Working with Suicidal Clients

Lecture Transcript

Welcome, everybody. I was just looking at the chat to see where you were joining from and it's from all sorts of places, so I'm delighted that you've logged in tonight to see this lecture. It's going to be quite a quick overview of working with suicidal clients. I normally present this sort of material over a full day, and it's much more experiential so I had the choice of either speaking really quickly or trying to take out the salient points. So, hopefully you're going to cover the things that will be useful to you. I'm based in Chester in the U.K. and as Colette says I've been working in this area for many years and I was propelled into this work as a trainee counsellor many, many years ago following the death of my client through suicide. I tell the story with a lot of detail changed to protect confidentiality, but to give you the kind of nature of the impact in this person I've been working with for six months on a weekly basis and was progressing really, really well and was very positive and had interviews set up for herself to begin some volunteer work and really moved her life forward. She stood up at the end of the session and she shook my hand and she said, "Andrew, I feel really good. I feel really positive. I know exactly my plans and I feel great" and we booked the next session and she left the room and she caught a bus and went home and took a large overdose. It was the following morning that I heard of her death. That was profoundly traumatizing for me at a professional level in terms of my sense of myself, not only as a social worker and a trainee counsellor, but also at a personal level as well and experiencing a really quite traumatic loss of somebody that I have got to know very closely over the months that we had been working. I turned for resources. I had fantastic supervision. I had personal therapy. The impact on me was traumatizing and I mean capital "T" trauma. I mean flashbacks, nightmares, disturbed sleep and having to suspend my practice for a while. I looked for help and guidance about how I could make sense of this. I was struck by, in the counselling and psychotherapy world, how little there was really to help practitioners like myself to navigate this process. I decided that I would start asking the questions and I would start writing and sharing my experience and other people's experience, which is what I've done now for nearly 30 years. I kind of assumed, actually

that when I started this, if somebody was to say to me in 30 years hence, do you imagine that we would be talking much more openly about this and this would be much more discussed in our world? I would say yes, of course, because my experience is and probably all counsellors will work with people who are suicidal at some stage in their work, if not regularly. It saddens me, I suppose, but not entirely shocks me that 30 odd years on, still relatively very little is written about this from a counselling and psychotherapy perspective. I'm delighted that you've joined, and I hope that what we are going to cover over the next kind of 30, 35 minutes is going to be of use to you.

It's going to be a quick rush through, but I hope a helpful one to you. I'm going to talk very briefly about what we mean by risk because we talk about clients at risk and this word risk is used and bandied around in the literature and in practice, and we never really deconstruct it and see what it means and what positive risk-taking means. I mean, risk is always defined in one way and I kind of want to open up the question a little bit more about whether we can use this much more proactively and collaboratively with our clients in our work? A little bit of looking at what the current literature tells us about working with suicidal clients and risk factors, protective factors and then sadly I'm going to debunk some of that a little bit and focus much more down on the therapeutic process, which I hope will be particularly helpful to you.

We are talking about suicide. There is nothing in today's talk which is deliberately going to set out and try and provoke difficult feelings in you, but my experience is that we have all been touched by suicide or most of us have been touched by suicide in some form or other. It may be that we have experienced suicidal feelings ourselves or have worked to end our own life at some point in our lives, or we know somebody who has or were bereaved with suicide or our work and our professional lives have been profoundly touched by suicide. My experience is that this is around for pretty much all of us so engaging with this and talking about this can kind of stir things for itself, so please just take care and pay attention to your own needs in today's session and the impact of today's session after we've finished.

I said I want you to look a little bit about what we mean by risk and me kind of get frustrated with the definitions of risk as they're applied to in counselling and psychotherapy and they're often delivered in a very binary way. You know, that kind of one zero one zero. Somebody either is at risk or they're not at risk, the risk is present or isn't present and we have to make some sort of determination as practitioners, whether risk is present, or risk isn't present. That, of course, raises all sorts of questions because if risk isn't present then we can all breathe a sigh of relief, can't we? Then if the risk is present, we can't breathe a sigh of relief because then what do we do about it? This binary of risk is there or is not there is really not very helpful to our work as therapists.

