How to Ask the Question about a Client's Wish to Die

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Gaps in Education

- Current suicide rates highlight importance of training and skills in suicide risk assessment and intervention
- Most states (including Wisconsin) do not mandate suicide risk training as part of licensure
- Graduate schools offer little or no preparation to prepare mental health professionals
- Existing trainings often don't cover techniques in how to openly discuss suicide and uncover suicidal thoughts and behaviors

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Beliefs, Biases, Personal/Professional Lived Experience

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Points to Consider

- Examine our biases, fears, personal/professional experiences with suicide
- Recognize power of suicide can bring about strong emotional reactions in most clinicians
- When unrecognized, reactions can drag us into unproductive interventions
- When we understand our attitudes, biases and responses to suicide, we become more available to suicidal client
- Clients sense when clinician is comfortable with topic of suicide and is more willing to share

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Lived Experiences with Suicide

- Influence our professional work with suicidal clients
- Be aware of our reactions and how we manage them
- Lived experience with suicidality?
- Clinician survivor?
- Survivor?
- Learning through others when we have no lived experience

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Professional Self-Awareness

- Uncover/reflect on your biases about suicide
  - Sin or a right?
- What is your attitude toward suicide and suicidal behavior?
  - Wrong vs. permissible?
- Ask yourself questions
  - Should suicide always be prevented?
  - Is suicide selfish, cowardly or courageous?
- May interfere with assessment and treatment

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Right to Die: Do We Have it or Don't We?

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Right to Die…Then

- Life was cherished, gift from God, not an individual choice
- If you have a duty to go on living, despite your better judgment, then your life does not belong to you and you exist by permission, not by right
- Suicidal thoughts come out of mental illness so therefore self-destruction is irrational act
- Suicide is irreversible act so society must protect person from themselves

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Right to Die…Now

- Now more open to suicide: Americans are granted rights to life, liberty and death
- Suicide viewed as moral and rational decision
- Moral right to end your life if you suffer from great pain and foresee no opportunity to improve physical and mental health condition
- Eulogize suicide as the "right to die" and "death with dignity"
- Rationalize and glamorize suicide?

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Do We Have the Right

- Your right to life includes/implies a right to suicide
  - You own your own body thus determining time, manner and method of our own deaths whatever reason is basic human right
- You need no one's permission to live
- "To declare society must give you permission to kill yourself is to contradict the right to life"*
- Respect for human freedom demands society permit suicides of competent persons even when they are expressing "unjustified" desire to die

*Tom Bowden, J.D. former civil litigator, is a research fellow at the Ayn Rand Institute

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Or Don't We?

- 1997, US Supreme court ruled death was not a constitutionally protected right leaving questions about assisted suicide to be resolved by each state
- Soon after Oregon passed law that allowed doctors to prescribed lethal drugs for patients who have less than 6 months to live
- Washington adopted similar law in 2008
- Montana decriminalized "assisted suicide" in 2009
- Vermont legalized it in 2013

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Can Suicide Ever be Considered an Acceptable Action?

- Can suicide be an act of competency or does every suicide demonstrate client's inability to be competent?
- Do clients ever have right to die by ending their life?
- When, if ever, is suicide ethically acceptable?
- What is our professional duty to protect client from him/herself?
- Each of you will have a different ethical position on these issues which will raise important ethical and practical considerations

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What do you think, feel or believe about concept of suicide?

- Suicide has been considered noble, an important freedom, as well as unacceptable, morally wrong, an indication of mental illness, a crime and an offense against God
- In working with the suicidal clients, it is essential to candidly consider and understand your own ethical, moral and valued beliefs relating to suicide and the impact they have on your practice
- **Exercise:** List your personal values and beliefs as they relate to suicide and how they influence your clinical practice both positively and negatively

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Wish to Die

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Suicide Prevention Starts with Understanding the Wish to Die

- How can a clinician gain insight into suicidal client's wish to die
- How to sensitively explore depths of suicidal wishes to understand, reduce or manage risk
- How can a clinician help to rebuild client's wish to live

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Wish to Die = "Psychache"

- Physical and emotional pain feels
  - Intolerable – exceeds threshold
  - Inescapable – no way out
  - Interminable – no end or change in sight
- Client feels trapped and desperate
- Tolerance for pain exhausted
- Problem solving strategies not working
- Awareness of "cessation" as possible way to end unbearable pain and solve problems

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Why People Die by Suicide

- Humans are solution-oriented species
- Suicide works as a solution to pain/problems
- As life ends, pain ends
- We need to accept that suicide is seen as a natural solution to pain and suffering
- We don't need to agree or accept solution, but need to convey nonjudgmental understanding of client's right to view suicide as solution

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Challenges for Clinician and Client

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Clinician Anxiety

- To talk about sensitive topics
- Your anxiety reduces reliability and validity when talking about sensitive subjects like suicide, substance use, abuse, violence
  - Cause of your own anxiety?
  - How could your anxiety affect information obtained during session?

