

INFORMED CONSENT WITH SUICIDAL PATIENTS: RETHINKING RISKS IN (AND OUT OF) TREATMENT

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Informed consent is uniformly accepted as essential to the treatment process. However, the relevant literature has not discussed issues of risk specific to suicidal patients, nor has such information routinely been included in the informed consent process. The implications of including suicide-specific risk information in the informed consent process is discussed and examples provided.

Keywords: informed consent, suicidal, reattempt rates, collaborative, treatment compliance

Informed consent is an essential element in psychological assessment and treatment, with ethics codes for mental health professionals routinely addressing the need for informed consent (American Association of Marriage and Family

Therapy, 2001; American Counseling Association, 2005; American Psychiatric Association, 2006; American Psychological Association [APA], 2002; Canadian Psychological Association, 2000). For example, the APA ethics code (APA, 2002) provides clear guidelines for obtaining informed consent to both psychotherapy and assessment. Most state licensing boards have supplemented these guidelines with additional requirements known as board rules for practice; routinely in much greater detail and more specific to clinical application than that provided by the ethics code (e.g., Association of State and Provincial Psychology Boards, 2003). In accordance with the APA ethics code informed consent has a number of identifiable features including: obtaining it “as early as is feasible” (p. 1072), recognizing the limits to privacy and confidentiality, providing the client/patient the chance to ask questions about the assessment/treatment process, as well as providing information about the “developing nature of treatment, the potential risks involved and alternative treatments” (p. 1072). In short, every individual that enters psychological treatment (or assessment) participates in an informed consent process; one that Bennett et al. (2006) noted is a continuous and evolving process not completed in just the first session or two.

Many have written about the application of the ethics code to the treatment process and informed consent procedures (Fisher, 2003; Haas & Malouf, 2005; Knapp & VandeCreek, 2006; Nagy, 2005), but we were unable to identify anything specific to suicidal thoughts, suicide attempts, or

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death by suicide. However, others have raised questions as to the clarity and accuracy of information about the risks inherent to psychotherapy. As Bennett et al. (2006) indicated clinicians are obligated to discuss risk by addressing patient factors, contextual elements, and individual therapist factors. Of particular relevance, patient factors included giving “additional information based on unique circumstances” (p. 40). Unique circumstances cover a broad range of issues, with suicidality qualifying. In other words, this means discussion of risk that is inherent to a targeted disorder or presenting problem. This does not imply that the risk is secondary to the treatment of the problem rather than the risk continues during the treatment process. As is discussed below, outcome data on the treatment of suicidality confirms this reality.

Handelsman and Galvin (1988) offered a list of questions to give clients that might facilitate more in-depth discussion and probing of the treatment process, particularly issues related to empirical support, potential risks, and alternative treatments. Pomerantz and Handelsman (2004) recently revised the list to incorporate changes and issues that have emerged over the last decade and a half. Some of the questions that clients/patients are encouraged to ask about therapy, risks, and alternatives include the following (Pomerantz & Handelsman, 2004, pp. 204–205):

1. What is the name of your kind of therapy?
2. How did you learn how to do this therapy?
3. How does your kind of therapy compare with other kinds of therapy?
4. How does your kind of therapy work?
5. What are the possible risks involved? (such as divorce, depression).
6. What percentage of clients improve? In what ways? How do you know? (e.g., published research? your own practice experience? discussions with your colleagues?)
7. What percentage of clients get worse? How do you know?
8. What percentage of clients improve or get worse without this therapy? How do you know?
9. About how long will it take?

10. What should I do if I feel therapy isn't working?

Although these questions probe the issue of risks, they are indirect when it comes to presenting problem or disorder-specific data such as actively suicidal clients. By suicidal, we mean clients that are having thoughts of suicide, those that have made a suicide attempt, or those that have made multiple-suicide attempts (i.e., those at chronic or enduring risk for suicide; Rudd, Joiner & Rajab, 1996, 2004). Considerable data has accumulated about disorder-specific suicide risk as well as the potential impact of various treatments. Consistent with the argument of Pomerantz and Handelsman (2004), sharing this information with clients as a part of the informed consent process should be considered.

