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ASSESSMENT AND TREATMENT STRATEGIES USED BY CLINICAL PSYCHOLOGISTS WORKING WITH SUICIDAL CLIENTS: A QUALITATIVE ANALYSIS

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ABSTRACT

The Assessment and Treatment Strategies utilized by Clinical Psychologists when working with Suicidal Clients were the subject of this phenomenological investigation. In-depth and semi-structured interviews with ten clinical psychologists were conducted, and the data were afterward iteratively analyzed using theoretical coding based on the phenomenological approach. The primary theme that emerged from the data was the "Clinical approach of Clinical Psychologists treating suicidal clients," it was supported by three auxiliary themes, including diagnostic techniques, therapeutic assessments, and therapeutic approaches. According to the study, clinical psychologists determine if a client is now contemplating suicide or has in the recent past to gauge their level of suicidality. To understand their customers' mental health, they use psychological diagnostic instruments and various treatment approaches, such as psychotherapy, for clients contemplating suicide, hospitalization, or patient care is required. This study serves as a foundation for future research by offering insight into the Assessment and Treatment Strategies employed by Clinical Psychologists.

Keywords: *Clinical Psychologists, Therapeutic Strategies and techniques, Psychometric tools, Suicidal Clients.*

INTRODUCTION

Suicide is a major global cause of death and a substantial public health concern (WHO, 2021). In order to treat suicide ideation and behaviours, clinical psychologists are crucial in dealing with suicidal clients, performing assessments, and devising treatment plans. Assessment of suicide risk and intervention fall under the purview of clinical psychologists' practise, according to the American Psychological Association (APA, 2013).

Theoretical frameworks provide a theoretical knowledge of suicide ideation and behaviour, guiding the assessment and treatment of suicidal clients. The interpersonal-psychological theory of suicidal behaviour (IPT; Joiner, 2005) is one of the conceptual frameworks in clinical psychology that is most frequently employed. According to the IPT, a person's urge to commit suicide is brought on by feelings of burdensomeness and a lack of belonging. The chance of suicide behaviour is increased by these elements working along with a learned capacity for lethal self-injury (Joiner, 2005). The cognitive-behavioral model (CBT) is another theoretical framework frequently employed in diagnosing and treating suicidal clients. According to the CBT paradigm, suicidal behaviour develops as a result of unhelpful cognitive schemas and

depressing automatic thoughts that cause hopelessness and despair (Beck et al., 1979). CBT seeks to recognise and alter these unfavourable thoughts and beliefs in order to swap them out with more adaptable and uplifting ones.

Another theoretical approach for treating suicidal patients, particularly those with borderline personality disorder (BPD), is dialectical behaviour therapy (DBT). DBT addresses the emotional dysregulation and impulsivity that frequently underlie suicidal behaviour in people with BPD by combining cognitive-behavioral therapy, mindfulness, and acceptance-based strategies (Linehan, 1993). Suicidal behaviour can be understood and treated using theoretical frameworks. Clinical psychologists who treat with suicidal clients often draw from a variety of theoretical frameworks, including the interpersonal-psychological theory, cognitive-behavioral model, and dialectical behaviour therapy.

Working with suicidal clients requires assessment, which entails determining the intensity of suicidal ideation, the existence of risk factors, and the presence of protective variables (Joiner, 2006). The Suicide Behaviours Questionnaire (SBQ; Osman et al., 2001) and the Beck Scale for Suicide Ideation (BSS; Beck & Steer, 1991) are two assessment tools that have been created to help in the evaluation of suicidal ideation and behaviours. Psychotherapy and medicine are frequently included in treatment plans for patients who are suicidal (APA, 2013). Antidepressant and antipsychotic drugs are among the psychopharmacological therapies that have been shown to lessen suicide ideation and actions (Kapur et al., 2017). Dialectical behaviour therapy (DBT) was created expressly for people with borderline personality disorder and recurrent suicide behaviours (Linehan, 1993), although cognitive-behavioral therapy (CBT) is beneficial in lowering suicidal ideation and behaviours (Brown et al., 2005).

