SAGE Counselling in Practice

Series editor: Windy Dryden

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Counselling Suicidal Clients

Andrew Reeves

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Praise for the Book

'Counselling suicidal clients is one of the most difficult tasks that we face, and Andrew Reeves approaches this subject with openness and integrity, writing about this difficult topic with warmth and empathy for the experiences of both counsellors and clients. There are no absolute, universally applicable answers to the complex issues that surround suicidality. This aspect of therapeutic work requires ethical awareness, a sound knowledge base and calm objectivity in assessing situations and at the same time, giving the very best we can each provide in therapeutic counselling skills. This book reflects these therapeutic requirements, as the author brings together his experience as a social worker, counsellor and academic, to create a very valuable resource for reflective practice.'
Barbara Mitchels, Solicitor and Director of Watershed Counselling Service, Devon.

'A uniquely accessible, comprehensive and practical guide. Essential reading for counsellors and psychotherapists and all helping professionals who work with clients at risk of suicide.'
Mick Cooper, Professor of Counselling, University of Strathclyde

'A "must read" for counsellors of all experience levels, offering sound practical strategies alongside thought-provoking case studies and discussion points. Reeves addresses this difficult topic with depth, breadth and integrity, questioning the over-simplifications of the "prediction-prevention" culture and challenging counsellors to develop context aware practices as well as personal position awareness. Excellent.'
Denise Meyer, C.Psychol & MBACP (Snr Accred), developer and lead author of award-winning website www.studentdepression.org

Preface

In my early career I would not have considered spending nearly 20 years of my life thinking, learning, talking and writing about suicide. For the most part I had not been touched by suicide, and it had remained almost entirely an intellectual consideration for debate and discussion, like politics or the economy. There had been quiet talk in my family of my cousin, living abroad, who had tried to 'top herself' – generally hushed and secretive discussions that I was excluded from as a child. Her 'activities' were not appropriate for my ears and as such suicide remained a distant knowledge, untouched by any sense of personal reality. My first real experience of death had been through early employment as a care assistant in a home for older people with severe and enduring mental health problems. This was the first time I had seen a dead person, and had come into personal contact with the process of living and dying. During the two years of this work I became familiar with the process of dying and cared for many dying and dead people. However, death had been as a consequence of age or disease, and as such had represented something of the natural progression of life.

Suicide began to impinge more closely on my life during my training and early work as a social worker. During training we had discussed the philosophical and legal implications of suicide, and had meandered through several enlightening and well-meaning debates about what were the 'rights' and 'wrongs' of the choice to take life. A social work placement in a hospice and oncology ward began to illustrate in a far more significant way the human realities and existential crises that contribute to an individual considering ending their own life. Many patients, diagnosed with terminal cancer, were torn between following the natural process of their disease, and reclaiming control over their dying.

The next transition, from the confinement of suicide to the safety of a textbook and classroom debate into my own experience, occurred in my contact with a 32-year-old man I was assigned to work with in my early social work career. Following a devastating diagnosis of a progressive condition, he quickly lost independence and autonomy over his life. We talked extensively about his wish to be dead, and his longing to act quickly while he could still complete suicide by his own hands.

With his permission I had talked to his counsellor with whom he also shared his suicidal desires. She was concerned for his safety, but felt that maintaining his confidentiality and not triggering an evaluation of his mental health state was the last dignity she could offer him. Due to a change in my working location I had to finish seeing him as his social worker. Four months later I heard of his death through an overdose. I battled with an internal debate about the nature of the dignity his counsellor's confidentiality had provided him – his right to choose set against an institution's capacity to prevent him from acting in such a way. I know that his choice and subsequent actions were informed and ultimately inevitable.

However, the ethical questions were not easy to resolve, and many years on, this remains the case.

Suicide had grown much closer to my experience in the same way that our own mortality creeps into all of our awareness as time passes. Then, during my training as a counsellor I wrote the following, an extract taken from a case study:

