2013a). In 2011, more adolescent males (20.2 per 100,000) than females (5.4 per 100,000) died by suicide (McIntosh & Drapeau, 2014). Sex differences in the opposite direction exist with respect to suicide attempts. YRBSS (Kann et al., 2014) data indicate that female high school students (22.4%)