There is a dearth of research in Pakistan on evaluation techniques and treatment approaches for suicidal individuals. But according to a study by Chaudhry et al. (2018), clinical psychologists in Pakistan frequently assess suicide risk using standardised instruments such the Suicide Probability Scale (SPS; Cull and Gill, 1988) and the Beck Scale for Suicide Ideation (BSS; Beck et al., 1979). The study also revealed that when determining suicide risk, psychologists take into account elements including psychiatric history, a family history of suicide, and recent stressors. In Pakistan, suicidal patients are frequently treated with psychotherapy, medicine, and hospitalisation. According to a study by Naeem et al. (2016), the two psychotherapies for suicidal clients in Pakistan that were used the most commonly were cognitive-behavioral therapy (CBT) and psychodynamic therapy.

The study also found that clinical psychologists typically treat the symptoms of depression and psychosis with medications such antidepressants and antipsychotics. Hospitalisation is another kind of care for suicidal people in Pakistan. According to a study by Khan et al. (2014), hospitalisation was the most common strategy for suicidal clients in Pakistan, especially for those with major suicidal ideation or attempts. During inpatient therapy, patients can receive intense care and help in a safe and organised environment.

Working with people who are suicidal calls for specialised abilities and knowledge. In order to assess and treat people who are at risk of suicide, clinical psychologists use a combination of evaluation instruments, psychotherapy, and medication. In order to promote mental health and well-being, it is important to assist clients in overcoming suicidal thoughts and actions. With an expected 13,337 fatalities from suicide reported in 2020 alone, suicide is a major public health concern in Pakistan (World Health Organisation, 2021). In Pakistan, clinical psychologists are crucial for diagnosing and helping suicidal patients. The diagnostic and treatment methods employed by clinical psychologists in Pakistan when assisting suicidal patients are examined in this qualitative study. The study's goals were to (a) examine and describe the assessment and treatment methods used by Pakistani clinical psychologists when working with suicidal clients and (b) create standards that other mental health professionals could use as a model when working with their own suicidal patients. The following research inquiries were put forth to fill in the information gaps.

1- What diagnostic procedures are clinical psychologists using for Pakistani suicidal clients?

2- How do clinical psychologists conduct therapeutic assessments on suicidal clients?

3- What therapeutic approaches do Pakistani clinical psychologists use for suicidal clients?

Method

Research design

The phenomenological research design was used to explore and describe Assessment and Treatment Strategies used by Clinical Psychologists while dealing with Suicidal Clients. The design was used to explore the experiences particular to Pakistani culture and understand the phenomenon in question. The interpretative phenomenological framework (IPA) approach was used with an ideographic focus to gain insight into the clinical psychologist's experiences and develop the framework of reference to assist mental health professionals in dealing with suicidal clients.

Sample Recruitment and Participant Characteristics

Purposive sampling was used to recruit suitable participants for the phenomenological exploration of religious orientation. Through deviant case sampling techniques, those participants were selected for voluntary participation in the study who: (a) were MS or Ph.D. in clinical psychology, (b) who had at least two years of experience in the field, (c) who were residents of Lahore, Pakistan (d) who handled at least two suicidal clients in their careers. According to Creswell (2012), the sample size in phenomenological research can range from 2 to 25 participants, and the recruitment of samples depends on homogeneity among participants. Therefore, recruiting a sample of homogenous participants is fundamental to better participants' overall perception of lived experience in an IPA approach. Therefore, the sample comprised ten clinical psychologists with no specific age range from Lahore, Pakistan.

Data Collection Tools

Demographic Information Sheet

The researcher developed a demographic information Sheet to record the participant's personal information, including their name, age, gender, academic qualification, years of practice, number of suicidal clients handled, and socioeconomic status.

Semi-structured Interview Questionnaire

The researchers developed a Semi-Structured Interview Questionnaire to conduct an in-depth face-to-face interview with the participants. The questionnaire contained open-ended questions on the experience of clinical psychologists while dealing with suicidal clients. During the interview, participants were asked to report, "How would you describe yourself as a clinical psychologist," "What are your professional experiences while dealing with a suicidal client," "In your opinion, what are the main factors that contributed to suicidal behavior in Pakistani psychologically disturbed clients?", "how do you assess suicidal behavior in the client?", "What are the therapeutic strategies you use to deal with suicidal clients" and "What measures should be taken to prevent suicidal behavior in clients."

