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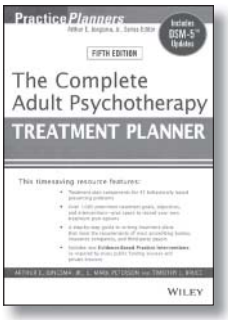

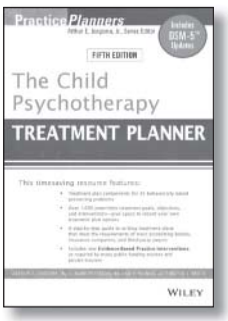

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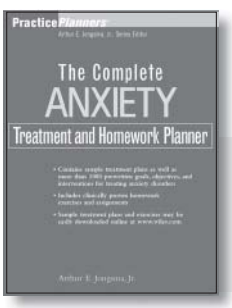

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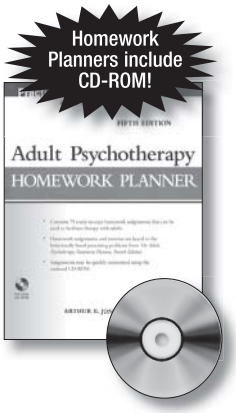

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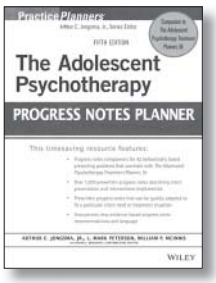

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Arthur E. Jongsma, Jr., Series Editor

The Suicide and Homicide Risk Assessment & Prevention Treatment Planner, with DSM-5 Updates

Jack Klott

Arthur E. Jongsma, Jr.

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In memory of my mother, Rosemary, whose grace in passing mirrored the grace of her life; and to my wife, Rebecca, who has lovingly invited me on her wondrous journey through life.

—J.K.

To my stepmother, Mae, whose Christian faith is clearly revealed in her sacrificial love and service given to so many others, especially my Dad. Thank you Mae.

—A.E.J.

CONTENTS

PRACTICE*PLANNERS*® SERIES PREFACE

Accountability is an important dimension of the practice of psychotherapy. Treatment programs, public agencies, clinics, and practitioners must justify and document their treatment plans to outside review entities in order to be reimbursed for services. The books in the Practice*Planners*® series are designed to help practitioners fulfill these documentation requirements efficiently and professionally.

The Practice*Planners*® series includes a wide array of treatment planning books including not only the original *Complete Adult Psychotherapy Treatment Planner*, *Child Psychotherapy Treatment Planner*, and *Adolescent Psychotherapy Treatment Planner*, all now in their fifth editions, but also *Treatment Planners* targeted to specialty areas of practice, including:

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- Co-occurring disorders
- Behavioral medicine
- College students
- Couples therapy
- Crisis counseling
- Early childhood education
- Employee assistance
- Family therapy
- Gays and lesbians
- Group therapy
- Juvenile justice and residential care
- Mental retardation and developmental disability
- Neuropsychology
- Older adults
- Parenting skills
- Pastoral counseling
- Personality disorders
- Probation and parole
- Psychopharmacology
- Rehabilitation psychology
- School counseling and school social work

- Severe and persistent mental illness
- Sexual abuse victims and offenders
- Social work and human services
- Special education
- Speech-language pathology
- Suicide and homicide risk assessment
- Veterans and active military duty
- Women's issues

In addition, there are three branches of companion books that can be used in conjunction with the *Treatment Planners*, or on their own:

- ***Progress Notes Planners*** provide a menu of progress statements that elaborate on the client's symptom presentation and the provider's therapeutic intervention. Each *Progress Notes Planner* statement is directly integrated with the behavioral definitions and therapeutic interventions from its companion *Treatment Planner*.
- ***Homework Planners*** include homework assignments designed around each presenting problem (such as anxiety, depression, substance use, anger control problems, eating disorders, or panic disorder) that is the focus of a chapter in its corresponding *Treatment Planner*.
- ***Client Education Handout Planners*** provide brochures and handouts to help educate and inform clients on presenting problems and mental health issues, as well as life skills techniques. The handouts are included on CD-ROMs for easy printing from your computer and are ideal for use in waiting rooms, at presentations, as newsletters, or as information for clients struggling with mental illness issues. The topics covered by these handouts correspond to the presenting problems in the *Treatment Planners*.

The series also includes adjunctive books, such as *The Psychotherapy Documentation Primer* and *The Clinical Documentation Sourcebook*, contain forms and resources to aid the clinician in mental health practice management.