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"Suicide Anxiety"

- Most mental health professionals fear losing client to suicide which can create "suicide anxiety"
- Healthy fear *keeps* us engaged to practice safely/ethically and pay attention to risk/danger
- Helps clinician to *remain* engaged and present when listening to clients talk about their suffering
- Understand your anxiety and fears by uncovering and challenging "suicide anxiety"

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Questions to Ask Yourself

- What scares me about trying to help suicidal client or asking the question?
- What have I experienced personally or professionally that might be a contributing?
- Am I over or under-reacting?
- What would I do differently if I were not so scared?
- Uncovering and challenging suicide anxiety is part of professional self-awareness

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Fears Keep Us from Asking Question

- Putting idea of suicide in client's head
  - Research says no
- Making it worse
  - Research says no lasting effect
- Upsetting, angering, insulting client
  - Stigma associated with suicide
  - Explore angry or upset feelings
- What if client says "yes?"
  - Far better to know than not

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Be Aware of Negative Reactions

- Common towards suicidal clients
  - Critical because not getting better
  - Missed appointments, not following through with or undermining treatment
  - Still suicidal despite efforts to help
- Feel impatient, taking it personally
- Lack of control, feeling manipulated, coerced
- May result in withholding empathy, not returning calls, scheduling less sessions
- "Firing" or transferring suicidal client

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Examine Your Reactions

- Recognize your discomfort that suicidal client can die by suicide despite treatment
- Blame illness, stress, pain happening to the client
  - Use compassion and patience
- Empathic stance recognizes suicidal person is doing the best they can and wants to improve
- Consider changing clinical approach
- Maintain proper boundaries by resisting obligation to rescue
- Treat your reactions with curiosity and compassion

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Rescuer Role?

- "If I don't do this, my client might die"
- Boundaries relaxed/crossed for clinical needs?
  - Ask yourself if you are making exceptions out of fear or belief only you can save client?
- Builds dependency in client so they don't have skills needed to live
- Might not save client and exhausts clinician
- Consultation to help determine if you're making exceptions due fear or valid clinical concerns

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Client Anxiety

- Difficult to talk about sensitive topics
  - Common worries, fears, concerns
    - Confidentiality
  - Embarrassment
  - Being judged
    - Weak, immoral, "crazy," selfish
  - Being detained, forced into treatment
- Tough topics one rarely discusses

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Techniques to Decrease Anxiety

- Use transparency to establish relevance to care
  - Explain why you are asking and be open about reasons
  - Example: "I need to ask you some specific questions about thoughts of suicide in order to better understand your current crisis"
  - "I need to make sure I have all the information and it is accurate"

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Asking Permission

- Asking permission
  - “Would it be alright with you if I asked you some questions about your suicidal thoughts?”
- Option of not answering question
- Addressing concerns

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Addressing Confidentiality Concerns

- Clients have right to be informed you can’t promise 100% confidentiality
- What to document depends
  - Need to document information if important to overall mental health status or care
  - If not important to overall care, decide on case-by-case basis in terms of client’s wishes
  - Mandated reporting needs to be documented
  - Risk to self/others must be documented

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Techniques to Improve Quality and Specificity of Data

- Asking for facts avoids judgments/opinions
- Asking in specifics vs. general: more difficult to deny specific question
- How you ask question
- Soften the question

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Asking the Question

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Which Approach Works for You?

- Suicidal people often don't disclose suicidal thoughts even to professionals
- Ask question directly with general follow up questions indicating not frightened of answer

  or
- Buildup to the question, first asking about pain and suffering, hope for future, relationships
  - Gradual progression allows for reduction in anxiety and building rapport
- "Harm/hurt" vs. "die or suicide"
- Culture, race, age, gender, needs/preferences

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Narrative Approach

- Ask client to tell how they got to this point
- Listen to client tell story of what led to suicidal crisis
- Avoid interruptions except to clarify
- Use minimal encouragers
- After hearing client's story in their own words, you can connect with empathy and respect to begin process of asking the question

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Sound Suicide Risk Assessment

- Risk assessment is not just a "yes" or "no" answer about suicide
- Accurate understanding of suicide risk starts with understanding of client's thinking including wish to die
- Value of listening to client's story without peppering them with questions
- Builds rapport and encourages dialogue

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Asking the Question

- Allow clients to get comfortable with you and uncomfortable with their pain
- Try different/indirect entries inviting discussion
- Age, development, culture & treatment alliance
- Don't accept the first "no" or denial if risk factors/information suggest suicide risk
- If client doesn't follow lead, ask question directly
  - "Are things so tough or are you feeling so bad you are thinking about killing yourself?"