Procedure

Initially, approval was taken from the Ethical Review Board of the Humanities Department of COMSATS University, after which the 10 participants who fit the study profile were selected through purposive sampling. Participants were asked for voluntary participation in the study, and their written consent was taken after providing them with informed consent. They responded to the demographic information sheet. Next, an in-depth face-to-face interview was conducted with each participant regarding their experiences with suicidal clients. The Interviews were taken in a separate and safe space to maintain the participant's confidentiality. A semi-structured interview focused on the emotional impact of experiences of suicidal clients on participants. The researchers conducted the interviews to gain deep insight into the phenomenon under study. The interviews mainly lasted for one or one and half-hour. Discussions were audio-recorded with the participant's permission, and transcripts were developed through the audio for analysis. All the participants were given random names to maintain their confidentiality, such as MG, SH, WA, LM, HA, AH, SS, KS, US, and ST. The transcripts were further analyzed through the Interpretive Phenomenological Approach to form emerging themes.

Data Analysis

The interviews were transcribed verbatim, and the analysis was based on the Interpretive Phenomenological Framework (IPA). At the initial stage, transcripts were read multiple times, and the audio was listened to a few times. The researchers noted their significant observations where distinctive phrases and emotions were highlighted and converted into codes. In the second stage, transcripts were transformed into emerging themes, where researchers worked on their detailed and comprehensive notes taken from the transcripts. These notes converted into codes were then transformed into emerging themes called subordinate themes. Researchers determined relationships between the emerging themes at the third stage, grouped them based on conceptual similarities, and named each cluster. These clustered themes were named superordinate themes, and a list of subordinate and superordinate themes was formed.

Ethical Considerations

The Ethical Review Board initially approved a synopsis of this study of the Humanities Department, COMSATS University Islamabad, Lahore Campus. Informed consent was provided to each participant, including a detailed description and purpose of the study, the time to complete the interview, and the potential benefits of their participation. Participants were assured of confidentiality while reporting their discussions in the research and disseminating the results. The interviewer monitored how it affected the participants to take preventive measures against emotional harm throughout the interview. Participation in the study was voluntary, and they had the right to withdraw from the interview whenever they felt it was given.

Results

Table 1. *Individual features of the Participants (N=10).*

No	Name	Gender	Academic Qualification	Years of Practice	No. of suicidal clients handled
1	MG	Female	MSC, ADCP, MS, PHD	19	300+
2	SH	Female	MS Clinical Psychology	9	4
3	WA	Female	MS Clinical Psychology	3	2
4	LM	Female	MS Clinical Psychology	7	10
5	HA	Female	MS, ADCP, PHD	17	100+
6	HI	Female	MS Clinical Psychology	6	12
7	SS	Female	MS Clinical Psychology	8	5-7
8	KS	Female	MS Clinical Psychology	11	8-10
9	US	Male	MS Clinical Psychology	15	8-10
10	ST	Female	MS Clinical Psychology	5	3-4

Table 2. *Transcription of verbatim and conversion into codes (N=9)*

First of all, we assess the level of suicidality in which we determine whether the client is having suicidal thoughts currently or had in the recent past. A complete history of the client is taken, and the timeline is checked to determine whether suicidal thoughts persist, how often suicidal thoughts occur, and the severity of thoughts **(HA).** The client's symptoms are assessed; prevalent stressors and the client's functional level are assessed (**KS).** The family and client history information is taken **(LM).** I Assess suicidal behavior in clients through complete history taking **(US).**	History Taking
When dealing with risky clients, as clinical psychologists, we ask open and close-ended questions from the clients **(HI).** I ask questions that give me insight into their behaviors, thoughts, and life approaches. Their verbatim tells a lot **(KS)**	Open and Close-ended questioning
It is assessed whether the client is planning to commit suicide. Do they plan to kill him? Has he thought about all the details of how to kill himself? Or is he only having vague thoughts? Then we must check whether he is planning ands the material to execute his plan is available. **(HI).** After assessing the client's plan, the third important thing is the intention to die. Many clients think of dying but don't intend and don't want to die. Assessment of all these three levels gives us a description of the risk factors. Some clients have suicidal plans, so we refine our questions to know their plans **(KS).** I assessed clients' recent behaviors, the number of suicidal attempts, and suicide threats **(LM).** The	Suicide Risk Assessment

