

Working with Suicidal Thoughts: Assessment, Therapeutic Communication, Safety Planning, and Treatment

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Narrative Clinical Review

Abstract—Suicidal thoughts require direct, humane inquiry and proportionate action; neither their presence nor a risk score determines an individual's future. This narrative clinical review distinguishes suicidal ideation, suicide attempts, suicide deaths, and self-harm irrespective of intent. It examines the form, function, intensity, duration, controllability, intent, planning, access, and rehearsal of thoughts, integrating diagnostic context in a collaborative, time-linked formulation. Evidence available through 30 May 2024 indicates that asking directly does not significantly increase suicidal ideation; risk factors, scales, and prediction models do not support low-, medium-, or high-risk categories as individual forecasts or stand-alone treatment or discharge decisions. Assessment should clarify current state and recent change, foreseeable near-term pathways, the safest setting, and an action for each concern. Safety planning, collaborative means safety, rapid follow-up, and caring contact address different links in care. Suicide-focused cognitive-behavioral treatment, dialectical behavior therapy when indicated, the Collaborative Assessment and Management of Suicidality, and the Attempted Suicide Short Intervention Program have bounded evidence in defined populations. Medication should address a diagnosed condition and be monitored for the outcome claimed. Alliance and communication support disclosure and implementation but do not guarantee safety or replace follow-up.

Index Terms—suicidal ideation, suicide risk assessment, therapeutic communication, safety planning, means safety, suicide-focused treatment

I. INTRODUCTION

A patient who says that life no longer feels bearable is communicating both suffering and a clinical question: what is happening now, and what would make the next hours or days safer? The response cannot be reduced to reassurance, a checklist, or a prediction. It requires language precise enough to distinguish a wish not to wake from an intention to act, curiosity about death from rehearsal, and nonsuicidal self-harm from behavior undertaken with at least some intent to die. It also requires attention to the person who is speaking. Shame, fear of coercion, previous dismissal, and uncertainty about one's own intent can all shape what is disclosed and when.

The central task is to connect understanding with action. Direct inquiry can clarify the form and function of thoughts; diagnostic assessment can identify treatable drivers; a time-linked formulation can show how a crisis is developing; and safety planning, means safety, treatment, and follow-up can interrupt different links in that sequence. None is sufficient alone. Risk factors and scales can organize information, but systematic reviews show that they do not classify an individual reliably into low, medium, or high future risk (Carter et al., 2017; Franklin et al., 2017; Belsher et al., 2019). A calm interview or a strong alliance likewise cannot certify safety after the encounter.

This review develops an evidence-bounded clinical position: communication is part of suicide prevention when it produces a more accurate shared understanding and leads to proportionate care. The patient should be treated as a collaborator whose experience contains essential data, not as the sole bearer of a decision that clinicians must make. Hope can be present without forced optimism, and uncertainty can be acknowledged without paralysis. The resulting standard is practical: name what is known, what remains uncertain, which change would trigger escalation, who will do what next, and how connection will be maintained during transitions.

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Clinical safety boundary

- Ask directly about suicidal thoughts, intent, planning, access, rehearsal, recent behavior, and the patient's ability to use help.
- Do not use a score, a low/medium/high label, denial of intent, or a no-suicide promise as a substitute for formulation and action.
- Escalate immediately when imminent intent, preparatory behavior, unsafe access, severe loss of control, impaired decision-making, or inability to sustain a safe setting is present or cannot be clarified.
- Create a collaborative, usable safety plan and address access to lethal means without eliciting unnecessary method detail.
- Involve a partner, family member, or other support only with consent when feasible and only when the relationship itself is safe; disclose without consent only within applicable emergency, safeguarding, and legal duties.
- Document the clinical reasoning, actions, responsibilities, contingencies, and follow-up rather than a prediction of certainty.
- This narrative review is not a stand-alone triage algorithm; local emergency, safeguarding, legal, and clinical pathways govern individual decisions.

II. SCOPE AND REVIEW METHOD

This narrative clinical review used a literature-search cutoff of 30 May 2024, exactly one calendar month before the nominal issue date; sources had to be publicly available by then. Searches covered suicidal ideation, attempts, self-harm, assessment, prediction, direct inquiry, formulation, safety planning, means safety, follow-up, caring contact, psychotherapy, medication, transitions, alliance, and communication. Major guidelines, reviews, and pivotal trials supplied foundational references.

