Facts and Myths about Suicide

Episode 1 – Common Misconceptions about Suicide

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At Colibri Healthcare, we developed this educational content with a genuine approach to bringing attention to mental illness from a healthcare provider's perspective. This podcast series contains content that may be unsettling to some listeners. Each episode involves an in-depth discussion of suicide, depression, and self-harm. We do our best to discuss sensitive topics such as these with discretion and sincerity. Because of the sensitive topics being discussed, we recommend this podcast series for adults only.

Content Warnings: Mentions of Depression, Death, Suicide, Firearms, Overdose, Strangulation

Guest

Reg Arthur Williams PhD, RN, BC, FAAN

- Dr. Williams is a professor emeritus in the School of Nursing and Psychiatry, Medical School at University of Michigan.
- He completed his PhD in higher education in 1980 and became the chair in Psychiatric-Mental Health Nursing at University of Michigan, where he taught undergraduate, graduate, and doctoral students
- As a board-certified clinical nurse specialist and nurse practitioner in the state of Michigan, he continues to carry a small caseload of patients who suffer from depression at the University of Michigan Depression Center, where he provides psychotherapy and medication management.
- He has conducted research on depression and was the principal investigator in research funded over a 15-year period by the Department of
- Defense, TriService Nursing Research Program, to examine stress and depression among young men and women in military service
- He has written four books and more than 80 journal publications.

Host

Leana McGuire, BS, RN

- Over 30 years' experience in healthcare
- Teaching experience in leadership development and executive coaching
- Background in content development, visual performance, speaking and podcast hosting

Content Reviewer

Candace Pierce DNP, RN, CNE, COI

- With 15 years in nursing, she has worked at the bedside, in management, and in nursing education
- She has demonstrated expertise and scholarship in innovation and design thinking in healthcare and education and collaborative efforts within and outside of healthcare.
- As the Lead Nurse Planner for Colibri Healthcare, she engages with nurse planners and subject matter experts to assist in developing high-quality, evidence-based continuing education for nurses and other healthcare professionals.

Transcript

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CANDACE PIERCE, Reviewer: Hello listeners, we are so glad to have you join us for our podcast series Facts and Myths About Suicide. One of the most serious outcomes to depression is suicide both attempted and completed. Suicide is a very difficult topic for many healthcare providers to bring up to a patient exhibiting signs of depression but is a necessary topic to discuss when it comes to patient safety.

Throughout this series, you will learn about the statistics of suicide, myths associated with suicide and suicidal thought, risk factors associated with suicide, and how to effectively assess a patient in regards to their risk of attempting suicide.

Before we delve into the discussion with our host Leana and mental health expert, Dr. Reg, please note that this podcast series contains content that may be alarming to some listeners regarding mental illness and self-harm. We at Colibri Healthcare developed this content to be educational and genuine in our approach to bringing attention to mental illness from a healthcare provider's perspective. Because of the sensitive topic being discussed, we do recommend this podcast series for adults only.

Now let us join in the discussion.

(SOUNDBITE OF MUSIC)

LEANA McGUIRE, Host: Welcome to a podcast featuring Dr. Reg Williams. Dr. Williams is Professor Emeritus at the School of Nursing and Psychiatry in the Medical School at the University of Michigan and serves as a nurse practitioner.

Dr. Reg did a previous podcast on depression. If you have not heard that, please look for it in our library. It's excellent. This episode will feature Dr. Williams speaking to us about suicide. Welcome, Dr. Williams.

REG ARTHUR WILLIAMS, Guest: Well, thank you so much. Pleasure being here with you.

McGUIRE: Yes. Another very, very important topic. And I'd like to first start out by there's some interesting statistics around suicide, if I'm not mistaken. It's more prevalent than most people would think. Is that correct?

WILLIAMS: You got it. And that is very true. Just as a lead into some of the statistics is to kind of tell you. I've often done a lecture to nursing students at the University of Michigan. And one of the things that I asked the nursing students and I've done this lecture a number of times, and this response has been consistent from term after term after term.

And what I do is I say, okay, how many of you know a person that's more than just an acquaintance could be a family member, could be a friend, it could be someone that you know fairly well that has made an attempt in

suicide. Then I ask that same question as to how many of you know people that have actually completed suicide with the attempt, about 80% or more of the students will raise their hand. So, they'll know someone who made an attempt. Out of completed, it will be half the class. And I have done that term after term and that has been consistent. So, it just sort of, I think in a way almost captures the essence of the statistics of suicide. But to answer your question, I mean, it is really the most serious outcome to depression, if anything, that is more earth shattering is having a patient complete suicide.

And I should mention, in terms of the term complete suicide versus they suicide or something like that. The proper term is to say completed suicide because sometimes the terms that have been used to talk about suicide are rather derogatory. And so completed has been shown to be the most really understanding of what a person goes through when they are thinking of suicide.

But in any event, there are probably about 12 million people that have seriously thought about suicide, 3.6 million that have had a plan, and 4.5 million have attempted. And so those are statistics that have been put out by the CDC in 2021. So literally just a year ago. And, you know, those are pretty, pretty serious when you think about it.

