Working With Suicidal Patients: What’s New and Why It’s Important

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The Menninger Clinic
Baylor College of Medicine

2011 Texas Suicide Prevention Symposium
June 16, 2011
Take-home Messages

- This is important work.
- It’s a very tough job.
- Special preparation is needed.
- New, useful tools are becoming available.
## Federal Research Funding

<table>
<thead>
<tr>
<th>Cause of Death</th>
<th>Deaths/yr (2007)</th>
<th>2010 NIH Research Funding (millions/yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>3,447</td>
<td>$292</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>11,295</td>
<td>$3,086</td>
</tr>
<tr>
<td>Parkinson’s Disease</td>
<td>20,058</td>
<td>$166</td>
</tr>
<tr>
<td><strong>Suicide</strong></td>
<td><strong>34,598</strong></td>
<td><strong>$37</strong></td>
</tr>
<tr>
<td>Breast cancer</td>
<td>40,970</td>
<td>$741</td>
</tr>
<tr>
<td>Diabetes</td>
<td>71,382</td>
<td>$1,052</td>
</tr>
</tbody>
</table>
There is a general perception in the field that generic training is adequate preparation for working with suicidal people, that no special preparation is needed. This view is reflected in graduate training curricula and in the relative lack of standards for provider competencies in mental health service organizations. Yet these are the patients in greatest need, and the implications are life-and-death, and suicide science tells us we can do better. How can we account for this disconnect?

One (though not the only) contributor is a general lack of awareness of options. Hence, today’s program...
It seems pertinent to raise a countertransference issue that many interviewers do not like to admit, but one which I think is present in most of us. Namely, if we uncover serious suicidal ideation, we are potentially creating a mess for ourselves.

Shawn Shea, M.D.

*Psychiatric Interviewing: The Art of Understanding*
Countertransference and Suicide

Anxiety/avoidance  I don’t accept suicidal patients into my practice.

Hopelessness  If a person’s really intent on killing himself, there’s nothing you can to do stop him.

Contempt  If I were him, I’d kill myself, too.

Disdain  It wasn’t serious – just a manipulative gesture.

Hostility  Maybe he’ll get it right the next time.
Clients seem to be able to sense when a clinician is comfortable with the topic of suicide. At that point, and with such a clinician, clients may feel safe enough to share the immediacy of their pull toward death.

Shawn Shea, M.D.
The Practical Art of Suicide Assessment
Another consideration:

To be in a position to help the suicidal patient, the clinician must manage negative emotions, and this requires cultivating understanding of and *empathy for the suicidal wish*...
…there’s nothing to be done. I can’t think, I can’t calm this murderous cauldron, my grand ideas of an hour ago seem absurd and pathetic, my life is in ruins and – worse still – ruinous; my body is uninhabitable. It is raging and weeping and full of destruction and wild energy gone amok. In the mirror I see a creature I don’t know but must live and share my mind with.

I understand why Jekyll killed himself before Hyde had taken over completely.

I took a massive overdose of lithium with no regrets.

Take-home Messages

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- It’s a very tough job.
- Special preparation is required.*
- New, useful tools are becoming available.
Suicide as a Public Health Problem

- Close to 1 million suicide deaths worldwide per year (more than homicide and war combined)
- More than 30,000 deaths per year in U.S. (3 per hour)
- 11th leading cause of death in U.S.
- 50% more suicide deaths than homicides
- 50% more suicide deaths than AIDS
- Approx. 1.1 million suicide attempts/yr in U.S. (2 per minute; SAMHSA, 2009)
Suicide Rates: U.S. vs. Texas

The graph shows the suicide rates per 100,000 people annually from 1992 to 2006 for the United States (US) and Texas. The US rates generally trend downwards, while Texas shows some fluctuation but remains higher than the US throughout the period.
## Closer to home...

