EXPLORING THE 'TALK' OF SUICIDE: USING DISCOURSE-INFORMED APPROACHES IN EXPLORING SUICIDE RISK

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Practitioner Highlights

From this chapter, there are six core practitioner messages:

- It is critical for practitioners to consider both professional and personal challenges when working with suicide, to support effective communication

- Predominant mental health practice around working with risk tends to favour a risk factor approach. While this is helpful to an extent, it should not replace effective communication

- Practitioners can be fearful of asking clients about suicide, retreating into predominantly reflective responses rather than more explicit, explorative ones.

- Asking open, empathic and clear questions about suicide does not prompt its likelihood, but instead can be an important factor in reducing risk

- Effective communication facilitates both practitioner and client understanding of suicidal thinking. A client is likely more able to talk openly about their suicidal thoughts where they experience the therapist to be compassionate and non-judgemental

- Human relationships, and clear communications, are the critical cornerstones of work with suicidal clients

Introduction

It is an interesting paradox that for many who train in the helping professions: social work, counselling, psychotherapy, occupational therapy and so on, the time spent on how they might most effectively respond to their clients or patients who are suicidal (herein after referred to as 'clients') is disproportionately low by comparison to the number of clients they are likely to see who present with some degree of suicide risk. That is, despite that the presentation of suicide risk of some degree is relatively common in practice, we are often ill-equipped by our training experiences to respond to it. Albeit some time ago now, I undertook a questionnaire study looking at how trainees on British Association for Counselling and Psychotherapy (BACP) Accredited training courses dealt with issues of risk in their training. Amongst several findings was the outcome that nearly 10% of Programme Leaders did not

feel their graduates – counsellors and psychotherapists – were adequately prepared to work with suicidal clients.

Over the years, and as a consequence of the suicide of one of my own clients in therapy (which I will discuss later), I have written about working with suicide extensively and trained many thousands of mental health practitioners in ways of working with suicide potential. It is probably fair to say there is not a shortage of risk assessment training sessions to attend but, as we will explore, very few focus on the dialogic mechanisms of effective work and instead look at the application of 'science' – the risk assessment tools and tick boxes – to the task of prediction. It seems anathematic to me that the energy invested in the science of risk assessment is, typically, at the expense of dialogic risk exploration; that we may understand more about an individual's self-annihilatory experiences through the ticking of some boxes rather than asking them about how they feel. This too has been the experience of many of the attendees to my training sessions.

It is my intention in this chapter therefore, to unpack some of the myths around working with suicidal clients, including the faith given to the risk assessment tools, and argue instead for a turn back to discourse. This is not without challenge however, as a dialogic approach to working with suicide risk demands things of the practitioner: to be truly present in the suicide shared-narrative, the practitioner but be prepared to go to difficult places with their client and understand what it is in themselves they bring along in that process. Perhaps it is this personal/professional demand of dialogic work with risk that leads many to retreat to the relative safety of the tick box?

The challenges of working with suicidal clients

The challenges of working with suicidal clients are multi-faceted and can, at a most basic level, be divided across a professional and personal frame. This, of course, does not do full

justice to the complexities that can be encountered, inter- and intrapersonally when working with suicide risk, but a consideration of the personal and professional aspects is an important starting point for most practitioners. It is critical that such challenges are outlined and explored because, as outlined previously, a dialogic approach to working with risk demands that the practitioner has some insight into their own professional and personal responses, to support the potential intimacy of the narrative.

Professional

There are a number of professional factors that will be present when working with suicide potential; these include:

- Managing expectations of confidentiality

- Understanding the different ways in which suicide may present

- Fear of 'getting it wrong'

- Translating risk in a multi-disciplinary context

- A careful balance of policy, practice, ethics and values

Managing expectations of confidentiality

Most practitioners will work to some form of confidentiality agreement, typically outlined in a contract agreed with the client from the outset. This will be the case for those working across a range of settings, such as statutory settings (health and social care, for example), education (schools, colleges and universities), third sector settings and independent (private) practice, for example. While the contract will attend to a number of practical factors, it also outlines how confidentiality, including that of risk to self (suicide potential or self-injury) will be responded to.