It's considered the 10th leading cause of death in the US and homicide is 16th. So that sends a big, important message to realize that suicide exceeds homicide. What's most concerning is the between the ages of 15 and 24, it is the second leading cause of death. And accidents for that age group is first. So, you're talking second compared to accidents. I mean, that's sobering in itself.

McGUIRE: It is.

WILLIAMS: The statistics sort of suggest that eight out of ten people give warning signs. My feeling is it's actually more than 8 to 10. Eight out of ten, I should say. It is the fact that people do give warning signs. They very often do, but a lot of people miss them. Family has exceedingly missed them. That they don't know that their family member is really seriously thinking of suicide.

And I can give you a couple of case examples of just this. But in any event, the COVID suicide attempts were slightly higher in adolescent boys, but 51% of adolescent girls had seriously attempted. So that is sobering when you're finding girls as adolescents making an attempt. And it's the stress of what they're under and the isolation that they experienced during COVID.

And so, you know, those things are quite sobering when you think about it.

McGUIRE: You gave a number when we talked about depression in a previous podcast interview that there were more than 47,000 completed suicides per year. And you made an interesting comparison at that time.

WILLIAMS: Yeah. Yeah, exactly. And I think what helps to kind of put that in perspective when you think about that many people are actually completing suicide that put in perspective. That's per year. While in the Vietnam War, 58,000 young men and women died in that war. But that was the entire war.

McGUIRE: That's incredible. Wow.

WILLIAMS: So, you know, when you think about it, how many people are dying from suicide as compared to how many people died in the Vietnam War? And that puts it again, puts it in real perspective for you to think about just how serious this is. And any suicide is tragic. That's one death that wasn't needed?

McGUIRE: Right. Right. I'm assuming these are American statistics. How do we compare with other countries? Just curious.

WILLIAMS: Yeah, it's rather interesting in terms of when you look at what's sort of out there in terms of statistics there. There's one research study that showed that 13.9 suicide deaths per 100,000. So, you're dealing with 13 or almost 14, basically suicide deaths in 100,000 people in the US, whereas in the UK it's 7.3. So, when you think about that, it's almost double.

And so, the suicide rate in the US is higher than any other developed country, as I probably would say. Because statistics that are kept in other countries that are poor or whatever are not very accurate. So, and even US statistics aren't necessarily completely accurate because of the number of people that might have died of suicide but were thought of as an accident or something like that.

McGUIRE: Right. So, I know that there are some things that we do understand about suicide, but there are also myths associated with it, correct?

WILLIAMS: Correct. And there are a number of them. Yeah. There is a number of myths that people hold about suicide. But let me give you a couple of examples. I think one that I've literally heard people say, well, you know, I'm afraid of asking the patient about suicide that will plant the idea in the patient's head. That is an absolute myth. I can assure you that in all the years that I've practiced and asked people about their suicidal thoughts, that they've ever said to me, well, no, I wasn't thinking of suicide. But now that you mentioned, that's a good idea. You know, I've never had that happen. And it's a myth. You're not going to plant the idea of suicide in their head by just asking them. If anything, it does, it is you will see a sense of relief that they now have told someone else because chances are good, they never let anybody else know that they were actually thinking of suicide, or they may have sent out warning signs. You know, let people sort of know, but no one picked up on it. So, it's that relief that someone asked them straight out, you know, and that makes them then feel like someone cares about what's happening to me. And that's what is so important in suicide.

Another myth is that nothing can be done about those who really want to die. That's a myth. Anybody that is thinking of suicide, you can actually prevent a suicide by the fact that you talked with them. And so, the idea that there's nothing that can be done is nonsense. There is. And now there are some people that are so bent to kill themselves that they still could do that. But I can assure you that most people, if they get it out and they know that you care about what's going to happen to them, etc., the chances of their actually completing a suicide is much, much decreased. So that's important.

And that multiple suicide attempts are just a means to get attention. No.

McGUIRE: I hear this all the time.

WILLIAMS: Yeah, you do. And what you have to understand is even with people who have maybe made more than several attempts. If they go without support and this is not dealt with, they eventually will complete suicide. So that's what's important to recognize. So, you never, ever ignore it and you never say, oh, well, they, you know, they just say it and they're not going to do it.

Yes. They are capable of completing suicide. The important thing is get them the resources they need to not get to that place.

McGUIRE: I know that depression leads to suicide? But why does this why do they become suicidal? Can you shed a light on that?

WILLIAMS: Yeah, I can give you a sort of an idea of sort of the typical pattern that's followed. But what usually happens is that the person has a loss of sense of self. So, they just they don't know who they are, you know, what they're feeling, that kind of thing. And that leads. So, you kind of think of almost like an arrow now leading to a loss of prestige. You know, I don't feel good about myself. I feel terrible. I feel worthless. I don't feel valued.

Much of the research that we did in depression was where we found sense of belonging was really a predictor of someone being depressed.

