Self-Determination Theory, Motivational Interviewing, and the Treatment of Clients With Acute Suicidal Ideation

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An overwhelming number of individuals who die by suicide suffer from mental disorders, but comparatively few are seen in psychological or psychiatric treatment. Given the efficacy of psychosocial interventions in decreasing suicide-related behavior, the development of strategies to increase motivation for treatment is critical for clients with acute suicidal ideation. Self-Determination Theory (SDT) provides a framework for understanding how the therapeutic relationship can affect clients' motivation for treatment. When working with clients with serious suicidal ideation, clinicians can use the principles of SDT or interventions that are congruent with SDT, such as motivational interviewing (MI), to increase clients' engagement in treatment and improve treatment outcome. SDT-based suggestions and an adaptation of MI are introduced to guide clinicians through this process. © 2007 Wiley Periodicals, Inc. J Clin Psychol 64: 52–66, 2008.

An empirical review of postmortem suicide studies estimated that 90% of individuals who die by suicide have one or more mental disorders, yet only 35% receive psychological or psychiatric treatment (Cavanagh, Carson, Sharpe, & Lawrie, 2003). Given evidence that psychological interventions can reduce the incidence of suicide-related behavior (Brown, Have, et al., 2005; Linehan et al., 2006), it is critical that mental health clinicians address treatment motivation among clients with acute suicidal ideation. Social psychological theories such as the Self-Determination Theory (SDT; Ryan & Deci, 2002) provide a framework for understanding how the therapeutic relationship can affect clients' motivation for treatment (Sheldon, Joiner,

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Pettit, & Williams, 2003). SDT assumes that people are innately motivated to engage in activities that promote health and growth. It posits that people are more likely to rely on their innate motivation when their social environment meets their fundamental needs for autonomy, competence, and relatedness. By applying the principles of SDT to the treatment of clients with serious suicidal ideation or using interventions that are congruent with SDT, such as motivational interviewing (MI; Miller & Rollnick, 2002), clinicians may increase clients' motivation for treatment and improve treatment outcome (Sheldon et al., 2003).

Suicide and Autonomy

Preventing individuals who are considering suicide from killing themselves is a daunting responsibility requiring accurate assessment of risk and provision of appropriate intervention. Identifying individuals who are at elevated risk for suicide is extremely challenging because many clients present with suicide-related symptoms, but most do not kill themselves (Pokorny, 1983) or make a suicide attempt (Joiner, Rudd, & Rajab, 1999; Rudd, Joiner, Jobes, & King, 1999). When clinicians are able to conclude that a client is at risk, it is often difficult to identify appropriate interventions as there is significant heterogeneity in individuals who die by suicide (Conwell et al., 1996) and they often experience more than one psychiatric disorder (Henriksson et al., 1993). Many clinicians also find working with clients who are considering suicide frightening (Pope & Tabachnick, 1993), which can interfere with clinicians' performance in these critical tasks.

Clinicians' legal obligation to protect clients from themselves provides additional pressure. Legal precedence suggests that failure to properly diagnose clients, take appropriate protective measures, hospitalize high-risk clients, and keep them hospitalized until they are no longer at risk may lead to charges of malpractice (Bongar & Greaney, 1994). Clinicians are in the precarious position of being legally responsible for failing at an extremely demanding task. In response, they may reflexively revert to interventions that could be perceived as unnecessarily controlling or restrictive such as no-suicide contracts and short-term hospitalization. Data indicate that no-suicide contracts are often ineffective (e.g., Drew, 1999, 2001; Kroll, 2000) and short-term hospitalization is not as effective as it was believed to be (e.g., King, Baldwin, Sinclair, & Campbell, 2001; Lawrence et al., 2000; Meehan et al., 2006), underscoring that these procedures are not a panacea.