suicidal risk assessment scale is used. Then, the biopsychosocial model is followed to identify stressors r factors leading to suicide **(HA).**	
There are many dimensions of clinical psychology. As a clinical psychologist, I mostly do psychodiagnostic assessments; based on that, I diagnose the client, then go on with the client, and therapy starts. I play three roles as a psychologist **(HA).** Multiple psychometric tests are applied to assess them **(HI)**. SASII is a comprehensive interview tool, BSI scale and BDI can also be helpful for assessment. Along with a detailed Clinical Interview **(ST).** In the formal assessment, we have multiple tools like CBT-based assessment scales (schemas, etc.) Beck inventories and suicide assessment inventories to assess suicide **(WA).** Assessment is done through Risk assessment methods/guidelines. Secondly, the intensity and impairment are accessed through the Beck Suicidal Intent Scale, Beck Suicidal Ideation Scale, Beck Depression Inventory, and Beck Anxiety Inventory **(US).**	Psychometric Tests
I have seen suicidal clients in the emergency ward of my hospital, where some had drunk acid, some had cut their wrists, some had jumped, and others had come in Infront of fast-running cars. Every client has their way and intensity of committing suicide **(MG).** The client's body language also explains their behavior **(HI)**. The client is kept in 24-hour observation, which helps us, the psychologist, in our observation **(LM).** We would see physical traces of attempts on the body if the client committed suicide in the past. If the client's severe suicidality, we admit him for 24/7 supervision and observation **(WA)**. Suicidal clients must undergo long-term treatment to improve; psychologists make them write thought diaries to assess and change their thought processes. Many clients report their suicidal ideation or attempts after 5 to 6 sessions. I make client's activity schedule and teach them to maintain a thought diary for their written catharsis and assess them in this way **(HI)**. We make thought process forms that help assess suicidal ideation in clients **(SS)**. Informally, based on their thoughts, we ask questions according to DSM criteria to reach a diagnosis **(WA)**	Observation Thought Diaries
I will say that there is no one factor, but there are many causes of suicidality. The leading cause is that the person is depressed. In mild, moderate, and severe depression, the chances of suicidality increase. The main factors behind depression are loss and genetic factors, and socioeconomic factors lead to emotional problems, which lead to psychiatric problems. Often, economic and social pressures lead to depression, which ultimately affects the suicide level. Therefore, the leading cause is depression, where any issue will likely be suicidality. Other disorders have associated symptoms of suicidality, like schizophrenia, delusion disorder, anxiety disorders, and mania **(HA).** It depends on the psychological disorder with which the suicidal behavior is associated; I have experienced that the attempts of some suicidal clients are merely non-suicidal self-injuries (NSSI), but sometimes these attempts can be chronic as well. In most cases, suicidal attempts are associated with major depression and bipolar disorder. **(MG).** Depression compels a client towards suicide; people should know what anxiety and stress are and how they affect physical and mental health **(HI)**. According to research, severe depression is the main factor contributing to suicidal thoughts, and personality factors may also be involved in suicidal behavior **(LM)**. However, the most potent risk factor is if that person has committed or attempted suicide. Suppose somebody has a history of suicide; even once, the probability of suicide is very high **(HA)**. One of my clients had the habit of cutting her wrist in anger; once she cut her wrist deep, she immediately died. Although she did not intend to die, she did this to take out aggression and seek attention and sympathy **(MG)**. While dealing with suicidal clients and people who deliberately harm themselves, my experience is that they mostly lack connection with their social world. They undergo a psychological constriction phenomenon that does not allow them to see and explore possibilities **(SH)**. Many patients have depression-associated suicidal behavior with multiple attempts and ideation. If they had committed suicide in the past, we assess entirely that. Then the precipitating factors are assessed informally **(WA)**. I think it depends on the psychosocial factors that contribute to suicide. Moreover, economic stability and educational or health policies lead to this problem **(HA)**. The prominent factors are relationship issues, attentional deprivation from family, attention-seeking, emotional pain confusion, social isolation, teenage issues, financial issues, and considering death better than life. Social factors include addiction, marital issues, aggression, and disturbed interpersonal relations. In suicidal women, the	Mental Health issues Prior History Psychosocial Issues