> 'I'm sorry to have to tell you that Isobel was found dead last night – she had taken an overdose.' This phone call abruptly and violently brought to an end six months of counselling which had touched on many painful and distressing life events, and had also shone light on Isobel's humanity and sensitivity which she so rarely felt able to recognize. Her fragile and painful grasp on life finally ended, leaving behind all that had brought her misery and despair. She left me with a cocktail of emotions and traumas – my own grief and anger at her actions, my own personal losses and bereavements and my overwhelming feeling of incompetence and failure as a counsellor.
>
> Our last session together had obvious signs of danger and imminent annihilation – Isobel was so positive and had a new energy, saying that she felt good – 'very, very good' – as she left the counselling room. I recall my own sense of lightness, exchanging a smile as the session finished, and feeling a completeness with a sense of some healing for her: that her pain today was not so great as it had been and that perhaps I had played some part in enabling that to happen.
>
> Possibly with a similar sense of lightness Isobel that night placed into her mouth large quantities of tablets which she washed down with a bottle of vodka and fell into sleep, and then death: perhaps for the first and final time feeling good – very, very good.
>
> I felt the tidal wave of her process the following morning. As I heard the news I felt a sense of sickness, almost like wanting to throw up something bad that I had swallowed. My stomach and throat creased into a tight knot and I felt a sense of separateness from what was happening around me – that I was spectating from a distance not quite making the connection. Someone asked me if I was okay, and I replied 'fine' as I left the room feeling devastated.

My relationship with suicidality had taken another, dramatic step forward. Isobel had been a client with whom I was working when based within a community mental health team (CMHT) and mental health crisis response service. Her death had personal and professional repercussions for me, and began a process of enquiry into suicide that I might never have otherwise anticipated.

Supervision, personal therapy and support from family and friends were invaluable in enabling me to consider the implications of Isobel's suicide in my personal and professional life, and regain the confidence to continue with counsellor training and in my work as an approved social worker (ASW) under mental health legislation. I was aware that my capacity to support myself with my anxieties and fears with regard to subsequent potential suicides was diminished. As I read about suicide, I became increasingly aware of the power of it in the life and work of professionals. This power was evident not only in the devastating experience for anyone working with someone who ends their life, but in my experience of building and maintaining a relationship with someone contemplating suicide.

As part of a masters degree, I embarked on a qualitative study to explore the experiences of counsellors who worked with suicidal clients. With a mixture of reassurance, identification and astonishment, I heard counsellors telling me that

when a client talked about or alluded to their suicidal thoughts, they experienced a range of responses including fear, incompetence, impotence, anger, anxiety, sleeplessness, nightmares, intrusive thoughts and anticipated grief (Reeves and Mintz, 2001).

I had experienced a range of difficult feelings as a consequence of suicide, as had the counsellors in my masters study. It seemed likely that other counsellors might also experience similar things and if they did, how might that influence their ability to work with suicidal clients? How did counsellor training help them in this process – for my own counsellor training had not attended to suicide in any explicit way? A review of the available research indicated that the results found in my own masters degree study had been found elsewhere (Panove, 1994; B. Richards, 2000). Several important factors were emerging as my own questioning continued:

- My own experience of working with suicidal clients seemed closely related to that of other counsellors in their work with suicidal clients.
- Suicidality in counselling often initiated powerful and difficult emotional responses in therapists.
- My own experience of counsellor training was of little time spent exploring the implications of suicide in a counselling relationship, or acquiring and developing the necessary skills and knowledge to enable me to work effectively with suicidal clients.
- Other counsellors felt ill equipped by their counselling training experiences to work with suicidal clients.
- Given that most counsellors work within a contract of confidentiality that would require them to refer if their client was thought to present a 'harm to self or others', little research existed that explored how counsellors respond to suicidal clients within sessions or how decisions about 'harm' were made.
- While post-qualification risk assessment training programmes existed, they appeared to be either targeted at health care professionals, or generic in their target audience. Through an investigation of the literature and the professional journals, there was little evidence to suggest that resources existed specifically for counsellors to help them consider suicidality from a therapeutic perspective.

As will be discussed in later chapters, the plethora of resources and literature that attend to suicide predominantly do so from a risk-factor-based approach. That is, how can we predict suicide potential by applying generic risk factors (gender, age, employment status, etc.) to an individual? How can we incorporate those risk factors into questionnaires and assessment tools that will enable us to know who is more likely to kill themselves than others? To some extent these resources are invaluable in helping to create a broad understanding of an individual's distress. Yet, I would argue that for all the research and enquiry, there is only one way by which true understanding of suicidality can be reached, and that is by talking to the suicidal person about their experience.

That is not to say that this is an easy process. For a start, it is likely that the suicidal client will not necessarily understand their distress in an articulate way; some intrapersonal phenomena are extremely difficult to put into words. Additionally, it is possible that that 'helper' – counsellor, social worker, psychologist and psychiatrist, for example – will be inhibited by their own responses to suicidal potential to feel sufficiently confident to articulate their concerns. As we

have seen, such responses can include fear, anxiety, anger, impotence and a sense of professional incompetence. These are difficult feelings to 'allow', and often the helper is caught in a process of denying their own responses, but still acting them out in the assessment encounter.