<table>
<thead>
<tr>
<th>City</th>
<th>2004 # deaths</th>
<th>2004 Rate</th>
<th>2005 # deaths</th>
<th>2005 Rate</th>
<th>2006 # deaths</th>
<th>2006 Rate</th>
<th>Avg #</th>
<th>Avg Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin</td>
<td>87</td>
<td>12.8</td>
<td>94</td>
<td>13.6</td>
<td>104</td>
<td>14.7</td>
<td>95</td>
<td>13.7</td>
</tr>
<tr>
<td>Dallas</td>
<td>116</td>
<td>9.6</td>
<td>94</td>
<td>7.7</td>
<td>96</td>
<td>7.8</td>
<td>102</td>
<td>8.4</td>
</tr>
<tr>
<td>El Paso</td>
<td>43</td>
<td>7.3</td>
<td>46</td>
<td>7.7</td>
<td>54</td>
<td>8.9</td>
<td>48</td>
<td>7.9</td>
</tr>
<tr>
<td>Ft. Worth</td>
<td>54</td>
<td>9.0</td>
<td>44</td>
<td>7.1</td>
<td>66</td>
<td>10.1</td>
<td>55</td>
<td>8.7</td>
</tr>
<tr>
<td>Houston</td>
<td>256</td>
<td>12.3</td>
<td>230</td>
<td>10.9</td>
<td>195</td>
<td>9.1</td>
<td>227</td>
<td>10.7</td>
</tr>
<tr>
<td>San Antonio</td>
<td>114</td>
<td>9.2</td>
<td>141</td>
<td>11.2</td>
<td>147</td>
<td>11.3</td>
<td>134</td>
<td>10.6</td>
</tr>
</tbody>
</table>

Rates are crude (unadjusted) deaths/100,000/yr.

Source: Texas Dept of State Health Services (2009).
Suicide Trends in the Military

Source: U.S. military branches (2001–09) and Centers for Disease Control and Prevention via APA Monitor on Psychology, September, 2010
Take-home Messages

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Special preparation is required.
New, useful tools are becoming available.
Patient Suicide as Occupational Hazard for Clinicians

More than half of psychiatrists and 20% of psychologists report having lost at least one patient to suicide. Between 20% and 50% of trainees report losing a patient to suicide during internship or residency. Research shows that suicide is the #1 source of stress for therapists (the emotional impact of a patient’s suicide is comparable to the death of a family member).
Prediction of Suicide

Studies have consistently failed in efforts to statistically predict suicide on an individual basis. Prediction via clinical assessment is equally problematic. Busch (2003) study of 76 inpatient suicides: At last communication, 77% denied suicidality; 28% had no-suicide contracts.
More bad news...

- Studies have consistently shown that most mental health professionals are seriously underprepared to assess and treat suicidal patients.

- Ellis & Dickey (1998): While >90% of residency programs addressed suicide risk in some fashion, only 28% provided skills training (cp. learning to play piano from a book on music theory).

- Melton & Coverdale (2009): Half or more of chief residents reported a need for greater exposure to a variety of topics regarding suicidal patients.
Treatment of Suicidal Patients

- Considering the size of the problem, there are remarkably few randomized controlled trials of psychosocial treatments for suicidal patients.
- Compared to the hundreds of outcome studies on anxiety and mood disorders, only 40 RCTs have been conducted focusing on suicidal behavior as an outcome.
- Upshot: We have remarkably little empirical evidence that our interventions actually reduce suicides.
Take-home Messages

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What’s new?