factor is emotional and sexual infidelity by the husband **(HI)**. Most students come to us with stress, social pressures, relationship issues, and psychosocial factors, including obsessive behaviors **(KS)**. Stressors in life and relational breakups **(LM)**. Interpersonal, financial, and relationship-related issues are the main reasons for self-harm and the Enmeshed family system and financial issues **(SS)**. Especially during adolescence, you do many things to get into a group or become famous. You do many Attention-seeking things to attain a specific image, and if you can't attain that, you commit suicide **(KS)**. Any incident, death of loved ones, and hopelessness. Failure is one of the problems because there are many comparisons here. Not having a good environment at home, and if you are facing circumstantial crises and your problem-solving skills are not suitable, you feel hopeless and helpless **(SH)**. Life stressors, disturbed relationships, early childhood adverse experiences, poor relationships with parents, strained family environments, financial issues, multiple breakups, trust issues, and personality traits are significant factors contributing to suicide **(WA)**. Factors include forced marriages, Pressure on men to earn beyond their capacities. They are conditioned to bear responsibilities from a young age. Women are pressured to stay in abusive marriages and tolerate marital rape. If men cannot earn well, they question their abilities. A rape survivor who has been through trauma believes it was her fault. Stress, Depression, End of relationship, Divorce, Physical or Sexual Abuse, Financial Issues, and Death of Loved Ones **(US)**.	
The one main reason for suicide is hopelessness. In suicidal cases, you find a cluster of symptoms, as Beck has given the concept of the unfavorable triad; everything seems black and gloomy **(HA)**. Hormonal changes in pregnancy, postpartum depression. People with severe physical illness also try to end their lives, and all these factors lead to negative thinking in clients **(KS)**. I assess the triggering factors behind suicide, including listening to sad music **(HI).** Excessive/over-consciousness regarding others' perceptions and rigid mindsets. The cognitive triad plays an important role. If it involves a cognitive triad, then there are many chances the patient can go towards suicidal ideation. Sometimes your thoughts have become so negative, and your frequent attempts are due to such thoughts **(ST)**. Low tolerance, frustration, and emotional disturbance contribute to suicide **(WA).**	Cognitive factors
I follow CBT, where cognitive restructuring is taught to the clients **(KS).** I give homework assignments to my clients. I make them engage in social activities, and all these techniques have been successful until now. I also teach my clients thought control techniques **(HI)**. I teach my clients problem-solving skills and apply cognitive behavior therapy using cognitive restructuring. I try to listen to the clients attentively, psycho-educate them and give them homework assignments for the next session **(LM)**. First, we must see the risk factor and then deal with CBT. If the thought process changes, half of the things will be sorted because these patients are often depressed, and behavioral management is also done **(SS)**. We use different techniques, including schema modification and cognitive restructuring. We use CBT techniques like deep breathing for stress reduction and relaxation exercises for stress release **(WA)**. We make a behavioral contract with the client in behavioral therapy. We teach them how to delay their urges to commit suicide. We also provide them emotional support on call in case of an emergency. We suggest physical exercise, walking, conversation with loved ones, and distraction techniques. We ask them to identify their reasons for living and make them realize they have reasons to live **(MG).** Before dealing with suicidal clients, first, we set goals and then develop a plan for the client.	Cognitive Behavior Therapy
I use Dialectical behavior therapy; although It is for borderline personality, its skills benefit depressed patients. Because one has to encounter painful events in life, we teach clients how to manage themselves when encountering stress (HA). I have adapted dialectical behavioral therapy for my suicidal client to manage their emotions (MG). I use Dialectical behavior therapy to give clients insight into their emotions and train them how to manage them (LM). We should focus on emotion management and developing problem-solving skills (US). Dialectical Behavior Therapy	Dialectical Behavior Therapy
I use mindfulness-based cognitive therapy as well (MG). Acceptance and Commitment Therapy (ACT) encourages people to embrace their thoughts and feelings rather than fighting or feeling guilty for them. Paired with mindfulness-based therapy offers clinically effective treatment. After all: Running away from any problem only increases the distance from the solution, and the easiest way to escape from the problem is to solve it. Medical conditions such as anxiety, depression, OCD, addictions, and substance abuse can benefit from ACT and Mindfulness-Based Cognitive Therapy (SS).	Mindfulness-Based Cognitive Therapy