And then that could lead to suicide. And a sense of isolation because the problem with depression is, is it creates that sense of isolation anyway. But that sort of falls out from that loss of prestige, feeling worthless and not valued. You know, why should I talk to somebody when I don't feel valued anyway and that kind of thing? That then leads to feelings of hopelessness and that sense of nothing's ever going to get better. I'll never get over this. I'm going to be I'm going to spend the rest of my life feeling like this, which is not true. But that's how they're thinking. That's when they will either attempt or complete suicide. So, it kind of follows that if you can sort of think of arrows, as I just described those. Just one leads to the next kind of thing.

I did a workshop some years ago on suicide and I was presenting, and this young man came up to me and he said, you know, you mentioned how hopelessness was a factor in someone actually completing suicide. He said, when I was a teenager, he said, I felt so hopeless that I actually made an attempt. And he says, you know, thank God I didn't die. He said, but I had such a sense of hopelessness that nothing was ever going to get better. And he says, I later found out, yes, it would. But at that moment, that's how I was thinking. And I thought, wow, that, you know, that's pretty profound. When he made that comment. And it really did send home, you know, that sense of hopelessness of how powerful it is in suicidal thought.

McGUIRE: What other contributing factors like what males compared to females or, you know, marital status? What are some of the factors that are more prevalent in different demographics?

WILLIAMS: Right. There's a ton of them that really contributes to a person feeling suicidal. But let's go over some of them. I think it'll help sort of put them in perspective. Interesting. Marital status is sort of the highest, going from the highest to the lowest is a person who is single and alone versus married. And they are twice as likely to complete a suicide than a person that's married with children. Now, that's not 100% guarantee, but I always have a little sense of relief when I'm dealing with a patient who's married and has children that they are more prone to think about their kids, of what it's going to do to them, which can help them from not acting on a thought. But that's no guarantee. And so, what's most important is just to put that as part of the total evaluation that you do when you are concerned about someone suicidal.

Another one is sex, you know, attempts. It's one male to four females. So, females are more likely to attempt where it's just the flip. It's 3 to 1. Three males will complete suicide as compared to one female. So, sex there is a difference in terms of suicidal rate. And so that's pretty profound. Race surprisingly, the highest is in whites and American Indians. Those are the two groups that have some of the highest rates of suicide. And what's also important is to recognize that age is a factor, and especially in white males in the ages of 45 to 59, they are more prone to complete suicide. And so, it's serious. And age is something that you look at as to, you know, what is a risk factor for that person of actually completing suicide or even attempting.

So, either one, it doesn't matter. The point is, is you need to be worried about their suicidality. Weapons, what happens here? And what's interesting about this is it sort of goes in this sort of fashion. The most common form of completing suicide is using firearms. And think about it. You know. If you put a gun in your mouth, well, there's no going back. You can't say, ooh, pulled the trigger and say, oh, I changed my mind. No, it's too late. And so, there's where it is high lethality. And we'll talk about lethality in just a moment. But in any event. Weapons are very serious and next is suffocation. So, you know, hanging can be a form of that kind of thing.

Poisoning. Where you are taking an overdose of sleeping pills or using a car in the garage and actually complete suicide by that method and then about 8% or others. So, the poison is about 15%. Suffocation is around 26% and others 8%. So those are sort of sort of statistically what happens in terms of firearms as compared to others.

McGUIRE: I wanted to ask you, when you talk about weapons, is it true that men generally use more violent means of suicide than women who are more passive? Or is that another myth? Would they be more likely to use handguns, for example?

WILLIAMS: No. The men would be more likely to use a gun. Women will generally use pills. That's not atypical. But again, those are relative. You know, some women do complete suicide using a gun. So, it isn't 100%. But if you're doing just on a statistical basis, that's more often the case. If you look at suicide rates across the US and you look at the number of guns that are across the US, it's almost as if you could put the two maps, superimpose each other so people in the West will use guns for making an attempt to suicide or completing suicide because they have more access to guns. And so, when you look at the map, you see that it actually shows where guns are more prevalent, there's a higher suicide rate because it is so, so darn dangerous in terms of what it does to a person in actually completing suicide. That's why, in part why we have a difference between us and the UK as an example, because we've got far, far more weapons in this country than anywhere else in the world. And boy, it's scary. Yeah. So that's a factor too.

McGUIRE: Yeah. It certainly is. Okay.

WILLIAMS: The whole concept of lethality is an interesting concept where there are certain methods that are what are considered high lethality. In other words, there's no going back. And guns would be an example of a high lethality. Jumping, hanging, drowning, barbiturates. And what's surprising, and this will be shocking to some people, is Aspirin and Tylenol are more dangerous and are highly lethal. And people say, well, that doesn't make any sense. But if you take a whole bottle of aspirin, some people thought that what it does is it caused bleeding. No. What it does is it actually changes some of your body chemistry and you actually start to go into organ failure. And so that's what it can do to kill you.

Tylenol has the effect on the liver, and it doesn't take a whole lot of Tylenol above the recommended maximum dose to actually cause damage to your liver. And there have been people that didn't even were just taking it for pain and literally got into real difficulty because their liver shut down. And so, it is something serious to be very careful in the use of Tylenol. Which leads to when you have someone suicidal just as a point of mention here, since we're talking about it, is that if it's always wise to ask the patient, you know, do you have access to a gun. Get it out of the house. And many times, patients are quite willing for you to have a family member, or a friend take the gun and get out of the house because it's too darn dangerous and they need to be removed. And so same thing with meds. You get them out of the house so that that there is no way that that person is going to be tempted, especially when they get to really feeling very down and very much suicidal thought.