Competencies
Risk factors vs. warning signs
Growing consensus on no-suicide contracts
Identification of cognitive vulnerabilities
Development of empirically-supported, suicide-specific therapies
What’s New #1

Competencies for Care Providers
Competencies

- Derived by expert consensus (2004)
- Sponsored by the American Association of Suicidology
- Designed to facilitate training, consistent with the National Strategy for Suicide Prevention from the U.S. Surgeon General’s office
Identified Competencies

- Basic knowledge about suicide (4)
- Basic attitudes and approach (4)
- Collecting accurate assessment information (5)
- Formulating risk (2)
- Developing an intervention plan (3)
- Managing care (3)
- Understanding legal and liability issues (3)
For more information about competencies in suicide risk assessment and intervention:

American Association of Suicidology
www.suicidology.org

Suicide Prevention Resource Center
www.sprc.org
What’s New #2

Risk Factors vs. Warning Signs
Psychopathology as Risk Factor for Suicide

- About 1.4% of deaths overall are self-inflicted.
- Suicide rates for various psychiatric disorders range as high as 10-15%.
- Suicide is associated with psychiatric disorder in at least 90% of cases.
- About half of people who die by suicide are in treatment.
## Psychopathology as Risk Factor for Suicide

SMR (Standardized Mortality Ratio) for Psychiatric Disorders

<table>
<thead>
<tr>
<th>Condition</th>
<th>SMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depression</td>
<td>20</td>
</tr>
<tr>
<td>Anorexia nervosa</td>
<td>23</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>9</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>8</td>
</tr>
<tr>
<td>Prior suicide attempt</td>
<td>38.4</td>
</tr>
</tbody>
</table>

*Harris & Barraclough (1997)*
Predictive of suicide occurring w/i 12 mos. vs. later suicides in 10-yr study:

- Severe psychic anxiety (intense and pervasive)
- Panic attacks
- Global insomnia
- Alcohol abuse (moderate-recent onset)
- Agitation (depressive turmoil, incl. mixed dysphoric mania)
- Severe anhedonia

Predictors of Severe Suicide Attempts (N=100)

(Hall, Platt, & Hall (1999), *Psychosomatics*, 40,18-27)

90% severely anxious before
92% insomnia (46% global insomnia)
84% saw MHP in past month
80% panic attacks before
78% relational conflict
68% alcohol/SA
83% no harm contract
Correlates of 76 Inpatient Suicides

- 5-6% of U.S. suicides occur in the hospital
- Only 49% had history of a prior attempt
- 78% denied suicidal ideation at last assessment
- 28% had a no-suicide contract in place
- 79% exhibited severe or extreme anxiety and/or agitation
## Suicide Risk Factors vs. Warning Signs

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Warning Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Current substance abuse</td>
</tr>
<tr>
<td>Age</td>
<td>Agitation</td>
</tr>
<tr>
<td>Race</td>
<td>Anxiety/panic attacks</td>
</tr>
<tr>
<td>Marital status</td>
<td>Social withdrawal</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Insomnia</td>
</tr>
<tr>
<td>Prior suicide attempts</td>
<td>Purposelessness</td>
</tr>
<tr>
<td>Family history</td>
<td>Plans/preparations</td>
</tr>
<tr>
<td>Unemployment</td>
<td>“Desperation”</td>
</tr>
<tr>
<td>Firearms</td>
<td></td>
</tr>
<tr>
<td>Etc.</td>
<td></td>
</tr>
</tbody>
</table>
In other words, warning signs (implying imminent risk) have more to do with the patient’s psychological state than diagnosis or demographics.

A memory device...
A New Mnemonic:  
*IS PATH WARM?*

**I** Ideation/threatened or communicated  
**S** Substance Abuse/excessive or increased  
**P** Purposeless/no reasons for living  
**A** Anxiety, Agitation/Insomnia  
**T** Trapped/feeling no way out  
**H** Hopelessness  
**W** Withdrawal, disconnection from friends, family, society  
**A** Anger (uncontrolled)/rageseeking revenge  
**R** Recklessness/risky acts - unthinking  
**M** Mood changes (dramatic)
For more information about suicide warning signs:

American Association of Suicidology

www.suicidology.org
What’s New #3

Emerging Consensus on No-Suicide Contracts
No-Suicide Contracts

- Psychiatrists who make use of no-suicide contracts: 57%

- Psychiatrists reporting patients who have attempted or died by suicide after agreeing to a no-suicide contract: 41%