I am probably an integrative interventionist. I select the therapy, techniques, and goals according to my client's needs. I use psychoeducation, skills training, and emotional regulation. There are so many valuable skills (HA). I teach clients Stress tolerance to work on their negative self-image first. Schema-focused and Cognitive Behavior Therapies are also eclectic approaches in cooperating with different techniques according to the client's needs. I use acceptance as a technique; I build rapport in two to three sessions and use active listening (MG). Initially, I don't start direct therapeutic work with them. I focus on rapport-building, take the client into confidence, and then develop insight into the client by applying the bio-psychosocial model (HI). I teach clients management skills to cope with their anxiety or any due to which they suffer. I have clients with suicidal attempts or ideation that are not very severe. Therefore, it is manageable with counseling; stress management training should be given at every level (KS).	Eclective Approach
While sitting with my client, my main goal is to help and understand them **(HA)**. I show empathy. Mental health professionals should be curious to gain more and more insight into the client's problem. The suicidal patient does not even talk at times **(MG)**. I show empathy and engage clients in catharsis individually and in group sessions **(US)**. I deal with my clients, showing empathy; therefore, I keep myself and my emotional state stable to deal with the Client **(HI)**. As a clinical psychologist, I empathize with and understand people to help them. I empathize with the client, show sympathy, and understand their feelings **(KS)**. Being empathetic is the central core of being a clinical psychologist or psychiatrist. In Repo-building, we show unconditional regard to the client, listening to them attentively or doing supportive work **(LM)**. You must be empathetic, deal with clients' stressors, and give them positive energy to resolve their issues. I give the client unconditional positive regard, which helps a lot. First, we make the client comfortable for disclosure, show empathy, help them look for possible solutions to the problem, and explore the resources within to deal with the problem while giving them unconditional positive regard (**WA)**.	Empathy and Unconditional Positive Regard
Clients come to us seeking therapy, but their family members do not know anything about it. Therefore, depending on the level of suicidality, you have to engage the client's family in the intervention and plan to prevent the client's suicide. Many clients refuse to cooperate and engage their families in their therapeutic process **(HA)**. Suicidal clients do not get emotional support from their families, so they come to us professionals for that. Their families do not understand their psychological issues and need counseling **(MG)**. We do alert their family to look after them. The experience of treating a suicidal client is challenging **(HI)**. Clients with a severe level of suicide need too much attention. I have to help family or friends and develop an intensive care program depending on the severity of their problem. The preventive measure against suicide includes parental psychoeducation **(KS)**. I involve the client's family and psycho-educate them **(LM)**. If a patient has suicidal ideation, there are chances of self-harm, so we must involve the family with permission because it can become life-threatening **(ST)**. We must be very alert; even I ask the family to be alert. Then, we extend family support to the client by psych-educating the family **(WA)**. We do psychoeducation and counseling for their family members **(US).**	Family Counseling
Most of the time, one has to refer the client to a psychiatrist for necessary medications at a severe level of suicidality **(HA)**. I recommend two weeks of psychiatric medication and then psychotherapy in severe cases. You must see how you can best serve your client **(MG)**. Refer them for medication in severe cases before counseling **(KS)**.	Psychiatric Medication
I bring my clients towards activities that are relaxing and helpful. The more a human stays alone, the more he gets depressed **(HI).** I teach relaxation techniques to clients to reduce stress **(KS)**.	Relaxation Training

Table 3. *Qualitative analysis of the Clinical approach of Clinical Psychologists treating suicidal clients (N=9)*

Codes	Subordinate Theme	Superordinate Theme
History Taking Open and Close-ended questioning Suicide Risk Assessment Psychometric Tests	Formal assessment	Diagnostic Procedures
Observation Thought Diaries	Informal Assessment	
Mental Health issues Prior History	Assessing Risk Factors	Therapeutic Assessment
Psychosocial Issues Cognitive factors	Assessing Triggering Factors	
Cognitive Behavior Therapy Dialectical Behavior Therapy Mindfulness-Based Cognitive Therapy Eclective Approach	Cognitive and Behavioral Therapies	Therapeutic Approaches
Empathy and Unconditional Positive Regard Family Counseling Psychiatric Medication Relaxation Training	Supportive Therapies	

Theme 1. Diagnostic Procedures

Clinical psychologists use a rigorous diagnostic procedure to determine the client's risk of suicide when treating suicidal patients. The two subordinate topics of formal assessment and informal assessment can be separated from this superordinate theme. The first stage of the evaluation process is known as "formal assessment history taking." The therapist gathers information about a client's personal and medical history, including any prior suicide attempts. With the use of these data, the doctor can develop an effective treatment strategy and gain valuable insight into the client's suicide risk. Open-ended and closed-ended questions are another interviewing method that uses structured interviews. It is used to find out more about the client's current mental state and any stressors that may have recently occurred and contributed to their suicidal thoughts. These questions can help the therapist get to know the patient better and establish a safe space for them to share their emotions. "Suicide Risk Assessment" is a word that describes. To assess the client's overall mental health and welfare, standardised psychological tests—also referred to as "psychometric tests"—are employed. These examinations can help the doctor ascertain whether the patient's suicidal ideas are being influenced by any underlying psychological or mental conditions.