Occupational factors are a contributor, sometimes. Surprisingly lawyers, police, musicians, physicians. And the highest is an unemployed and unskilled worker.

So, it's kind of like, well, why lawyers? It's kind of like, that’s sort of odd. Well, they're in a business of either winning or losing. There is no in between. It's either win or lose. If you have a lot of losses, that'll kind of get to you. And I imagine that there are some lawyers that really get down and get very depressed because they're not able to win a case. And so that could be one factor that contributes to lawyers, higher rate and lawyers. Police. Well, that's pretty simple. Who's got access to guns? Police. So, that explains that. Musicians, what do they have access to? Drugs. So, there you go. In terms of how it puts them at higher risk. And physicians, because they have access to medications, and they will sometimes overdose on something.

And so that happens. But the highest, though, is in unemployed and unskilled. And you can see that that would contribute. The biggest factor in occupation is to recognize that they have a feeling of failed in their role as either a parent or, as, you know, a lawyer or as a physician, etc. They failed in a lawyer and or they failed in a

marriage. You know, they feel like they're just a total loss. And so that that then justifies that in their mind to then go ahead and make an attempt. So that's why it's sort of important.

Other factors are, you know, a psychiatric disorder. Well, you know, obviously, depression is probably the biggest psychiatric disorder that can contribute to suicide. Alcoholism. And alcoholism. It's almost. Which came first, the chicken or the egg? Is it that they were using alcohol to self-medicate because they were feeling so lousy and therefore, they used alcohol to just feel better? Or is it that they actually were suffering depression, which then led them to alcoholism? It's hard to know, but the factory means is that alcoholism and depression can go hand in hand. And again, what I often have to talk with patients about is if they're overdrinking, that I explain to them that in reality it's making their depression worse, which makes them even more at risk for suicide. And so that's another factor. Surgery a recent surgery or chronic pain are more of physical illnesses that a person can have that can contribute to it.

The one thing I didn't mention with psychiatric disorders is if they are abusing drugs and then they even go higher, if they're not only abusing street drugs, but they also are abusing alcohol. Those two combinations really make them even at higher risk. So those are serious. But getting back to physical illnesses, chronic pain is a factor.

McGUIRE: Yeah, right.

WILLIAMS: Recent surgery, if they've had surgery or chronic diseases where they know that it's not going to get better. It's very chronic and it's just the downhill side. Or they have a terminal illness such as cancer. And cancer is not necessarily a terminal illness, but it can move to a terminal illness, and they can be at higher risk for suicide. So, physical illnesses can really be a factor. In social factors, living alone is one that is really dangerous because they're by themselves, with no one to talk with. And one of the things I know about people that are feeling suicidal is they need to get their feelings out. And if they have no one else to talk with, they just sit there and they just start ruminating about the same thought over and over and over and then eventually say, you know what, I'm better off dead.

PIERCE: Thank you for joining us for episode 1 of our series Facts and Myths about Suicide. The statistics Dr. Reg shared with us early in this episode translates the number of annual suicides in the United States to an average of one person every 11.1 minutes and one attempt every 26.6 seconds.

(SOUNDBITE OF MUSIC)

As he stated, the statistics are very sobering. There are many myths regarding suicide, and we hope this episode has helped to clear up some of these misconceptions.

If you or someone you know is struggling with thoughts of taking their life or in an immediate health crisis, please call or text the national suicide prevention lifeline at 988. This line is open 24 hours a day, 7 days a week. And you will be connected to trained counselors who can provide support and resources.

I hope you can join us for Episode 2 of this series where Dr Reg and Leana will continue the discussion of suicide risk factors and provide encouragement in how to evaluate someone appropriately to determine if they are at risk for completing suicide.

This is Dr. Candace Pierce for Colibri Healthcare.

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Episode 2 – Suicide Risk Factors and Evaluation Questions

(SOUNDBITE OF MUSIC)

PIERCE: Welcome back to episode 2 of Facts and Myths about Suicide. I am Dr. Candace Pierce for Colibri Healthcare.

In episode 1, we discussed the statistics and common misconceptions about suicide.

In this episode, we will be joining Dr. Reg and Leana to continue the discussion of the risk factors and to learn some strategies on how to assess someone's risk of committing suicide.

As a reminder, this podcast series does contain content that may be alarming for some listeners regarding mental illness and self-harm. We at Colibri Healthcare developed this content to be educational and genuine in our approach to bringing attention to mental illness from a healthcare provider's perspective. But, because of the sensitive topics being discussed, we recommend this podcast series for adults only.

Now, let's rejoin Dr. Reg and Leana.

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WILLIAMS: In social factors, living alone is one that is really dangerous because they're by themselves, with no one to talk with. And one of the things I know about people that are feeling suicidal is they need to get their feelings out. And if they have no one else to talk with, they just sit there and they just start ruminating about the same thought over and over and over and then eventually say, you know what, I'm better off dead.