No-Suicide Contracts

- Percentage of outpatient therapists using no-suicide agreements: 83%
- Percentage of therapists with no training in use of NSAs: 43%
- Percentage of therapists reporting suicide attempts or deaths by patients while NSA was in place: 31%

Growing Consensus on No-Suicide Contracts

The Case Against No-Suicide Contracts:
The Commitment to Treatment Statement as a Practice Alternative

M. David Rudd  
Baylor University

Michael Mandrusiak  
Baylor University

Thomas E. Joiner Jr.  
Florida State University

.... Our primary conclusion is that no-suicide contracts **suffer from a broad range of conceptual, practical, and empirical problems.** Most significantly, they have no empirical support for their effectiveness in the clinical environment. The authors [recommend] the commitment to treatment statement as a practice alternative to the no-suicide contract.

Problems with the No Suicide Contract

- No scientific proof of effectiveness in preventing suicidal behavior
- Potentially destructive to therapeutic relationship (CYA)
- May lead to patient’s concealment of suicidal ideation and behavior
- May lead to false sense of security in the clinician
- Useless as defense in liability litigation
Alternatives to No-Suicide Contracts

Evolving model:

- A collaboratively developed safety plan
- Specification of what to do, whom to call in a crisis (alternatives to self-harm)
- Family, support system included, where appropriate
- Goal is to promote patient autonomy, facilitate positive coping responses, and prevent hospitalization
Safety Plan Form

A. Warning signs that problems may be developing:
1. _____________________________________________________________
2. _____________________________________________________________
3. _____________________________________________________________

B. Things I can do on my own to cope:
1. _____________________________________________________________
2. _____________________________________________________________
3. _____________________________________________________________

C. Ways I can reach out for help:
People who can help distract me: 1. ___________________________ 2. ___________________________
People I can ask for help: 1. ___________________________ 2. ___________________________
Professionals I can ask for help:
Therapist Name____________________________________
Phone #_____________ Pager # or Emergency Contact #_______________
Other Professional Name____________________________________
Phone #_____________ Pager # or Emergency Contact #_______________
National Suicide Hotline (free 24/7): (800) 273-TALK
Hospital ER ____________________ Address______________________________
Phone #________________________
For More on Safety Planning:

_Cognitive Therapy for Suicidal Patients_
A. Wenzel, G. Brown, & A. Beck
APA Books (2008)
What’s New #4

Cognitive Vulnerabilities
(The Suicidal Mind)
Cognition and Suicide: Research Findings

Cognitive rigidity
Problem-solving deficits
Hopelessness
Dysfunctional attitudes/irrational beliefs
Reasons for living/dying
Low self-esteem
Perfectionism
Rumination
Overgeneral autobiographical memory
Joiner’s Interpersonal Theory

Question: What makes it possible for a person to harm or kill himself?

Desire for death
- Failed belongingness (disconnection)
- Perceived burdensomeness
- [Unbearability]

Acquired capability to self-harm
The introduction of the cognitive model marks a paradigm shift in the study of suicide. For perhaps the first time, thought processes contributing to suicide risk are seen, not only as part of the problem of suicide, but as causal components that may also be targeted as part of a potential solution.

Choosing to Live: How to Defeat Suicide through Cognitive Therapy

Thomas E. Ellis and Cory F. Newman

New Harbinger (1996)
What’s New #5

Development of evidence-based therapies designed for suicidal patients
Conventional Therapy

“When the person is no longer highly suicidal-then the usual methods of psychotherapy...can be usefully employed p. 345).”


