Working with Suicide: Part 2

Introduction

One of the biggest anxieties for therapists when working with clients who are suicidal is how best to talk to them about their thoughts and feelings. The persistent myth in working with suicide is that if we name it as a possibility, we inevitably increase its likelihood. However, as we explored in the previous article in our work with Jake, the reality is that, for many clients, having an opportunity to talk about their suicidal feelings is an immense relief, at worse leaving their suicide risk unchanged or, more often, leading to a reduction in its possibility.

However, talking about suicide is not the only concern of practitioners: managing contractual issues; meeting the needs of organisations; working ethically; doing the "right" thing and, ultimately, not "getting it wrong" can contribute to significant anxiety [1]. Indeed, research has suggested that the emotional and psychological impact on the therapist of working with ongoing suicide risk is as significant as the feelings should a client actually end their life through suicide [2]. This is a notable finding given the high numbers of therapists who routinely work with suicidal clients and the potential negative impact it has on their own emotional well-being.

Working in an Organisational Settings and Private Practice

Most organisations that employ therapists have their own policies and procedures in relation to clients who present at risk. Likewise, private practitioners routinely work to their own stated policies and practices so as to ensure equitable service delivery, as well as ethical requirements. As we have talked about individual anxiety, this not uncommonly parallels at an institutional level too, where organisations try to 'pin down' practice so as to avoid the potential for client suicide. If there is one thing that is known in working with suicidal clients however, it is that much of it is unknown. Therapy is shaped and informed by a multitude of factors, not least the subtle and individual interplay of dynamics between the client and therapist themselves.

In an attempt to apply 'science' to this process, organisations retreat into tick boxes, flowcharts, and an approach to suicide that is informed by "if client says A, the therapist does B" expectation. This is profoundly difficult as suicide risk is always and inevitably in the realms of the mostly unpredictable. A great deal of practitioner anxiety can stem from a sense that, despite their best efforts, the client isn't thinking and feeling in the way the procedure suggests they should.

That is not to say however, that therapists should freely abandon all notion of any organisational expectations. Research has suggested that when therapists disagree with

organisational policy, they manage this dissidence by disregarding the policy [3]. This places both the therapist and client in a potentially difficult situation, where practice ceases to be held by the contractual expectations in which it was originally located.

Rather than disregarding policy simply because it does not seem to be a good fit to the ethos and philosophy of therapy, practitioners have three options: the first, to simply work with the policy unquestioned; the second, to work within the policy but to challenge it at every possible opportunity; finally, the third, is if the policy cannot be changed and it so contradicts the practitioner's view of how therapy should be, they have to leave the work of the organisation. I do not assert this last point lightly: I am very aware of the challenges of finding paid employment for therapists; walking away from work would never be an easy or first option to make. However, there are no reasons to compromise good, ethical practice and sometimes – albeit rarely – difficult decisions might need to be made.

The Personal Views of the Therapist

I remember in my own training being told that when we, as therapists, enter into the counselling room we leave ourselves at the door. If there is one thing that I have learnt since I qualified as a therapist, it is that this assertion is entirely untrue. Indeed, it is my own view that it is the very essence of who I am as a therapist, held within the context of a professional therapeutic relationship, that is an important part of the relational process. If I'm not present in some form, who might I expect the client to relate to? However, this position brings particular challenges for us when working with clients who are suicidal.

Suicide, similarly to other potent dynamics, rarely leaves us unmoved. There are few of us who would not hold some personal position in relation to suicide, or who have not been touched by it personally and professionally. My own route into working with suicidal clients and how I came to be writing about it for the last 25 years was my own trauma following the death of the client through suicide during my counsellor training.

It is not the purpose of this article to take a particular position on suicide: I am not here suggesting that we should be pro or against a choice for suicide; rather that, as therapists, we should be engaged in a reflective way with our own position. This will change of course, over time and in response to life experiences. The range of factors that might shape and inform our personally held views on suicide are multifaceted but might include: music we listen to; books we read; news articles; training; supervision; other professional experiences; how suicide has impacted on those we love; and of course, our own relationship with suicide and our own mental health.