I am therefore interested in several areas, and hope that this book will provide the practitioner with sufficient provocation to facilitate a self-engagement in their journey into the world of the suicidal client. It is important that we are able to recognize our responses when thinking about suicide; are able to acknowledge those parts of ourselves that are fearful, judging or angry; are willing to ask the difficult questions; and know how to respond to the answers we might hear.

I am a registered social worker, and have for many years worked in multi-professional settings. I have worn my counsellor 'hat' while writing this book. However, it is important to stress that almost all of the factors that I discuss and explore about working with suicidal clients can be applied to most settings and helping professionals. I have tried to outline what we all do well, and areas that we can pay attention to. I hope that, whatever your professional background or working context, there is something in these pages that speaks to you.

There is no 'right' and 'wrong' position to take regarding suicide – just our own position. Throughout this book I will endeavour to draw out some of the difficulties and dilemmas faced by counsellors when working with suicide potential. These will, inevitably, be defined by context, amongst other factors. I will try to articulate my own position: however, that is not to say that other perspectives are less valid. I hope that in reading this book you will be encouraged or facilitated to engage with your own views, for ultimately it is those that you will take into your work with suicidal clients.

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Reeves, A., Bowl, R., Wheeler, S. and Guthrie, E. (2004). The hardest words: exploring the dialogue of suicide in the counselling process – a discourse analysis. *Counselling and Psychotherapy Research* 4(1), 62–71. www.informaworld.com.

Reeves, A. and Mintz, R. (2001). The experiences of counsellors who work with suicidal clients: an explorative study. *Counselling and Psychotherapy Research* 2, 37–42. www.informaworld.com.

Reeves, A., Wheeler, S. and Bowl, R. (2004). Confrontation or avoidance: what is taught on counsellor training courses. *British Journal of Guidance and Counselling* 32(2), 235–247. www.informaworld.com.

To the thousands of counsellors I have talked to over the years about their experiences of working with suicidal clients, and therefore for their huge contribution to the writing of this book. Finally, to Diane, Adam, Katie and Emily for putting up with the familiar sight of me sitting at the computer … again.

[1] Reeves, A. (2004). Suicide risk assessment and the ethical framework. *CPJ* May, 25–28.

Part I

Contextual Aspects of Working With Suicide Risk

1 Suicide and Counselling: An Introduction

Chapter overview

This chapter provides an overview for the rest of the book by discussing the role of counsellors with clients who are suicidal. It challenges the idea that counselling is generally not a helpful option for suicidal clients, or that counsellors generally should not see clients who are suicidal. It raises the dilemmas that counsellors face in managing and responding to suicide potential in their work. The overall structure of the book is outlined.

I can recall many years ago, when still early on in my research journey, looking at counselling and suicide risk. I had attended a conference (not about suicide) and was offered a lift home by a consultant psychiatrist psychotherapist. As the journey progressed the conversation moved to my research, and she asked more about it. I explained that I was interested in how counsellors work with clients who are suicidal; that is to say, how they use current information to inform their assessment of risk, whether they formally assess risk at all, how the counselling discourse was altered as a consequence of the disclosure of suicidal ideation, what the implications were of this influence, and so on. My listener was attentive and interested, but also confused. She eventually interrupted me with her statement, 'But counsellors would never see clients who are suicidal, they would be referred immediately to someone with greater competency.'

This made me reflect on my past and current client caseload. In secondary care nearly all of my clients had attempted suicide, and most were currently still actively suicidal. Since leaving secondary care and moving into higher education, a significant number of my current caseload (at the time of writing) had disclosed some degree of suicidal ideation, and a significant number had made attempts on their life. I didn't have any reason to assume that my caseload was particularly different to most other counsellors working in a variety of settings: primary care, secondary care, social services, mental health services, further education, higher education, bereavement services, voluntary services, independent practice, and so on. Indeed, if we relate counselling agencies to suicide risk factors – bereavement, relationship breakdown, psychopathology, physical health problems, etc. – it seemed a fair bet that virtually all counsellors would have some profile of suicide potential in their past or current caseload. I returned to the statement made by my listener, and wondered how quiet my caseload would in reality be if I referred everyone who presented with some degree of suicidal thought/intent to 'someone with greater competency'. I concluded, rightly or wrongly, that despite my listener's own competency and experience, she seemed to understand little about the nature of counselling.