While some independent practitioners may hold confidentiality in the face of suicide risk, most organisational settings and the majority of independent practitioners will limit confidentiality should they believe their client presents with an immediate suicide risk.

While many practitioners will routinely make these agreements, fewer actually consider the ramifications of them: how will *immediacy* of risk be measured. Many clients will explore suicidal ideation in helping relationships (thoughts of suicide, rather than an intent to act on those thoughts), but this would not constitute an immediate risk and many practitioners would hold their client's confidentiality to allow for exploration of such thoughts. Herein lies a truth spoken by Schneidman (1998) when he wrote, "Most people who commit suicide talk about it; most people who talk about suicide do not commit it. Which to believe?" Making judgements about the intent of another, and particularly around whether they are focused on ending their own life, can feel onerous judgements indeed.

Understanding the different ways in which suicide may present

While suicide can be defined simply as "the act of killing yourself" (APA, 2000), the process of *being suicidal* can be highly complex and individual. There are many theories that offer some understanding of a move towards suicide (Schneidman, 1998; Joiner, 2005; O'Connor, 2011). My own research, based on a critical discourse analysis (Reeves et al., 2006) identified three primary interpretive repertoires around suicide:

- suicide ends existential crisis

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"What's the point, what's the point in carrying on?  I feel
really alone with it all… I just feel that I don't exist – I
don't belong in the life I live in…".
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- suicide removes a sense of being 'stuck' with the negotiations and manoeuvrings of life:

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"I'm thinking about stopping it.  I don't see what keeping me
here, or why I carry on.  I feel stuck and cannot see a way
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forward. I need to get out and go somewhere else – I need to

get out of peoples way and get out of this stuckness".

- suicide ends apathy and fatigue generated by the burdensome nature of life:

"I just feel too tired to carry on. It feels so heavy, I

don't know if I can continue to mange it any longer/further.

I feel so tired and exhausted in keeping it going. I don't

want people to worry about me anymore. I need to take the

pain away – to ease the pain".

These different intrapersonal drivers for suicide are further complicated by behavioural

presentation. That is, suicide is often considered as a slow move towards death, perhaps

following a trauma or as a consequence of physical illness, with the person putting their

affairs in order, perhaps writing suicide notes, and so on. While this is certainly true for

many, it does not capture others' experience, which can include living with the thoughts of

suicide on a daily basis, through to not having suicidal thoughts but responding to a crisis

with an impulsive act. This can be captured in Figure *.1. Living with suicidal thoughts

daily, a move towards suicide or an impulsive act each presents different challenges to the

practitioner.

Figure *.1: The Continuum of Suicidal Action
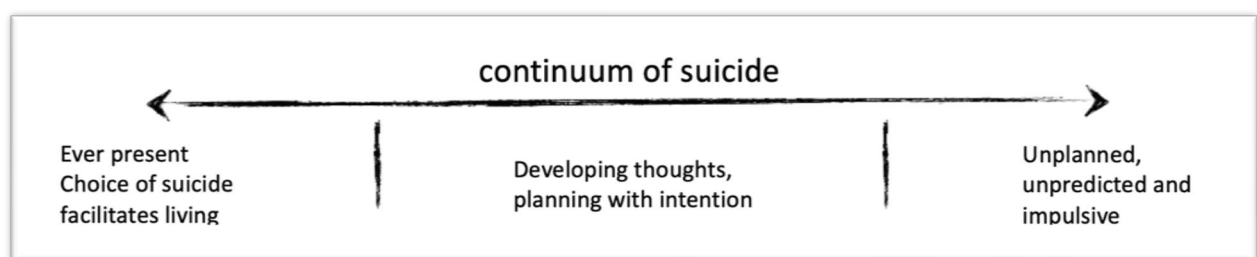
Fear of 'getting it wrong'