And of course, that's never true. But that's how they feel. If they've had a loss of a loved one. I would say that in the people I've treated for depression, especially college students, usually they've had a breakup in relationship that actually sort of was the precipitant that got them in to seek treatment because they just felt so awful over the breakup. But certainly, a loss of a relationship is really profound. Or they had a loss of a family member that really sent them in a downward spiral. And those two things can be really serious in terms of increase in suicidal thought.

Family history could be a factor. There's some question whether there is a genetic factor that puts a person more at risk for suicide. That can happen. But some families actually have a sense of permission to force suicide in other family members. And so that could be a contributor. It's hard to know and it's hard to think that that, you know, you're suicidal because of a genetic factor. But it could be possible. And, you know, that's very, very difficult to research because the work that's been done has been on people that have already died, not before. And.

McGUIRE: Right. Right.

WILLIAMS: You can't there is no absolute model that you can say if they have these factors. Therefore, they're going to complete suicide. It doesn't exist. And so that's what makes this whole area so difficult, because there are no absolutes in it in that sense. So.

McGUIRE: Now when you say sense of permission, in other words, it's been, you know, Dad committed suicide. Grandpa committed suicide; uncle committed suicide. It's you know, it's acceptable or

WILLIAMS: Must be the way it is now.

McGUIRE: Must be the way it is. It's the way to cope when things get when things get to that point, this is how we deal with it.

WILLIAMS: You got it.

McGUIRE: Okay. And you were mentioning when you said the unemployed or unskilled worker, it's related to that sense of worth or value. Is that correct?

WILLIAMS: Exactly. Yeah. I mean, if you're also you know, you can well imagine, you know, if you are having a heck of a time finding a job, what is it going to do to your self-esteem? And, you know, it's going to create that that little paradigm that I gave you earlier when I said, why do people become suicidal? Well, loss of sense of self, you know, which then leads to loss of prestige and worth and value. You can just see how it just sets that whole paradigm up in a person's mind to then become very seriously suicidal.

McGUIRE: I have I do have a question or maybe it's a comment, but you can address it as when we talked about marital status, and you said that single was twice that of people who were married or people who had a spouse or had children. I've often heard the comment when someone has committed suicide and they have a family. I wanted to circle back on something related to marital status. And you mentioned that people who are single are twice, twice more likely than people who are married or have family and children. And I often hear if someone has completed suicide and they have a family. I often hear people say, how could they be that selfish?

How do you feel about that verbiage of selfish?

WILLIAMS: Yeah. I mean, I, I understand how people can make that statement because what you have to keep in mind when someone is really seriously thinking of suicide, what happens in their thinking is that they really frame it all. You know, everyone is going to be so better off with me dead because I am such a burden to this family. I brought discredit to the family. Look what I've done. You know, these kinds of things that they will go through, and they literally convince themselves. So, it's not selfishness. It's literally that they're thinking everyone's going to be better off with me dead. So, one of the things that I do with patients when I'm talking about them, I will often bring that up and say, you know, have you thought that your family or your friends would be better off with you dead?

And they might say, yes. And I say, well, let me assure you, under no circumstances ever, ever will they be better off with you dead. Do you understand? They will live with that for the rest of their days. It will never go away. And that's what you would be leaving your family, your friends, whoever it is that's important to you. And that boy I literally have had when I've had to do that and I don't have to do that very often, but I've had to do it a few times. I've had the patient say to me, oh, goodness, I didn't think of it that way. Because see, they're so focused on their pain that they aren't. And believe me, when they tell you how much pain they're in. They are absolutely miserable.

I mean, they just feel to the core of their being, of just how miserable they feel. They feel hopeless. Nothing's ever going to get better. And so, oh, I've got to be better off dead. Well, they're never they never are. And so hopefully that corrects that idea that they're being selfish because they really are not.

McGUIRE: Right. I'm so glad that you said that because I've often thought the same thing, that it's not selfish from their perspective. So now from a clinical perspective for nurses listening to this interview, what's the best way to interview a suicidal patient? We talked about depression in another podcast, but someone who's truly suicidal, what is the best way?

WILLIAMS: Well, the one thing that as a nurse and we'll make the assumption that the nurse doesn't have a psych background but is dealing with a patient who they pick up with some of these factors that we've talked about that put them at high risk. And they're worried they need to talk to the patient about that. And so, if ever any nurse ever is dealing with a patient. And nurses are good at this. They can have it in their gut and say,

something's not right here. I'm worried about this person. I've seen it over and over and over. I worked in ICU. And nurses can pick up on when a patient was going to die, when no one else, no physician could see it because they're that skilled.

So, I know the skill that nurses hold in terms of picking up on something that's there. And so how do you approach it? Well, what's most important is that you always have a plan for a backup. So that's the first thing to always know, that if I assess that this person is suicidal, I'm calling in resources. I'm calling in help. I'm not going to deal with this myself. Never put yourself in the position of trying to determine, is this person really at risk of suicide? If you picked up that, they said, yes, I am thinking about it, then call in the resources because you don't want to have just you trying to make that determination. And so that's the first thing.

