

## THE REALITIES OF RISK, THE NATURE OF HOPE, AND THE ROLE OF SCIENCE: A RESPONSE TO COOK AND VANDECREEK

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*A response is offered to the critiques of both Cook and VandeCreek. Among the points emphasized are the simple realities of risk with suicidal patients, existing empirical research with informed consent in both clinical psychology and other health care areas, as well as the persistence of common myths in clinical practice with suicidal patients. Although empirical science provides a firm foundation to much of what is proposed, it is critical for practitioners to recognize and respond to the ethical demands for openness and transparency with high-risk clients in an effort to achieve shared responsibility in care.*

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We want to thank both Cook (2009) and VandeCreek (2009) for their thoughtful responses to the manuscript. In crafting the article the hope was to generate discussion and debate about the nature of the informed consent process with suicidal individuals, along with encourage scientific study of informed consent as a clinical intervention. Cook and VandeCreek offer interesting comments and raise important concerns. Both make a valid point about reading level and we cannot disagree. As indicated by the Flesch–Kincaid Grade Level score, the example provided is complex. We are currently exploring ways to simplify the language without altering critical elements of the content and would certainly encourage others to do the same.

Cook (2009) raises a number of concerns, however, with which we disagree. Perhaps at the forefront is the issue about empirical support and informed consent. She makes the mistaken assumption that every element of the psychotherapy exchange has to be subjected to the same intense level of scientific scrutiny. Taken to the extreme, such an assumption would demand that even absurd elements of care be examined and supported in randomized clinical trials. For example, there is no scientific data available to date that demonstrates that psychotherapy should be conducted in rooms with furniture, that therapist and patient should sit in chairs, that psychotherapy sessions that are 50 min in duration are the most effective and efficient, or that routine therapy should not be conducted between the hours of midnight and 5 a.m. These examples are purposefully absurd but demonstrate the point. With respect to informed consent as a clinical intervention, however, there is empirical support about its impact on both attitudes and behavior change.

The genetic counseling literature includes a number of studies (e.g., Aspinwall, Leaf, Dola, Kohlmann, & Leachman, 2008) demonstrating that information shared about genetic risk for melanoma results in improvements in self-care and related health behaviors. We also noted in our article that, contrary to a common myth, disclosure of accurate psychometric testing results is both helpful and a positive emotional experience for patients (Holm-Denoma et al., 2008). The notion that withholding information from suicidal patients smacks of the old myth that openly asking about suicidality might somehow plant the idea in someone's head. There is now convincing scientific evidence to the contrary (Gould et al., 2005). What we are proposing is certainly not novel. We are simply suggesting that informed consent with high-risk suicidal patients be a thorough, accurate, and continuous process as demanded by our professional ethics. We are by no means suggesting a "one size fits all" approach. The nature of risk information should be specific to the problem and diagnosis, with multiple attempters representing the highest risk group. There is more than ample scientific evidence to support this claim (e.g., Rudd, Joiner & Rajab, 1996).

As argued in the article, we believe that it is simply an ethical obligation of clinicians to provide accurate and detailed informed consent to all patients, not just those lower on the risk spectrum. As we noted, there is data currently available about the frequency of both suicide attempts and death by suicide during treatment. If there was data suggesting that disclosure of such information was iatrogenic, we would agree with Cook (2009) but that is not the case. The data available point in the other direction and, as we noted, suicide attempt rates and deaths among the highest risk suicidal patients are not rare events. Even in inpatient settings, commonly believed to be safe, suicides occur with some regularity with an estimated 300 suicides per year in psychiatric hospitals (Maris, Berman, Maltzberger, & Yufit, 1992). Other estimates are considerably higher (e.g., Jacobs, 1999). Two recent court rulings in both Wisconsin (Bubb v. Brusky, 2007) and Maryland (McQuitty v. Spangler, 2009) agree with our argument, indicating that informed consent must include all treatment options and a detailed discussion of related risks and benefits.

Many of the concerns raised by Cook (2009) are consistent with the anxieties and worries we routinely hear when talking with and training clinicians around the country. The suggestion that we should withhold risk information from patients is troubling

and contrary to the intent of most, and arguably all, professional ethical guidelines. The notion of shared responsibility in care is certainly not a new one, but it is an important element in the treatment of the highest risk suicidal patient. Accurate, detailed, and blunt discussions with high-risk patients are an essential first step. Without such discussions we do not believe that either the patient or clinician can make informed decisions about care. From a clinical perspective, it is important to assess how the patient responds to risk information and steps that can be taken to mitigate risk (e.g., the use of safety planning). A number of us recently discussed some of the ethical issues raised in more depth and would refer the reader accordingly (Jobes, Rudd, Overholser & Joiner, 2008). We will continue to study informed consent as a clinical intervention and would welcome any and all input about this critical issue.

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