In considering the management of the contract, in the context of the complex way in which suicide might present intrapersonally, cognitively, interpersonally and behaviourally, understandably leaves many practitioners fearful of 'getting it wrong' (Reeves and Mintz, 2001). Of the research available exploring the demands of working with suicidal clients in helping relationships (of which there is surprisingly little), the fear of getting it wrong – of either breaking confidentiality unnecessarily, or not acting in response to concerns with a subsequent suicide, can haunt many practitioners in their daily work. The fear has often been described as immobilising, leading to practitioners avoiding discussions about suicide, where possible, through to the impact of vicarious trauma. It is noted in the research that ongoing work with suicide potential can be as impactful, psychologically and emotionally, on the practitioner as experiencing the death of a client through suicide.

Communicating risk in a multi-disciplinary context

While this is not the case across the board, many practitioners are based within multi-disciplinary teams, where interventions are informed through an array of different, and sometimes competing or contradictory, theoretical and philosophical lenses. Finding a common language through which client experience can be understood and, where necessary, shared, can be a significant hurdle. In the context of working with suicide potential, increasingly the shared language has been through the 'reading' of risk assessment tools and the interpretation of such data. The dialogic interpretation of a client's experience, often in the face of science, is pushed down the pecking order. Communicating concern to others, or indeed supporting ongoing work in the face of perceived risk, can be difficult when the data speaks otherwise.

A careful balance of policy, practice, ethics and values

Overall therefore, practitioners professionally navigate their way through a difficult terrain of: policy expectations; practice parameters; the interpretation and application of various

'ethical frameworks' and good practice guidance; as well as their own values they have often worked tirelessly to embed in their own work. It is not uncommon for such values to sit at odds with the expectation of policy that, in turn, adds to the personal challenges to be considered.

Personal

In addition to the professional factors, some of which have been outlined above, are the personal ones. Many writers in counselling and psychotherapy argue that the therapist should 'leave themselves at the door' of the therapy room. While this expectation might be theoretically more consistent with some schools of therapy, e.g., psychoanalysis, the reality might instead be argued that no practitioner, regardless of their theoretical orientation, can ever be truly objective in a helping relationship and therefore, the subjective experience of the practitioner will inevitably be present. In this context, there are some specific personal challenges practitioner will need to address:

- Personal experiences of mental health crisis

- Personal views in relation to suicide

- The degree of dissonance with agency policy

- Self-care and ongoing coping strategies

Personal experiences of mental health crisis

While some would have us believe that there are people who experience mental health difficulties, and then there are the rest of us who are, presumably, 'sorted', this is, of course, nonsense. In the same way we all have our physical health to attend to, which might include being well, temporarily impaired or struggling with longer-term conditions, the same is true for our mental health. In that frame therefore, the practitioner's own experience of mental health difficulties and how they have been able to navigate them – through their own support

and/or help from others – will play an important role in shaping how they respond to mental health distress in others. Specifically, the extent to which the practitioner has been able to find a narrative for their distress, again, either for themselves or to be shared with others, will be important here too. Put simply, if we have been able make sense of our own distress through self-talk, or by talking with others, that is more likely to position us to provide that space with our clients.

The concept of the 'wounded healer' (Larisey, 2012) is well established: that those who find their way into helping professional roles do so, at least in part, because of their own previous 'wounds'. It is not uncommon however, drawing anecdotally over 30 years of practice and support by some limited research evidence (Adams, 2013), that helpers often struggle to be helped themselves. Relationally therefore, one might speculate, as to the impact of a helper who struggles to verbalise their own distress on their capacity to support another do the same.

Personal views in relation to suicide

Suicide is one of those topics that is rarely viewed through a neutral lens; people can often have a visceral response to suicide, in the same way they can about death more generally. The narrative mechanisms developed through social story-telling to soften the truth of death are everyday apparent: going to sleep; being at rest; passing on, and so on. Add into the mix the stigma that still surrounds mental health – albeit to a lesser extent recently perhaps – and certainly the historical echoes of the shame of suicide when it was seen to be 'against God', or an illegal act, still abound.