The second thing is before you get into talking with the patient about suicidal thought, is you got to establish rapport with the patient. You can't just jump in and say, well, are you thinking about killing yourself? Because it'll it can be very off putting if you have not built some kind of rapport with that patient. But if they have a sense that you are being empathetic, that's a key. Being empathetic to the person. But also, that you're showing concern they will answer you honestly. They will tell you whether they're thinking about it or not. But if you don't have that, then that's a problem. One of the things that I get very concerned about within the health care system, you know, when you are in a clinic and because of the paperwork that practitioners and nurses and anybody, any provider has to do, while they're sitting there on the on the laptop or the computer with their back to you.

How do you build rapport with your back to the patient? You don't. And so, you got to turn that chair around and stop worrying about the charting. Worry about the patient that's in front of you. That's what you need to be concerned about. So, you can't build rapport with your back to the patient. So that's another factor. But once you've established that, what I recommend is that you approach in an empathetic but sort of first circumscribed way or circumspect way so that they're not just getting a boom, you know, hit in the face. So, you know, talk with them about what's going on in their life, you know, what's been happening. You know, how's work going, blah, blah, blah.

That kind of thing where you're building rapport with that person. The one thing is so important that I always tell nurses when they're asking about how do I approach about suicide? Is, for goodness sakes, be yourself. Don't try to sound like a textbook. Don't try to sound like a phony. Patients will see through you in a heartbeat. If you're not real, they will not tell you what's going on in their head. So, you have got to be real with them. That's so critical. So, what I think is always important is to proceed from the general questions and go to the more specific. So, you go from the general, then the specific. You can start out with things like. And these are my words.

But I think what you want to do is think about how would you ask this to a patient and use your words, not necessarily these, but this will give you a hint as to how you could go about it. You might say to them, you know, how badly or hopeless do you feel? You know, just that question alone will start to open up. Where they're going to be honest with you, as to what what's going on with them, that kind of thing. You could ask them, were things so bad that you were thinking a lot about death or that you would be better off dead? Some patients find it easier to talk about death than to just go to the word suicide. It's too sort of shocking. And so, you can use the word death. You know, it works. It works very well. And they will get to it where they will tell you. Or you could ask them, are you feeling so bad that sometimes you would prefer not to go on living? Another way to ask it to get at the same thing.

Or what about thinking of hurting yourself? That’s another way. You know, because they hurting themselves could be anywhere from hanging to, you know, taking a knife. I'm going to cut my wrists, that kind of thing. If thing if you are thinking of killing yourself, how would you do it? And lastly, are you thinking of killing yourself? I

think you need to ask that question if you really are they are kind of him-hauling and going around in a circle. You need to ask it straight. And you and you have to ask it matter of fact matter of fact and don't never. Oh, good Lord. The one thing never to do is pass judgment or say to the patient, you know what? You have a good life. You have no reason to kill yourself. Oh, good gracious. Don't ever say that. That is not effective whatsoever. But I've literally heard people do that and it is not helpful. You will turn the patient off so badly by doing such a thing because you're passing judgment and you can't be judgmental. That is really important.

So. those are just some ideas in terms of how you can approach it. But the bottom line is never ignore it, never ever. And if you are having a hard time asking, then call someone else to have them ask it. All you want to do is make sure that you have assessed it before that patient leaves your spaces. That's what's most important.

McGUIRE: You know, it's interesting that you brought that up because I've heard clinicians do that in the past and say, you know, you have so much to live for. You've got this, you've got that, you've got this. And, you know, it always kind of it's a little cringeworthy because that person is not seeing the positive in those things. I'm so glad that you brought that up.

Also, when you when you're asking the question about how badly or hopeless are they feeling, is it okay to use a scale of 1 to 10 on that like we do with pain? Or is it better to have a subjective answer?

WILLIAMS: Yeah, I've done that to where I want to get a handle on just how hopeless are they? And I've had people tell me, you know, I'm a ten. I feel totally hopeless. And boy, then you got an answer. Yeah, definitely. If you're trying to weigh it, certainly ask that. That is quite acceptable in my mind and patients, you know, will respond because if you're sending the message, you're concerned about them, they will answer you honestly. They really will. And I've been fortunate when I've had to deal with someone that was suicidal in front of me as to what in the world am I going to do and I'm not going to ignore it, that is for sure. So going back to so what did you do after let's say they say, yes, I'm thinking of killing myself and two I've got a very specific plan. What do you do? Well, there is where you say, you know what? I don't want you to harm yourself. If you were on the road bleeding, I would not just drive by you and let you bleed to death. Nor, am I going to just let you go and kill yourself when we can do something about it. So, I'm going to call for help, and we're going to get this further evaluated to make sure that you stay safe. The most important thing is that we keep you safe. And that is okay to say. And that can be you. I've seen it where the patient is out. You can get a sense of relief on their part that it's like, oh, finally it's out.