As I said before, in reality, I think that probably we all move in and out in a relationship with risk at various stages of our lives. I can certainly think of times in my life from a personal perspective where I felt very despairing and have really struggled to kind of see a future. Has that meant that I've wanted to actively end my life at any stage? I cannot think of a time when I've wanted to actively end my life, but I can really relate to that sense of not knowing how to live my life, how to move forward with my life. I think all of us maybe have some place or some experience on that continuum. Risk and suicide is something that can provoke quite strong feelings in us and our views about risk will be shaped by many, many things, like workshops that we attend, seminars that we attend or our training, our core training, or maybe the context in which we work or films that we watch or music that we listen to or our own experience of crisis. I really like to try and dispel the Domino's notion in working with risk. There are people at risk and then the rest of us are all sorted and we're absolutely fine, where the risk is a much more nuanced sense. I think actually we sit in that place most of the time.

So, how do we define risk? If we go to a dictionary, it's more helpful than we imagined. Exposure to the possibility of loss, injury or other adverse or unwelcome circumstances, chance or situation involving that possibility. To act in such a way as to bring about the possibility of an unpleasant or unwelcome event. Notice the two points that I've started on, focused very much on the negative of risk of something unwanted like a loss or injury. I guess in the counselling context and what we're talking about here, we might be thinking about a client's death through suicide, but actually there was another line in that dictionary definition, which was about to take a risk, be bold or daring. That really appeals to me and my hunch is that most therapists most of the time are actually bold and daring. I think that's not uniquely so in terms of the helping professions, but I think very predominantly so. We're one of those few professions that are really willing and perhaps able to sit alongside risk without always feeling as if we have to do something about it. So, I kind of think that we take a position that is much more nuanced and a much more refined about risk than some of the literature talks. That notion of risk is there or it's not there.

What does all that mean? What's the consequence of that? So, yes, of course, risk is about being exposed to danger or uncertainty or the possibility of that and it's the possibility of that that I think is most challenging for us as practitioners because we like or we hope that the literature is such that we can predict reasonably accurately who is more likely to end life through suicide and thus take whatever steps we feel we need to take to safeguard their well-being. As I'll talk about in just a very short while, it's not as clear as that so we're kind of left in this is anxious, unknowing place. The possibility of risk can be brought out by our actions. We can do things that put ourselves in greater levels of risk or not. As I say, risk is not always about danger. It can be associated with bold or daring. I just want you to reflect on this question that I will ask of you. Can you

think of a time in your practice, either historically or now when you have worked with a client who has talked to you about suicidal thoughts? Maybe they've said things like they don't know how to go on, they want to go to sleep and not wake up. They can't imagine how they can continue with what's causing them distress. Thinking of those clients that you've worked with, have you always referred them on to mental health services or to GP's or to accident emergency departments? For the most part, do you think that you probably have held that confidentiality and created the therapeutic opportunities to explore what that means to those clients? I'm not talk about those clients for whom risk is immediate. I feel so bad that I'm going to kill myself now. I'm talking about those clients that sits before that immediate risk and perhaps are exploring the worth of their lives in a more substantial therapeutic way. So, that's my question. How many times have you broken confidentiality if you couldn't obtain client consent? How many times have you sat with the client's level of uncertainty about them living or dying? If I was to answer that question for myself, I would say having worked in mental health crisis services, in secondary care mental health crisis services, with young people in schools and with young people in university context and having practiced for, as I've said, 30, 35 years, I would say about 95 percent of the clients who have talked to me about some degree of suicidal thought, I have held their confidentiality and I have respected their confidentiality. As long as they had capacity as in, they were able at that point to make an informed decision about their life, I have held their confidentiality. As such, we have collaboratively, positively risk taking. We have worked in a way that has acknowledged the risk, has tried to mitigate the risk, has done what we can to try and put safeguards in place to protect the client's well-being, but actually, I've respected the client's willingness and wanting to be able to explore these things with me, perhaps in a way that they can't do with anybody else. We're positively risk taking and while those clients come back to see us then that risk pay off, because we can create, I think, an almost unique space for clients to really, truly explore the kind of existential struggles they might be having with their life. There are times, of course, when I refer clients on almost always with their consent and sometimes without it, if need be, but the overwhelming majority we've acknowledged the risk and we've worked with it as a therapeutic process. We positively risk take.

