In a Search for Meaning: Challenging the Accepted Know-How of Working with Suicide Risk

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Abstract: This opinion piece considers the current predominance of assessment tools and strategies in working with people at risk of suicide, and questions their efficacy and how they are privileged in day to day mental health practice. While such tools and an evidence-based 'scientific' approach to assessment clearly has its place, the author instead asserts that the modus operandi of therapy – a discursive based exploration – has much more to offer and should be the primary intervention in understanding suicide potential. Helping the client to gain insight into the meaning of their suicidality helps position the client – and practitioner – in the best possible place to reduce risk.

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Setting the Scene

When my client, whom I have previously called Isobel (a pseudonym), died through suicide nearly 25 years ago I went in a search for meaning. Prior to her death Isobel and I had been collaboratively engaged in a search for meaning too: a meaning for her life in the face of abuse, disempowerment, alcoholism, frequent suicidal thinking and self-injury. This had, it seemed, been relatively fruitful, with Isobel emerging from many years of exile spent in the psychiatric services facing new realities and opportunities. Indeed, the therapy session we had the afternoon of her death later that day was spent with Isobel talking about new opportunities and a revived hope. It was lost on me of course, probably deliberately so on Isobel's part (for she knew the 'system' well), that her revived hope paradoxically probably emanated from her planned death. After her death, it was just me in search for something that I thought I had clearly missed or overlooked.

Exposing Holes and Missed Opportunities

In the immediate aftermath of Isobel's death that is how I saw my re-shaped professional world: of missed opportunities and overlooked meanings. Certainly my training, neither as a social worker nor as a therapist, really equipped me to navigate this terrain. Risk assessment, as it had been discussed, seemed such a simple affair: the identification of risk factors, the naming of protective factors, weighed up with a healthy dose of client capacity. Isobel, of course, ticked many of the risk factors boxes, there were emerging protective factors too, and as for client capacity, well, Isobel understood where her actions would lead her and why she wanted to go there. In theory, it all sounded so understandable whereas, in practice, it was nothing of the sort.

I wish, in this short opinion piece – my own views forged from practice rather than those belonging to any other or organisation – to challenge some of the accepted norms that pervade working with suicide risk and assert that, as therapists, we have much to bring to the table. I wish to unpack what was, and still is, referred to as *risk assessment,* and instead offer an approach that, I believe, is much more meaningful: *risk exploration*. More specifically, I wish to argue that as the culture of working with suicidal potential seems to have been increasingly shaped and informed by research that privileges risk factors and empirical evidence, the less we seem to be supported as practitioners to listen to people's experiences of suicide. That is not to say the empirical does not have a place in understanding suicide potential, because it surely does, but not at the risk of us skipping over another's suicide narrative and experience. Ultimately, regardless of the positive contribution they may make, a risk assessment form or judgement of risk and protective factors are never going to help us understand individual experience; talking to a client and really hearing their story is much more likely to do that.

The Culture of Assessing Suicide Risk

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The culture of risk assessment needs to be understood within the ontological and epistemological pool in which it floats. That is, how do we conceptualise the nature of being, and how might we go about understanding knowledge that underpins it. This is important because, if we understand suicidality as a symptom of psychopathology and demographics, we might take a spanner to 'undo' it and fix it, whereas if we see it instead as a mechanism of experiencing both living and not living, we might reach for a magnifying glass so that we might understand it more. The tool we reach for to fix the problem is, fundamentally, informed and shaped by the problem itself, if it is indeed a problem at all. Within mental health cultures suicide is most definitely seen as a problem and everyone is tasked with fixing it. If we trace back to the late 1990s and the publication of *Saving Lives: Our Healthier Nation* (DoH, 1999), we will see perhaps the latter day re-emergence of health-based targets, of which suicide reduction was one of them. Fast forward to the present and we see the policy of Zero Tolerance to suicide within the NHS (Deputy Prime Minister's Office, 2015).

Positioning Therapy in Relation to Prevention Strategies

I simply do not have the words here to give justice to the subtleties of the debates around whether or not we should always prevent suicide: such views will be shaped personally and professionally by a raft of factors, including: faith; personal experience of crisis or suicidality; training; news stories; media; culture, and so on. It is incumbent on us as practitioners to fully know our own positioning with regard to the 'rights and not-so-rights' of suicide. Suffice to say that mental health policy does not deal in such subtleties, but rather in the requirement of all mental health workers to prevent suicide, wherever possible and practicable – and has a zero tolerance to anything but.