The goal of our series is to provide practitioners with the resources they need in order to provide high-quality care in the era of accountability. To put it simply: We seek to help you spend more time on patients, and less time on paperwork.

ARTHUR E. JONGSMA, JR.
Grand Rapids, Michigan

ACKNOWLEDGMENTS

When Dr. Art Jongsma and I first met to discuss the concept of the *Suicide and Homicide Risk Assessment & Prevention Treatment Planner*, I felt a significant fear about my ability to complete the task. It has only been with his guidance that I was able to complete this work. I remain deeply indebted to him for not only the opportunity, but also the patient support he has provided during this effort. Our manuscript manager, Jennifer Byrne, also has been a major contributor to this final product; and to her I give a sincere thank you!

I began my study of the complexity of suicide in 1976, when I was assigned the duty of developing a Suicide Prevention Program for the Veteran's Administration Hospital in Battle Creek, Michigan. With the support of that facility, I was exposed to an abundance of trainings and seminars to develop and broaden my knowledge base of this most significant of human tragedies. During that process I have met many of the leaders in the study of suicide in our society, and to all of them I want to express my most sincere thanks. Although I have met many of them, I am sure they hardly know me. They all made those moment-in-time, cameo appearances that shaped my thinking on the nature of the suicide and homicide act. Dr. Edwin Shneidman spoke to me about the complexity of suicide and encouraged me always to be searching for the real issue of pain. Dr. David Clark impressed on me the value of specific, labor-intensive epidemiology to distinguish certain cultural, psychological, and gender issues that individualize the suicide populations. Dr. John McIntosh gave me insight into the suicidal crisis of the elderly. And, finally, Dr. Ron Maris greeted me with personal warmth as a fellow student in the pursuit of the truth about violent behavior. To all of these men I feel a sincere sense of gratitude for their insights.

Finally, I thank the untold numbers of men and women I have had the privilege of meeting over the past 30 years; those men, women, teens, and children who have led me to where they hurt and gently have guided me as to how to help them.

J.K.

INTRODUCTION

PLANNER FOCUS

The Suicide and Homicide Risk Assessment & Prevention Treatment Planner acknowledges and respects the challenging complexity of these tragic human behaviors. Edwin Shneidman (*Definition of Suicide,* 1985 and *The Suicidal Mind,* 1996), icon of the study of suicide in our society, claimed years ago that there are only two questions the therapist need ask the suicidal or homicidal client: "Where do you hurt" and "How can I help you?" The structure of this *Treatment Planner* is based on that simple and profound approach. In the 27 chapters of *The Suicide and Homicide Risk Assessment & Prevention Treatment Planner,* the reader will find a focus not on a diagnosis or condition but on the person. Each individual will come to the therapist's table with his or her own stressors that result in unbearable psychological agony. The tragic suicides of the 19-year-old college student and the 52-year-old homeless alcohol abuser need separate examination and treatment focus. While their outcomes were similar, the pathways were dramatically different. It is common today to abandon the exploration of the client's unique personal experiences of pain. Clinicians rely, instead, on standardized and boilerplate risk-assessments and treatment plans that put all suicidal or homicidal clients into one category. The complexity of each suicidal client fails to be respected.

Therefore, the first task for the therapist is to know the client and discover the unique nature of his or her hurt. With that in mind, the initial section of each chapter of this *Treatment Planner* is the risk-assessment phase. The examiner must pursue a thorough examination of the individual variables that put a client in harms way for suicidal or homicidal activity. The reader will find that in each of the 27 chapters the assessment section will note idiosyncratic factors, consistent with current research, that contribute to the suicide or homicide intent in each population.

Men and women who seek the help of counselors and therapists do so because the pain they are experiencing has escalated to an unbearable level and, therefore, they feel out of control. Ironically, suicide, and in some circumstances assaultive and homicidal behaviors becomes a problem-solving strategy for those seemingly unbearable psychological agonies. The initial stage of the therapy alliance is designed to provide hope. That hope will be nurtured by allowing the client to sense, with the therapist's help, alternatives to suicide or homicide as methods of managing their pain. The key issue in that process is the term *management.* The elimination of pain is the ultimate goal of the suicide or homicide intent. The therapist is encouraged to facilitate the client's insight that psychological turmoil is an unavoidable human experience. Increased feelings of self-worth and self-confidence serve to enhance the capacity to safely cope with the painful experiences that life has to offer. This is the goal of therapy.