Suicidality In and Out of Treatment

Each year, approximately 32,000 individuals die by suicide in the United States (Hoyert, Heron, Murphy, & Kung, 2006). A substantial proportion of these deaths, possibly as many as half, are in active treatment at the time of their death (Fawcett, 1999), with estimates of greater than 90% suffering a mental disorder at the time of death. This relationship is certainly not causal, with the risk inherent to the mental disorder rather than treatment itself. Randomized controlled trials for the treatment of suicide attempts or intentional self-injurious behavior have found average reattempt rates during treatment as high as 47% of patients (highest in the treatment as usual arm of the study), with those making subsequent attempts in treatment routinely making more than one (see Rudd et al., 2004, for a review). Data have emerged about several treatments that have been proven effective at reducing suicide attempt rates posttreatment, including both dialectal behavior therapy (Linehan, 1993) and cognitive therapy (Wenzel, Brown, & Beck, 2008), but the list is limited given the considerable difficulty and expense conducting clinical trials with high-risk patients. Data are also available about both suicide and attempt rates for targeted disorders. For example, with bipolar disorder, 25 to 50% will make a suicide attempt during the course of the illness, with 10 to 20% dying (Goodwin & Jamison, 2007). For those suffering from schizophrenia, between 20 and 40% will make a suicide attempt (Meltzer, 1995)

and 5% will die (Palmer, Pankrantz, & Bostwick, 2005). For major depression, 2% receiving outpatient treatment will die by suicide and 9% of patients receiving inpatient treatment will die (Bostwick & Pankrantz, 2001).

There are also converging and convincing data about the high-risk nature of multiple-suicide attempters (i.e., those making more than one lifetime suicide attempt) in clinical care. In relationship to single attempters, multiple-suicide attempters evidence more significant suicidal thinking, depression, hopelessness, higher rates of alcohol and substance abuse, poorest histories of interpersonal coping, greater perceived stress, and the lowest reports of available and accessible social support. They also evidence greater diagnostic complexity, with more Axis I and II comorbidity, and are more likely to make a subsequent suicide attempt (Brown et al., 2005; Forman, Berk, Henriques, Brown, & Beck, 2004; Reynolds & Eaton, 1986; Rudd et al., 1996; Stein, Apter, Ratzoni, Har-Even, & Avidan, 1998). Available findings on multiple attempters are fairly robust, with effects remaining significant even after controlling for the diagnosis of borderline personality disorder (Forman et al., 2004; Rudd et al., 1996). What is clear from available data is that multiple-suicide attempters are at considerably greater risk for a reattempt or death by suicide in contrast to single attempters or those experiencing suicidal thoughts.

Despite available data, we are unaware of any publications addressing the need to include the potential risks of death or suicide attempt in the informed consent process. The recent Food and Drug Administration (FDA) black box warning label for antidepressant use with adolescents and young adults has amplified concerns about adverse events (including suicidal thoughts and attempts) in the treatment of suicidal thoughts and behaviors (Posner, Oquendo, Gould, Stanley, & Davies, 2007; Rudd, Cordero, & Bryan, 2009). It is certainly arguable about the need to include this information in the consent process, with the most common argument against inclusion being that the risks are not a consequence of or secondary to treatment. However, as the questions offered by Pomerantz and Handelsman (2004) suggested and the various ethics codes indicate, we are ethically obligated to facilitate a detailed and frank discussion with clients/patients about the potential risks and benefits of treatment, as well as the risks of a decision to opt out of treatment.