It's out in the open. I've now admitted to it, you know, maybe I will get the help I really think I need. And again, remember that whole thing about suicide. It's the part of them that wants to die. And there's the other part of them that wants to live. That ambivalence that they are experiencing, I go to the ambivalence of wanting to live, not the part of wanting to die. And so, I lean to that ambivalence and make sure that I've done everything I can to get them the assistance they need to get it further evaluated to then either be put in the hospital. And then I think one of the other points that I would make, and this is where nurses don't sometimes think about it as part of their practice code along with their state licensure. They cannot ignore someone who is telling them they are suicidal. You cannot do that by your practice and so you are licensed to make sure that you would never allow or make it permissible for the patient to go out and commit suicide or complete suicide. So that's what I think is important.

McGUIRE: Think that's true. It's very important. Yes. Thank you for that reminder. Now, just a few kind of indirect questions or different questions for you related to suicide. I know that on occasion when someone has committed suicide, people will say, well, at least they are no longer suffering. And actually, that was the patient's ultimate goal to begin with. So, when treatment plans are completely exhausted, we ever feel this from a personal perspective as well, or do we label each completed suicide as a failure from a professional perspective?

WILLIAMS: Well, certainly, if there was all kinds of warning signs and you ignored them, you know, you really have not fulfilled your role as an effective practitioner. And so, yeah, it could really be very damaging to you if you got into that position. But if you've done everything in your power to make sure that this patient stays safe, you can always feel that you've done everything you can possibly do. Now, again, I don't carry a big case load. You know, I've not done that the whole time because, you know, much of my career has been in teaching and research, but I certainly have carried a small caseload of patients I've treated. I've never lost a patient, you know, knock on wood, you know, that I've never had that happen. And I hope by the time I'm done seeing patients that it never will, because I certainly don't want that for me. And I've had patients that were very suicidal, and I took the appropriate steps and called in the resources. I don't do this by myself. I don't make the decision if I've got someone that I think is really very likely to complete suicide, I'm going to send them to the hospital.

And the University of Michigan, as an example, has a procedure so that if I if I as a provider assess that, I literally send them to the psych E.R., so the psych emergency room where they will be further evaluated and then they will be hospitalized if they are really that much of a serious suicidal risk. Every time I've done that, it hasn't been a lot of times, but I've certainly done it. They've been hospitalized because the staff picked up on exactly what I was picking up on and that this person was dangerous. And, you know, thank goodness I got them over to there to get further evaluated, but I didn't rest just to me to make that decision. If that makes sense. And I would tell any nurse that's out there practicing, never put yourself in the position that you are the sole decision making as to how much of a risk they are. If you're worried, get them further evaluated. That's what's important. And call in the resources that are available to you in the health care system. And believe me, everyone has a sigh of relief knowing that you did that. And that's important.

McGUIRE: And how do we support each other in our profession? If we do lose a patient, what should we do for ourselves?

WILLIAMS: Well, one of the things that that oftentimes happens in the health care system is there's sort of an evaluation of what went on in terms of this patient leaving and then ended up dying, that they will really reevaluate, go over it, you know, and everyone not to blame. It's never to blame. It's a matter of literally trying to figure out what could have been done differently. And people learning from that experience. So, there is always an evaluation that will happen if a patient does actually complete suicide. So that's not atypical. And that can be very supportive to the nurse because, you know, they're devastated. The nurse that has this happened to them. Oh, good lord. That is just devastating. And so, they need support in dealing with their feelings about this loss. And so that's what's important. So, the same applies to the staff members. You know, empathy and understanding and support is something that goes hand-in-hand. So, as we take care of patients, we also need to take care of ourselves, too. That goes both ways.

McGUIRE: Absolutely. Absolutely. So, I know we touched on how suicide is more common in like a permission in a family that has had a lot of suicides, for example. And I'm sure that there are some cultures that feel differently about it than others. But what do you feel is behind our drive to save those who genuinely, really don't want to be saved or do you feel that they always have an element that wants that on some level?

Is it social bias? Is it our religious beliefs? Is it just our culture? What are your thoughts?

WILLIAMS: Yeah. That’s an interesting question. It's one that, you know, there's any number of factors that probably could affect it. You know, one of the things, of course, I come my perspective on it to sort of answer your question to some degree, is that I don't think anyone is truly, truly bent to kill themselves. There is some element in them that still wants to live. It's just that they are feeling so hopeless that they don't think there's any way out and so I don't want to go to that stage. You know, some religions believe that suicide is wrong.

Well, one of the things that I always tell students and any nurse doesn't matter, student or not, you have no right to impose your religious beliefs on your patient.

You're there to take care of the patient, not take care of your religious beliefs. So, bringing in religion is totally, totally inappropriate. And I would never and if you can't let that go, then turn it over to someone else. That can because religion does not come in here to say, well, you're wrong. You are committing a sin. Oh, good Lord. All you've done is remember that guilt that they're operating with, with their depression and feeling so hopeless that they are feeling so guilty. They're imposing all this on their family, and their family would be so much better off of if they were dead and all that stuff. And then you put religion on top of that.

You just made him feel even more guilty and oh, good lord, that could be just disastrous. Just disastrous. So, for whatever that's worth.