Edwin Shneidman urges that the priority in treatment is to identify and reduce the level of turmoil, or "perturbation," that the suicidal or homicidal client feels as unbearable. This can be done in a variety of ways. One common approach is to evaluate the client for an underlying mental illness and introduce a medication program. However, there are traps here. The current environment appears too eager to reduce all maladaptive human behaviors to biochemical mayhem. An example is depression. Sadly, we are treating suicidal and homicidal intents by introducing the clients to medication. The problem is that we stop there. We fail to respect that, while any medication program has an important place in a treatment plan, it cannot be the *only* focus. Depression and other mental illnesses play an important role in the multidimensional malaise correlated to suicidal and homicidal behaviors, but we cannot accept a suicide or violence treatment plan that is nothing more than an effort to diminish the symptoms of mental illness through a prescription. We also need to examine the client's coping skill deficits and historical pattern of maladaptive problem solving. More often than not, the therapist will find the client to be deficient in this area. Therefore, we teach. We develop a plan that identifies the most hurtful conditions currently felt by the client and we help them to learn individually formulated coping strategies. We give them alternatives to implementing suicide and homicide as problem-solving techniques; therefore, we provide hope.

An important piece in this teaching effort is to respect that our clients come to us with historical *baggage.* These are personality traits that are basically developed in early childhood but, later in life, become personal vulnerabilities and hinder the client's efforts to effectively cope with life's tragedies. An example is the role of perfectionism in the client's personality. With this trait comes the

inability to cope with self-identified failures. Perfectionism is usually developed through early childhood experiences in which the child attempts to meet the needs of a demanding love object. In adulthood, however, perfection can become a vulnerability and a significant impediment to healthy coping. Our teaching efforts with this client, therefore, may be significantly challenged if we don't spend some effort revealing this issue to the client and working toward a resolution.

Finally, *The Suicide and Homicide Risk Assessment & Prevention Treatment Planner* addresses special issues for healing. Encouraging such issues as acculturation efforts, social cohesion, and spiritual enhancement can play a vital role in the overall strategy of allowing the client to live a full, if not challenging, life.

Our goal in the development of *The Suicide and Homicide Risk Assessment & Prevention Treatment Planner* is to discourage boilerplate treatment plans for suicidal and homicidal populations. Therefore, we encourage the development of treatment strategies that respect the individual client and the special cultural, environmental, medical, actuarial, gender, and psychiatric issues he or she presents, which contributes to the wish to die or to kill. The *Treatment Planner* was developed with a focus on current research and studies on each of the 27 populations noted. The reader will note many commonalities among those populations. However, their differences are more important. This *Treatment Planner* is designed to help you focus on, assess, and treat the idiosyncrasies that the client presents that have precipitated a crisis.

HISTORICAL BACKGROUND

Since the early 1960s, formalized treatment planning has gradually become a vital aspect of the entire health-care delivery system, whether it is treatment related to physical health, mental health, child welfare, or substance abuse. What started in the medical sector in the 1960s spread into the mental health sector in the 1970s as clinics, psychiatric hospitals, agencies, and so on, began to seek accreditation from bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to qualify for third-party reimbursements. For most treatment providers to achieve accreditation, they had to begin developing and strengthening their documentation skills. Previously, most mental health and substance abuse treatment providers had, at best, a bare-bones plan that looked similar for most of the individuals they treated. Clients were uncertain about what they were trying to attain in mental health treatment. Goals were vague, objectives were nonexistent, and interventions were

applied equally to all clients. Outcome data were not measurable, and neither the treatment provider nor the client knew exactly when treatment was complete. The initial development of rudimentary treatment plans made inroads toward addressing some of these issues.

With the advent of managed care in the 1980s, treatment planning has taken on even more importance. Managed care systems *insist* that clinicians move rapidly from assessment of the problem to the formulation and implementation of the treatment plan. The goal of most managed care companies is to expedite the treatment process by prompting the client and treatment provider to focus on identifying and changing behavioral problems as quickly as possible. Treatment plans must be specific as to the problems and interventions, individualized to meet the client's needs and goals, with measurable milestones that can be used to chart the client's progress. Pressure from third-party payors, accrediting agencies, and other outside parties has therefore increased the need for clinicians to produce effective, high-quality treatment plans in a short time frame. However, many mental health providers have little experience in treatment plan development. Our purpose in writing this book is to clarify, simplify, and accelerate the treatment planning process for clients who are in danger of suicidal or homicidal activity.

TREATMENT PLAN UTILITY

Detailed written treatment plans can benefit not only the client, therapist, treatment team, insurance community, and treatment agency but also the overall psychotherapy profession. A written plan stipulates the issues that are the focus of the treatment process. It is very easy for both provider and client to lose sight of what the issues were that brought the client into therapy. The treatment plan is a guide that structures the focus of the therapeutic contract. Since issues can change as therapy progresses, the treatment plan must be viewed as a dynamic document that can and must be updated to reflect any major change of problem, definition, goal, objective, or intervention.