This would appear to include disorder-specific and problem-specific information if it is available. Similarly, Bennett et al. (2006) suggested the need to provide “additional information based on unique circumstances” (p. 40), and suicidality would appear to qualify as unique and clinically relevant. Although the science of clinical suicidology is far from maturity, there are available and emerging data that help address what can be described as clear risks inherent to either entering treatment for a targeted disorder or problem or, likewise, opting out of care for patients presenting with suicidality. We argue including this information in some form or fashion is critical to the informed consent process and consistent with existing ethical guidelines and rules of practice. It may also have an impact on treatment compliance and crisis management. It is possible that offering specific information about the risks and appropriate steps in crisis management make it easier to match crisis intervention and treatment complexity with the patient’s identified skill level and overall assessed competence.

An Understanding and Expectation of Risks: Consequences and Implications for Treatment

As Pomerantz and Handelsman (2004) noted, informed consent is intended to provide the opportunity for a patient to understand the risks that are inherent to their clinical care, including information specific to their diagnosis, along with risks of being in or out of treatment. It is arguable that for a percentage of patients, suicide attempts and death are secondary to the refractory nature of their mental disorder, something routinely accepted with certain medical illnesses such as cancer or heart disease. From a forensic and legal perspective, the expectation of risk in treating high-risk patients needs to be clearly established at the outset. As summarized above, there is considerable information available that speaks to the issue of risks of suicide and suicide attempt related to: targeted disorders, multiple-attempter status, and expected rates of reattempts during the course of treatment. What is somewhat surprising is that this issue has not surfaced and been debated previously.

There are several reasons for including the risk of suicide and suicide attempts in the informed consent process. First and foremost, this information should be shared in an effort to help the

patient and family understand the true nature of risks during the treatment process, recognizing that shared responsibility during treatment is essential to reduce the likelihood of a suicide attempt or death. Second, it would help make it clear, distinct, and understandable that treatment compliance and crisis management are vital to maximize treatment efficacy. Third, it would provide the opportunity for the clinician to emphasize the need for effective self-management during outpatient care and that self-management is a primary target or goal of treatment. Fourth, it would help the clinician broach the idea of crisis management that includes identifiable skill deficits that might limit the patient's willingness or ability to access emergency services when needed and target those deficiencies immediately. Fifth, a clear statement of risks of suicide attempt and death would hopefully provoke a sober and frank exchange as well as facilitate a more direct and open exchange about the responsibilities of the provider and client/patient. Whether inclusion of such a statement would actually alter the nature or course of care is yet to be seen. What is ultimately needed is a clear recognition that the treatment of suicidality (including ideation, single, and multiple attempts) is a high-risk endeavor and that during the course of treatment adverse events are possible and, in some cases (such as with multiple attempters) even probable and routinely occur as a function of the targeted disorder. As Bennett et al. (2006) noted, it would "encourage genuine patient participation" (p. 40) in the informed consent process.

Recent research has examined the impact of providing patients/clients with assessment feedback, though this work focuses on feedback from personality testing, rather than regarding suicidality per se (e.g., Finn & Tonsager, 1992; Lequense & Hersh, 2004; Lewark, Marks, & Nelson, 1990; Newman & Greenway, 1997). The general conclusion from this line of research is that receiving feedback (even about maladaptive personality characteristics) is a positive experience for patients/clients. In a representative study, patients/clients awaiting treatment who received feedback on the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) experienced significant decreases in global symptom severity and had higher self-esteem than clients who did not receive feedback (Finn & Tonsager, 1992), even though patients/clients in the feedback group had significantly lower self-esteem scores

prior to feedback than those in the control group (Newman & Greenway, 1997). It is important to note that these studies involved the clinician using a collaborative approach to feedback provision, consistent with approaches summarized here.

