

Empathy Integral to Working With Patients at Risk for Suicide



From Science to Practice

Using Research to Promote Safety and Prevent Suicide

Issue

Much research has been conducted to examine suicide through the lens of risk and protective factors, based on the premise that people with certain traits, people who engage in certain behaviors, or people who are subject to stressful or traumatic events may be more prone to suicidal ideation and behavior. For example, people who perceive themselves as lonely or are socially isolated are at increased risk for suicide, while people who have close, personal relationships with family and friends and derive satisfaction from these relationships may be at decreased risk for suicide.¹

While researchers continue to learn more about risk and protective factors at the population level, understanding how individuals go from being at risk for suicide to thinking about suicide and then engaging in suicidal behavior is more challenging. After all, not everyone in a population identified as at risk will have suicidal thoughts or engage in suicidal behavior. Although identifying risk and protective factors can be informative, no single risk or protective factor accurately predicts suicide.² Take mental illness, for example. More than half of people in the United States who died by suicide between 1999 and 2016 had no known mental illness.³ And while mental illness is common among people who die by suicide, most people with a mental illness do not attempt suicide.⁴ Furthermore, suicidal ideation does not always lead to suicidal behavior.⁵

Multiple theories for explaining suicidal behavior (so called ideation-to-action theories of suicide) have been proposed and tested.⁶ One well-studied theory is the interpersonal theory of suicide, which posits that three ingredients are necessary for a person to engage in suicidal behavior: thwarted belongingness, perceived burdensomeness, and an acquired capability to harm oneself.⁴ Even though application of the theory may help predict who is at risk for suicidal thoughts and behaviors, it is not as helpful in predicting when self-harm will occur.⁷

Reasons that someone may engage in suicidal behavior are highly personal and contextual. Thus, preventing suicide requires understanding suicidality from the suicidal person's subjective perspective, as proponents of a phenomenological approach to suicidality assert.⁸ These proponents also posit that the desire to escape from unbearable psychological pain, or psychache, is a primary driver of suicidality.⁹ The main sources of psychological pain — shame, guilt, rage, loneliness, hopelessness, and so forth — stem from frustrated or thwarted psychological needs. These psychological needs include the need for achievement, for affiliation, for autonomy, for counteraction, for exhibition, for nurturance, for order, and for understanding.⁸ A suicidal crisis is imminent when someone is so perturbed and pressured by external events (separation, divorce, death of a loved one, losing a job, financial hardships, etc.) that they believe that ending their life is the only means of escape from psychological pain; all other options have been rejected or exhausted.

Key Findings

- Fewer than 1 in 3 people who have had suicidal ideation have attempted suicide.¹⁰
- Suicidal ideation can change considerably over just a few hours, as can feelings of hopelessness, loneliness, and burdensomeness.¹¹
- Recent onset of suicidal ideation and the presence of a suicide plan are highly associated with suicide attempts. But brief periods (less than five hours) of suicidal ideation are not associated with an increased risk of attempting suicide; longer periods are, as is a lack of ability to control suicidal thoughts.¹²
- The capacities for extreme risk-taking and nonsuicidal self-injury are significant predictors of the transition from suicidal ideation to behavior.¹²



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Implications

Evidence-based care requires understanding the specific drivers of suicidal desire in your patients and exploring what a life worth living would look like to them. Treatment of suicidal patients must be tailored to address their psychological pain and mollify it. It requires empathy. And it requires the recognition that suicidal ideation is fluid: thoughts come and go and change in intensity.

Ways You Can Help

- Because feeling understood may help a suicidal person's recovery, demonstrate deeper empathetic insight by exploring metaphors, analogies, and imagery to enable expression of painful or distressing feelings.¹³
- Consider using evidence-based treatments, such as cognitive behavioral therapy, that can help you and your patients understand what is driving their suicidal desire and ease their psychological pain. Other evidence-based treatments based on the phenomenological approach include problem-solving therapy, dialectical behavior therapy, and crisis response or safety planning.¹⁴
- When appropriate, involve the suicidal patients' families and caregivers in treatment to support recovery.¹⁵
- Given the diversity of patients' suicidal experiences and drivers, ensure that treatment planning is grounded in evidence-based recommendations, conducted in consultation with experts, and responsive to patients' preferences.¹⁵
- Because suicidal ideation can come and go and change in intensity, include techniques in your treatment that help suicidal patients anticipate and cope with such changes.¹¹
- Consult with your local VA Suicide Prevention Coordinator or suicide risk management consultation service (www.mirecc.va.gov/visn19/consult/promote.asp) for assistance with risk assessment, case conceptualization, and treatment planning.

There is no single cause of suicide. It is often the result of a complex interaction of risk and protective factors at the individual, interpersonal, community, and societal levels. To prevent Veteran suicide, we must maximize protective factors and minimize risk factors at all of these levels.

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