Clients and therapists benefit from the treatment plan that focuses on outcomes. Behaviorally stated, measurable objectives clearly focus the treatment endeavor. Clients no longer have to wonder what therapy is trying to accomplish. Clear objectives also allow the client to channel effort into specific changes that will lead to the long-term goal of problem resolution. Therapy is no longer a vague contract to just talk honestly and openly about emotions and cognitions until the client feels better. Both client and therapist are concentrating on specifically stated objectives using specific interventions.

Treatment plans aid providers by forcing them to think analytically and critically about therapeutic interventions that are best suited for objective attainment for the client. Therapists were traditionally trained to "follow the client," but now a formalized plan is the guide to the treatment process. The therapist must give advance attention to the technique, approach, assignment, or cathartic target that will form the basis for interventions.

Clinicians benefit when clear documentation of treatment provides a measure of added protection from possible client litigation. Malpractice suits are increasing in frequency, and insurance premiums are soaring. The first line of defense against allegations is a complete clinical record detailing the treatment process. A written, individualized, formal treatment plan that is the guideline for the therapeutic process, that has been reviewed and signed by the client, and that is coupled with problem-oriented progress notes is a powerful defense against exaggerated or false claims.

A well-crafted treatment plan that clearly stipulates presenting problems and intervention strategies facilitates the treatment process carried out by team members in inpatient, residential, or intensive outpatient settings. Good communication between team members about what approach is being implemented and who is responsible for which intervention is critical. Team meetings to discuss client treatment used to be the only source of interaction between providers; often, therapeutic conclusions or assignments were not recorded. Now, a thorough treatment plan stipulates in writing the details of objectives and the varied interventions (pharmacologic, milieu, group therapy, didactic, recreational, individual therapy, etc.) and who will implement them.

Treatment agencies or institutions are looking for ways to increase the quality and uniformity of the documentation in the clinical record. A standardized, written treatment plan with problem definitions, goals, objectives, and interventions in every client's file enhances that uniformity of documentation, easing the task of record reviewers inside and outside the agency. Outside reviewers, such as JCAHO, insist on documentation that clearly outlines assessment, treatment, progress, and termination status.

The demand for accountability from third-party payors and health maintenance organizations (HMOs) is partially satisfied by a written treatment plan and complete progress notes. More and more managed care systems are demanding a structured therapeutic contract that has measurable objectives and explicit interventions. Clinicians cannot avoid this move toward being accountable to those outside the treatment process.

The psychotherapy profession stands to benefit from the use of more precise, measurable objectives to evaluate success in mental health treatment. With the advent of detailed treatment plans, outcome data can be more easily collected for interventions that are effective in achieving specific goals.

DEVELOPING A TREATMENT PLAN

The process of developing a treatment plan involves a logical series of steps that build on each other much like constructing a house. The foundation of any effective treatment plan is the data gathered in a thorough biopsychosocial assessment. As the client presents himself or herself for treatment, the clinician must sensitively listen to and understand what the client struggles with in terms of family of origin issues, current stressors, emotional status, social network, physical health, coping skills, interpersonal conflicts, self-esteem, and so on. Assessment data may be gathered from a social history, physical exam, clinical interview, psychological testing, or contact with a client's guardian, social service worker, and school personnel. The integration of the data by the clinician or the multidisciplinary treatment team members is critical for understanding the client, as is an awareness of the basis of the client's struggle. We have identified six specific steps for developing an effective treatment plan based on the assessment data.

Step One: Population Selection

Although the client may initially present as belonging to a specifically designated population, the clinician may have to explore special issues that pertain to other populations. This will reveal other problems on which to focus the treatment process. As an example, an Adolescent Male presents with suicidal impulse. It may be discovered, however, that some of the contributing issues of his intent are gender identity concerns that may be included in the Gay/Lesbian/Bisexual chapter. Therefore, the clinician will establish a *primary* focus that will attend to those concerns established in the assessment process that appear to have the highest correlation to a specific population. However, that same youth may be also well served by creating flexibility in the treatment plan to include problems from other populations.

At all times, it is essential to include opinions from the client on his or her prioritization of treatment issues which appear to be at the core of the suicide or homicide intent. A client's motivation to participate

in and cooperate with the treatment process depends on the degree to which treatment addresses his or her greatest needs.