The tension between respecting clients' autonomy and protecting them is not new to the suicide literature. At one extreme is Szasz (1986), who argued that clinicians who prevent clients from killing themselves undermine their fundamental human rights, whereas a more common position adopts the opposite stance that suicide should be prevented by any means necessary (e.g., Shneidman, 1996). With a few notable exceptions (Jobes, 1995; Linehan, 1993; Omer & Elitzur, 2001; Orbach, 2001), there has been little discussion in the suicide literature on the impact of clients' perception of autonomy on the treatment process; however, case studies have suggested that perceived autonomy may affect both motivation for treatment and its outcome. In a qualitative analysis of interviews with palliative caregivers who worked in the homes of five clients who were diagnosed with cancer and died by suicide, all of the clients struggled with the loss of autonomy and independence, were reluctant to depend on others, and feared losing greater autonomy (Filiberti et al., 2001). In a review of 36 cases of clients who died by suicide while receiving psychiatric treatment, two of the six recurrent problems involved issues of autonomy

(Hendin, Haas, Maltsberger, Koestner, & Szanto, 2006). At one end of the continuum, clinicians allowed clients to control therapy (some of whom used threats of suicide to gain control) or permitted patients' relatives to seize control. At the other end, clinicians engaged in ineffective or coercive actions to reduce their own anxiety.

Suicide prevention research provides additional support for the critical role of perceived autonomy. The Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2000) is an approach to assessing risk for suicide and resolving suicide-related problems (Jobes & Drozd, 2004). It consists of multiple components and emphasizes an empathic and cooperative relationship as a key to providing clients' with a sense of autonomy. In a retrospective study comparing CAMS to treatment as usual, clients receiving CAMS resolved their suicidal crises in less time and used less health care in the 6 months following the crisis than did clients receiving treatment as usual (Jobes, Wong, Conrad, Drozd, & Neal-Walden, 2005). These findings suggest that understanding the relationship between autonomy and motivation may be essential for effectively treating clients with acute suicidal ideation.

Self-Determination Theory

SDT (Ryan & Deci, 2002) addresses the association between perceived autonomy and motivation. It assumes that people are naturally curious about the world and innately motivated to explore it, better themselves, and right themselves when something is wrong. The natural tendency to engage in inherently enjoyable and healthy activities is known as *intrinsic motivation* (Deci, 1975). People rely on their intrinsic motivation when they perceive that their fundamental needs for autonomy, competence, and relatedness are met. *Autonomy* is the need to perceive oneself as the source of one's behavior (Deci, 1975). Motivation for activities perceived as interesting is strengthened by perceived autonomy (Deci & Ryan, 1987) and undermined by external contingencies (Deci, 1971; Deci, Koestner, & Ryan, 1999). *Competence* is the need to feel capable of obtaining one's goals (Deci, 1975). Perceived competence increases intrinsic motivation when it is accompanied by perceived autonomy (Fisher, 1978; Ryan, 1982), suggesting that people who feel responsible for engaging in an activity care about their performance. *Relatedness* is the human need for frequent and persistent caring (Baumeister & Leary, 1995). People need to feel safe and secure before they are able to explore their environment and experiment with new behaviors (Baumeister & Leary, 1995; Ryan, Deci, & Grolnick, 1995). In the context of psychotherapy for clients with acute suicidal ideation, an SDT framework underscores the value of supporting clients' perceived autonomy, competence, and relatedness to enhance their motivation for activities they find interesting or helpful.

Findings show that intrinsic motivation is associated with improved mental health and well-being (for a review, see Ryan, & Deci, 2000), but SDT contends that not all beneficial behavior is intrinsically motivated (Deci & Ryan, 1985). *Extrinsic motivation*, or motivation from external sources, is often required to promote engagement in activities that are perceived to be unimportant or unpleasant, but necessary for the socialization individuals need to function in society (Deci & Ryan, 1985). Because behaviors and activities that comprise medical treatments are often unpleasant or inconvenient (e.g., taking medication with side effects, eating healthy, exercising), they are commonly considered to be extrinsically motivated (Williams,

Grow, Freedman, Ryan, & Deci, 1996). The same argument can be made for psychosocial treatments such as talking with a therapist about life and death. Thus, clients with acute suicidal ideation, particularly those with a plan or intent to carry out a suicide attempt, may require extrinsic motivation.

