When a Patient in Addiction Treatment Talks Suicide

People with a substance use disorder who are in therapy have one of the highest risks of suicide. Yet many skilled clinicians are clueless about how to help in this emergency.

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Perhaps nothing is more devastating to a clinician than the pain of losing a patient to suicide. About **25%** of mental health providers will face such a loss at some point in their career. Suicide usually leaves much suffering in its wake for the patient's significant others, but it can also have long-lasting ramifications for the therapist.

People with addiction disorders are 10 times more likely to take their own lives than the general population. Factoring in accidental overdose, and the gray area between overdose and suicide, the sad reality is that death is a frequently encountered misfortune in addiction work, especially those clinicians working with **teens**, who have a higher rate of suicide. But it's not necessarily the physical toll of substance use that engenders suicidality—of all addictive behaviors, **gambling** has by far the highest rate of suicide

Somewhat paradoxically, people with substance use disorders *who are in treatment* are **at greatest risk** because they seek out help when their use is out of control, when they are in crisis and when they are most depressed. Certain moments in the treatment process, such as at relapse, at transitions in treatment planning and at discharge (particularly if involuntary), can present heightened risk of suicidality. And some clients, by virtue of co-existing disorders such as major depression, PTSD or borderline personality disorder, may have an increased risk at any stage of treatment.

So it is critical that those engaged in addiction treatment have some expertise in suicide care. Unfortunately, many of us received little or no training in managing suicidal ideation and know little about suicide prevention. If you were to be confronted by a suicidal patient, would you be prepared to respond adequately?

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One of the hallmarks of **good suicide care** is advance preparation. When a patient is sitting in your office, telling you that he or she is actively considering suicide, it's already too late to figure out the optimal approach—you need a plan *before* you're confronted by the situation. Fortunately, even a small amount of training goes a long way in **suicide prevention**. Here are some key guidelines.

All clients should be screened for suicide risk, all suicidal ideation should be taken seriously and all risk should be treated appropriately.

Clinicians should develop and employ, at the outset of treatment and as appropriate thereafter, a method of inquiring about suicidality that is in keeping with their unique manner of engaging clients. Basic questions include:

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• "Are you thinking about suicide?"

• "Have you thought about it at any time in the last two weeks?"

• "Have you ever attempted suicide?"

When novice clinicians are confronted by a patient's suicidality, their natural reaction is often to rush into action: to call 911, bring in the medical cavalry, insist that the patient sign a "suicide contract" in which he or she "agrees" not to self-harm. These actions may relieve the therapist's anxiety but do little to help the patient; indeed, they will likely interfere with the empathic communication that patients need.

Ask your patients about suicide. Some clinicians worry that doing so may "plant" the idea of suicide, but that's seldom the case. Asking about suicidality doesn't make people worse; it makes people feel cared for. For people who are struggling with suicidal ideation, being able to discuss it can be a great relief. Each year, about 8.5 million people in the US experience serious suicidal ideation, while around 38,000 kill themselves. So the vast majority of people with serious suicidal ideation do not die by suicide, and these people benefit when they can openly discuss their thoughts and feelings about ending their life.

Many therapists avoid asking about suicide for fear of opening a Pandora's box of problems that they will not be able to handle. The more capable a therapist feels about his or her ability to treat suicidality, the more likely he or she will ask about it and be in a position to help. That is why training and preparation are so important.

When assessing the risk of suicide with a patient, there are **four risk factors** that need to be considered.

1. A patient's desire for suicide. This is likely to be expressed in fairly explicit statements of the "I wish I was dead" or "I want to die" type.

2. A patient's intent to die by suicide. This is what separates the many patients with suicidal ideation from the far fewer who complete the act. Intent is apparent in statements such as "I am going to kill myself" and in behaviors that represent planning for suicide, such as getting affairs in order or giving away important possessions.

3. A patient's acquired ability to make the attempt. This can be evaluated by determining what, if any, planning they have undertaken for the act and what their level of impulse control is. Patients with a history of previous suicide attempts are, of course, at greater risk of suicide, and the patient's home environment, particularly if the means to kill oneself is readily available (guns, for example), should be assessed. Obviously, some people with substance use disorders can also make use of their drug of choice—opiates, for example—to take their own life.

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These three risk factors are likely engaged in an ambivalent struggle with a fourth:

4. The person's reasons for wanting to live. As counterintuitive as it may seem, the urge to "talk the patient out of it" is not what a therapist should do. Instead he or she should "do what you already do well"—stay connected, calm and engaged with all aspects of the patient's inner world. Of course, most clinicians would prefer to engage the part of the client that wants to live rather than the client's thoughts and feelings about ending life. Yet the therapist must engage the patient's ambivalence, eliciting both the reasons for wanting to die and the reasons for wanting to live. Before the session ends, you might ask your patient, "In spite of all of your pain, you are still with me now. Can you give me two or three reasons why you have not killed yourself"?

The best clinicians are able to collaborate with a patient in exploring his or her suicidal ideation, determining the actual risk and helping the patient develop a plan for preventing suicide. Such an approach uses the patient's self-knowledge as an ally and treats the patient as an agent rather than as a potential victim in need of rescue.

When a patient is in serious danger of suicide, therapists too often make the mistake of focusing on what they believe to be the underlying issues for the suicidality—for example, substance use, marital

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discord and financial problems—on the assumption that exploring these "causes" will provide hope or at least relief, reducing the risk of suicide. While there may be an intuitive logic to this reasoning, for a patient at real risk of committing suicide, the treatment must shift to keeping him or her safe. Warning signs and risk factors should be reviewed, and coping strategies employed—thoughts and techniques that foster safety, such as helping the patient write a list of self-soothing activities and reasons for living, identify supportive contacts when feeling distressed and reduce access to lethal implements (firearms, pills, etc.).

Good suicide care puts the patient's safety first, and that means taking advantage of significant others and family members (where appropriate) as well as other professionals and agencies that can be relied upon to help. One of the hallmarks of good suicide care is that it is an ongoing team effort, with the therapist as team leader. The professional failure is in *not* responding.

Patients struggling with suicidal ideation should be made aware of 24-hour suicide prevention hotlines (800-273-TALK is the National Suicide Prevention Hotline and can be accessed from 911 as well). One of the protective factors against suicide is the patient's attachment to the therapist, so extra sessions, phone contacts and other services that enhance connectedness to the therapist (and other beneficial members of the patient's world) should be employed in a full-out effort to keep the patient from self-harm.

Lucky is the therapist who is never called upon to save from **suicide** a client with substance use disorder. But as clinicians we depend on skill, not luck—and knowing how to treat a suicidal patient may even reduce his or her risk because you will be more confident and competent in asking about, assessing and treating suicidality when it presents itself.

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