Step Two: Problem Definition

Each client presents with unique nuances as to how a problem behaviorally reveals itself in his or her life. Therefore, each population that is selected for treatment focus requires a specific definition about how it is evidenced in the particular client. The symptom pattern should be associated with diagnostic criteria and codes such as those found in the *Diagnostic and Statistical Manual* or the *International Classification of Diseases (DSM-5)*. The *Planner*, following the pattern established by *DSM-5,* offers such behaviorally specific definition statements to choose from or to serve as a model for your own personally crafted statements. You will find several behavior symptoms or syndromes listed that may characterize one of the 27 presenting populations.

Step Three: Goal Development

The next step in treatment plan development is that of setting broad goals for the resolution of the target population. These statements need not be crafted in measurable terms but can be global, long-term goals that indicate a desired positive outcome to the treatment procedures. The *Planner* suggests several possible goal statements for each population, but one statement is all that is required in a treatment plan.

Step Four: Objective Construction

In contrast to long-term goals, objectives must be stated in behaviorally measurable language. It must be clear when the client has achieved the established objectives; therefore, vague, subjective objectives are not acceptable. Review agencies (e.g., JCAHO), HMOs, and managed care organizations insist that psychological treatment outcomes be measurable. The objectives presented in this *Planner* are designed to meet this demand for accountability. Numerous alternatives are presented to allow construction of a variety of treatment plan possibilities for the same presenting problem. The clinician must exercise professional judgment as to which objectives are most appropriate for a given client.

Each objective should be developed as a step toward attaining the broad treatment goal. In essence, objectives can be thought of as a series of steps that, when completed, will result in the achievement of the long-term goal. There should be at least two objectives for each problem, but the clinician may construct as many as are necessary for goal achievement. Target attainment dates should be listed for each objective. New objectives should be added to the plan as the individual's treatment progresses. When all the necessary objectives have been achieved, the client should have resolved the target problem successfully.

Step Five: Intervention Creation

Interventions are the actions of the clinician designed to help the client complete the objectives. There should be at least one intervention for every objective. If the client does not accomplish the objective after the initial intervention, new interventions should be added to the plan.

Interventions should be selected on the basis of the client's needs and the treatment provider's full therapeutic repertoire. *The Suicide and Homicide Risk Assessment & Prevention Treatment Planner* contains interventions from a broad range of therapeutic approaches, including cognitive, dynamic, behavioral, multisystemic, pharmacologic, family-oriented, and patient-centered therapy. Other interventions may be written by the provider to reflect his or her own training and experience. The addition of new problems, definitions, goals, objectives, and interventions to those found in the *Planner* is encouraged because doing so adds to the database for future reference and use.

Some suggested interventions listed in the *Planner* refer to specific books that can be assigned to the client for adjunctive bibliotherapy. Appendix A contains a full bibliotherapy reference list. When a book is used as part of an intervention plan, it should be reviewed with the client after it is read, enhancing the application of the content of the book to the specific client's circumstances. For further information about self-help books, mental health professionals may wish to consult *The Authoritative Guide to Self-Help Books* (2003) by Santrock, Minnett, and Campbell (The Guilford Press, New York, NY).

A list of resources is also provided for the professional provider in Appendix B. These references are meant to elaborate on the methods suggested in some of the chapters.

Assigning an intervention to a specific provider is most relevant if a client is being treated by a team in an inpatient, residential, or intensive outpatient setting. Within these settings, personnel other than

the primary clinician may be responsible for implementing a specific intervention. Review agencies require that the responsible provider's name be stipulated for every intervention.

Step Six: Diagnosis Determination

The determination of an appropriate diagnosis is based on an evaluation of the client's complete clinical presentation. The clinician must compare the behavioral, cognitive, emotional, and interpersonal symptoms that the client presents to the criteria for diagnosis of a mental illness condition as described in *DSM-5*. The issue of differential diagnosis is admittedly a difficult one that research has shown to have rather low interrater reliability. Mental health professionals have also been trained to think more in terms of maladaptive behavior than disease labels. In spite of these factors, diagnosis is a reality that exists in the world of mental health care and it is a necessity for third party reimbursement. (However, recently, managed care agencies are more interested in behavioral indices that are exhibited by the client than the actual diagnosis.) It is the clinician's thorough knowledge of *DSM-5* criteria and a complete understanding of the client assessment data that contribute to the most reliable, valid diagnosis. An accurate assessment of behavioral indicators will also contribute to more effective treatment planning.