Priority went to official guidance, reviews, meta-analyses, and randomized or well-characterized comparisons, with foundational papers retained when they define current practice. The synthesis asked what changes an immediate decision, which communication makes information usable, which interventions reduce suicidal behavior or strengthen continuity, and where each claim stops. Ideation, attempts, deaths, self-harm, engagement, and symptoms remained distinct outcomes.

This is not a systematic review, and no pooled estimate was calculated. Populations, settings, definitions, outcomes, and follow-up differ, and package trials seldom isolate active components. Because suicide deaths are rare, even large studies may be underpowered. Findings are therefore reported with their design limits, and population associations are not converted into individual forecasts.

III. TERMS, EPIDEMIOLOGY, AND OUTCOME DISTINCTIONS

Suicidal ideation includes thoughts about death or suicide that vary from passive wishes through active thoughts with intent and planning. A suicide attempt is a nonfatal, potentially injurious act undertaken with at least some intent to die; a suicide death is a fatal outcome. Self-harm is often defined more broadly as intentional self-injury or self-poisoning

irrespective of stated intent, and some studies use still other definitions. These categories overlap clinically but are not interchangeable. Ambivalence and mixed motives are common, yet uncertainty about intent should prompt careful description rather than automatic recoding of every act as either clearly suicidal or clearly nonsuicidal (Posner et al., 2011; Witt et al., 2021).

The distinction matters because denominators, determinants, and intervention effects differ. The World Health Organization estimated that more than 700,000 people died by suicide worldwide in 2019 and described marked variation by age, sex, country income, and access to care (World Health Organization, 2021b). Those population estimates establish the scale and inequity of the problem; they do not estimate the probability that a particular patient will act. Likewise, the comparatively common experience of ideation cannot be used to minimize one patient's crisis, and the rarity of suicide death in a clinical cohort makes accurate individual prediction harder rather than less important.

Outcome language should follow the evidence. A study may show fewer repeat attempts without demonstrating fewer deaths; an intervention may reduce ideation without changing behavior; another may improve treatment attendance while leaving symptoms uncertain. The Cochrane review of psychosocial interventions for adult self-harm, for example, addresses repetition of self-harm irrespective of suicidal intent and reports varied certainty across comparisons (Witt et al., 2021). Treating that literature as if every episode were a suicide attempt would misstate both the population and the outcome. A clinically useful review therefore asks not simply whether an intervention works, but for whom, compared with what, over which interval, and on which endpoint.

Terminology also shapes conversation. Phrases such as attention-seeking, manipulative, or failed attempt obscure function, invite judgment, and can weaken care. Neutral descriptions are more informative: what the patient did, what outcome was anticipated, what communication or relief was sought, what changed during the episode, and what followed. Respectful precision does not remove accountability or urgency. It makes the target of assessment and treatment clearer.

IV. THE FORM AND FUNCTION OF SUICIDAL THOUGHTS

The presence of suicidal thoughts is only the beginning of assessment. Clinicians need to understand their form: verbal thoughts, images, impulses, memories, imagined aftermaths, or a felt pull toward escape. Frequency should be separated from duration and intensity; controllability from willingness to seek help; and intent from the detail of a plan. Access to a potentially lethal means, preparatory actions, rehearsal, recent interruption of an attempt, and what prevented action carry

different implications from abstract knowledge that a method exists. The inquiry should obtain the detail needed for safety without requesting vivid or operational description that does not change care (U.S. Department of Veterans Affairs & U.S. Department of Defense, 2024; Posner et al., 2011).

Function is equally important. Thoughts may express a wish to end psychological pain, escape perceived entrapment, communicate a need that has not found another channel, punish the self, imagine reunion, regain a sense of control, or manage overwhelming arousal. A single episode can serve several functions, and its meaning can change across hours. Asking what the thought does for the patient is not an endorsement of suicide; it can identify the need that a safer intervention must address. For example, a thought that temporarily quiets panic may require a different immediate coping step from one that is becoming more compelling as intoxication increases.

Temporal pattern often reveals more than a lifetime tally. The clinician asks what is different today, what happened before the thoughts intensified, which states or interactions amplify them, what has interrupted them previously, and what is likely before the next contact. Protective influences should be described as processes, not possessions. A valued relationship may help when contact is available and safe, but may not protect during conflict or shame. Responsibility to children may support survival for one patient while deepening perceived burdensomeness for another. The practical question is whether an influence can operate in the foreseeable crisis and how it will be activated.

The resulting description should remain revisable. A patient can be uncertain, conceal some information, or become more able to speak as trust grows. Contradictions are not proof of deception; they can mark ambivalence, changing intent, memory limitations, fear, or different meanings attached to the clinician's words. Good assessment records the uncertainty and responds to its safety significance rather than forcing premature coherence.