Practitioners are not tabula rasa when it comes to suicide therefore, and their personal views about suicide – ranging from believing people have a right to end their own life if they have the capacity to make that decision, through to the choice of suicide never being acceptable – will be present in the helping relationship, explicitly or implicitly. Such views will be shaped by a range of factors, such as: faith; music; literature; experiences of suicide personally or

amongst family and friends; training, and so on. The challenge is for the practitioner to be willing to engage with an internal reflection so that their views are known to them, and held accordingly in the helping relationship so that they do not consciously, or unconsciously, shape the nature of the help being offered. Supervision, which is discussed in a little more detail later, is important here in helping practitioners to reflect on their own philosophical, practical and theoretical relationship to suicide. Important here is Shea's (2011, p 4) observations that,

> *"... when a [practitioner] begins to understand his or her own attitudes, biases, and responses to suicide, he or she can become more psychologically and emotionally available to a suicidal client. Clients seem to be able to sense when a [practitioner] is comfortable with the topic of suicide. At that point, and with such a [practitioner], clients may feel safe enough to share the immediacy of their pull towards death."*

The degree of dissonance with agency policy

In the light of personal experiences of mental health crisis, and personal views about suicide, it is not uncommon for practitioners to find themselves working in settings where their personal views are contradictory with those of the agency. This has to be professionally managed, with practitioners sometimes having to act in a way inconsistent with how they might personally. My own research amongst counsellors suggested however, that when there was a conflict between a counsellor's own view of suicide and that of the agency within which the work was taking place, they tended to favour their own view, disregarding that of the agency (Reeves and Mintz, 2001). This, of course, raises some difficult professional and ethical questions.

Self-care and ongoing coping strategies

It is an ethical requirement of most commonly referred to ethical frameworks for practitioners to pay explicit reference to their own wellbeing and self-care. Formal supervisory

arrangements, again often a requirement of professional bodies for a number of different professions, play an important role in ensuring the restorative care of the practitioner. Beyond such formal arrangements however, it is imperative the practitioner puts in place their own strategies for self-care. Failure to do so often leads to vicarious trauma, compassion fatigue and burnout (Marriage and Marriage, 2005; Moore and Donohue, 2016). Helping professionals are not immune to the dangers of dissociation, where the felt experience of the helping relationship is lost to a sense of attack, anger and resentment of clients who are perceived to be 'too needy' or 'manipulative'. In this context, the capacity for an empathic and meaningful narrative is lost.

Research Insights and the Evidence-Base

The literature on working with suicide is extensive, but also limited too. Extensive insofar as the search for a definitive answer to the question, *who is most likely to end their life through suicide* seems to lead to an insatiable quest and endless studies. In writing this chapter I undertook a brief literature search of academic papers related to the search terms "suicide risk assessment", since 2019, and returned in the region of 17,200 papers. Of those reviewed, the majority attended to one of the following predominant themes:

- The broad identification of specific risk factors

- The delivery of suicide intervention programmes

- Understanding suicide across different demographic and cultural groups

- The epidemiology of suicide

- Models of suicide thinking and pre-suicidal process

- The development, implementation and evaluation of suicide risk assessment tools

Space does not allow for a meaningful account of the extent of literature here; rather, and perhaps more importantly, is a consideration of what might be missing. In that context it is

helpful to consider the meta-analysis, conducted by Large et al (2016), cited in Reeves (2019), who stated,

> *"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".*

Reeves (2019, p 3) goes on to state that suicide risk assessment tools,

> *"may contribute to an understanding [of suicide risk] 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 Zero Target for suicide in the UK in National Health Service (NHS) settings (Deputy Prime Minister's Office, 2015) is predicated on the assumption that sufficient is known of the *who* and *how* of suicide that such targets become not only aspirational, but instead achievable. Whereas, looking back at Large et al's assertion, the *who* and *how* continue to be elusive concepts that set up false expectations for policy makers, researchers, practitioners and, perhaps, clients too.