It is also important to consider that treatments proven effective at reducing suicide attempt rates posttreatment (dialectical behavior therapy and cognitive therapy) routinely include suicide-specific risk information in the informed consent process. In addition, the process and content of informed consent are integrated into the therapy process for both treatment approaches. For example, dialectical behavior therapy (DBT; Linehan, 1993) includes a consent process that begins at the start of therapy, but also includes agreements and procedures that continue throughout the duration of therapy. At the start of therapy the therapist reviews with the client/patient a set of agreements that describe the expectations and responsibilities of the patient, as well as the therapist. Subsequently, violations of these agreements continue to be discussed through the therapy relationship. For example, at the start of therapy the patient agrees that he or she will work toward solving problems without the use of suicidal behaviors. Violations of this agreement (e.g., suicide attempts) have specific consequences that are explicitly spelled out and agreed on. In response to a suicide attempt, DBT mandates a 24-hr period without contact with the treatment team. Following return to therapy, the original agreement is discussed and a process of recommitment to the agreement unfolds. Similarly, during each session, any "therapy interfering behavior," typical behaviors that are inconsistent with these agreements or interfere with therapy in a way that impedes progress, are discussed. In these ways, the process of consent is ongoing and involves direct statements and collaboration between the therapist and client/patient.

A similar approach to the informed consent process is used in cognitive therapy (CT; Wenzel, Brown, & Beck, 2008). A hallmark of CT is the emphasis on building a collaborative therapeutic relationship that focuses on addressing specific problems. The first step of the informed consent process is for the clinician and patient to agree on the focus, expectations, goals, and structure of treatment. This includes educating the patient in collaboratively setting an agenda for each session and eliciting and responding to patient feedback

throughout the session. In addition to the goals and expectations for treatment, the clinician may include the following agenda topics during the initial session: (a) discussion of the limits of confidentiality, (b) emphasis on the importance of therapy attendance, (c) completion of a suicide risk assessment, (d) completion of a safety plan, and (e) discussion of the problems that prompted treatment.

When treating high-risk patients, specifically, CT clinicians are explicit in communicating to them that the primary goal of treatment is to prevent a future suicidal act (Brown et al., 2005). Patients are educated about the particular strategies that will be used to achieve this aim, such as providing a narrative description of the events that precipitated their recent suicidal crisis and developing problem solving skills and other strategies that can be utilized during a future suicidal crisis. For example, given the patients who have recently made a suicide attempt are likely to not attend outpatient treatment (e.g., O'Brien, Holton, Hurren, & Watt, 1987), the clinician may use general cognitive therapy strategies to identify the factors that prevent patients from attending therapy and to brainstorm ways to overcome those obstacles. These factors might be cognitive (e.g., low expectations for treatment), behavioral (e.g., easily loses appointment card), or situational (e.g., no transportation) in nature. For example, clinicians can elicit patients' beliefs about coming to therapy, general expectations for the likelihood of success in treatment, and expectations about the utility of specific features of cognitive therapy. In instances in which it is clear that patients' negative beliefs would interfere with therapy attendance or compliance, the clinician can use guided discovery to help them evaluate the degree to which the belief is realistic (Wenzel et al., in press).

Similar to DBT and CT approaches to suicidal risk, the collaborative assessment and management of suicidality (CAMS) approach developed by Jobes (2006) and colleagues (Jobes, Wong, Conrad, Drozd, & Neal-Walden, 2005) places a major emphasis on the importance of informed consent, mutual expectations, and transparency of the therapeutic process. These aspects of informed consent are particularly germane in cases of "suicidal blackmail"—in which a clinician feels compelled to modify treatment or boundaries because if they do not the patient will attempt suicide. As discussed by Jobes (2006), such acquiescence by the clinician is

virtually never in the best interest of the patient—or the clinician for that matter—and serves to behaviorally reinforce in the patient the efficacy of suicidal threats.

Within CAMS, informed consent is strategically used to help create therapeutic leverage in an effort to avert or delay suicidal coping in lieu of learning about new and better ways of coping and problem solving. Basically, the CAMS clinician does not debate whether the patient should die by suicide or not. Rather, the clinical dyad collaboratively pursues a discrete suicide-specific treatment plan that is designed to make suicidal coping systematically obsolete thereby strategically side-stepping power struggles that are inherent in cases of suicidal blackmail (Jobes, 2006). Thus, we see in the most effective existing and emerging treatments that informed consent is a crucial element of the treatment process.