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Modify the Question

- Do you ever wish you could go to sleep and not wake up?
- Do you sometimes wish you would die?
- Do you ever wish you were dead?
- Do you even wish you did not have to be here or live your life any more?
- Do you ever feel life is not worth living?
- Have you ever wanted or tried to stop living?
- Have you ever hurt yourself on purpose?

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Reluctance to Discuss Suicide

- Don't want suicide attempt thwarted
- Feel embarrassed, believe sign of weakness, immoral or taboo
- Fear of being labeled "crazy" or put in hospital
- Don't spend time thinking or planning ahead
- May need to repress awareness of suicidal desires in order to kill themselves
- Attempt to overcome fear and dread when contemplating own death by avoiding direct mention of suicide

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Tips for Decreasing Reluctance

- Appear unhurried and calm
- Ensure client knows safe to talk about suicide
  - Be direct/use calm frankness, conveys okay to discuss thoughts of suicide
- Ask…ask again if risk/warning signs present
- Notice hesitancy, body language suggesting anxiety, discomfort, deception
- Clients often deny, minimize their suicidality so clinician does not get the information needed for risk assessment

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Go Beyond a Single Question

- Don't accept first "no," ask follow up questions
  - Soften question or return to it later
- Remember client may be embarrassed, fearful of being judged as weak, immoral, "crazy"
- Ask how willing client is to disclose suicidal ideation now and/or in the future
- What would keep them from disclosing
- Explain agency policy when clients are at risk for suicide, including confidentiality and using least restrictive dispositions

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How to Increase Reliability & Validity of Client Self-Reports

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Use of Validity Techniques

- Eliciting valid information regarding sensitive issues such as suicide, substance use, abuse, violence
- Normalization: making it clear it is normal to *think* about suicide during times of pain and suffering
- Gentle assumption: act as if client already said yes
- Behavioral incident: verbal video, "walk through"
- Shame attenuation: blaming pain, illness, situation not the suicidal person
- Denial of specific: ask separately about each possibility vs. lumping into one question
- Symptom amplification: set number high→valid info

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Normalization

- Clients may be nervous/anxious admitting to a thought/feeling or symptoms and find it helpful if clinician lets them know that *others* have same or similar thoughts/feelings or symptoms
- Question always related to what *other* people sometimes think, feel or do
  - Example:"Sometimes when people are feeling very …, they notice....Has this happened to you (at all)?"
- *Caveat:* contraindicated for malingers, exaggerators or eager to pleasers because it cues for answers

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Behavioral Incident

- Ask specific, close-ended questions leading client to describe concrete behavioral facts and events *or*
- Ask client to walk you through event, "verbal video"
  - What happened next…then what happened…?
- Elicit description of behaviors and associated cognitions, but not opinions
  - Examples: "Where were you…," "how many pills…," "were you using…," vs. "Tell me about your suicide attempt"
- *Caveat:* may be time consuming

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Gentle Assumption

- Assume client has done what you're asking about
- Helpful when client is reluctant to discuss sensitive topic due to shame, guilt, or other reasons
  - Example: "When was the last time you overdosed?" vs. "Have you overdosed before?"
- You can add "if at all" or "if ever" as needed
- *Caveat:* children or other clients may give false info because eager to please clinician by "agreeing" with you

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Shame Attenuation

- Ask about suicidal behavior from framework of client's rationalization of it, putting it on the illness, pain or situation
  - Example: "Do you become trapped in suicidal ideation when your family is not being supportive and won't stop pressuring you?" vs. "Do you threaten suicide to get people's attention?"
- *Caveat*: client may perceive clinician as endorsing behavior

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Denial of the Specific

- When you get a negative response, continue asking specific examples
- It's harder for people to deny specific actions they have taken, vs. general behavior
  - Example: "Have you used cocaine?...ecstasy? …heroin?" etc. vs. ending questions after "Have you tried any other drugs?" – "No."
- *Caveat*: Ask each as a separate question, pause between each question to get response before asking the next one to avoid "cannon balling"

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Symptom Amplification

- When quantifying a behavior, set bar so high that client can minimize and still give you relatively accurate information
- Ask how many times/how much followed by offering artificially high example
  - Example: "How many beers do you have in a day, 15, 20?" vs. "How much do you drink in a typical day?"
- *Caveat*: client who wants to impress may agree to amplified numbers; don't set number so high you look like you don't know what you are doing

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Active Listening for Imagery, Pain/Suffering and Mood Changes

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Suicidal Imagery

- Clinicians often don't ask about clients picturing themselves in the act or afterwards
- Images triggers stronger emotional response than verbal material
- Ask about daydreams or mental pictures
  - When client thinks about suicide, what do they see or imagine/rehearsal? Able to control?
- What are client's reactions to imagery
  - Distressing or able to tolerate/less fearful
- Images involve funeral, loved ones reactions

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Assess Pain and Suffering

- Uncover pain associated with life stressors
- Try to find out what client feels may be most likely to intensify suicide intent
- "What would have to happen for you to try to kill yourself or to try it again?"
- "If ___ occurs, what do you think you'll do?"
- "How long can you go on as you are?"