Risk, of course, is much broader than suicide. We talk about risks in that way when you look at the literature, it almost exclusively talks about the risk of suicide for a client or maybe child protection or maybe self-injury, those things that I would call situational risks, those things in a therapeutic process that relate to a very particular situation that the client finds themselves in and that we find ourselves in relation. There are, of course, other risks. I'm not going to go into details here because time doesn't allow but other risks that I've described as relational - issues around erotic transference, things that we get drawn in the context of the relationship with our client, which isn't about suicide, but actually can be equally damaging to ourselves and to the client if not attended to. The contextual - where we work and the demands of our work. To the professional, some of the things that we are required to do to hold good ethical practice and the

personal. The personal is very particular here because literature tells us that, of course, the suicide of our client can be profoundly impactful on us as practitioners as I've experienced myself as I started this talk with that account, but also working with people who are suicidal can present for practitioners the same degree of kind of vicarious trauma, that traumatic response, that compassion fatigue and that holding of the uncertainty with our clients, that positive risk taking with our clients, that can slowly eat away our resilience and our resolve until get to a point where it's really hard to support ourselves if we're not really paying attention to our self-care needs. So, working with risk isn't just about positive risk taking, it is also about really good self-care and self-care in a very explicit, known and thought through way.

To summarize, what is positive risk taking. Positive risk taking is an important aspect of any help in relationship, otherwise the danger is that all helping relationships could become limited by the possibility of risk. What I mean by that is if we are only going to be risk focused, if we are only going to work up to the point where we identify risk as being present, then actually we profoundly limit, I would argue, what we can do as therapists. Risk is therefore not a binary concept. We are not in a situation where people are at risk or are not at risk. Risk comes in all sorts of shapes and sizes and is present to a lesser or greater degree all of the time. Therefore, risk taking, positive risk taking is about acknowledging the risk. It is about being very explicit with our clients about the risk that we perceive or identify. Putting measures in place to help mitigate that risk and reviewing that regularly in the context of the confidentiality we have. That first statement is hugely important, acknowledging the risk, being brave, being able to talk to clients about suicide, to ask them about suicide, to say things like, 'I wonder how bad this gets for you. Are there times when you've thought of ending your life or harming yourself to cope with this? Have you thought of suicide?' The biggest myth, of course, is that by asking about suicide, we might increase its likelihood. There is no evidence to support that fear we have. Worst case, if we ask about risk and I'm talking across age groups and I'm talking face-to-face and online, the worst that can happen is that we leave the level of risk unchanged, that things are not affected in any notable way by asking the question. My experience, however, is that in asking the question more often, more often if the client has capacity to understand and make decisions about their living and actually just asking a question can in itself, reduce the level of risk, at least to a point where we can begin to work more effectively. This is a real anxiety provoking situation. This is something that therapists, not just new therapists or qualifying therapists or training therapists, but therapists who've work for 20, 30, 40 years can be hugely anxious about. I can still think of times now in my client work, even though I've been writing and reading about this for many, many years, where there can still be moments where I feel a little immobilized by my own anxiety. So, we turn to science. We turn to risk factors and protective factors.

Let me just read the short snippet out. "So, the turn to science: enter stage left the risk factors (as in those factors that indicate a higher risk of suicide, such as psychopathology and demographics, males and age): enter stage right, the protective factors (those factors that indicate a lowering of suicide, such as a good therapeutic relationship, family, friends) and centre stage is of course, 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. Of course, sometimes it does and of course, sometimes it doesn't. Herein of course, lies the paradox. For all we know about suicide, there is so much that we don't".

I can present to you a slide on risk factors and I'm not going to go through all of those now because we haven't got time, but you'll be familiar with a lot of those risk factors. This is research that comes from all sorts of angles.

Of course, the research that identifies protective factors. Again, I'm not going to go through all of those now. The things that make suicide more likely and things that make suicide less likely.

We can distil them into warning signs. Again, I'm not going to talk about those in any meaningful way.

Our organizations will often shape us to use those things. If I talk about our individual anxiety as a therapist and of course, we can extrapolate that out to an organization of anxiety, organizations are for the most part, terrified about the possibility of the suicide of one of the clients using their services so they require us to use all sorts of forms. The risk factor industry, the risk assessment industry is very lucrative indeed. There would be many people who will sell you all sorts of forms and will tell you that this particular form will give you a good indication of whether this client is likely to end their life or not.

