## **Holding and Containing Suicide risk: Assessing and working with suicide**

One of the most difficult aspects of our work in counselling/psychotherapy is handling the pain and uncertainty when a client may be feeling suicidal. Of course it is often impossible to know or predict whether or not a client is going to actually commit suicide. While we have to accept that *we may not be able to prevent the suicide*, we have a professional/ethical duty of care to assess foreseeable risk and to be mindful about levels of risk and safety measures. It is also important to take appropriate action if a vulnerable adult is at risk of harm [[1]](#footnote-1).  For instance, we might inform the client’s GP or other professional if we are concerned.

Our duty of care is not to *prevent* the suicide as such but to take reasonable care to forestall suicide (through showing our concern while containing our own anxieties).  Our job is to keep the therapy safe and boundaried, towards ‘being-there’ for the client.  Sometimes, we might be required to stay in that dark potentially suicidal place with that client, allowing them to express their ideas as that might help them to feel they don’t have to act on it. We don’t want to stop the client telling us their dark thoughts! Asking about whether or not someone is feeling suicidal doesn’t put that idea into their head. The trust and openness that comes with open disclosures and dialogue about problematic areas are valuable.

In this handout, I would like to offer a few ideas about how to assess suicide risk and what to do about it.

When working with someone who is depressed or at risk of suicide it can be helpful to ask about suicide early on, e.g. “Sometimes when people are depressed they consider taking their life. Have you ever had thoughts about committing suicide?” You can ask this other ways too such as: “Do you ever feel life is not worth living?” or “Have you thought of ending your life?” or even “What would have to change in your life in order for you to make the choice that you want to live?”

From that initial question it’s important to get a sense of ***what*** thoughts the client has had and ***when***. The point is to assess the frequency, intensity and duration of the thoughts. If it has been an occasional fleeting thought over the years, we will be less concerned (indeed you could say this is ‘normal’). If the client has been ruminating about it recently there is more cause for concern. Then it is necessary to ask about the ***how***, i.e. if they have made any plans or preparations. Ask: “Have you planned what you might do?” The plan usually has a social context which needs to be considered, for instance, does the person have access to pills. If the person has a plan, then you need to ask about concrete preparations: “Have you made concrete preparations (e.g. hoarding pills, going on instructional websites, writing letters to tie up business affairs, etc.)?” There are warnings and clues to look out for such as if the person is giving away personal items or writing a will or if they suddenly exhibit a sense of calm which may indicate the final plan is in place.

**If the person has got as far as making plans/preparations then it is important to inform someone like the GP.** (This is a possibility that is best to contract at the beginning of therapy where the client knows that the therapist may take action to break confidentiality in cases where the client or others are deemed to be at risk).

Part of the risk assessment is to be alert to wider ‘**risk**’ factors. Suicide can be linked to bereavement or chronic pain/ill-health and also to lack of social support/isolation (i.e. when life no longer feels worth living). It also is associated with mental illness, for instance, if someone has been psychotic and begins to recover, that insight into how ‘mad’ they have been is a danger point. It is also tied up with excessive alcohol or substance use which impairs critical faculties. Repeated suicide attempts in the person’s history need to be investigated also. Research shows many people who self-harm can go on to actually commit suicide. (In other words, it is inappropriate to view suicide attempts as simply ‘attention-seeking’).

Drye, Goulding, and Goulding (1973) developed a method which was later called “the no-suicide contract” to evaluate the suicide risk a client presents. The client is invited to make a short statement: ‘‘No matter what happens, I will not kill myself accidentally, or on purpose, at any time’’ (1973, p. 172). The person is then asked to report their internal subjective responses to making that statement. If they report a feeling of confidence or a sense of relief, then the suicide risk is less present. Responses which signal a potentially higher level of risk include when the individual refuses to say the statement or uses qualifications when saying it.

In addition to focusing on the suicide risks, it is important to consider ‘***protective factors***’. “What might prevent you doing it?” This is a key question to ask. Here the person may not want to hurt their family, or they wouldn’t think of doing it to their children. Even the desire not to leave their dog alone could be enough of a protective factor. Almost all of the people who attempt or complete suicide have mixed feelings about it. Part of them wants to die; part of them wants to live; another part may be uncertain. So our job is to ‘breath life into’ that part that wants to live.

Research shows that the three factors which tend to mitigate against suicide are: 1) having a strong supportive relationship (including the therapy one); 2) having awareness and understanding about the process; 3) Being able to talk openly about the dark thoughts – i.e. talking about it releases it so that it doesn’t need to be acted upon.

Exploring the whole field of the suicidal ideation can help both you and the client better understand what triggers these thoughts and then look at what can be done about them, i.e. nourish some new coping strategies and resources. It can be fruitful to ask the client directly why they have chosen to disclose their suicidal thoughts to you. *Are they wanting to be stopped?*

Where we assess there is a real risk we need to consider (ideally in supervision) what action to take. It may be sufficient to simply **contract** with the client that they agree not to commit suicide during the course of therapy. In more acute high risk situations, the contract may involve the client in agreeing to call someone before actually doing anything.

Beyond this contracting, it might be useful for the person to have a **diary recording their suicidal thoughts** which they then bring into therapy. The process of writing down and sharing their thoughts can be helpful. It can also be helpful as it gives both client and therapist a chance to better understand the triggers and process around.

As therapy proceeds, our work needs to focus on helping the person to **reframe their situation** more fully and realistically and to consider how to develop meaningful coping strategies and resources. All the interventions discussed above are only part of the larger therapy journey directed towards helping the person feel more positive about themselves and to develop a more meaningful life and relationships.

Finally, as therapists ‘hold’ and ‘contain’ clients who are considering suicide and are in the depths of despair, we also need to be held and contained in **supervision and therapy**. It is important to explore our own position about suicide as well. Do we believe it is someone’s ‘right’? Can we empathise? Can we tolerate the depth and darkness of the feelings in order to be-with our client? What would help and support us?

Linda Finlay, December 2016

References

Drye, R. C., Goulding, R. L., & Goulding, M. M. (1973). No-suicide decisions: Patient monitoring of suicidal risk. American Journal of Psychiatry, 18, 17–23.

1. Our UKCP guidelines offer two slightly contradictory messages that 1) psychotherapists undertake to respect client’s autonomy (including decision to take their own life) and 2) that we undertake to not harm or collude in the harming of the client.  The UKCP guidelines also say that we undertake to take appropriate action if a vulnerable adult is at risk of harm.  [↑](#footnote-ref-1)