Related to these epistemological and ontological conundrums with respect to suicide, is the place of communication. As asserted elsewhere in this chapter, we too often rely on the efficacy of risk assessment tools for fear of going to a more frightening place. I offer a personal reflection here.

Reflections on the Science

I mentioned previously the death of my client early on in my career and the traumatic impact that had on me. By traumatic impact, I refer to trauma with a capital T, as opposed to it simply being distressing. I became hypervigilant to potential risk, experienced flashbacks, nightmares etc., and stepped away from practise for a while to allow for a period of recovery. Embarking on my own doctoral studies in this area, my research proposal to an established

UK university was the development of a short-risk assessment tool for humanistic counsellors that would, when completed with clients, definitively tell the practitioner whether the client was going to kill themselves. Needless to say, the University enthusiastically bit my hand off and invited me to study there.

It was only during the course of my doctorate that the reflective penny finally dropped: such a tool didn't exist, but I had wanted it to because of my trauma following my client's death and, simply, never wanting to go there again. I had lost the capacity of working with uncertainty, which remains the cornerstone of practice with suicide potential. On this realisation my research took a very different turn – a turn to discourse – and looked at ways in which practitioners might be supported, through training, to sit with uncertainty too, while building confidence and capacity to talk to clients about suicide. My anxiety, which drove me initially to undertake the development of a risk assessment tool was neatly captured by one of my latter participants, who insightfully said as part of a feedback session,

> *"I was wondering, is this a personal journey, are you Sir Galahad on his horse riding out to save the nation because you felt such a failure in yourself. And I wondered about that. I didn't in any way feel judgmental I just felt, oh, what's that about. This poor man has to tell the nation, to protect the nation…".* She continued, *"What I was left with was the fact that it was something that you were passionate about… which is a strange use of words… but from your experience you had been through with your client, you didn't want any of us… you were quite protective… you didn't want any of us going through what you had been through."*

That sense of "*failure in yourself"* poignantly captured that fear of getting it wrong. As one therapist once said to me, the feared perception from others is that "good enough therapists keep their clients alive"; even acknowledging the ridiculous nature of this comment, deep down the fear might be of it being a truth.

The Importance of Discourse

The central assertion here of this chapter is of the critical importance of effective communication with clients at risk of suicide that transcends the two-dimensional nature of a risk assessment tool or questionnaire. The explorative nature of communication not only provides the best opportunity for the practitioner – and more importantly, the client – with an opportunity of sense-making in relation to suicidal thinking, but also creates further opportunities for deeper exploration and helps position the client with greater opportunities for change. Discourse, in of itself, will not prevent suicide; it will however, provide the narrative space for suicide to be explored in a meaningful way. Revisiting the work of Schneidman (1998, p**), he asserts,

> *...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 study of human emotions described... in 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?"*

Exploring the 'where do you hurt and how can I help you' is not a straightforward endeavour however. In my own critical discourse analysis (Reeves, Bowl, Wheeler and Guthrie, 2004), a large number of practitioner-client assessment transcripts were analysed. They key findings of this study were that:

- Suicide is often not disclosed explicitly by clients – at first mention – and is typically talked about implicitly through the use of metaphor, e.g., "*I wish I could get out of everyone's way*"

- At the first reference to suicide by the client, practitioners – regardless of theoretical orientation – tend to revert to reflective responses rather than explorative ones, e.g., "*So it seems as if… I hear that… you are saying that…*"

- The predominant use of reflective responses following an implicit reference by a client to suicide typically hinders exploration, as the practitioner becomes defined in the dialogue by the client's position, rather than enabling any meaningful dialogic shift, e.g., [client] "*It just goes round and round in my head and I can't seem to find a way forward*"; [practitioner] "*You feel really stuck – round and round – and you can't find a way forward*". Both client and practitioner get stuck in the 'round and round' metaphor, both defining each other and neither finding a way forward

- Practitioners are often fearful of naming suicide – of making the implicit, explicit – for fear of 'getting it wrong' or putting the thought into the client's mind: explicit exploration becomes a feared prompt for suicide, where there is no evidence to support this. As institutions and individuals perhaps retreat into risk assessment tools to avoid the relational, practitioners retreat into the reflective to avoid the exploration.