Table 1. Dimensions of suicidal-thought assessment and their clinical use

Dimension	Questions to clarify	Decision relevance
Form and content	Passive wish, active thought, image, impulse, or rehearsal; self- or other-directed content	Distinguishes distress from an increasingly action-linked cognitive sequence
Intensity and time	Frequency, duration, peaks, recent change, foreseeable triggers	Locates the crisis in time and identifies when additional support is needed
Controllability	Ability to disengage, delay, use coping, or contact help	Tests whether an outpatient plan is usable under the expected state

Dimension	Questions to clarify	Decision relevance
Intent and ambivalence	Expected outcome, wish to die, reasons for and against action, fluctuation	Informs urgency without treating a denial or a reason for living as a guarantee
Planning and preparation	Degree of planning, access, preparatory acts, rehearsal, interrupted or aborted behavior	Identifies action proximity and prompts immediate means-safety or escalation
Function and context	What the thought changes or communicates; pain, entrapment, conflict, intoxication, psychosis, loss	Links the safety response to treatable and situational drivers
Recent and past behavior	Attempts, self-harm, medical lethality, rescue, learning, consequences	Provides history while preserving intent and outcome distinctions
Supports and barriers	Safe people, services, transport, privacy, coercion, caregiving, language, access	Determines whether agreed actions can actually occur

V. DIRECT, COMPASSIONATE INQUIRY

Patients should not have to produce a perfect phrase before suicide can be discussed. The clinician can move from the patient's language to direct questions: 'When you say you want everything to stop, have you been thinking about dying or killing yourself?' If the answer is yes or uncertain, the conversation continues to intent, planning, access, preparation, recent behavior, and current ability to stay safe. A systematic review found no statistically significant increase in suicidal ideation among participants asked about suicide (Dazzi et al., 2014). This supports direct questioning; it does not support asking without a plan to respond.

Tone affects the quality of the data. A hurried series of closed questions can teach a frightened patient that the safe answer is no. Normalizing the difficulty of disclosure, explaining why questions are being asked, and responding without shock or moral judgment make detail more speakable. Validation should name the suffering or function without validating suicide as the solution: 'It sounds as if the thought promises an end to unbearable pressure; I want us to find a way through the pressure that keeps you alive.' The clinician can summarize and ask for correction, particularly when intent is mixed or language differs across cultures. Across adult psychotherapy, alliance is associated with outcome, although causal direction remains unresolved and the finding is not evidence that rapport guarantees safety (Flückiger et al., 2018). Earlier JPPC work on men's help-seeking underscores a related point: self-reliance, stigma, and narrow norms of emotional expression can delay disclosure for some men, while language that respects agency can support engagement (Haverkamp, 2021).

Confidentiality requires honesty. The patient should know early that privacy will be respected and that information may need to be shared when immediate safety, abuse, neglect, or another legal duty requires it. Promising absolute confidentiality and later breaking that promise damages trust; threatening automatic hospitalization for any disclosure suppresses useful information. The aim is transparent collaboration: describe what action is being considered, invite the patient's view, use the least restrictive safe response, and explain any necessary decision that cannot be shared. Local law, capacity, safeguarding duties, and service procedures still govern the final action.

Direct communication continues after disclosure. Ask, 'What would make this plan hard to use tonight?' Such questions test implementation, not politeness. Agreement in the room may conceal barriers involving transport, privacy, telephone access, medication, or a safe contact. The relevant test is whether the planned actions remain possible in the state and setting most likely to occur.

VI. COMPREHENSIVE ASSESSMENT AND DIAGNOSTIC CONTEXT

Suicidal thinking is a clinical phenomenon, not a diagnosis. Assessment should examine depressive and bipolar episodes, psychotic symptoms, substance use and withdrawal, anxiety, trauma-related symptoms, personality-related difficulties, eating disorders, neurodevelopmental and cognitive conditions, pain, sleep disturbance, medical illness, medication effects, recent loss, interpersonal violence, legal or financial stress, and access to care. The purpose is not to accumulate labels. It is to identify states and conditions that alter judgment, distress, impulsivity, opportunity, or the feasibility of a safety plan, and to begin treating them without assuming that diagnosis-specific care alone addresses suicidality (U.S. Department of Veterans Affairs & U.S. Department of Defense, 2024).