Yet, if we look at some of the research in 2016, large et al from their meta-analysis said that 95 percent of high-risk patients do not die through suicide. Its kind of starts to make the risk factor approach a little less compelling. There has been no meaningful increase in the accuracy of prediction of suicide over the last 40 years. Risk factors and warning signs may contribute to an understanding, for sure they do and I'm absolutely not throwing them out as not having any value at all. They can be hugely valuable and can provide an opportunity for us to have the dialogue and to help us shape an understanding with our clients. They can also get permission if we're anxious about

asking the questions, but the problem is that too many views them as the start and stop of working with suicide rather than simply a starting point. How many times have you heard that somebody has scored low on risk and therefore that's not something that we need to really attend to? We place so much trust in that predictive accuracy that too often we forget to turn back to the client and to use our skills as therapists to really be prepared to go to the difficult places in an empathic and a sensitive and a respectful way. Don't forget, there has been no meaningful increase in the accuracy of the prediction of suicide over the last 40 years. In other words, even 40 years on, we still don't really know. We still don't really know who is more likely to end their life through suicide when we bring that down to an individual level. That's who we are as therapists. I say use those forms for sure and I've used those forms for many years in the practice. Use them therapeutically. You don't use them as a tick box approach. Engage the client in the dialogue.

Shneidman's quote, I think is really very, very profound here. Shneidman wrote "our best route to understanding suicide is not through the study of the structure of the brain, nor through the study of social statistics, nor through 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 test of blood or spinal fluid, but "where do you hurt and how can I help you?" That, for me, speaks to the absolute essence of what we can bring to our client's lives. Those people who may be thinking about ending their lives. Somebody who's really brave enough, is really willing to ask the question, where do you hurt and how can I help you? Sounds simple, doesn't it? It's not simple. It's really hard. I've been training therapists and mental health workers and GP's and psychiatrists and other support workers for many, many years in this. This is an area of huge anxiety, as I said at the beginning and we will use all sorts of mechanisms to explain why we didn't ask that question, why it felt too risky and we'll often make that the client's level of risk.

We can tell ourselves that this person probably isn't suicidal. We probably don't need to ask the question. We can actively avoid asking the question. We can sometimes change the subject and consciously steer the client away from what we fear might be a move towards talking about suicide. We can be too quick to be reassured at the lack of risk or that the client feels that they have improved around risk. We kind of fear that if we ask about suicide, it's going to sound clumsy. It's going to sound really insensitive. We project our fears, we minimize the importance of our relationship. Somebody else will ask the question. Somebody else will explore this with them. Sometimes we cannot actively work to engage our clients while we engage our clients. We too, can feel overwhelmed or hopeless. That sense of what we don't know can't hurt us if we've not asked the question and the client hasn't told us what they feel then we don't actually

officially learn that this is an issue. The research that has been very profound, I've done a lot of research into this area, as have other people, that we can feel incompetent, we can feel fearful, angry, anxious, we can feel impotent but what can we do to effect change here? As I said at the beginning, so much of this is around our own relationship to this topic. I gave that slide at the beginning, which was a warning about taking care of yourself. As well as taking care of ourselves, we have to use supervision. We have to push ourselves to really get to a place where we too, can feel comfortable to have these dialogues.

Shea said 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 the 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". That quote has always struck me, particularly that line "clients seem to be able to sense when a practitioner is comfortable with the topic of suicide". I've been asked many times, why do you think that is? For me, the answer is really obvious, actually. Our clients may be very vulnerable, may be highly distressed, may be in a profoundly difficult situation, may not know which way to turn in their lives, may feel just overwhelmed with the awfulness of what it is they're having to contend with. Our clients aren't stupid. Our clients are very astute. When they're sitting with somebody, they'll just know that this is not an okay thing to talk about and it is our responsibility as practitioners, I would argue, to take those extra steps to effectively say to our clients, I would argue explicitly things like 'this is always a right place to talk about, it's always okay for us to talk about things like suicide, because that might be very real for you'.

How do we do that? I have a go and I'm not saying that this is scientifically valid, and I'm not saying that this is meaningful in every single situation, but I have a go at mapping levels of risk. If you look on the black text subheadings. Distressed but no risk. Low risk, vague ideation. Low risk, more focused ideation, ideation being ideas of suicide without an intention to end your life. Moderate risk, vague ideation that turns moderate to high, that move to intent and very high risk which is specific intent. Using research that I'd undertaken; I try to dialogically map that. I did quite a lot of research about how people talk in therapy about suicide and how, so their therapists respond. I kind of pulled this together and I'm not saying this is perfect at all, but on the left-hand side of this triangle is the therapist dialogue, and on the right-hand side is proposed client's dialogue. These are just meant to be indicators, indicative phrases that people can sometimes use. If you move to low risk focused ideation, a question might be from the therapist 'you have thoughts of harming yourself, do you think you could act on this? The client might be saying 'sometimes I just want to get out of everyone's way. I feel like I'm a burden'. That would be a dialogic representation with focused ideation, which is

