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Managing Suicidal Emergencies: Recommendations for the Practitioner

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All practicing psychologists with an active caseload occasionally encounter a patient or client whom they consider to be a suicidal emergency. Few psychologists, however, have had education or training focused on managing such cases. The current article conceptualizes what a "behavioral emergency" is, gives recommendations for containing the emergency client's emotional turmoil, and sets forth an evidence-based approach, using diagnosis-specific risk factors, for improving the clinician's ability to estimate suicide risk. Recommendations are also given for appropriate responses to the patient or client on the basis of the level of estimated risk. Having such an algorithm or plan for dealing with the suicidal client is essential to good practice.

You are covering the walk-in desk at a community mental health center. A 45-year-old man is accompanied to the desk by several friends, one of whom is his girlfriend. The girlfriend explains that they are separating and that he has made a suicidal threat. The client has an odor of alcohol and seems somewhat hostile. You begin to interview him, but he ignores your questions and paces around the room. In an agitated way, he states that there is nothing wrong with him and he wants to leave. How do you decide whether it is safe to let him go or whether he should be held against his will? What do you do if he walks out?

What you decide and what you do depends on whether you consider the case a potential emergency or not. Faced with such decisions, it can help to be clear about what is meant by an emergency in mental health practice. As Callahan (1994) pointed out, the concepts of psychological or behavioral "emergency" and "crisis" have been "frequently confused, or erroneously used interchangeably" (p. 165). It is important to understand the distinction between these concepts because it drives our thinking, our decision making, and our interventions when dealing with potential emergencies.

A *crisis* is a serious disruption of a person's baseline level of functioning such that his or her usual coping mechanisms are inadequate to restore equilibrium. It is an emotionally significant event in which there may be a turning point for better or worse. It does not necessarily imply danger of serious physical harm or life-threatening danger. A crisis often contributes to or precipitates the development of an emergency, but it should not be considered sufficient to explain an emergency. There are typically many factors involved in the making of an emergency.

An *emergency* occurs when an individual reaches a state of mind in which there is an imminent risk that he or she will do something (or fail to do something) that will result in serious harm or death to self or others unless there is some immediate intervention. High-risk suicidal states constitute one such emergency. Potentially violent states constitute another. States of very impaired judgment in which the individual is endangered constitute a third, while situations of risk to a defenseless victim (e.g., an abused child) constitute a fourth.

The purpose of this article is to present empirically supported recommendations for the evaluation and management of suicidal emergencies. In this regard, the term *recommendations* is used advisedly and with the understanding that other terms that might have been used (such as *standards of care* or *practice guidelines*) could have the undesirable connotation of being put forth by an authoritative or governing agency. The recommendations we present in this article are ours on the basis of the empirical findings in the literature on suicide and on our collective clinical experience. The recommendations are meant to be aids and suggestions for evaluating and managing suicidal patients who are at acute or imminent risk. They are not static but should be viewed as continually evolving as more knowledge is accrued to inform them.

As an initial and general caveat, the clinician is well advised to approach all situations of alleged suicide risk as potential emergencies until convinced otherwise. Moreover, given the fact that we are unable to predict accurately such rare or low base rate events as suicide (Hilliard, 1995; Murphy, 1984), it is also important to be aware at the outset that we look through a glass darkly in evaluating and managing suicidal emergencies; that is, we operate on the basis of our best estimates but usually have no certainty.

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