The mental-state examination attends to affect, agitation, hopelessness, guilt, psychosis, command experiences, intoxication, dissociation, cognition, judgment, and capacity. Acute agitation, severe insomnia, escalating substance use, or abrupt behavioral change may matter even when the patient appears composed during a short interview. Conversely, intense emotion does not by itself establish imminent intent. Collateral information can clarify recent behavior and access when the patient consents or when emergency duties justify limited disclosure. Physical assessment is needed after self-poisoning, injury, altered consciousness, or suspected medical contributors; apparent psychological stability cannot rule out delayed medical harm.

Past suicidal behavior is clinically important, but its meaning needs reconstruction. Ask what was intended, expected, planned, interrupted, concealed, and learned; what

medical treatment followed; and how the person now understands the episode. Self-harm without intent to die still warrants careful assessment because intent can vary between episodes and because repeated self-harm may signal severe distress, but it should not be retrospectively relabeled as a suicide attempt without evidence (Witt et al., 2021). The same precision applies to aborted and interrupted attempts, which can reveal movement toward action even when no injury occurred (Posner et al., 2011).

Relationships belong in diagnostic context without becoming simplistic protective factors. Conflict, separation, coercive control, caregiving burden, bereavement, social isolation, shame, or feared rejection may be central drivers. A partner or family member may instead provide observation, transport, companionship, or help limiting access to means. The clinician asks about both possibilities and speaks with others only in a way that does not expose the patient to retaliation or forced disclosure. If abuse or exploitation is suspected, private assessment and appropriate safeguarding take priority over routine family involvement.

VII. RISK FACTORS, SCALES, AND THE LIMITS OF PREDICTION

Risk factors inform populations and formulations, but most are common, correlated, and weakly specific. Across 50 years, commonly studied factors predicted suicidal thoughts and behaviors only slightly better than chance (Franklin et al., 2017). Reviews also found low and variable positive predictive values for scales, while prediction models were inadequate for individual clinical use (Carter et al., 2017; Belsher et al., 2019). History and current state still matter; no weighted sum supplies the certainty of a categorical label.

The base-rate problem is practical: suicide death is uncommon relative to suicidal thoughts and risk factors, so apparently discriminating models yield many false positives, while a low score can miss a changing state. Thresholds shift with prevalence, setting, and follow-up. Low-, medium-, and high-risk labels hide the action question: 'low' can suppress follow-up, while 'high' can prompt restriction without identifying what it should change.

Neither a scale nor a category can predict an individual outcome or decide care. NICE advises against predictive scales or global low-, medium-, or high-risk strata for treatment or discharge decisions (National Institute for Health and Care Excellence, 2022). The 2024 VA/DoD guideline retains acute and chronic categories in its care algorithm but found insufficient evidence to endorse a particular stratification method (U.S. Department of Veterans Affairs & U.S. Department of Defense, 2024). The Columbia instrument describes ideation and behavior; it does not forecast suicide (Posner et al., 2011). Assessment should end in a needs- and action-linked formulation.

Assessment should conclude with an action-linked formulation: relevant vulnerabilities, recent change, foreseeable pathways toward action, available interruption points, the response assigned to each, and remaining uncertainty. This cannot guarantee an outcome, but it makes reasoning reviewable—why a setting was chosen, what triggers escalation, and when reassessment is due.

VIII. COLLABORATIVE, TIME-LINKED FORMULATION

Formulation turns a list into a sequence. A useful version may read: longstanding trauma and episodic depression create vulnerability; a separation and three nights without sleep increased entrapment; alcohol narrowed inhibition; an argument intensified suicidal imagery; access to a lethal means moved the crisis closer to action; and fear of hospitalization delayed help-seeking. The immediate plan then follows from the sequence: address access, intoxication, sleep, safe company, and rapid reassessment while beginning treatment for depression and the relational crisis. The formulation belongs in plain language that the patient can correct (U.S. Department of Veterans Affairs & U.S. Department of Defense, 2024).

Time horizon should be explicit. Enduring factors may inform long-term treatment, but tonight's decision depends on the current state, foreseeable exposures, and available support. The clinician asks what is likely before the next contact and uses if-then contingencies: if intent intensifies, if the patient begins preparing, if substance use resumes, or if the safe support becomes unavailable, then a named person or service will be contacted and a higher level of care considered. A contingency is credible only when access, transport, timing, privacy, and responsibility have been checked.

Protective factors become useful when translated into actions. 'Family' becomes a specific safe person who has agreed to remain available; 'treatment engagement' becomes a confirmed appointment and a route to earlier review; 'reasons for living' become words, images, or commitments the patient can access when attention narrows. Some patients cannot identify a compelling reason for living during acute pain. The clinician should not demand one or interpret its absence as refusal. Agreement on one observable next step, followed by reassessment, may be the achievable target.