In SDT, extrinsic motivation is conceptualized along a 4-point continuum characterized by increasing degrees of autonomy and self-regulation (Ryan & Deci, 2000, 2002). *External regulation* is motivation through external contingencies such as punishments and rewards. Clients with acute suicidal ideation could perceive involuntary hospitalization as an attempt to control them, which may inadvertently increase thoughts of suicide. *Introjected regulation* is motivation through self-esteem-related contingencies such as shame or guilt. Encouraging clients with acute suicidal ideation to sign a no-suicide contract to show they are committed to therapy may (rightly) be perceived as manipulative, although it may be seen as less controlling than involuntary hospitalization. *Identification* is a more autonomous form of extrinsic motivation and includes a conscious acceptance of a behavior as personally important. By reframing suicide as a permanent solution to problems that may be temporary, clinicians may help clients consider alternatives such as engaging in psychotherapy; however, this reframe may not help clients identify the core values and beliefs that provide energy for engaging in healthy behaviors. *Integrated regulation* is motivation for a particular goal that is consistent with the individuals' core values and beliefs. It is the most autonomous variety of extrinsic motivation and is therefore the type most similar to intrinsic motivation. A woman who wants to be a better mother may find the energy she needs to enter into treatment if her clinician can help her understand that therapy might improve her parenting. When clinicians are more *autonomy supportive*, clients perceive themselves as responsible for their behavior and are hypothesized to become more invested in treatment leading to better outcomes (Ryan & Connell, 1989).

Applications to Medical Research

SDT principles have been shown to be associated with treatment engagement and outcome for a range of health-related behaviors (Ryan & Deci, 2000, 2002). Prospective research applying SDT to medical treatments has focused on patients' preference to be autonomous or controlled (i.e., *autonomous orientation*), their perceptions of physician support for their autonomy (i.e., *autonomy support*), and their *autonomous motivation* for and *perceived competence* in carrying out target behaviors. These findings indicate that an autonomous orientation and provider support for patients' autonomy increases patients' autonomous motivation (Williams et al., 1996; Zelman, Ryan, & Fiscella, 2004), which increases their perceived competence (Kennedy, Goggin, & Nollen, 2004), and both autonomous motivation and perceived competence increase treatment engagement, which improves treatment outcome (Kennedy et al., 2004; Williams, Rodin, Ryan, Grolnick, & Deci, 1998; Zeldman et al., 2004). In-depth research programs replicating these findings in treatment for tobacco dependence (Williams, Cox, Kouides, & Deci, 1999; Williams & Deci, 2001; Williams, Gagne, Ryan, & Deci, 2002; Williams et al., 2006) and diabetes (Williams, Freedman, & Deci, 1998; Williams, McGregor, King, Nelson, & Glasgow, 2005; Williams, McGregor, Zeldman, Freedman, & Deci, 2004) provide further empirical support for these processes.

Applications to the Treatment of Clients With Acute Suicidal Ideation

SDT provides a framework for understanding why autonomy support may be a critical component of treatments for clients with acute suicidal ideation and offers guidelines for how clinicians can support clients' autonomy while protecting them. An SDT-based approach is client centered and assumes that people innately value activities that contribute to their health and growth (Rogers, Kirschenbaum, & Henderson, 1989). By supporting clients' autonomy, competence, and relatedness, clinicians may help activate clients' intrinsic motivation, which may increase treatment engagement and improve treatment outcome. SDT also acknowledges that some beneficial activities require extrinsic motivation in the form of direction, structure, expertise, information, and the communication of expectations (Sheldon et al., 2003). Clinicians also may increase clients' internalization of extrinsic motivation by providing as much support for their autonomy, competence, and relatedness as is possible. The following suggestions apply recommendations for general psychotherapy from a previous article to the treatment of clients with serious suicidal ideation (Sheldon et al., 2003), and include new suggestions informed by SDT. These recommendations are applicable to consultation as well as long-term therapies.

Application of Recommendations for General Psychotherapy (Sheldon et al., 2003) to Patients With Serious Suicidal Ideation

When addressing suicidal ideation, clinicians should support clients' autonomy by acknowledging their perspective, conveying that they have choices, and providing a meaningful rationale for recommendations or decisions (Deci, Eghrari, Patrick, & Leone, 1994).