This study, in itself a little dated now, has been replicated by me (unpublished), additionally focusing on working with young people. Even with intervening research, the findings were the same. The implications of avoiding an open communication around suicide with clients is that a number of professional responsibilities are more difficult to meet: the appropriate management of the contract of confidentiality; maintaining work consistent with procedural expectations of the organisation; consistent work with legal and ethical expectations; and missed opportunities for greater therapeutic exploration. The personal implications are often an increased sense of anxiety and a greater propensity to burnout.

Reflections on Client Work

Research aside, this chapter is fundamentally based on my experiences of working with people who are suicidal, which I have been undertaking for 30 years. I have experienced several client suicides across that time, each one impacting on me professionally and personally in a different way; ranging from an early traumatic response I experienced following the death of a client through suicide soon after a completed counselling session while I was a trainee, through an end-of-life suicide that had been communicated by the individual to all those involved in his care. I will offer an account of some work with a client, who I will call Jake, to illustrate some of challenges raised 'in action'. Sufficient details of Jake's story have been changed (as well as his name) to protect identity, as well as to illustrate some of the wider issues, not all of which were present in the original work.

Introducing Jake

Jake is 19 years old and comes to see me in a third sector setting for young people. He is well-dressed, articulate and thoughtful. He is seeking out counselling he says, because he is feeling crap and it has been like this for some time. He tells me he lives with his mother, who is very supportive, his father having left the family home many years before. He lives with his younger sister but has no contact now with his father. He tells me he specifically wants to see a male therapist because there are no men in his life he can talk to. As the agency requires, he has completed an assessment form before seeing me, which includes questions about risk. He has scored zero on risk, indicating no thoughts of suicide and self-harm. We begin the session with introductions and I invite Jake to tell me his story, which he does. It is a sad story of loss – a grief and anger for his missing father; the death through an accident of a friend four years previously; and his overwhelming sense of loneliness, of truly being on his own in the world. He tells me that while he loves his family dearly, he could never talk of his feelings with them "because guys just don't do that, people just don't understand". He is lost, adrift and struggles to find his words.

Early responses to Jake

I am struck by the paradox of Jake: of someone so strong outwardly, yet so young inside and struggling with a searing distress. Also, of someone wanting to be heard, but having been taught that male words for feelings are not acceptable. I have to tread warily because if I expect too much from him too soon, he might not return. I have to find his language of strength while, at the same time, offering an implicit permission to speak of himself.

I ask him about this assessment form and note, given how he is feeling, he has indicated he doesn't feel suicidal. I am tentative here, but it also strikes me that suicidal thoughts might well be present for him. He nods and says "yes, that's not an issue for me". I want to be reassured but I am not. But I have asked the question and, in doing so, am hoping I have opened a door if he ever wishes to walk through it.

Subsequent sessions with Jake

We get on well and he comes to the next, and subsequent sessions. I have found a shared humour, and we laugh a lot. I feel a little guilty about whether I am colluding with an avoidance of his feelings, but the laughter feels relational and intimate and a bridge across which we have found a mechanism to truly speak to each other. Then he stops laughing and the eye contact breaks. He says that I asked him a couple of weeks ago about suicide, and he said he was okay. I say yes, I remember. He says he is not okay and thinks of suicide often; he feels that no-one would miss him, even though he knows they would.

