<TITLE> **The Missing Link: Relational Exploration in Working with Suicide**

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<TEXT BOX> **Abstract**
Empirical research has driven the agenda around suicide risk assessment for many years leading to mental health services and allied professionals, including counsellors and psychotherapists, relying more heavily on risk factor-based questionnaires as the primary mechanism for identifying suicide potential. Research also suggests however, that the efficacy of such risk questionnaires is, at best, questionable and does not really provide a reliable insight into the likelihood of harm. This article argues the position that while factor-based information can be contextually helpful, the only way in which a deeper understanding of the meaning of, and potential for, suicide can be achieved is through the therapeutic discourse. Suicide exploration, it is asserted, provides not only greater insight into the process of suicide for the client, but also contributes to a context where the client may be enabled to support themselves effectively at times of suicidal crisis.

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Suicide, assessment, risk, vicarious trauma

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Encountering Suicidal Potential

It could be asserted that all counselling and psychotherapy (herein after simply referred to as ‘therapy’) demands a subtle interplay of a number seemingly straightforward, yet ultimately complex, factors. The list of these factors is extensive but might include: the relationship (of course); how the client presents; the specific aspects of their experience and difficulties; the position of the therapist in relation to the client, including differences and similarities; the context of therapy; and the capacity of the therapist to tune in to and hear the client’s narrative.

These factors, and others, are present in all therapy, all of the time. However, it might be argued there are certain types of situations, or particular points in therapy, where any one of these factors becomes more prominent; either to facilitate the process or, ultimately, to impair or rupture it. While there is still surprisingly little written in the mainstream therapy literature about working with suicide, what we do know confirms that the discourse around suicide specifically is often encountered as a difficult one (Leenaars, 2004). Simply put, even the most experienced practitioner can experience difficulties in naming suicide with a client whom they suspect might be suicidal; or can be reluctant to enter into a client's suicidal phenomenological space (Reeves, 2015).

As someone who has talked about and delivered training on suicide for many years, it is not uncommon for me to hear therapists, of many year's working experience say, "well, I have never worked with a suicidal client". It is, of course, entirely possible that such an assertion is true: that through many thousands of hours of delivering therapy not a single client has ever contemplated suicide – either with an intent or suicidal ideation. There is also a possibility however, that suicide potential has not been asked about, nor identified, rather than it not existing at all.

The Dynamics of Avoidance

Given what we know about the challenges of working with suicide, a number of avoidance dynamics may be apparent. The literature tells us, for example, that therapists will often actively avoid asking a client about suicide for fear the question will put the thought into the client's mind, thus prompting their suicide (Centre for Suicide Research, 2018, Leenaars, 2004). The literature also tells us that asking a client about suicide will not increase risk but, in many cases, will reduce it as the client will be able to explore their own thoughts more fully.

Likewise, the literature tells us that therapists' own views about suicide will be highly influential in the therapeutic process with a suicidal client (Reeves, 2015). That is, a therapist who strongly believes that suicide is a client's free choice, or one who believes that suicide should never be a choice, are likely to respond to their clients accordingly: either by disregarding their own contract re confidentiality at times of risk and not raising concerns, or perhaps intervening too quickly, despite the client talking of general suicidal ideation rather than an intent. These are not 'bad' therapists, but they are simply experiencing a very real and understandable personal response to the presence of suicide in their work. After all, one area the literature is entirely clear on is the extent to which therapists – and other mental health workers too – experience high levels of anxiety in response to suicide potential in their clients (Fox and Cooper, 1998; Panove, 1994; Richards, 2000).

What we can see in the response of the individual, we too can see institutionally. In the world of a 'zero tolerance' to suicide in mental health care settings, it is not surprising that the level of anxiety experienced by the individual practitioner can be paralleled in the institution too. For example, there has been a notable growth in the 'risk assessment industry' for several decades, alongside the greater concern in public health about national and international suicide rates. The World Health

Organisation (WHO) report that 800,000 people die each year across the world through suicide, and that suicide prevention is a "global imperative" (WHO, 2014). In the UK, 4 men die through suicide each day, when the number of male suicides is averaged out across a year. Suicide is, indeed, a public health crisis and one that health, social care and third sector institutions are tasked by Government to deal with (including independent practitioners too).

It is therefore, unsurprising that we see a turn to science – through the development of risk assessment tools and questionnaires – to help us attend to this crisis. While risk assessment forms clearly have something important to offer, they are not without problems too. Large et al (2016) undertook a meta-analysis of risk assessment tools and stated that 95% of 'high risk' patients did not die through suicide. This means that high risk factors might contribute to a level of accurate predication of the likelihood of suicide, but risk factors are insufficient, in of themselves, to help us understand an individual's suicidal crisis. Likewise, Large et al further state that, "*there had been no meaningful increase in the accuracy of prediction of suicide over the last 40 years*" (Reeves, 2017 p 2-3). The turn to science is unlikely, certainly for the foreseeable future, to provide us with the certainty we so crave.

The Missing Link?

Herein lies a 'perfect storm': a public health policy arguing for a 'zero target' for suicide (Deputy Prime Minister's Office, 2015); institutional anxiety increasingly resorting to tools and questionnaires in the hope they will provide clarity, where that is unlikely; and therapists feeling that same anxiety too with the ever-present spectre of 'getting it wrong'. In the meantime, however, as the approach to suicide appears increasingly immobilised through fear, people continue to die who might otherwise have been given an opportunity to consider alternative solutions to their distress and despair (this article does not have the scope to discuss whether *all* suicides should always be prevented…).

If we turn back to the literature, we know that therapy can be very effective with suicidal people (Reeves, 2010) because, perhaps, it provides both an important relational connection and offers a space – a unique space for many – where they can actually voice their suicidal thoughts without fear of judgement or immediate action. It seems slightly bizarre to be suggesting that, as social beings, the missing link in supporting people who are suicidal is the capacity and willingness to actually engage with, talk to and explore what suicide means, but that is the assertion I make. We might wonder why the Samaritans is such an effective and important organisation: amongst many reasons it might simply be they are willing to listen to and hear what others increasingly are shying away from. It is also interesting to note that the Samaritans is often included as part of a patient's mental health care plan on discharge from hospital; perhaps consciously – or unconsciously – there is an acknowledgement that at a time of mental health crisis people primarily need, amongst other things, a relational contact that is safe, secure, ethical, professional and human.

The Place of Therapy

The argument here is not for the exclusivity of therapists in providing that space for people in suicidal crisis; many others can provide that important point of contact too. Rather, that therapists are often uniquely placed to offer such contact in virtue of the very nature of the work they do. Regardless of modality, therapists are trained specifically to build a therapeutic relationship in which any aspect of the client's world could – and should – be explored, if that is the wish of the client to do so. The client's suicidal experience should be welcomed into that therapeutic space so that the client can not only voice their inner experience but, through the contact with another, can understand and make their sense of it. After all, we can medicate, legislate and incarcerate, but none of these will ultimately prevent a client's death through suicide if that is their intent. Assuming a client has capacity to do so (and being suicidal does not automatically mean a lack of capacity), they can use therapy to work with their suicidal thinking to help take, or retake, their responsibility for their own safety and wellbeing. What is needed however, is therapeutic courage and a willingness to go with our clients into difficult and treacherous waters, with the confidence that we are securely bound to the shore by the professional ties that ground our work.

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