Really?
Conventional Therapy
(current standard of care)

- Suicidality viewed as a symptom
- Measures to ensure safety
- Crisis stabilization
- Treat primary disorder
Empirically-supported foci for conventional psychotherapy with suicidal patients

- Effective management of psychiatric illness
- Inspiring hope
- Improving self-esteem
- Enhancing interpersonal relationships
- Cultivating reasons for living (existential issues)
Editorial comment #2:

The problem with conventional therapy with suicidal patients is that, although the patient may feel better, if underlying vulnerabilities are not addressed, the next stressful life event is likely to again precipitate a suicidal crisis.
Suicide-focused therapy

- Suicidality center-stage in treatment
- Emphasis on collaboration, acceptance, and empathy for the suicidal wish (validation)
- Suicidal behavior labeled as a *coping response*
- Intensive training in coping skills
  - Crisis management
  - Emotion regulation
  - Relationship management
- Addressing vulnerability to future suicidal episodes
Empirically Supported Interventions for Suicidal Patients

- Problem-solving Training
- Dialectical Behavior Therapy (DBT)
- Rudd and Joiner’s CBT
- Beck’s Cognitive Therapy for Suicidality
- Mentalization-based Therapy
- Collaborative Assessment and Management of Suicidality (CAMS)
Cognitive-Behavioral Treatment of Borderline Personality Disorder

Marsha M. Linehan
Guilford (1993)
Dialectical Behavior Therapy

Initially designed for patients with borderline personality disorder, but now applied to various disorders.

Employs a combination of cognitive-behavioral and mindfulness/acceptance-based interventions.

Combines group therapy for skills training together with individual therapy (12 mos.).
Treating Suicidal Behavior: An Effective, Time-Limited Approach

Rudd, Joiner & Rajab
Guilford (2004)
Rudd and Joiner’s CBT

- Cognitive-behavioral model of suicidality
- Description of the Suicidal Belief System and “suicidal mode”
- Structured, time-limited protocol (20 sessions)
- Emphasis on skill building and problem-solving
- Promising results in a randomized controlled trial
Cognitive Therapy for Suicidal Patients: Scientific and Clinical Applications

Wenzel, Brown, & Beck
APA Books (2009)
Cognitive Therapy RCT (JAMA)
(Brown, Ten Have, Henriques, Xie, Hollander, & Beck, 2005)

Randomized controlled trial
Enhanced Usual Care (with vs. w/o CT)
N=120 pts with recent suicide attempt
10 sessions of CT, 18-month follow-up
Repeat attempts by 13 pts (24%) in CT group, 23 pts (42%) in control group
Risk of repeat suicide attempts was 50% lower in the CT group (hazard ratio=.51)
Cognitive Therapy for Suicidality
(Brown et al., 2005)
Managing Suicidal Risk
A Collaborative Approach

David A. Jobes
Guilford (2006)
Collaborative Assessment and Management of Suicidality (CAMS)

- A structured approach to risk assessment, including assessment of the nature of psychic distress, reasons for living and dying, treatment goals, and safety planning
- Places particular emphasis on development of collaborative process
- Maintains focus on suicidality and its “drivers” (esp. self-hatred)
### Suicide Status Form III (SSF III) Initial Session

**Patient:**

**Clinician:**

**Date:**

**Time:**

#### Section A (Patient):

Rate and fill out each item according to how you feel right now. Then rank items in order of importance 1 to 5 (1 = most important to 5 = least important).

<table>
<thead>
<tr>
<th>Rank</th>
<th>Item Description</th>
<th>Low Pain</th>
<th>Medium Pain</th>
<th>High Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rate psychological pain (being anxious, stressed, or irritable in your mind; not stress; not physical pain)</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What I find most painful is:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Rate stress (general feeling of being pressured or overwhelmed)</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What I find most stressful is:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Rate agitation (emotional urgency; feeling that you need to take action; not irritation; not annoyance)</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I most need to take action when:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Rate hopelessness (your expectation that things will not get better no matter what you do)</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am most hopeless about:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Rate self-hate (your general feeling of disliking yourself; having no self-esteem; having no self-respect)</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>What I hate most about myself is:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Section B (Patient):

6) Rate overall risk of suicide:

N/A

<table>
<thead>
<tr>
<th>Rank</th>
<th>Low Risk</th>
<th>Medium Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Section C (Patient):

1) How much is being suicidal related to thoughts and feelings about yourself?