HOW TO USE THIS PLANNER

Our experience has taught us that learning the skills of effective treatment plan writing can be a tedious and difficult process for many clinicians. It is more stressful to try to develop this expertise when under the pressure of increased client load and short time frames placed on clinicians today by managed care systems. The documentation demands can be overwhelming when we must move quickly from assessment to treatment plan to progress notes. In the process, we must be very specific about how and when objectives can be achieved, and how progress is exhibited in each client. *The Suicide and Homicide Risk Assessment & Prevention Treatment Planner* was developed as a tool to aid clinicians in writing a treatment plan in a rapid manner that is clear, specific, and highly individualized according to the following progression:

1. Choose one presenting population (Step One) you have identified through your assessment process. Locate the

corresponding page number for that problem in the *Planner*'s table of contents.

2. Select two or more of the listed behavioral definitions (Step Two) and record them in the appropriate section on your treatment plan form. Feel free to add your own defining statement if you determine that your client's behavioral manifestation of the identified problem is not listed. (Note that while our design for treatment planning is vertical, it will work equally well on plan forms formatted horizontally.)
3. Select a single long-term goal (Step Three) and again write the selection, exactly as it is written in the *Planner* or in some appropriately modified form, in the corresponding area of your own form.
4. Review the listed objectives for this population and select the ones that you judge to be clinically indicated for your client (Step Four). Remember, it is recommended that you select at least two objectives for each problem. Add a target date or the number of sessions allocated for the attainment of each objective.
5. Choose relevant interventions (Step Five). The *Planner* offers suggested interventions related to each objective in the parentheses following the objective statement. But do not limit yourself to those interventions. The entire list is eclectic and may offer options that are more tailored to your theoretical approach or preferred way of working with clients. Also, just as with definitions, goals, and objectives, there is space allowed for you to enter your own interventions into the *Planner.* This allows you to refer to these entries when you create a plan around this problem in the future. You will have to assign responsibility to a specific person for implementation of each intervention if a multidisciplinary team is carrying out the treatment.
6. Several *DSM-5* diagnoses are listed at the end of each chapter that are commonly associated with a client who has this problem. These diagnoses are meant to be suggestions for clinical consideration. Select a diagnosis listed or assign a more appropriate choice from the *DSM-5* (Step Six).

Congratulations! You should now have a complete, individualized treatment plan that is ready for immediate implementation and presentation to the client. It should resemble the format of the "Sample Treatment Plan" presented on page 11.

A FINAL NOTE

One important aspect of effective treatment planning is that each plan should be tailored to the individual client's specific population needs. Treatment plans should not be mass-produced, even if clients have similar problems. The individual's strengths and weaknesses, unique stressors, social network, family circumstances, and symptom patterns *must* be considered in developing a treatment strategy. Drawing on our own years of clinical experience, we have put together a variety of treatment choices. These statements can be combined in thousands of permutations to develop detailed treatment plans. Relying on their own good judgment, clinicians can easily select the statements that are appropriate for the individuals they are treating. In addition, we encourage readers to add their own definitions, goals, objectives, and interventions to the existing samples. It is our hope that *The Suicide and Homicide Risk Assessment & Prevention Treatment Planner* will promote effective, creative treatment planning—a process that will ultimately benefit the client, clinician, and mental health community.

SAMPLE TREATMENT PLAN

CLIENT: COLLEGE STUDENT

Definitions: Communicates to someone (e.g., friend, counselor, resident assistant, help line, teacher) a wish to die (e.g., "Life just isn't worth living," "I feel like giving up," "I wish my life would end," "There is no solution to my problems other than taking my own life").

Expresses feelings of social isolation because of large geographic distance from home (e.g., foreign or out-of-state students).

Expresses feelings of being under severe pressure to perform academically or athletically to gain a measure of acceptance and self-worth.

Expresses a need to win parental love and/or approval through academic and/or athletic excellence.

Goals: Report a wish to live.

Develop an integrated self-concept and reject the belief that love, affirmation, and value are gained only through performance.

Develop a balanced self-concept that can accept temporary failures and integrate them into the growth experience.

OBJECTIVES

1. Identify general feelings of satisfaction with the college experience.

INTERVENTIONS

1. Explore the motivations for choosing the current college (e.g., proximity to home, distance from home, academic standards, athletic opportunities, elitist reputation, parental pressure, desire to be with close friend) with the client and note any motivations that could be considered problematic for a healthy adjustment.