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Ask About Mood Changes

- Observation is not enough to assess risk
- Ask about mood and inform about possibility of episodes of extreme upset
- Repeatedly tell client about necessity of reporting mood changes when symptomatic
- Make sure clients understand about self-disclosure and that you "can't read their minds"

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Active Listening Involves

- Not trying to talk client out of their thoughts or feelings
- Not saying or presuming you understand
- Not advice-giving
- Not offering superficial reassurance
- Not problem solving (yet)
- Listen without trying to change what client is saying

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Reconcile Differences

- Conflicting goals so may view clinician as adversary
  - Clinician's goal is to prevent suicide
  - Client's goal is to stop their suffering via suicide
- Remember suicide is *not* a problem for the client, but a solution or option to the pain and suffering or unsolvable problem that they can no longer tolerate
- Recognize and explore your different agendas

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Forging an Alliance

- Clinician needs to find common ground to forge an alliance with suicidal client
  - Understand useful purpose of suicide
  - Maintain nonjudgmental and supportive stance
- Allow client to talk about both wanting to live *and* die before helping client decide to live
- Understand client's sense of desperation without agreeing their situation is hopeless

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Understand Wish to Die by Using Empathy, Validation and Collaboration

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Recognize Suicide is an Option

- Arguments against suicide can result in client defending their option (some see as their right)
  - Power struggles may interfere with relationship
- Hard to do when you feel responsible to keep client alive
- Don't want to convey approval in accepting it as an option…the reality is suicide is an option
- By not getting into power struggle, you & client are free to work on determining if suicide is the best option for them given other alternatives

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Being Present with Client's Pain

- Reflection: use active listening by summarizing to make sure you understood what was said
- Curiosity: ask client to "convince" you that suicide is the only solution left
- Empathy: look for the "yes, buts" which indicate you have not fully understood
- Helps clinician to be fully present with pain without trying to talk client out of it

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Understanding Wish to Die

- To understand suicidal wishes, clinician needs to understand why client wants to die
  - Have client rank order reasons for wanting to die
- Bear witness to client's pain without trying to fix, change it or talk client out of it
- Be willing to explore client's reasons for wanting to die so client feels heard, understood and less alone = empathy
- Summarize and check with client to ensure you have fully understood

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Empathy

- Does not mean you condone suicide
  - Empathy ≠ agreement
- See things the way client sees them as if you were that person *and* never forget you are not
- Not tying to talk them out of suicide, (things will get better or effects on others) or rushing in to solve or fix them
- Understanding the pain and suffering and why suicide is an understandable & tempting option

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Validation

- Find something client thinks, feels or does that you can validate
- Demonstrates you understand why client thinks suicide is solution to their pain even if you don't agree
- If you don't engage in power struggle that suicide is not an option, you free up client to explore other alternatives

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"Collaboration is Key"

- In the desire to prevent suicide, clinicians resort to coercion and control (in some high risk situations coercion/control may be needed to keep client safe)
- Creates and intensifies power struggles
  - Forcing no-suicide contract
  - Threatening to "fire" client if don't give up suicide
  - Using hospitalization to calm clinician anxiety
- Work with the client against drivers of wish to die vs. working against client's suicide plan
- Clinical alliance in CAMS: Collaborative Assessment and Management of Suicidality

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Finding Common Ground

- Validating suicidal wish does not mean you agree suicide is a valid choice
- Shows understanding for client's suicidal emotions, acts, wishes given their pain and suffering
- Look for what makes sense and acknowledge it using empathy (not agreement)
- Suicide as solution to end pain or solve problems even if you don't agree, but is it the best or only solution…? Will client set it aside for now…?

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Carry Banner of Hope

- Use empathy to learn about client's pain/suffering
  - Unbearable pain/suffering can make client feel there's no hope and death is only solution
  - Seek consultation if you start to lose hope about helping your client
- Remember treatment and medications reduce risk
- Learn from personal accounts of transformation from suicidal despair to hope/healing
- Find hope in your client's ambivalence, seeking help and staying alive

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