Clinical psychologists' treatment methods for suicidal patients also include a non-formal diagnostic procedure to determine the client's risk of suicide. During therapy sessions, the clinician's capacity to notice the client's behaviour, body language, and emotional state is referred to as observation. This can give important insights into the client's emotional state, amount of suffering, and any possible suicidal ideation triggers. Another term for a specific method used in cognitive-behavioral therapy (CBT) to assist clients in recognising and challenging the negative thinking patterns that are fueling their suicidal ideation is thought diaries. This method is having the client keep a daily journal of their thoughts and feelings, using that information to spot and correct any negative or skewed thinking.

Theme 2. Therapeutic Assessment

A subordinate feature of therapeutic assessment is a collaborative and non-pathologizing approach to evaluation and treatment planning. It entails collaborating with the client to pinpoint their assets, resources, and any potential roadblocks to recovery. Finding factors that might make a client more likely to commit suicide is the focus of the secondary theme of risk assessment. Risk factors include a history of suicide behaviour, mental health issues, substance misuse, and social isolation may fall under this category. Mental

Health Issues, such as depression, anxiety, or bipolar disorder, are distinct mental health conditions that may be linked to the client's suicide thoughts or actions. In order to build a specialised treatment plan, it is essential to comprehend the client's particular mental health difficulties as part of the therapeutic assessment process. Another category that denotes the client's prior history of suicidal behaviour, including any prior attempts or hospitalisations, is "previous history." The formulation of a safety plan using this information can help reduce the client's risk of suicide and help stop current suicidal behaviour.

Another subordinate subject is Assessing Triggering causes, which entails determining the precise causes that cause the client's suicidal thoughts or actions. This may involve cognitive variables like hopelessness, pessimism, or negative self-talk as well as psychosocial problems including interpersonal conflict, financial hardship, a history of trauma, and cognitive concerns like financial stress. The term "psychosocial issues" refers to the different social and environmental aspects that the client's suicidal thoughts or actions may be caused by. Relationship issues, financial stress, or a lack of social support are a few examples of these. The client's risk of suicide may be decreased by identifying and addressing these psychosocial concerns as part of the therapeutic assessment process. Another code, "Cognitive Factors," refers to the precise cognitive processes and patterns that the client's suicidal thoughts or behaviour are influenced by. These could include self-deprecating thoughts, emotions of hopelessness, or sentiments of unworthiness. The client's risk of suicide may be decreased by recognising and addressing these cognitive elements as an integral component of the therapy assessment process.

Theme 3. Therapeutic Approaches

The therapeutic approach is a subordinate subject that encompasses many therapeutic methods and strategies to lessen suicidal thoughts and actions. A variety of cognitive, behavioural, and psychosocial interventions may be a part of these strategies. A secondary subject that focuses on employing cognitive and behavioural interventions to assist lessen suicidal thoughts and behaviour is cognitive and behavioural therapies. The following codes could fall under this: The goal of cognitive behaviour therapy (CBT) is to recognise and alter harmful thought and behaviour patterns. CBT may be used to assist clients in recognising and challenging harmful thoughts and beliefs that support suicidal ideation in the setting of treating suicidal clients. A form of therapy called dialectical behaviour therapy (DBT) focuses on enhancing emotional control and discomfort tolerance. Clients who struggle with deep emotional experiences and are more likely to act suicidally may find DBT to be especially helpful. A form of therapy called mindfulness-based cognitive therapy (MBCT) combines cognitive therapy methods with mindfulness approaches. By raising clients' awareness of their thoughts and feelings and assisting them in creating more adaptable methods to deal with these experiences, MBCT may help decrease suicidal thoughts and behaviour.

The term "eclectic approach" refers to a variety of therapy modalities used to treat suicidal patients. The use of a combination of therapies to address the numerous causes of suicidal ideation and behaviour may be part of this strategy, which may also involve treating each client according to their unique needs. The term "Supportive Therapies" refers to interventions that offer psychological and practical help to people with mental health issues as part of the superordinate theme that has been defined. The management of medications, counselling, and psychotherapy are a few examples of supportive therapies. Empathy and Unconditional Positive Regard, Family Counselling, Psychiatric Medication, and Relaxation Training are the four codes that have been identified to study the idea of supportive therapies. These codes stand for various supportive therapies that specialists in the field of mental health may employ to treat their patients. Referring to therapists' supporting behaviour towards their patients, empathy and unconditional positive regard are used. This entails listening to the client's experiences and feelings without passing judgement or offering criticism. Working with the family of a person who has a mental health illness is a component of the therapy practised as family counselling. The family unit may benefit from this strategy's improved communication, comprehension, and support. Medication used to treat mental health disorders is referred to as psychiatric medication. These drugs can be combined with various therapeutic modalities and are normally recommended by a psychiatrist or other medical specialist. Individuals can learn relaxation techniques, such as progressive muscular relaxation, deep breathing exercises, and meditation, through relaxation training.