The Use of Medication

The process and elements of informed consent with suicidal patients (whether currently suicidal, chronically suicidal, or suicidal in the recent past) also relates to medication prescribing, monitoring, and maintenance. Large numbers of high-risk suicidal patients will also be taking medications (Olfson et al., 2002). For example, it is estimated that 48% of depressed patients receive both medications and psychotherapy as the treatment of choice (Olfson et al., 2002). Accordingly, it is important to consider the role of medications in the treatment process, particularly when it is most likely to be prescribed by a general practitioner without a mental health background (Olfson et al., 2002). It is also important to keep in mind that if the medication is prescribed by a general practitioner it is unlikely that suicide risk is routinely assessed at medical visits (Feldman et al., 2007), that adherence to practice guidelines for the management of depression in primary care settings is poor (Heppner et al., 2007), and that the patient's adherence to prescribed medications is highly influenced by the patient's beliefs about the medication as well as the general quality of the treatment relationship (Chakraborty, Avasthi, Kumar, & Grover, 2008).

Viewing the patient (as well as family members and/or significant others) as a partner in this relationship is critical to the outcome of the treatment. Both physician and patient must weigh the risks and benefits of the use of medication. This

process should be collaborative and cooperative, and in many cases, is in and of itself, therapeutic. A strong doctor–patient relationship can be cemented with the informed consent process as it relates to the use of medications as part of an overall treatment plan. The informed consent process delineates the roles and responsibilities of both parties.

The physician has many duties and responsibilities attendant to the prescribing of medications. The list includes (but is not limited to): (a) the evidence-based treatments that are available; (b) the dynamics of adherence and compliance with medication regimens; and (c) the pharmacology, pharmacokinetics, effectiveness, efficacy, recommended dosages, frequency of administration, side effects, adverse reactions, contraindications, complications, abuse potential, and risk of potential harm in overdose for each medication being prescribed. Hence much has to be conveyed to the patient prior to a decision to prescribe, adjust, or switch a medication.

The patient has the responsibility to take the medication(s) as prescribed, and to inform the physician of both therapeutic benefits (e.g., relief of symptoms), as well as complications (e.g., untoward reactions, side effects, adverse reactions, etc.). It is also the responsibility of the patient to read and inquire about any package inserts or medication guides (e.g., from a pharmacy or physician) that are included with the dispensing of the medication.

Many medications that address psychiatric disorders do not cure the targeted disorder, or completely eradicate, eliminate, or ameliorate the symptoms associated with that disorder. Hence the physician must be sanguine about the role that a medication might play in a total treatment plan and communicate that to the patient. The informed consent process therefore must acknowledge the inherent risks and benefits in the use of medications, especially as they relate to the potential for exacerbation of symptoms, as well as the potential for abuse and overdose.

The informed consent process must follow guidelines and recommendations as set forth by federal and state statutes and regulations. State statutes and regulations may differ from state-to-state. However, regulations and guidelines as set forth by the FDA and the Drug Enforcement Agency (DEA) are standardized nationwide.

Possible Legal Implications

As Jobs and Berman (1993) noted, foreseeability is always an issue in malpractice liability. Informed consent should address this aspect of care, that is, we can expect certain percentages of suicidal patients to encounter problems during the course of care. And those problems are not unusual, rather secondary to the problems (including psychiatric diagnosis) being targeted in treatment. Such statements of risk are routine in medical care in which there is a clear expectation of adverse events and enduring problems, including death. In oncology for example, a clear expectation of the risk of death exists and is communicated in the informed consent process. Clearly, there is a mixture of risks inherent to the treatment as well as the identified illness. As indicated by the data presented previously, very much the same is true for those presenting with suicidality and, as such, apparent risks should be presented in the informed consent process. In patients with suicidality, there are high rates of reattempts during treatment, with some studies approaching 50% of those in care. Whether this is secondary to the treatment is really not the issue. What is clear (or foreseeable) is that this adverse event occurs, and there should be an expectation of risk shared with patients (and family members) at the outset. Similarly, up to half of all suicides are in active treatment at the time of their death (Fawcett, 1999). Although the overall base rates for attempts and death are low, this information clearly indicates that adverse events, including both suicide attempts and death, will occur during treatment and are often times a function of the refractory nature of the disorder, rather than negligence or incompetent care. It is essential that patients, their families, Institutional Review Boards, licensing and regulatory boards, and professional insurance agencies understand this simple fact. In short, a clear expectation of risk in the treatment of suicidal patients needs to be articulated and understood, consistent with current data. Treating high-risk suicidal patients is no different than other areas of health care in which risk is an inherent part of treatment. Accordingly, information specific to risks for suicidality should be included in the informed consent form and process.