The challenge here is for us to know, at any given stage, how our personally held views might shape and influence the work we do with our clients. Paradoxically, those

practitioners who assert to themselves that their own views on suicide would never 'creep' into the counselling process, are the ones for whom it is most likely to happen. It is a human process underpinned by emotion, poignancy, anxiety and – sometimes – fear. It is not our views about suicide in of themselves that are problematic, rather, unacknowledged views that have the potential to shape and inform what we do with clients.

Managing the Contract and Confidentiality

The majority of us will contract with our clients to guarantee confidentiality limited to the organisation in which we work, or in the event of risk of harm to self or others (with additional particular aspects around legal requirements). In undertaking this contract, we are, of course, taking on particular responsibilities in relation to the client's well-being. That is, that we are able to determine to the best of our ability the presence and likelihood of harm to the client, and that we would act to safeguard the client's well-being should we determine that is necessary.

My experience over the years and talking to many thousands of therapists who I have trained in relation to suicide, is that while the details of the contract trip lightly of our tongue during early sessions in therapy, the realities of the contract with clients at risk of suicide come home to roost in all too difficult ways when risk is strongly suspected. It is at these stages when personally held views around suicide, as discussed previously, become particularly pertinent. It may well be that a client discloses high levels of suicidal risk in response to enduring and deteriorating physical health problems, e.g. with a terminal diagnosis; or perhaps, following a major and traumatic bereavement. At one level there may be part of us that can understand the clients pull towards suicide; however, it is a very easy position to slip into in making decisions about the 'rights' and 'wrongs' of the client's decision-making process and lose sight of our original contractual obligations.

However, there is another side of that contractual coin. My own experience of practice and, I suspect, similar to many other therapists, is that a large number of my clients at any one time may present with some degree of suicidal thought or risk. If I were simply and unthinkingly to break my client's confidentiality simply because suicide had been named or explored, I might be routinely referring on 80-90% of my clients. Simply put, in the context of the contract in which I have made my client, and the organisational demands of practice, I make an informed decision to work with my client's suicidality in the belief that the therapeutic process will provide a restorative and safe space for them to move away from their risky thinking.

Positive Risk Taking

It is my assertion here that all therapists, a significant amount of time, positively risk-take with their clients. That is, they make informed decisions collaboratively with their clients to work proactively around suicide potential, with a view to supporting their clients to a safer space. We do this through careful evaluation of a number of factors: the risk factors (those factors that might make suicide more likely); the protective factors (those factors that might make suicide less likely); our experience of therapeutic relationship and process; our judgement of the client's capacity to engage with therapy and to take active steps to help themselves be safe; the contract and policy in which therapy is situated; and our own capacity to hold our anxiety in the context of this uncertain situation.

There is an important premise underpinning this assertion of positive risk taking: that is, if an adult client has capacity as deemed by the Mental Capacity Act (2005) [4], work focuses on enabling them to take steps to keep themselves safe; in short, it is not a therapist who will keep the client live but, rather, it is the therapy that will equip the client to help safeguard their own well-being. There is a creeping sense, at times, and particularly in the light of suicide potential, for us to feel a responsibility *for* our clients as opposed to a responsibility *to* our clients. This latter assertion is not semantic juggling, but a significant factor that underpins the nature of the relationship we hold with our clients.

Working with children and young people however, brings additional challenges. A young person's competence in making decisions around their own well-being is, of course, informed by additional and complex factors. Furthermore, the context in which such therapy takes place has a profound influence on the nature of therapy itself. The safeguarding responsibilities of a school for example, may place additional responsibilities or limitations on the work of the therapist. However, in reflecting on my own supervisory work of counsellors in schools and in the role of Governor Safeguarding Lead in a large comprehensive school for many years, I am aware that young people too commonly present suicide risk and that counsellors are routinely weighing up this risk to ensure they offer the best therapeutic experience they can for their clients. With adults and young people alike, the weighty responsibilities that therapists can feel are ever present.