Formulation is collaborative but responsibility is not transferred to the patient. Agreement strengthens implementation, yet a clinician may need to act when capacity, imminent danger, safeguarding, or severe loss of control makes voluntary arrangements insufficient. The ethical aim is the least restrictive safe response, not agreement at any cost. Documenting the patient's perspective alongside the clinician's reasoning preserves dignity and makes disagreement clinically visible.

Table 2. From formulation component to observable action

Formulation component	Clinical question	Action-linked output
Current state	What has changed in thoughts, intent, control, sleep, substance use, psychosis, or agitation?	Immediate treatment, observation, medical care, or reassessment interval
Proximal sequence	What happens before the crisis moves closer to action?	Specific interruption points and if-then contingencies
Access and opportunity	What accessible means or unsupervised periods increase danger?	Collaborative, temporary means-safety steps and safer setting
Drivers	Which psychiatric, medical, relational, and material problems sustain the crisis?	Named treatment or practical response for each modifiable driver
Inhibitors and supports	What has interrupted action, and will it be available in the expected context?	Activated support with consent, confirmed contact, and backup
Barriers to care	What could prevent disclosure, attendance, transport, or use of the plan?	Barrier-specific solution and assigned responsibility
Uncertainty	What important information is missing or changing?	More conservative setting, collateral information, or earlier review
Review trigger	Which change invalidates the current plan?	Explicit escalation threshold understood by patient and team

IX. IMMEDIATE SAFETY DECISIONS AND ESCALATION

Immediate escalation is indicated when the patient has imminent intent, preparatory or recently interrupted suicidal behavior, unsafe access to a lethal means, rapidly increasing or poorly controllable urges, severe intoxication or withdrawal, psychosis or agitation that compromises judgment, inability to participate in a viable safety plan, or an environment that cannot sustain safety. Uncertainty itself can justify a more protective response when essential information cannot be obtained and the plausible consequence is grave. The response may include emergency medical assessment, continuous observation, crisis-team involvement, or psychiatric admission according to need, capacity, law, and local service pathways (U.S. Department of Veterans Affairs & U.S. Department of Defense, 2024).

The setting should be chosen for a purpose. Admission may provide containment, medical treatment, diagnostic clarification, or rapid stabilization; it is not proof that risk has been eliminated. Discharge may be appropriate only when the immediate state has been assessed, access addressed, a workable plan agreed, follow-up arranged, and the patient can use the proposed supports. A bed or a discharge document is therefore one link in care, not the endpoint. The exceptionally

high pooled suicide rates after psychiatric discharge, particularly in the first week and month, underline the need for active transition planning while remaining population estimates rather than individual predictions (Chung et al., 2017; Chung et al., 2019).

Coercive measures carry relational and practical costs and should not be used reflexively, yet concern about those costs cannot justify inaction when danger is imminent. Explain the decision, invite preferences within the available choices, preserve privacy, and revisit restrictions as the state changes. A patient who fears hospital may still help identify the least distressing route, a trusted support, medication needs, caregiving arrangements, or communication preferences. If the relationship or home environment is unsafe, do not treat return to a partner or family member as routine discharge support.

No-suicide contracts are not a safety intervention. A promise may reflect a wish to please, fear of admission, or a state that changes after the encounter; it neither predicts behavior nor specifies what to do. The alternative is a documented plan with observable steps, named responsibilities, and a response to failure points (Stanley & Brown, 2012). When safety cannot yet be sustained over a long horizon, the next clinically meaningful interval may be much shorter: remain with staff, allow removal of access, and accept reassessment while acute drivers are treated.

X. SAFETY PLANNING, MEANS SAFETY, AND SUPPORTIVE RELATIONSHIPS

A safety plan is a brief, collaborative, prioritized set of actions for a suicidal crisis. The Stanley–Brown model moves from recognizing personal warning signs to internal coping, social settings or people that can provide distraction, people who can be asked for help, professional and crisis services, and steps to make the environment safer (Stanley & Brown, 2012). It should be written in the patient's language, accessible under stress, and rehearsed for foreseeable barriers. It is not a no-suicide contract, a generic handout, or evidence that outpatient care is safe regardless of current intent.