very different to moderate to high risk and move to intent, where we're getting to a point where we feel that somebody is really very risky. We might say something like 'are you saying that you're intending to kill yourself?' The client talks about that 'I've collected some of my medication', so they start talking about means of suicide now. Again, this isn't perfect, but all its intended to do is to help us think about typical phraseology that clients might use in sessions, questions that we might usefully ask, a mechanism of trying to pitch in relational terms the level of risk and action required on those three. Those will change depending on your context and how you're expected to practice. The point comes where maybe if you were contracted to hold confidentiality and unless you believe is an immediate risk, then some ideas about the point at which you might need to think about talking to your client about perhaps needing to speak to somebody else.

Before that happens and just before we finish, I just wanted to talk briefly about the idea of crisis plans or keep safe plans. I would argue and the literature argues, too, that probably better than the idea of no harm contracts. I appreciate that some people use no harm contracts, but the danger of no harm contracts is that they tend to go on the lines of 'are you able to commit to not harm yourself or not try to end your life between now and when we next meet?' The literature generally argues that they are often put in place in the absence of a proper exploration of rooms. Can be emotionally coercive and, of course, if a client does self-injure or does take an overdose, for example, between that session and the next one, they can introduce a fracture into the relationship. Whereas a keep safe plan, a crisis plan can be really good dialogic ways of helping somebody make sense. They can focus on the inter- and the intrapersonal relationship of risk. Things that clients can do to support themselves from others and things that clients can do to support themselves within themselves. They can help the client understand when the danger is higher or maybe when the danger is lower. The plan would include very realistic, detailed support options. You can ring this number; you can ring this service. You can ring this agency. This is the number, and this is when they're open and this is their website, are always written collaboratively, either on a big piece of paper on the floor or on a pen and paper or online, and they help engage the client in a sense of ownership. If a client has capacity, an adult client has capacity, it won't be you that keeps them alive, it will be they who keep themselves alive and these are mechanisms by which we can help them think about what steps they can take to safeguard their own well-being. Obviously reviewed regularly and it can include others and the client can choose to share them with others if it's helpful to do so.

I'm going to stop in just a moment because I know there'll be some questions coming through, but how do we do them? I usually begin with a score of one to ten. How are you feeling now? One is 'I have no suicidal thoughts' and then ten is my thoughts are overwhelming'. The client says 'five' and I say, 'okay so your thoughts are quite significant' and then we'll explore that. I'll say 'how bad do they get? What's the highest

score it ever gets?' The client says, 'a seven or an eight or so'. We'll acknowledge that and spend a bit of time acknowledging what that eight feels like. 'How low does it get?' 'It goes to a two'. Then I'll reflect that 'you can go from a place where you barely have any thoughts of suicide right through to a point where they're almost overwhelming and today there are very present, but they are not as bad as they can be. What pushes the number up?' They'll write it down and maybe say 'at night, I feel really bad at night. I could feel more risky at night. I could feel more risky when I have had a drink. I feel more vulnerable when I've argued with people'. So, we're writing first person statements and then, of course, we'll do the same in terms of what brings the score down. You know, 'if I do some exercise, I could feel better. If I have a hobby that makes me feel better'. We'll try to be really specific. We might introduce some kind of therapeutic techniques like diffusion, maybe distraction. Sometimes humour works really well for people, mindfulness or other mechanisms that clients can draw on. What the client is collating for themselves is an inner sense, an insight, a commentary onto what makes things more difficult. What makes them less difficult and it can become a mechanism through which we have the dialog.

So, bringing all that together, it's really important that we understand the context that we work in. We might be working independently, we might be working in a school, we might be working online, we might be working in education, we might be working in statutory services. We must contract clearly and carefully. Yes, of course, it's important to know the risk factors and it's important to know the protective factors and the warning signs but actually, they cannot be the start and stop of our work because we're therapists and we're able to go much further than that. We have to be willing to explore suicide openly, explicitly and transparently whilst balancing those factors together collaboratively with our clients using supervision, maybe colleagues and the manager if we're in a service. Recording concerns, of course, is really important for ourselves, but also to be able to share with our clients. To obtain consent if we need to speak to others, but if we believe our clients is immediately evidence, we obtained that consent if we can but if we can't, we need to act depending on your context.

That is a rapid run through of what something would be I would normally take several hours to do. I hope that that has been helpful.