Recommendations for Clinical Practice and Treatment Research

We argue that a clear and succinct statement of risks in psychotherapy for suicidal patients should be included in the informed consent statement and process. Although not comprehensive and specific to every targeted psychiatric diagnosis, the statement would provide an opportunity, consistent with that suggested by Pomerantz and Handelsman (2004), to discuss the topic in more detail and answer the patient's questions about therapy and a decision to possibly opt out of treatment. Consistent with available data, any statement whether consistent with the example provided below or not, should include several identifiable elements including:

1. For patients who have attempted suicide or who have reported suicidal ideation, risk can endure throughout the treatment process and, for possibly as many as half, can result in a subsequent suicide attempt (and for a very small percentage the possibility of death).
2. Patients who have made multiple-suicide attempts are at the greatest risk to continue to experience symptoms, associated dysphoria, and make a subsequent suicide attempt.
3. Therapy will involve emotional experiences and related upset. The patient and therapist will work together to help the patient work through difficult emotions, but at times painful issues will be discussed and purposefully targeted in treatment.
4. Therapy will involve experimenting with and learning new skills that will lead to more effective problem solving without using suicidal behaviors.
5. Procedures to follow in a crisis situation will be explicitly described and the patient and therapist will work together to determine thoughts and behaviors the patient is willing (and capable) to do. Crisis management strategies will be matched to the client/patient's level of competence.
6. One of the primary targets in treatment is the reduction of suicidal behaviors.
7. It is important to consider and explore other available modes of treatment (including

medication) for certain disorders. There are a broad range of treatments available.

8. A collaborative approach to treatment, compliance with the treatment plan, and effective crisis management are all essential to reducing risks and maximizing positive treatment outcomes.

We recognize that there may be other situations or specific psychiatric disorders, especially co-occurring psychiatric disorders, in which the risk of suicide attempts or death is elevated. Clinicians may wish to adapt or expand these statements for other specific high-risk populations. What follows is one possible example of what could be included in the risks/benefits section of an informed consent statement:

If you're presenting with some form of suicidality (i.e., suicidal thinking or a suicide attempt), it's important to recognize the risks inherent in treatment, as well as a decision not to seek treatment. Randomized controlled trials for the treatment of suicidality have found reattempt rates during treatment as high as 47%, with a number of experimental treatments significantly reducing the rate of subsequent attempts by as much as half. The risk of a suicide attempt during treatment is greatest for those who have made multiple-suicide attempts (i.e., two or more). Treatments have also been found effective at preventing repeat suicide attempts, reducing symptoms related to suicidality (e.g., depression, anxiety, hopelessness), and associated problems (e.g., interpersonal stress, problem-solving ability). One of the risks both in and out of treatment for various disorders (e.g., major depression, bipolar disorder, schizophrenia, anorexia, borderline personality disorder) is death, although this is infrequent and relatively rare. Specific rates vary across diagnoses in outpatient (or inpatient) care. Treatments for all of these problems have been found to be effective. If you would like diagnosis-specific information, please let me know.

We will talk more specifically about the issue of suicidal thoughts and behavior in our commitment to treatment agreement. A primary target in treatment will be the reduction of suicidal thoughts and behaviors. An important element of therapy involves learning new skills that will help you to more effectively manage your emotions, reactions, and relationships with others without suicidal behavior. As you learn these new skills, you should begin to notice improvements in your mood and how you feel you are managing your life.