The evidence is encouraging but bounded. A predominantly male Veterans Health Administration cohort associated safety planning plus telephone follow-up with fewer suicidal behaviors and greater engagement, but allocation was not randomized (Stanley et al., 2018). A meta-analysis found fewer suicidal behaviors, not a comparable reduction in ideation, across heterogeneous interventions (Nuij et al., 2021). NICE recommends considering collaborative safety planning after self-harm; the 2024 VA/DoD guideline, applying different criteria, found insufficient evidence for or against safety or crisis-response planning to reduce attempts in the reviewed populations (National Institute for Health and Care Excellence, 2022; U.S. Department of Veterans Affairs & U.S. Department of Defense, 2024). A safety plan is

therefore an active component of care, not proof that outpatient management is safe.

Means safety addresses the period in which intent, opportunity, and access converge. Population and clinical reviews support reducing access to highly lethal means as part of suicide prevention, while method substitution is not complete (Yip et al., 2012; Barber & Miller, 2014). Clinically, the conversation is collaborative, specific, and temporary: identify what is accessible, agree how distance or delay will be increased, assign who will carry out the step, and check that it occurred. Ask only for the detail needed to make access safer. The aim is not to teach methods or to imply that one environmental change removes all danger.

A partner, family member, friend, or other trusted person can help implement the plan by staying present, supporting transport and appointments, holding the plan, or assisting with means safety. Involvement requires the patient's consent when feasible, a clear role, and an assessment that contact is safe. The clinician should not disclose a trauma history, diagnosis, or other private information merely because someone is helping. If imminent safety or safeguarding law requires limited disclosure without consent, share only what is necessary and explain this to the patient where doing so is safe.

The plan should be tested aloud. Ask the patient to imagine the next likely difficult period and walk through the steps: which warning sign will be noticed, which action comes first, what happens if it fails, and who is available at that time? This rehearsal often exposes practical barriers that assent conceals. Review the plan after any attempt, self-harm episode, emergency presentation, major transition, or meaningful change in drivers. A plan that cannot adapt to the patient's life becomes paperwork rather than protection.

XI. TRANSITIONS, FOLLOW-UP, AND CARING CONTACT

Transitions create discontinuity when attention and motivation may already be narrowed. Before handover, confirm the receiving service, appointment, transport, medication supply, contact route, and response to nonattendance.

Brief acute-care packages can help bridge this interval. A meta-analysis found that interventions initiated in emergency or inpatient settings were associated with fewer subsequent attempts and better linkage to follow-up, although components and effects varied (Doupnik et al., 2020). In ED-SAFE, screening alone was not the effective element; a later multifaceted phase that included discharge resources and follow-up calls was associated with fewer subsequent suicidal behaviors in a sequential-phase design (Miller et al., 2017). These studies support coordinated bundles, not the claim that one call or form is sufficient.

Caring contact can show that a patient remains held in mind without demanding disclosure or improvement. Among selected patients declining ongoing care, a randomized trial found fewer suicide deaths with periodic letters during early follow-up (Motto & Bostrom, 2001). A later trial of caring texts in active-duty personnel found null primary ideation and suicide-risk-event outcomes, although secondary binary outcomes favored messages (Comtois et al., 2019). Contact should be brief, respectful, linked to re-entry to care, and shaped by privacy preferences; it complements assessment, treatment, and emergency access.

Continuity is relational as well as administrative. A concise warm handover can preserve the patient's account of what precipitated the crisis, what helps, what feels unsafe, and what has already been agreed. Requiring the patient to begin again at every transition increases burden and may change what is disclosed. At the same time, the next clinician must reassess rather than inherit a static risk label. The most useful continuity document is a current formulation, plan, and contingency structure.

XII. SUICIDE-FOCUSED PSYCHOTHERAPIES

Treating depression, psychosis, substance use, trauma symptoms, insomnia, pain, or relationship violence may reduce important drivers, but suicidality can also require an explicit treatment target. Suicide-focused therapies examine the sequence leading to an attempt or crisis, identify beliefs and action patterns that maintain it, rehearse alternative responses, and plan for recurrence. Their evidence applies to defined populations and outcomes; it does not support replacing acute safety measures with a future therapy appointment.

Among adults after a suicide attempt, cognitive therapy plus usual care reduced repeat attempts over 18 months in a small randomized trial (Brown et al., 2005). Brief cognitive-behavioral therapy reduced attempts over two years in one military trial (Rudd et al., 2015). Both explicitly target suicidal behavior through episode analysis, cognitive and behavioral work, skills practice, and relapse prevention. Their shared principle travels more readily than any claim that one manual fits every service.

Dialectical behavior therapy has particular evidence for recurrent suicidal and self-injurious behavior in borderline personality disorder. In a two-year trial of women with borderline personality disorder and recent suicidal or self-injurious behavior, DBT produced fewer suicide attempts and less crisis-service use than expert community treatment (Linehan et al., 2006). This supports DBT when its indication and treatment structure fit; it does not make the diagnosis synonymous with suicide risk or DBT the default for all suicidal patients. Skills coaching without the wider treatment model should not be described as full DBT.