It is difficult to make a definite statement about how many counsellors will have actively suicidal clients on their caseload, or how many counsellors will have seen actively suicidal clients in their professional lifetime, as I am not aware of any research that provides us with this information. My own study (Reeves and Mintz, 2001) indicated that most counsellors will have experience of supporting a suicidal client, although this was small scale and any wider conclusions are based only on estimations and extrapolated figures. Seber (2000) found, by analysing GP and practice nurse referrals for counselling in primary care, that such referrals often included clients with a previous history of suicide attempts. I developed a one-day training programme for counsellors to help them work more effectively with suicidal clients. During the development of this programme, and subsequent delivery, I have met with in excess of 3000 counsellors to specifically talk about suicide potential. Barely any, whether they be post-qualified, experienced counsellors or counsellors in training, did not have some experience of working with suicide potential, and too many had experienced the trauma of client suicide.

It might be helpful therefore to consider my listener's assertion in more detail.

Counsellors should not work with suicidal clients

Some might believe that the person who stated that counsellors should not work with suicide potential had a point. There are some interesting arguments that might contradict the accepted knowledge that counsellors are sufficiently competent to work with suicide risk. These might be summarized around four primary tenets: training around risk; knowledge of psychopathology; research awareness; and knowledge of relevant policy.

Training

> I just feel quite sad that it is an issue that does not come up more in training. It wasn't in ours but it is such an important thing that we should address. – Counsellor

Whether counsellors receive sufficient training to enable them to work effectively with suicide risk remains uncertain. Anecdotally, many counsellors will report that they did not feel sufficiently prepared by their core training to work with suicide potential. I undertook a questionnaire survey of all British Association for Counselling and Psychotherapy (BACP) accredited training programmes at that time to try to obtain a profile of risk competency development for counsellors (Reeves et al., 2004a), given that training courses have the task of preparing their trainees to become qualified and competent counsellors in a demanding and complex arena of helping.

There are many important and difficult areas to cover in training. Increasingly, as has been identified through the developments in mental health, risk assessment is one of these important areas (Department of Health, 1999b). No counsellor can ever accurately predict the behaviour or intent of their client, but counsellors must make use of their assessment knowledge and skills to maintain psychological contact with their clients as they explore these difficult areas of human experience.

The completed questionnaires returned by the respondents provided insight into trends and ideas informing counsellor training, as well as trainers'/counsellors' perceptions of the profession's response to risk.

The courses accredited at the time of my questionnaire study represented several primary theoretical models of practice: person centred, psychodynamic, psychosynthesis and gestalt, with several courses defining their model as integrative or eclectic. Person centred courses were the single largest group (which parallels the trend in BACP membership, with some estimating that 50% of the membership work within a person centred orientation: Thorne, 2004), followed by psychodynamic, integrative/eclectic programmes, psychosynthesis and gestalt.

There was no apparent difference for non-response between the core theoretical models of the courses. This is worth noting, given that a person centred approach is less likely to embrace the concept of risk 'assessment' than other models. Merry writes that 'issues concerning psychological assessment and "diagnosis" are complex, but the person centred approach tends to view these activities as unnecessary and even harmful to the development of a counselling relationship' (2002: 75). In written feedback received, those involved in person centred courses commented on the nature and meaning of risk assessment more than those running other courses. For example, comments included the belief that risk assessment 'pathologized' groups of people, and that the presence of the three core conditions as stated by Rogers (1997) – empathy, congruence and unconditional positive regard in work with clients at risk – was more important than the development of 'skills'. This philosophical difficulty with the questionnaire was further reflected by other comments stating that the questionnaire did not reflect the 'style' of training being offered.

Throughout the questionnaire the term 'assessment' was used frequently, chosen to reflect the language that is used in policy documents and mental health guidance, as well as within many medical and psychotherapeutic settings. However, it is important to acknowledge the potential philosophical difficulties that the term 'assessment' might have presented to some of the questionnaire respondents, and how that might in turn have influenced both the return rate and the nature of responses received. It might be the case that some courses or individual respondents did not see 'assessment' as having a relevant place within the philosophical context of a person centred training course. If this was an influencing factor, then other responses might have been received if different terms had been used, such as 'evaluation', 'exploration' or 'consideration' rather than 'assessment', for example.

Psychodynamic and integrative course respondents however were more likely to offer comments about the structure or design of the questionnaire. One respondent could not entirely understand the purpose of the questionnaire given that risk assessment was integral to their training and could 'never understand how colleagues work without it'. Other courses valued the structure and purpose of the questionnaire and believed the research question to be of significant value.

The returned questionnaires in general terms acknowledged the importance of understanding risk in the counselling process, and the need for trainees to be provided with appropriate opportunities to acquire knowledge and develop skills. However, there was less evidence that the acquisition of knowledge and development of skills were located within the core curriculum of training. Instead, many respondents stated that supervision was the primary source of risk-based teaching and development.