	2. In general terms, explore the client's current feelings toward the college experience (e.g., very satisfied, a balanced view, dissatisfied, very unhappy) and isolate current emotional reactions that could be problematic for a healthy adjustment (e.g., homesick, absence from a significant relationship, feeling lost, missing high school identity).
2. Provide information on personal experiences with high-risk *behavioral* markers for suicide in the college student.	1. Assess the client for the high-risk, college-student suicide marker of escape and/or avoidance behaviors (e.g., missing classes, isolative substance abuse patterns, attitudes of passivity, or social isolation by choice where he/she makes a conscious effort to avoid drawing attention to himself/herself). 2. Assess the client for the high-risk, college-student suicide marker of fascination with issues of death and suicide (e.g., demonstrated in a subtle fashion in study groups, dormitory discussions, or class assigned writing projects). 3. Assess the client for the high-risk, college-student suicide marker of excessive medical consultations (e.g., complaints of fatigue, tiredness, lack of energy but denying or not discussing issues of depression or suicide ideation and/or intent).

3. Provide information on personal experiences with high-risk *emotional* markers for suicide in the college student.	1. Assess the client for the high-risk, college student suicide marker of hopelessness and helplessness (e.g., significant despair that renders current coping strategies inadequate). 2. Assess the client for the high-risk, college student suicide marker of depression (e.g., sadness, self-directed anger, reduced appetite, sleep disturbances, low self-esteem, family history of depression and psychiatric illnesses). 3. Assess the client for the high-risk, college student suicide marker of emerging schizophrenia (e.g., social withdrawal, feelings of persecution, intrusive thoughts, inability to concentrate, thought disorganization). 4. Assess the client for the high-risk, college student suicide marker of socially prescribed perfectionism (e.g., examine closely its linkage to depression and hopelessness, inquire about the object of the need to please, examine the history of the socially prescribed perfectionism, and examine its linkage to the suicide intent).
4. Provide information on personal experiences with high-risk *social* markers for suicide in the college student.	1. Assess the client for the high-risk, college student suicide marker of termination of a romantic relationship or social network disruption because of college bound status. 2. Assess the client for the high-risk, college student suicide marker of rigid family

	expectations (e.g., school was chosen by parents because of family tradition or prestige, course of study was influenced by parents because of family tradition or prestige, or parental expectations are seen as exceedingly high and beyond the student's capacity).
5. Identify solutions and coping strategies that do not include suicide or the wish to die.	1. Assist the client in noting in his/her treatment journal a detailed plan (e.g., self-calming techniques, focus on the positive aspects of efforts to accomplish tasks, cognitive restructuring leading the client to replace his/her focus on failure to a sense of "I did good enough," "I did the best I could") with specific instructions responding to and managing the perturbation associated with his/her immediate, priority symptoms; these responses should be detailed and structured to assist the client during extreme emotional upset (e.g., safe and simple skills). 2. Use role-play, modeling, and behavior rehearsal to teach the client to implement the symptom-management skills noted in his/her treatment journal.
6. Increase the frequency of verbalizing statements indicating improved comfort with the college experience, appropriate anxiety with academic demands, and smoother transition to autonomy.	1. Assist the client in finding and utilizing enjoyable aspects of campus life (e.g., creating a life balance between fun and work); encourage a sense of autonomy by emphasizing decisions made that reflect self-determination.

2. Encourage the client to see himself/herself in a social context by emphasizing the benefits of participation in friendships and group activities; assign participation in selected campus activities or community volunteer activities; reinforce success and redirect experiences of failure.

Diagnosis: F32.1 Major Depressive Disorder, Single Episode, Moderate

I. SUICIDAL POPULATIONS

AFRICAN AMERICAN MALE

BEHAVIORAL DEFINITIONS

1. Verbalizes a wish to die.
2. Reacts to the homicidal death (especially by stabbing) of a friend with a diminished fear of death and a lowered value of life.
3. Is involved in serious patterns of drug dependence (especially cocaine and injectable drugs) to escape reality or cope with life.
4. Reacts to community violence with an attitude of a diminished value of life.
5. Reacts to community poverty or lowered socioeconomic condition with an attitude of hopelessness and helplessness.
6. Demonstrates behaviors positively correlated with the diagnosis of depression (e.g., agitation, sleep disorder, anhedonia, or dysphoria).
7. Distances himself from cultural, family, social, and religious support systems because of negative and hopeless attitudes about their value.
8. Has a history of serious, near-lethal suicide attempts and gestures needing medical attention.
9. Has established a pattern of behavior best described as self-destructive (e.g., joins violent peer groups, is involved in criminal and combative behavior).
10. Has possession of and/or quick and easy access to firearms coupled with a verbalized attitude of "I am ready to die."
11. Exhibits an undiagnosed and untreated paranoid psychosis (either schizophrenia or substance related) coupled with carrying a firearm.