Discussion

Understanding the treatment strategy employed by Pakistani clinical psychologists in treating suicidal clients is crucial because suicide is a serious public health issue in that country. A number of crucial elements go into the clinical approach to treating suicidal patients, including diagnostic techniques, therapeutic assessments, and therapeutic strategies.

The initial stage in treating suicidal patients is diagnostic procedures. Clinical psychologists in Pakistan frequently assess clients' suicide risk using formal measures like the Suicide Probability Scale (SPS) and the Beck Scale for Suicide Ideation (BSSI) (Aslam et al., 2018). In order to evaluate clients' mental health and pinpoint suicide risk factors, other techniques like history-taking, open- and closed-ended questioning, and psychometric testing may be used (Ali et al., 2017).

In therapeutic evaluation, risk factors for clients are assessed, and any psychosocial or cognitive issues that contribute to suicide thinking and behaviour are addressed. Clinical psychologists in Pakistan may examine a client's mental health problems and history of suicidal thoughts or attempts in order to better understand their requirements and create a suitable treatment plan (Bano et al., 2018). In order to pinpoint the areas where therapies may be most successful, clinical psychologists may also evaluate the triggering factors of their clients, such as psychosocial and cognitive components (Rana & Khan, 2019).

Clinical psychologists in Pakistan may utilise cognitive and behavioural therapies, such as dialectical behaviour therapy (DBT) and cognitive-behavioral therapy (CBT), to treat suicidal clients. While DBT emphasises developing skills for emotional regulation and distress tolerance, CBT concentrates on identifying and altering negative thought and behaviour patterns (Siddiqui et al., 2020). According to Aslam et al. (2018), mindfulness-based cognitive therapy (MBCT) may also assist patients in being more aware of their thoughts, feelings, and reactions to their experiences.

Limitations and future suggestions

This study has some limitations, including self-selection bias, where the participants may have had specific interests or experiences related to working with suicidal clients, which could have influenced their responses and could limit the generalizability of the findings firstly. Secondly, the data collected relied on self-reports from the participants, which may be influenced by social desirability bias, recall bias, or the lack of awareness of their own biases. Lastly, the study was conducted in a specific region with a specific population, which may not represent all clinical psychologists working with suicidal clients leading to a lack of diversity.

Future studies should replicate this study with larger samples to increase generalizability and ensure the findings are robust and reliable. Studies should also aim to include diverse samples of clinical psychologists working with suicidal clients, including different regions, countries, and populations, to ensure that the findings apply to different contexts and cultures. Researchers could use a mixed-methods design to collect qualitative and quantitative data to provide a more comprehensive understanding of clinical psychologists' assessment and treatment strategies. Future studies could also explore the effectiveness of the assessment and treatment strategies identified in this study through empirical research to establish their validity and reliability.

Conclusion

The clinical approach of Pakistani clinical psychologists in treating suicidal clients involves diagnostic procedures, therapeutic assessment, and therapeutic approaches such as cognitive and behavioral therapies. Understanding the clinical approach used by Pakistani clinical psychologists can help to develop effective interventions and promote suicide prevention efforts in Pakistan.

Declarations

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Conflicts of interest: The authors have no conflict of interest to declare.

Ethics approval: The study was conducted after the approval of the Ethical Review Board of COMSATS University, Lahore, with Ref. No. CUI/LHR/HUM/0285 on April 20, 2022.

Availability of data and material: Already included in the manuscript.

Code availability: Not applicable

Authors Contribution

All authors made substantive intellectual contributions to this study to qualify as authors.

Dr. Muneeba Shakil conceived the idea, designed the study, and performed the statistical analysis. She also wrote an initial draft of the manuscript.

Ms. Khola Rao designed the study, collected data, re-drafted manuscript parts, and helped with Statistical Analysis.

All authors were involved in writing the manuscript. All authors have read and approved the final manuscript.

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