Supervision and Self-Care

Supervision sits at the heart of all therapy, helping us to reflect on both therapeutic process and our part in it. Work with suicidal clients needs to be profoundly shaped by the supervisory process, in that it offers the space where we can step away, albeit temporarily, from our personal responses and potential anxieties and reflect on the process of the work from a more objective position.

However, as ever, it is not as simple as that. Everything that has been written about organisational and practitioner anxieties applies to the supervisor. While this is a generally

under-researched area, we know enough that supervisor training rarely spends a great deal of time focusing on work with risk (paralleling that of counsellor training), and that individual supervisors can feel as anxious about risk in therapy as their supervisees.

The importance of an early, open and honest dialogue with the supervisor about risk cannot be overstated: reflecting on the organisation's position in relation to risk; the practitioner's view of risk; how the client is presenting specifically with risk; and supervisor expectations all need to be explored, preferably before having to make quick decisions in a high-risk situation. It is my assertion that, only then, can supervision and the supervisor be positioned to offer truly challenging and supportive space, enabling the supervisee to work as effectively as possible with their clients and the supervisee be best positioned to attend to their self-care.

Responding to Suicide Potential

There might be three particular scenarios to consider here: where risk is immediate; where we risk is high but not immediate; where risk is low but still present.

Where risk is immediate
It is important that when a client presents with immediate and pressing risk, e.g. it is their intention to leave the counselling room and end their life immediately, that therapists should not delay in action. Wherever possible, therapists should consult with a manager and/or supervisor before take any action but should not allow a delay in consultation to prevent them from acting to safeguard the client's (and potentially others') well-being. Albeit a very rare situation, should a client leave the room with a stated intention to end their life and immediate consultation is not possible, the therapist should have confidence in contacting the emergency services to request an immediate response. As a rule of thumb, my own view is that it is better to defend positive action to safeguard the client's well-being, than to defend a lack or delay in action, which might have contributed to client harm.

When risk is high but not immediate
This is a familiar scenario for many therapists and is the one where we move towards positive risk-taking in some situations; however, such decisions have to be informed and supported by action. While No Harm Contracts are generally poorly viewed in the literature as being potentially emotionally coercive and introducing fractures into the therapeutic process [5, 6], Keep Safe Plans, where risks and protective factors are transparently considered and actions the client may take in the event of risk between sessions are written down, can support therapy effectively. An example of a Keep Safe Plan may be found at the following link: https://www.studentsagainstdepression.org/wp-content/uploads/2018/04/my_safety_plan.pdf.

Where risk is low but still present

Low risk, or even no risk, should not be taken for granted. Any client has the potential to present with suicide risk and the possibility of low risk moving to higher risk cannot be underestimated. Returning to the previous article and the examples of how suicide was explored with Jake, therapists should feel confident in talking openly and honestly about suicide in a way that keeps the door open for clients to do the same. The more the client can feel a permission from their therapist to talk about suicide when it comes important to do so, the greater chance there is of the risk remaining low or, indeed, disappearing completely.

Final Thoughts

I have outlined here a number of significant challenges in working with suicidal clients. However, if we approach this work less as a science and more as a relational process that is inevitably uncertain and unpredictable – following good practice guidelines, remaining focused on our ethical responsibilities and taking active steps – the more we can proactively engage with our clients. It is my final assertion, having worked in mental health services for many years, that counselling and psychotherapy can be one of the most important relational spaces for clients to explore feelings they may not discuss with anyone else. While the challenges are therefore real, the opportunities to truly help and support clients move past a point of crisis are significant and should not be undervalued.

References

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