The Collaborative Assessment and Management of Suicidality organizes assessment and treatment around the patient's suicidal drivers and a shared stabilization plan. A randomized trial in suicidal soldiers compared CAMS with enhanced usual care, and a later meta-analysis found small advantages for ideation and several patient-centered outcomes but no significant pooled advantage for attempts or self-harm (Jobes et al., 2017; Swift et al., 2021). The Attempted Suicide Short Intervention Program uses a narrative interview, collaborative case understanding, safety strategies, and continuing letters. Its single-site randomized trial after an attempt found substantially fewer repeat attempts, but the result requires cautious interpretation and replication (Gysin-Maillart et al., 2016).

Adult self-harm trials suggest possible benefit from cognitive-behavioral psychotherapies for repetition, with varying certainty (Witt et al., 2021); mixed or unspecified intent means that endpoint should not be renamed suicide attempts. Across models, therapist and patient can reconstruct a recent episode, identify change points, practice alternatives, and test them under stress. This practical commonality neither establishes one mechanism nor erases model-specific training.

Table 3. Selected suicide-focused and related psychotherapies: evidence and boundaries

Approach	Central clinical task	Evidence-bounded use
Cognitive therapy after an attempt	Reconstruct the episode; modify suicide-related beliefs and behavior; rehearse relapse prevention	One RCT in recent attempters found fewer repeat attempts; apply with acute safety care and population limits
Brief cognitive-behavioral therapy	Suicide-focused chain analysis, emotion-regulation and cognitive skills, relapse-prevention plan	One military RCT found fewer attempts over two years; do not assume identical effects in every setting
Dialectical behavior therapy	Hierarchy prioritizing life-threatening behavior within a comprehensive skills and consultation model	Supported for recurrent suicidal/self-injurious behavior in borderline personality disorder; indicated, structured use
CAMS	Collaboratively identify suicidal drivers, stabilization needs, and patient-defined treatment targets	Meta-analysis supports small ideation and acceptability advantages; attempt/self-harm advantage not established
ASSIP	Narrative reconstruction of the attempt, collaborative prevention strategies, and continuing letters	Strong single-site trial signal for repeat attempts; replication and package attribution remain important
CBT-based therapy for self-harm	Identify episode functions and strengthen alternative coping and problem-solving	Cochrane evidence concerns self-harm irrespective of intent; do not relabel the endpoint as suicide death or attempt

XIII. TREATING DRIVERS AND USING MEDICATION RESPONSIBLY

A suicide-focused plan sits alongside treatment of the conditions and circumstances that sustain the crisis. Depression, bipolar disorder, psychosis, substance use, trauma symptoms, anxiety, insomnia, pain, medical illness, interpersonal violence, housing insecurity, and acute loss may each require a different intervention. Sequencing matters: withdrawal, intoxication, delirium, severe agitation, or an unsafe home may need immediate action before reflective therapy is possible. Practical help with shelter, income, transport, discrimination, or caregiving is not peripheral when those conditions repeatedly precipitate crises.

An updated randomized-trial meta-analysis did not establish that lithium prevents suicide or suicidal behavior, and the 2024 VA/DoD guideline found insufficient evidence to recommend for or against it for reducing suicide or attempts in mood disorders (Nabi et al., 2022; U.S. Department of Veterans Affairs & U.S. Department of Defense, 2024). In InterSePT, clozapine reduced suicidal behavior relative to olanzapine among high-risk patients with schizophrenia or schizoaffective disorder (Meltzer et al., 2003). This supports diagnosis-appropriate prescribing; neither drug is a general treatment for a patient merely because suicidal thoughts are reported.

A midazolam-controlled trial in 80 adults with major depression found a greater reduction in suicidal ideation 24 hours after ketamine, with subsequent treatment and follow-up not providing a controlled test of attempts or deaths (Grunebaum et al., 2018). Rapid change in ideation can be clinically valuable, but it is not proof of durable safety. Specialist assessment, physiological monitoring, diagnostic screening, management of adverse effects, and continuity of care remain necessary. Similar caution applies whenever a surrogate outcome is used to imply prevention of a rarer behavior.

Prescribing itself can alter safety. Review adherence, recent starts or dose changes, activation, sedation, withdrawal, toxicity, interactions, and the amount of medication accessible at one time. Decisions about supply and supervision should be individualized, collaborative where possible, and balanced against treatment interruption. A partner or family member may help only when consent and relationship safety are established. Medication review should end with a named clinical target and review date, not the implication that tablets have replaced communication, safety planning, or follow-up.