2) How much is being suicidal related to thoughts and feelings about others?

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

<table>
<thead>
<tr>
<th>Rank</th>
<th>REASONS FOR LIVING</th>
<th>Rank</th>
<th>REASONS FOR DYING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8: Very much

I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8: Very much

The one thing that would help me no longer be suicidal would be: 

From Managing Suicidal Risk by David A. Jobes. Copyright 2006 by The Guilford Press. Permission to photocopy this page is granted to purchasers of this book for personal use only (see copyright page for details).
CAMS patients reached resolution of suicidality about 4-6 weeks more quickly than treatment as usual patients (Jobes et al., 2003; Wong, 2003)

Figure 1. Estimated proportion of patients in the CAMS and TAU group to remain suicidal as a function of session number.
CAMS-M Outcome Study

- Team of Menninger therapists trained and certified in CAMS
- Small (N=21) feasibility study
- Case series design (nonrandomized)
- Repeated measures to track suicide-specific variables such as hopelessness and suicidal ideation
Outcomes from Menninger Pilot Study of CAMS with Suicidal Psychiatric Inpatients (N=21)
Outcomes from Menninger Pilot Study of CAMS with Suicidal Psychiatric Inpatients (N=21)

SSF "Drivers"

Weekly Evaluations

- Pain
- Stress
- Agitation
- Hopelessness
- Self-Hate
- Prob of Suicide
Discussion

Why are these interventions effective?
Probably a combination of:

- Emphasis on collaborative relationship
- Suicide as focus of therapy rather than symptom
- Training in alternate coping responses (e.g., Coping Cards, Safety Plan, etc.)
- Enhancement of social support
- Problem-solving training
- Addressing cognitive vulnerabilities
So, what’s the bottom line?
Conventional Treatment

- Risk often assessed via risk factors (long-term risk) rather than warning signs (imminent risk)
- Routine use of no-suicide contracts
- Suicidal patients treated essentially the same therapeutically as nonsuicidal patients.
- Suicidality treated as a symptom of Axis I or Axis II disorder, expected to lift as the disorder is treated
- Crisis stabilization, followed by treatment-as-usual
New Paradigm?

• Risk assessment focused on warning signs rather than risk factors
• No-suicide contracts replaced with collaborative safety planning
• Suicidal patients assessed for trait-like vulnerabilities to suicide (e.g., self-hate, low distress tolerance)
• After the crisis is resolved, treatment is focused on those specific vulnerabilities (e.g., trait hopelessness)
• Suicidality viewed as central focus of therapy rather than symptom
Thoughts in closing…

• Don’t be afraid to “go there.” Keep suicidality front and center (and measure regularly).
• Endeavor to work with (not on) the patient around his or her pain, eschewing a struggle over the suicide option.
• Teach patients practical coping skills (insight is not enough).
• Cultivate empathy (rather than judgment) for the suicidal wish (read William Styron or Kay Jamison).
• Practice relapse prevention by anticipating future trigger events.
Thoughts re: professional development

Training opportunities: American Association of Suicidology [www.suicidology.org](http://www.suicidology.org)


Please do not be afraid to ask your patients about their death thoughts…Empathize first, and ask how the suicidal thoughts affected them. Ask for the details…

Keep asking, so that your patient knows you care, you’re willing to hear about this symptom without overreacting to it, and you’re not afraid of it. You might remind them that the decision to die is such an important one, such a final choice, that we want to be sure it is being made wisely and well. Shneidman (1998) offers this maxim: ‘Never kill yourself while you are suicidal’. It is not a decision to be made impulsively, or in an altered state or when one’s brain is ill.

I would add only one important piece: you and your patient are teammates or colleagues in the fight against depression and despair. Your contribution at this empathic juncture requires your active support, your unflagging optimism that pain will pass, your conviction that problems can be managed, and your dogged devotion to the patient. I learned that from experience.

Thank you!