I am tempted to refer back to his strengths, but see that Jake has said the unsayable and I must be brave and stay with this uncertainty. I acknowledge what he has said but it doesn't feel enough. I say "how much have you thought about killing yourself Jake? Have you thought about what you would do?" It feels brutal, to the point and I know the phrase 'killing yourself' was not his phrase. But I also remember how easy it is to not say the difficult things and, in avoiding them, take Jake away from them too. I am metaphorically holding my

breath, wondering if I might have prompted him into thinking more, leading him to the edge. He says no, he hasn't got that far, but he is pleased he has told me. Me asking him so straightforwardly at the beginning didn't make him think about suicide, but did enable him to think about his suicidal thoughts – if I know what he means. I say I do; he begins to cry and I feel terribly sad too. We talk a lot about suicide and it seems now the door has been opened, all sorts of things can now be talked about. He talks of shame, of having previously been silenced, of hurt, and of not knowing how to live, rather than wanting to die. It strikes me how closely liberation and annihilation can often sit so closely together.

Further Reflections

Jake and I worked together over several months and, in that time, his thoughts of suicide ebbed and flowed, like some terrible tide he sometimes wanted to avoid bathing in, but at other times needed to immerse himself in. It would have been so easy from the outset not to have asked Jake about suicide, given his negligible scores on the tick box tools. But I also remind myself that it is often the task of the practitioner to name the difficult things, knowing that the client will decide whether to go there or not. I am also reminded of the big myth about suicide: that by asking about it we might prompt the thought in the other's mind. I know that is not the case, in that asking about suicide, at worst, will leave the level of risk unchanged. At best, it will provide an opportunity to talk about it and, in doing so, the risk of acting on the thoughts can be diminished. I was further reminded too that there isn't a suicidal 'type', as Leenaars (1994) calls it, the "bump on the head" (p**) that is the definitive indicator of the person who is likely to end their life by suicide. Rather, in moments of crisis or despair, we all have that potential.

Good Practice Indicators

Drawing together the threads from this chapter, we are able identify some key good practice indicators that can support our communications with people at risk of suicide. To reiterate, the tick box approach to suicide risk assessment is not all bad: such tools can be helpful, but generally in providing a structure through which dialogue can be initiated and explored. The assertion here, and reflecting on Large et al's (2016) conclusions, is that risk assessment tools will not offer what we hope of them: a definitive answer, or indeed a good indication, of whether someone is at risk of suicide; it always comes back to the dialogue and how we can support ourselves in the relational process of communication. The following practical tips for improving communication with people at risk of suicide are, in part, directly related to the discourse and, in part, related to those factors that support discourse. In working with suicide potential, communication does not take place in a vacuum: the professional and personal factors discussed previously need to be addressed fully, carefully and with due reflection to ensure the discourse is direct, clear, respectful, honest, empathic and honours the nature of the helping relationship.

Practical tips for improving communication
• Understand the policy and expectations of the setting
• Contract carefully and clearly, making clear reference to suicide while considering its potential in the context of the client's narrative
• It is important to know the higher risk groups, but this information only informs dialogue, rather than answers questions
• Know the warning signs
• Be able to identify the protective factors and help the client name them

- Be willing to explore through open and direct questions: *Have you ever thought of hurting yourself when you feel bad, or have thoughts of not wanting to be alive anymore?*

- Balance both risk factors and protective factors

- Discuss with supervisor/colleagues/manager, where appropriate

- Record concerns and actions carefully

- Obtain consent, where possible, if you need to discuss your concerns with someone else

- If in doubt about immediate safety, act

Summary

This chapter has maintained a central assertion as to the critical importance of effective communication, rooted in a relational approach, with clients presenting at risk of suicide. A number of professional and personal aspects pertinent to effective communication have been highlighted, with a supporting discussion of the importance of discourse in the context of the literature that largely ignores it. Reflections from some sessions with a suicidal client, Jake, have been offered, together with some top tips for effective communication in this frame. One practitioner, when interviewed by me, said that "working with suicide demands that you be brave; be willing to go there". The paradox is that the more suicide is brought into the helping process, the less frightening it can become for both practitioner and client; that effective communication not only enables greater insight, but can be a critical holding process at a time of challenge.

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