XIV. MONITORING, DOCUMENTATION, AND EQUITABLE CARE

Monitoring should follow the formulation: track thought form, intensity, duration, controllability, intent, and preparation; record attempts and self-harm separately; and

follow identified drivers. Check whether the safety plan was accessible and used, means-safety steps were completed, follow-up occurred, and barriers emerged. Scales can support consistency, but change should be interpreted with the patient and never used as a discharge certificate (Posner et al., 2011; Carter et al., 2017).

Documentation should show reasoning rather than defensive volume. Record the patient's account, relevant mental and physical findings, recent change, behavior and intent distinctions, access and preparation, collateral information and its source, formulation, capacity where relevant, options considered, chosen setting, safety-plan and means-safety steps, consent and disclosures, follow-up, assigned responsibilities, and review triggers. Avoid copying a static label forward. If information is uncertain or accounts differ, state that plainly and explain how the uncertainty affected care.

Equitable care requires attention to how services hear distress. Language barriers, disability, neurodivergence, racism, stigma, poverty, insecure immigration status, sexuality, gender identity, culture, and previous coercive care can affect both exposure to harm and willingness to disclose. Use qualified interpreters where needed rather than relying on a partner for sensitive assessment. Ask how the patient names suicide, self-harm, family, and safety, while still using direct clarifying questions. Cultural responsiveness changes how communication and support are arranged; it should not lower the standard for assessing imminent danger.

Team communication is part of safety. Handover should distinguish observation from inference, preserve the patient's words where clinically useful, and identify the next decision rather than transmit alarm alone. Supervision or senior consultation is appropriate when intent is unclear, legal or safeguarding duties conflict, resources are limited, or clinician anxiety is driving either excessive restriction or premature reassurance. The purpose is a more coherent plan, not the diffusion of responsibility.

XV. SYNTHESIS: FIVE PRACTICE PROPOSITIONS

First, direct inquiry does not appear to induce suicidal ideation, but it is clinically complete only when it leads to a proportionate response (Dazzi et al., 2014). Second, structured description is not individual prediction: scales can improve consistency, but risk factors and models do not justify confident low-, medium-, or high-risk forecasts (Carter et al., 2017; Franklin et al., 2017; Belsher et al., 2019).

Third, formulation is useful when temporal and actionable: identify current change, foreseeable pathways, interruption points, and escalation conditions. Fourth, communication and relationship are mechanisms of implementation, not guarantees. Collaboration can improve disclosure, correction,

and use of a plan; rapport and promises do not replace means safety, treatment, or follow-up.

Fifth, match interventions to the outcome and interval they can plausibly change. Safety planning and means safety address crisis behavior and opportunity; follow-up and caring contact address discontinuity; suicide-focused therapy addresses recurrent patterns; diagnosis-specific and social care addresses drivers. No one link protects the whole chain (Stanley et al., 2018; Nuij et al., 2021; Doupnik et al., 2020). Layered care therefore needs explicit handoffs, consistent with WHO's LIVE LIFE approach (World Health Organization, 2021a).

These propositions are testable in ordinary practice. A record should show whether the patient was asked directly, whether terms and outcomes were distinguished, whether the plan addresses the formulated sequence, whether supports were both consensual and safe, and whether each action has an owner and review point. When any answer is unclear, the weakness is not solved by adding a risk adjective; it is solved by improving the assessment or the care pathway.

XVI. CONCLUSION

Working with suicidal thoughts requires precision without coldness and compassion without false reassurance. The clinician asks directly, distinguishes ideation from behavior and self-harm from suicidal intent, examines psychiatric, medical, relational, and practical context, and acknowledges the limits of prediction. The product is not a verdict about who will or will not die. It is a collaborative, time-linked account of how danger may increase and what will be done to interrupt it.

Communication matters because it makes ambivalence, function, barriers, and changing intent more available to care. Human relationships matter when they provide safe, consented, specific support. Neither substitutes for action. Safety planning, means safety, the safest feasible setting, rapid continuity, treatment of drivers, and suicide-focused therapy each address a different link. Care is strongest when those links are joined, responsibilities are named, and the formulation is revised whenever the patient's state or circumstances change.

XVII. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and writes about Communication-Focused Therapy (CFT). Where CFT is discussed, it is presented as a formulation perspective and not as a substitute for established assessment, evidence-based treatment, or independent replication. No other conflict of interest was reported.

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