Acknowledge the clients' perspective. The ability to listen to and acknowledge clients' views is a challenging skill that is often taken for granted, and it may affect clients' engagement in potentially life-saving treatments. Individuals who consider suicide are often ambivalent: They want to die and they also want to live (Brown, Steer, Henriques, & Beck, 2005; Jobes & Mann, 1999; Kovacs & Beck, 1977). As a result of ambivalence about living and dying, the stigma associated with both suicide and psychotherapy, and competing demands for limited resources, clients who are considering suicide also may be ambivalent about seeking treatment. To understand the complexity of their clients' experience, clinicians need to listen to and acknowledge clients' doubts and concerns. Open acknowledgment of clients' fears and obstacles may free them to consider the potential benefits of treatment.

Convey to clients that they have choices. Clients who are considering suicide have a number of important decisions to make, the most obvious being whether they are going to make an attempt. It is important for clinicians to realize that the decision to live or die is ultimately the client's. Although hospitalization no doubt prevents some suicides, the alarming rates of suicide during hospitalization and in the months following discharge underscore its limitations (King et al., 2001; Lawrence et al., 2000; Meehan et al., 2006). Once discharged, the clinician and hospital staff have little power to prevent clients from taking their own lives. Acknowledgment of clients' choices provides them with the opportunity to take responsibility for their lives, which may enhance their natural protective tendencies.

Discussing options may be particularly beneficial for clients with acute suicidal ideation because the suicidal state is characterized by a lack of critical thinking (for a review, see Baumeister, 1990). Many individuals who are considering suicide are unable to generate alternatives on their own. The discussion can be initiated through the exploration of suicide as a permanent answer to a temporary problem, the possibility that life may be worth living in the future, and the prospect of putting off the decision to die or live. Clinicians also can help clients explore the changes that are needed to make life worth living, what they can do to make those changes, and what they need to get started. If clients decide treatment is an option, clinicians may provide them with the opportunity to choose their treatment modality (i.e., outpatient psychotherapy, group psychotherapy, psychotropic medication, day treatment, or inpatient treatment). Clinicians may educate clients who are already in treatment about the types of treatments that are available and help them choose the best one for them (i.e., problem-solving therapy, cognitive therapy, behavioral activation). Final decisions should be informed by clinical judgment and the scientific literature, but clients should not be pressured or coerced into making decisions. If clients do not feel a particular treatment will be helpful and enter into treatment against their wishes, the experience of feeling controlled may reduce their engagement in treatment and the likelihood of a positive outcome.

Provide a meaningful rationale. Clients are more likely to accept recommendations if they are congruent with their values and beliefs. Helping clients see how a recommended treatment can facilitate their meeting personally meaningful goals may increase their motivation for treatment. A meaningful rational may be particularly important when treatment choices are limited or when clinicians feel there is only one viable option. No insurance, poor insurance, or limited resources (i.e., a limited number of inpatient beds) may reduce the options that are available. Clinicians are also required by law to hospitalize clients who intend to kill themselves, leaving little opportunity for autonomy support. SDT suggests that clinicians may increase clients' acceptance of recommendations such as hospitalization if they are able to convey its personal meaning and importance. To the extent that it is possible, taking the time to provide a rationale that is congruent with clients' core beliefs and values may go a long way to increasing their sense of autonomy, their engagement in treatment, and improving treatment outcome.

Support every client's autonomy, not just those who seem to prefer it (Sheldon et al., 2003). There is heterogeneity among individuals who engage in suicide-related behavior (Conwell et al., 1996; Kessler, Borges, & Walters, 1999), and it is possible that an autonomy-supportive approach may not suit all clients. Individuals who have a control orientation, for instance, prefer and seek out external guidance (Deci & Ryan, 1985; Grolnick & Ryan, 1989), and an autonomy-supportive stance may conflict with their preferences; however, data suggesting that individual differences moderate or mediate the impact of autonomy support on treatment engagement or outcome among individuals at risk for suicidal behavior are not available. In a study that examined the impact of autonomy support on health-related behaviors, a control orientation was not found to limit the effect of autonomy support (Williams et al., 1996), illustrating that it cannot be presumed that an autonomy-supportive approach will not benefit individuals with a control orientation. More research pertaining to this question is clearly needed.