You should be aware that we will talk about some things that will be very painful for you. We will do this when both of us feel that you have acquired the skills to be able to deal with these emotions and we will work together to help you benefit from these experiences.

Early in your therapy we will set up a crisis response plan that will include specific steps for you to follow when you begin to feel upset or in crisis. I expect you to make every effort to carry out these plans and we will address any obstacles that come up when you try to use this crisis response plan. This is a very critical part of your treatment and it is less likely that

your treatment will be successful if you do not utilize this plan.

What is clear is that use of a crisis response plan and a willingness to fully engage in the treatment process will reduce risks and increase the effectiveness of treatment. Given the risk of problems in treatment for those with chronic suicidality, it's important to recognize and understand up front the potential need for family support and involvement in care. This might mean allowing me to contact a family member or significant other during a suicidal crisis. It's also critical to recognize the need for an honest and trusting relationship in treatment, one allowing for you to be direct and specific when problems with treatment compliance emerge. To provide you with the best possible care, we may decide to (or need to) involve other professionals (e.g., physicians, clergy) in your treatment. Therefore, we will need to maintain an open line of communication between and among all those professionals involved in your treatment.

Although by no means comprehensive (and purposefully so), the statement provided offers an opportunity to engage the patient in a dialogue about suicidality and how it will be addressed and managed in care. It provides an opportunity to discuss shared responsibility in care, along with the possible integration of family members and/or significant others into the crisis management process. At a minimum, it makes it clear when a suicidal patient enters treatment risks are present and persist. It is also important to note that the complexity of the information shared is considerable and should be communicated in such a way that patients can comprehend it effectively. The language used above may well need to be simplified considerably for various populations.

Clearly, this approach is most compatible with cognitive-behavioral and related theoretical orientations that target skills training as a treatment outcome. We argue, however, that it is amenable to a broad range of orientations given the focus on shared responsibility and the collaborative nature of care. These are elements common to, arguably, all psychotherapeutic orientations.

Some Concluding Thoughts

We have little doubt that some readers might find the current article provocative. We suggest very much to the contrary, though, that the current article simply articulates what data indicate and clinicians have known for a long time; that the treatment of high-risk patients is associated with negative outcomes (suicide attempts and death by suicide). Consistent with existing ethical guidelines for mental health clinicians, presentation and discussion of this information in the

informed consent process is essential. Future research will reveal whether it facilitates treatment compliance, a better therapeutic alliance, and more effective crisis management. Unlike other areas of health care, the treatment of mental disorders has not been identified as a high-risk endeavor. For some patients, though, the data suggest a very different picture. An expectation of risk needs to be reflected in the informed consent process, especially when the patient presents with or develops suicidal ideation or behaviors.

The need for research in this area is clear. The clinical impact of the informed consent process with high-risk patients has yet to be explored. That is, the nature of informed consent as an actual clinical intervention with suicidal patients has not been studied. A simple study comparing provocative consent with a standard consent process would be invaluable. Such a study would also provide information on the potential therapeutic benefits of feedback about risk status, to complement existing data on the benefits of feedback about personality problems (e.g., Finn & Tonsager, 1992). In particular, knowing whether suicide-specific information improves treatment compliance and use of crisis intervention services during high-risk periods would be a significant contribution to the extant literature and a wonderful first step.

Undoubtedly, there will be concerns about the potential clinical impact of this information on the treatment process, for example, the possibility of reinforcing a sense of helplessness or hopelessness in suicidal patients. Although dismantling studies have not yet been done, it is important to remember that several approaches already proven effective at reducing suicide attempt rates (e.g., DBT and CT) routinely include such information in the consent process. This early data is reassuring. Regardless, though, it is important to accumulate the empirical evidence to answer what are intriguing and a potentially critical series of questions about informed consent as a clinical intervention.

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