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LONG-TERM GOALS

1. Embrace the wish to live and establish futuristic, hopeful thinking.
2. Reestablish involvement with nurturing, supportive community, social, religious, and family systems.
3. Manage community and socioeconomic stressors with positive, healthy coping skills.
4. Have personal pride in cultural history.
5. Integrate traditional African American value system with an increased sense of ethnic identification and social cohesion.
6. Manage perturbation caused by thought or mood disorder.
7. Manage rage caused by acts of racism or discrimination in a resilient, validating fashion.

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SHORT-TERM OBJECTIVES

1. Identify any high-risk characteristics associated with previous suicide activity. (1)

THERAPEUTIC INTERVENTIONS

1. Assess for high-risk characteristics inherent in any of the client's previous suicide activities (e.g., did the activity result in medical attention; was it performed with a firearm; was the client under the influence of alcohol or drugs at the time of the incident; was the client motivated at the time by feelings of hopelessness and helplessness connected to current social, economic, or neighborhood stressors; was the activity calculated for rescue, self-interrupted, or was it accidentally stopped against the client's wishes).

2. Identify specifics of current suicide ideation and/or intent. (2, 3, 4)	2. Explore the motivation or goal for the current suicide intent with the client (e.g., escape from hopeless economic, social, or environmental stressors; a passivity toward life because of consistent experiences with poverty, violence, or death; an expressed method of curing rampant chemical dependence). 3. Explore whether the client has any formalized plan for the suicide intent (e.g., will a firearm be used and is it currently or readily available, has a time or place been chosen, has he written a suicide note). 4. Explore whether the client has shared his intent with anyone in his social environment (e.g., wife, minister, or friend) or if he has no identified resource and currently is in social isolation.
3. Provide information on personal experiences with high-risk *behavioral* markers for suicide in African American males. (5, 6, 7)	5. Assess the client for the high-risk African American male suicide marker of cocaine/crack, heroin, and injectable drug abuse; examine for age of onset, current usage, readiness to change, supportive environment, losses because of dependency, or concurrent disorders. 6. Assess the client for the high-risk African American male suicide marker of firearm possession; examine for consistency of possession, motivational factors (e.g., unrealistically high levels of distrust, suspiciousness, or realistic fears of neighborhood

violence), and whether the weapon has been used in violent activity.

7. Assess the client for the high-risk African American male suicide marker of adopting a self-destructive lifestyle in a deprived living environment (e.g., carries an attitude of "I am ready to die"; has witnessed death by homicide; lives in an environment marked by underemployment, non-nurturing social institutions, impoverished and/or segregated conditions; easily engages in fatalistic behaviors, which may include acts of victim-provoked suicide).

4. Provide information on personal experiences with high-risk *emotional* markers for suicide in African American males. (8)

8. Assess the client for the high-risk African American male suicide marker of depression (e.g., low self-esteem, social withdrawal, anhedonia, sleep disturbance, increase in anger/hostility, or low energy levels).

5. Provide information on personal experiences with high-risk *social* markers for suicide in African American males. (9, 10, 11)

9. Assess the client for the high-risk African American male suicide marker of isolation from traditional community institutions (e.g., no sense of family cohesion or nurturing from religious organizations or a demonstrated sense of "being out on the streets").

10. Assess the client for the high-risk African American male suicide marker of low occupational and economic hopes and realities; evaluate current occupational status, educational level and socioeconomic environment,

	and hopes and aspirations to improve current socio-economic status.
	11. Assess the client for the high-risk African American male suicide marker of being raised in a highly dysfunctional family; examine for a history of physical abuse, incest, extrafamilial sexual abuse, or marital conflicts within the current family or the family of origin.
6. Cooperate with psychological testing designed to evaluate conditions correlated to elevated suicide risk in African American males. (12)	12. Assess the client's risk factors for completed suicide by administering psychological tests most commonly used for this purpose (e.g., MMPI-2, Suicide Probability Scale, Beck Hopelessness Inventory, Reasons for Living Inventory).
7. Designated community resource individuals agree to support the client in his recovery from hopelessness. (13, 14)	13. Develop a list of citizens with knowledge of the current crisis and with whom the client may agree to involve in the treatment plan (e.g., minister, personal physician, community outreach professional, or concerned persons from community-based African American institutions).
	14. Integrate the concerned citizens identified by the client into his treatment plan by meeting with them and gathering information.
8. Provide complete information on current mood, affect, and thought process in a psychiatric evaluation, while taking psychotropic medication as prescribed. (15, 16)	15. Refer the client for a psychiatric evaluation to determine the need for psychotropic medication and to validate any at-risk diagnoses (e.g., major depression, generalized anxiety