The turn to science therefore, becomes compelling. It is pointless having a zero tolerance to something unless we truly believe we can affect change. When climbing a mountain to enjoy the view I have a zero tolerance to cloud, but that tends not to stop it from getting in the way. So the turn to science: enter stage left the *risk factors*, (i.e., those factors that indicate a higher risk of suicide, such a psychopathology and demographics); enter stage right the protective factors, (i.e., those factors that indicate a lowering of the risk of suicide, such as a good therapeutic relationship, family, friends etc.); and centre stage is capacity. A compelling script we are all required to follow. Yet, we imagine that the bringing together of all three considerations into a judicious interpretation will position us to prevent suicide. And sometimes it does. And sometimes it doesn't. Herein of course lies the paradox: for all we know about suicide, there is so much more we don't.

There is the risk assessment industry at play too: the churning out of risk assessment tools, protocols, questionnaires, flow-diagrams, and so on, all hoping to provide certainty in what is essentially a very uncertain place. Very few, if any, have any efficacy in predicting individual action in relation to suicide. Large et al (2016) assert from their meta-analysis that 95% of high risk patients do not die through suicide, and that there had been no meaningful increase in the accuracy of prediction of suicide over the last 40 years. They may contribute to

an understanding and may give permission for more of an exploration, but the problem is that too many view them as the 'start and stop' of working with suicide, rather than simply a starting point. We place so much trust in their predictive accuracy that, too often, we forget to turn back to the client.

The Power of Suicide Exploration

My assertion here is that the only meaningful way to work effectively with people who are suicidal is through a process of suicide exploration, supplemented, as helpful, with structured assessment process: that is, talk first, tick later. I am reminded here of the terms 'child protection' and 'safeguarding', for it is a good comparison. The language of working with children and young people has become technically and factually lazy. For 'child protection' we say 'safeguarding', for 'safeguarding' we mean 'child protection', implying they are the same thing when they simply are not. Child protection sits within our safeguarding responsibilities, but safeguarding is also a much broader term that encompasses all sorts of things, such as wellbeing too. Risk assessment is one part of suicide exploration, but it is not the same as.

Rather, suicide exploration is about the opportunity to sit with and really hear what another's living, or not living, is really like. To ask about suicide, to question it, to be prepared to go to the difficult places, to be brave. That sounds so easy but can be so difficult. In a study I undertook a while ago I was surprised how few therapists – regardless of theoretical orientation or practice experience – were actually prepared to ask the 'suicide question' (*Tell me, how difficult does this get for you? Are there times when you feel like ending your life in response to how things are'* – or something like) (Reeves, et al 2004). As a Samaritans volunteer we were taught from day one to ask the suicide question of everyone. Despite the persistent myth, asking about suicide will not put the thought into another's mind. Instead, it will leave the level of suicidal pain unchanged, or may help reduce it simply by talking about it.

Yet, suicide exploration is also not simply about asking the suicide question either. I have written previously of therapy as akin to emotional potholing (Reeves, 2010). We accompany our clients into their labyrinth of caverns and systems – some known and others unknown – securing the rope so that we can both leave safely at the end of the exploration. Suicide exploration demands that we also go into those caverns that are particularly frightening – or soothing – that again may be known to the client or may, in turn, thunder up unexpectedly out of the darkness. We know that therapists can often feel a range of responses when working with suicide potential: fear, anger, despair, hopelessness, even trauma. The demand to be brave is a very real one, and one that demands commensurate courage and attention to self-care.

Our Particular Contribution

The benefits to be had of asking about, exploring, meandering, staying with and being witness to another's being is very familiar to us as therapists; that is what we do. Having worked as a mental health social worker for many years I am also aware of the role of others' in supporting people through crisis. However, our

particular contribution as therapists is, perhaps, honouring our way with clients while, at the same time, advocating and challenging the systems in which clients can find themselves lost. If we can ensure our contribution to an understanding of working with suicidality centres around the importance of exploration, rather than simply assessment, then our contribution might turn out to be significant. In the words of Schneidnam (1998 p6), "*… our best route to understanding suicide is not through the study of the structure of the brain, nor the study of social statistics, nor the study of mental diseases, but directly through the words of the suicidal person. The most important question to a potentially suicidal person is not an inquiry about family history or laboratory tests of blood or spinal fluid, but 'where do you hurt?' and 'how can I help you?'.*"

It is my final assertion that, in the light of Large et al's assertion of the lack of progress over the last 40 years in understanding and, thus, predicting suicide, as therapists we could – and should – be taking the lead in re-introducing into the mental health arsenal the exquisite and profound insightful process of exploration, with science a firm second.

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