New Suggestions

SDT research has focused on the use of autonomy support to activate individuals' intrinsic motivation and internalize extrinsic motivation; however, SDT also suggests that individuals' perceived competence and their sense of relatedness are integral to supporting their intrinsic motivation. Attending to clients' sense of competence and relatedness may have an effect on treatment engagement and outcome over and above that of autonomy support.

Support Clients' Perceived Competence

Findings confirm that positive verbal feedback enhances intrinsic motivation because it increases the individuals' sense of competence (Deci et al., 1999). The Theory of Self-Efficacy provides a rationale that explains why clinician support of client competency may increase treatment-related behaviors (Bandura, 1999). It states that people are more likely to engage in an activity if they believe they can perform it and believe it will produce the desired effect. In the context of suicide prevention, clinicians may increase client engagement and improve the outcome of treatment if they explicitly affirm clients' adaptive beliefs and behaviors, and their efficacy in treatment and treatment-related behaviors.

Emphasize the Relational Aspects of the Therapeutic Relationship

SDT theorists assert that behaviors are more likely to be internalized if they are prompted, modeled, or encouraged by individuals whose relationship is valued (Ryan, Stiller, & Lynch, 1994). Although the contribution of perceived relatedness has not been directly examined by SDT research, the psychotherapy literature provides strong support for its importance. The therapeutic alliance is one of the most consistent predictors of treatment outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000), and treatment success in turn improves the alliance (Tang & DeRubeis, 1999). When working with clients with acute suicidal ideation, therapists should attend to the quality of the relationship, especially when making recommendations. A strong alliance may increase clients' engagement in suggested activities and improve outcomes.

Motivational Interviewing to Address Suicidal Ideation

An alternative to using SDT-based suggestions is to use interventions that are congruent with SDT, such as MI (Sheldon et al., 2003). MI is a therapeutic approach that was developed to help individuals with alcohol-related problems change their drinking (Miller & Rollnick, 2002). It is a client-centered, directive method for helping people explore and resolve their ambivalence about changing. The fundamental principles of MI include *expressing empathy* for clients' experiences, *rolling with resistance* rather than confronting, *developing discrepancy* between actual and desired behavior, and *promoting self-efficacy* that change is achievable. These principles are supported through the use of *reflective listening* to ensure that clinicians listen to their clients and understand them, *open-ended questions* to encourage client elaboration, *affirmations* to support clients' self-efficacy, and *summaries* to integrate and reinforce what was discussed. MI has been determined to be an effective treatment for substance-use disorders and other health-related problems (Hettema, Steele, & Miller, 2005), and to promote follow-through with treatment (Carroll et al., 2006; Carroll, Libby, Sheehan, & Hyland, 2001).

Theorists have recognized the congruency between the assumptions, principles, and techniques of SDT and MI (Markland, Ryan, Tobin, & Rollnick, 2005; Vansteenkiste & Sheldon, 2006), and have posited that SDT may explain why MI works and that MI may provide a vehicle for implementing the principles of SDT. Both SDT and MI are based on the assumptions that people are innately motivated to engage in behaviors that contribute to their health and growth, and take part in activities that are congruent with their core beliefs (Markland et al., 2005). Both propose that clinicians should help clients access their intrinsic motivation to make positive changes, in part by helping clients identify their personal reasons for doing so (Vansteenkiste & Sheldon, 2006). The principles promoted by SDT also closely parallel the principles that form the foundation of MI (Markland et al., 2005; Vansteenkiste & Sheldon, 2006). SDT's principle of *autonomy* is closely associated with MI's principles of expressing empathy, rolling with resistance, and developing discrepancy. In MI, these principles are supported through the use of reflective listening and open-ended questions. SDT's principle of *competence* is similar to MI's principle of supporting clients' self-efficacy, which is supported in MI through the use of affirmations. SDT's principle of *relatedness* is associated with MI's principles of expressing empathy, rolling with resistance, and supporting self-efficacy. MI upholds these principles through the use of open-ended questions, reflective listening, and affirmations.