McGUIRE: Yeah, no, that's a good answer. I'm glad that you said that. I'm just curious if you have any final thoughts that you'd like to share. Anything that we really need to remember or keep in our back pockets when we're dealing with these patients who are brought to the hospital or outside outpatient, who we're assessing. What are the important things that we need to remember?

WILLIAMS: Probably one that I would emphasize is that sometimes a patient and I've seen this more on inpatient units where they will take a nurse and they'll say, you know, I'll tell you about my thoughts only if you agree to never tell anybody keep it a secret.

McGUIRE: Yeah.

WILLIAMS: Never, ever agreed to that. Never. Because you don't know what their what they're about to reveal to you. And if anything, my response to that patient would be, I can't agree to that because I'm here to make sure that you stay safe. And if I determine that you're telling me that you're not safe, I can't keep that as a secret. I have to let the system and others in the unit here to know and that's how you deal with that. So, you never, ever agree to keeping a secret. I think what's most important is that if you send the message that you are concerned about them, that you do not want them to harm themselves, and you're going to do everything in your power to make sure that they stay safe.

That gives them a sense of hope, because right now they don't feel safe. They don't they know that they are really in trouble, but they don't know how to get out of it. And so, you don't want to put them in the position of, well, I'm going to solve the problem in this way. No, it's a matter of you taking command of the situation and helping the patient get the resources that they absolutely need. And if it takes someone else to reevaluate the person as to how suicidal they are, then let that happen and call in the resources that you have available to you. If, let's say you're so afraid that the patient is actually while you leave the room to go call in resources, they're going to do anything well, go to the door and yell for help, you know, in other words, don't leave the patient alone.

You know, it would be a simple way to address that if that ever happened. I will give you an example of what happened to us. This was some years ago. And a colleague and I were teaching a class together, and we had a teaching assistant that was helping with the class. Really neat, neat woman, really doing an exceptional job as being a teaching assistant. And we taught the class and things really went well. And we're talking after class had ended. And a student, she was a graduate student, made a comment that both of us, my colleague and I looked at each other and said, what did she just say? And it was like there was something that she said that made her sound suicidal.

So, guess what we did? Well, we had a rapport with her. We'd work with her for that whole term. And we said, wait a minute, are you feeling like you want to kill yourself? And I don't know that if we asked it that way, we might have gone through a little more of what I just described in terms of, you know, are you thinking you would be better off dead? I think that was really what we asked her. And she said, yes. And we said, Oh.

McGuire: Wow.

WILLIAMS: How would you kill yourself? And she said, well, I had plans of leaving here and I was going to drive into a bridge abutment and it's like, oh my God, she's got a very serious plan here. We need to act on this. Luckily my colleague had a car where it was kind of a bench seat, so we decided we were putting her in the middle of it so that she couldn't jump out of the car because we were really so worried about how suicidal she truly was. We took her right over to the psych ER. They admitted her, and it was such a relief. And she later came back to us and said, thanked us up one, side and down the other, and said, had you ignored that had you just. I had every plan to drive into that bridge and I would have killed myself. Good Lord.

And if that wasn't sobering, I don't know what would be. But it truly was one of those moments in your life where you said, "I did the right thing" and we did, and she did fine. After that, she got treatment. What she needed. She was very depressed. And we found all that out after. And so, it was it was such a relief to know. But she was covering it. She you know, if you talk to her happy as a little lark, you know, happy as all get out. Oh, no, that was an academy performance, and it wasn't true.

McGUIRE: I'm so glad you shared that with us, because it really speaks to not ignoring those statements. I think sometimes we think I couldn't have heard that right or oh, it's just me. And we don't address those issues. But that was the perfect story to share as we wrap up this podcast, I am so grateful as I know our listeners will be for you, this information on suicide and sharing your expertise with us again. It's such valuable information, great reminders for us in our clinical practice. Please turn your computers around for rapport and to be able to express true empathy because we can't do it when we're not looking at our patients. So, thank you so much, Dr. Williams. We really appreciate the time that you've spent with us. This has been a great experience.

WILLIAMS: You're so welcome. And it was my pleasure.

McGUIRE: All right. We hope you've enjoyed this episode with Dr. Reg Williams. Again, we encourage you to explore all the courses that we have available at Elite learning dot com to help you in your career. And we appreciate you listening. This is Leana McGuire for Colibri Healthcare.

PIERCE: Thank you for joining us for this podcast series. Through this series, we hope you have been able to dismiss some common misconceptions about suicide and replace them with facts, to understand the risk factors of suicide, and take away some helpful strategies in evaluating someone who may be showing signs of thinking about suicide. I know this is a difficult topic for many of us to discuss with our patients, but it is an important assessment of patient safety.

(SOUNDBITE OF MUSIC)

If you or someone you know is struggling with thoughts of taking their life or you are in an immediate health crisis, please call or text the national suicide prevention lifeline at 988. This line is open 24 hours a day, 7 days a week. And you will be connected to trained counselors who can provide support and resources. You can also find more resources through the National Alliance for Mental Health, also known as NAMI at www.nami.org or by calling or texting 1-800-950-6264.

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This is Dr. Candace Pierce for Colibri Healthcare.

(SOUNDBITE OF MUSIC)

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