MI's focus on exploring and resolving ambivalence about a specific behavior may also provide a useful strategy for addressing acute suicidal ideation. Individuals who consider killing themselves are typically ambivalent (Brown, Steer, et al., 2005; Jobes & Mann, 1999; Kovacs & Beck, 1977). In MI, clinicians consider ambivalence about important changes natural and directly address it. Clinicians attend to both sides of clients' ambivalence to avoid activating resistance and to increase the probability of a positive resolution. If clients who are considering suicide both want to live and die, and clinicians only seem interested in their reasons for living, clients may feel the need to express their reasons for dying. In the context of suicide prevention, the consequences could be dire. Tests of Self-Perception Theory have confirmed that people who feel ambivalent about a topic often take the side they hear themselves arguing for (Bem, 1967). Clients who hear themselves explaining their reasons for considering suicide may begin to believe their arguments. To avoid this outcome, MI clinicians initiate a discussion about clients' *reasons for dying* to develop an understanding of their clients' perspective and promote their need to express their *reasons for living*. Clinicians, in turn, reflect their clients' reasons for living and ask pertinent open-ended questions so that they will engage in *living talk*, a verbal signal that clients have decided to live or engage in life-sustaining activities.

To test the effectiveness of this approach, two of us (Britton and Conner) have been piloting an adaptation of MI to Address Suicide Ideation (MI-SI) in the Psychiatric Emergency Department at the University of Rochester Medical Center. Two brief case examples from clients seen in the pilot study illustrate how an MI-based approach might be applied.

Case 1

Robert was a 52-year-old African American married man and the father of two. He was escorted to the Emergency Department by his outpatient therapist. Robert had been a successful journalist for over 20 years until he was diagnosed with cancer.

Although his cancer was resolved through chemotherapy, he had difficulty coping with his diagnosis and treatment, and became severely and chronically depressed. During the next four years, he isolated himself, alienating his family and friends. At the time of the interview, he reported severe suicidal ideation.

> **Patient:** I've been having bad thoughts . . . I've been thinking about suicide a lot and I can't stop.
> **Therapist:** There's something about thinking about suicide that you find helpful.
> **Patient:** Right, I have nothing to live for, nothing's going right and I can't bear the pain, I'm tired of it all . . . it's a way out.
> **Therapist:** An escape from the pain.
> **Patient:** Yeah . . . it hurts . . . my wife left me and my kids don't call anymore . . . don't want to talk to me . . . don't have time for me.
> **Therapist:** You feel like they don't care about you anymore.
> **Patient:** My son cares, but he doesn't have time for me. He's doing his thing with his friends and doesn't want to see me . . . .
> **Therapist:** Your relationship with your son is very important to you.
> **Patient:** He's the reason I'm still alive.
> **Therapist:** You really love him.
> **Patient:** I do and I can't do that to him.
> **Therapist:** Suicide is a way out, yet you can see it would hurt your son.
> **Patient:** That wouldn't be right. That's not how I want to be. I want my son to look up to me . . . respect me . . . you know? I don't want him to learn that you escape your problems by killing yourself.
> **Therapist:** You really care about the example you set for your son.
> **Patient:** Yeah I do, I want to help him learn to face his problems.
> **Therapist:** So that he can overcome them.
> **Patient:** That's right. I don't want to kill myself, but I just can't go on feeling this way.

In this exchange, the therapist used reflective listening to shift the client's ambivalence from suicidal ideation to positive life statements such as ''I want my son to look up to me.'' By reflecting the positive life statements, the clinician elicited phrases that suggest movement in the direction of choosing life (e.g., ''He's the reason I'm still alive.'' ''I don't want to kill myself.'') that we refer to as ''living talk.''

Case 2

Betty was a 40-year-old Caucasian woman who had been a crack-cocaine addict for 10 years. She had recently run out of money and had sold her boyfriend's television and stereo to maintain her use. Her boyfriend, whom she had lived with for 8 years, reacted by evicting her from his home. When Betty stopped using, she experienced withdrawal symptoms, began to feel depressed, and started to think about suicide. Five years earlier, she had tried to overdose and hang herself in the same day, but was saved by her boyfriend. During her most recent crisis, Betty aborted her suicide plan, called 911, and was triaged to the Emergency Department. By the time she was seen, she was feeling ashamed and regretful, but was still considering suicide.

> **Patient:** It seems like nothing has ever worked out for me and I can't do anything right. It's just one thing after another and everybody tells me I'm feeling sorry for myself and I need to get up and stop crying about it . . . .
> **Therapist:** They don't understand how much pain you're in.

Patient: No they don't . . . and they tell me to do things and I've done them all, I've tried them all, and they don't work . . . .

Therapist: And you're tired of people not listening to you, not listening to how much pain you are in.

Patient: I can't go on feeling this way . . . it needs to stop.

Therapist: And suicide is a way of stopping it.

Patient: Yeah . . . I've tried everything and nothing has worked…

Therapist: You can't imagine ever being happy again.

Patient: Sometimes I can . . . sometimes when I'm with my boyfriend I feel happy and he just said he'd take me back again. He always takes me back no matter what I do and I don't want to keep doing this to him. I want to get a job and help keep the house . . . I want to be good to him.

Therapist: You want to give to him like he's given to you.

Patient: I do . . . I just don't know how to do it . . . .

Therapist: You don't feel like you can do it alone.

Patient: I wouldn't be here if I did, I just don't know how to handle it all. What do you think I should do?

Therapist: Well, I recommend that we work together to figure out what you need to do to overcome this . . . . I can tell you what your options are, and help you identify what you think will work.

Patient: What are my options?

Early in this exchange, the patient expressed her frustration with other peoples' insistence on giving her advice, and the clinician reflected her desire to be listened to. Feeling understood, the client expressed her hopelessness and then asked for help. The clinician provided information only after the client asked for it, and in a manner that supported her autonomy.

Future Directions

Depression is the most common mental disorder among suicide decedents (Cavanagh et al., 2003), so an emphasis on depression is vital for developing treatment strategies to reduce risk for suicide. The potential for an SDT- or MI-based approach to increase depressed clients' engagement in treatment that may reduce suicide-related behavior or depression is an important line of research to pursue. We call for such research because individuals who are depressed and attempt suicide may experience a sudden improvement in their depressive symptoms (Bronisch, 1992; Davis, 1990; Jallade, Sarfati, & HardyBayle, 2005; Van Praag & Plutchik, 1985; Walker, Joiner, & Rudd, 2001). Such improvement, which may be dramatic and temporary (Watzlawick, Weakland, & Fisch, 1974), may create a window of opportunity that is particularly well suited to interventions that target clients' motivation and energy.

SDT- or MI-based approaches to treating clients with serious suicidal ideation can and should be used in a way that is fully compatible with legal standards of care. The standards require clinicians to make a ''reasonable'' attempt to assess clients' risk for suicide and take ''reasonable'' steps to prevent suicide when clients are at elevated risk (Bongar, 2002). SDT- or MI-based approaches provide clinicians with guidelines for how to respect clients' autonomy while also protecting them. When assessing suicide risk, clinicians taking an SDT- or MI-based approach use empirically supported measures and ask questions that are needed to conduct rigorous assessments. They also make a concerted effort to allow clients freedom to elaborate

upon their suicide-related concerns, which may improve their ability to identify clients at elevated risk. Clinicians' who take an SDT- or MI-based approach also make empirically supported recommendations when necessary. Although it is not optimal from the perspective of SDT or MI, it is appropriate to involuntarily hospitalize clients who intend to kill themselves and who cannot otherwise be safely treated. In keeping with the principles of SDT, such an intervention is to be used only as a last resort and should be implemented in as autonomy supportive a manner as possible. Systematic research on the putative benefits and costs of forced hospitalization is urgently needed, and SDT may provide a theoretical perspective to examine the costs in particular.

Conclusion

SDT suggests that autonomy support may be critical to treating clients' with acute suicidal ideation and provides clinicians with recommendations addressing how they can support clients' autonomy while protecting them. Although these suggestions are supported by SDT research in medical treatment, they are only beginning to be studied in the context of acute suicidal ideation. Research examining the application of SDT- and MI-based approaches may contribute to a better understanding of the associations among autonomy, motivation, treatment engagement, and treatment outcome. Moreover, the application of MI may provide insight into how clinicians can resolve clients' ambivalence about living by helping them access their motivation to live.

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