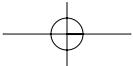
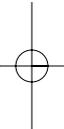
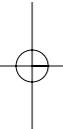


# Part 1

## 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 I had left secondary care and moved 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.

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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; psychopathology knowledge; 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.

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### Competency of supervisors in working with risk

There are important questions about how supervisors develop their own specialist knowledge and skills in risk assessment. Many counselling supervisors begin their work in supervision through a process of evolution from counsellor to counsellor supervisor without additional training. At the time of writing there is currently no legislative requirement for counsellors to be registered, and there is no requirement for counsellor supervisors to have training in either counselling or supervision. Through the work of professional organizations such as BACP, and the development of the supervisor accreditation scheme, 'benchmarks' for supervision have begun to emerge. As a consequence there is an increasing number of supervisor training courses, although such courses are not yet able to apply for 'accreditation' in their own right.

The competency of supervisors to work with trainees around the complexities of risk assessment in their clinical work, including the development and enhancement of skills, is uncertain. That is to say not that supervisors are not competent, but that we just don't know. Due to the confidential nature of the supervisory relationship, the quality and standard of how risk is managed within supervision are also likely to be uncertain to the tutors on the training programme. In this context there is an argument to locate teaching about risk assessment and risk management more explicitly within the core curriculum. Supervision should build and develop knowledge and skills in working with clients at risk, rather than being the primary source of those qualities.

### Importance of 'risk competency'

Neimeyer et al. (2001) stress the importance of training counsellors in risk assessment skills. This view is reiterated by other studies that note the importance of counsellors across a range of disciplines, including counselling, psychology, nursing and teaching, having the opportunity to develop skills in risk assessment (Appleby et al., 2001; Morriss et al., 1999; Richards, 2000; Werth, 2002). In this context it is important to note that while 95.8% of respondents believed that a specific consideration of risk was an essential component of a counsellor training curriculum, 47.8% did not include or had not considered including in their generic skills development work any opportunities for trainees to develop and practise skills for working with risk.

This result suggests that a number of training courses do not provide their trainees with opportunities to develop and practise risk assessment skills in their core teaching curriculum. This reflects comments received from some respondents that skills acquisition is less important than the presence of the 'core conditions' in the therapeutic relationship, for example. Competency development in this area instead is often located in external supervision contracts outside the immediate remit of the training course.

With the increasing likelihood of counsellors being based within a variety of working settings, including multi-disciplinary teams, it is worth noting that a majority of respondents stated that they considered different approaches to the assessment of risk of suicide within the teaching programme. This diversity might reflect the variation in clinical practice between different professional groups in the assessment and management of risk. It is interesting to note that some respondents did not believe

their students were competent to work with suicide risk on completing the diploma programme. This is a surprising result, and begs the question as to how they believed competency was to be developed.

Learning is an ongoing process, and the diploma in counselling structure is increasingly seen as a basic level training from which counsellors should seek to further develop (Dryden and Thorne, 1991). Within the structure of BACP individual counsellor accreditation, applicants need to provide evidence of continuing professional development. However, whether competency in working with risk in counselling is required at a basic level or could be acquired later is an interesting consideration. Within their work, counsellors have the potential to work with clients at risk from the beginning of their training placement as well as from qualification.

While regular supervision is a BACP requirement for ethical practice, it could be argued that counsellors need to be competent in responding to clients at risk not only when they are no longer working within the context of a training placement but also at the beginning of such a placement. If this is true then perhaps all heads of training courses should ensure that their qualifying trainees are competent to work with clients at risk.

Given the complexities and unpredictable nature of client work, there is little time to adequately cover all important practice areas within the limited structure of counselling training. In the light of this, possibly course leaders believe that core training cannot provide trainees with all that they need for working with clients at risk, and that instead this is an ongoing developmental area. Alternatively or additionally, course leaders may consider that the acquisition and development of skills in working with risk are best located in clinical supervision, as has already been discussed.

This might reinforce the idea that risk is best included in the core curriculum given that trainee counsellors might need time to consider how they manage such demands on a personal and professional level. In practice terms, when working with a client at risk, it is helpful for counsellors to understand their own responses to the presenting risk and formulate a rationale for responses to their clients. In working within our own competence there are occasions where a client's level of risk requires the involvement of more specialist agencies. Training arguably has a role to play in helping counsellors to understand when this might be needed, and how it might be achieved. These findings perhaps leave questions unanswered as to whether current training benchmarks are sufficient to equip counsellors to work effectively with suicidal potential. Given the demands placed on counsellors when working with suicide potential, training needs to ensure that they are equipped with basic competencies. The training need of counsellors when working with risk of suicide is explored in more detail in Chapter 18, 'Training Implications for Counselling'.

### **Psychopathology and mental health systems**

In my questionnaire study of BACP accredited training programmes, I was also interested in whether counsellors were given an opportunity to develop an understanding of basic psychopathological theories and diagnostic structures, as well as mental health 'systems'. The majority of course leaders agreed that their trainees were provided with opportunities to understand the working of mental health

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'systems'. Additionally, the majority of course leaders agreed that they spent course time considering how a diagnosis of mental illness was reached and the implications on a personal and societal level of such a diagnosis on an individual.

There was also general agreement that different 'models' of 'mental health' were considered. Within the context of broad agreement, there was disagreement by leaders of a small number of courses, all of whom were person centred in their theoretical approach. In disagreeing with these statements, the course leaders were perhaps again reiterating their view that the therapeutic process with an individual is more about the client/counsellor relationship, and the presence of the 'core conditions', than the context in which the relationship was located. Whether such a focus is sustainable in the longer term, given that person centred counsellors are employed to work in a variety of organizations, is uncertain. Some organizations and practice settings, such as in health care, as well as policy and legislative developments, may demand that counsellors are both competent and willing to practise with a broad and relevant mental health knowledge, which would include working with clients at risk and in multi-disciplinary settings.

However, it remains unclear whether counsellors fully integrated diagnostic thinking into their work. It is important to stress that in terms of this discussion, 'counsellors' is probably too generic a term, and that the extent to which psychopathology is seen as relevant or not is more likely to be determined by the core model of training. For example, cognitive behavioural or psychodynamic counsellors might see diagnostic terms as more pertinent to their core philosophy, whereas for person centred counsellors the principle of diagnosis would be contradictory to their core principles: 'Psychiatric diagnosis is of no issue in client-centred theory and therapy' (Sommerbeck, 2003: 33).

There are some useful discussions to be had around the relevance of diagnosis for counsellors. It is true to say that counsellors are not diagnosticians, so the expectation would never be that they would diagnose their clients. However, some might argue that diagnostic structures in themselves, as outlined in manuals such as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV: American Psychiatric Association, 1994), offer counsellors much insight into personality types. Certainly for working with suicidal clients, diagnoses can offer a useful structure of thinking that counsellors could use to help them order an approach. Additionally, given that higher suicide risk is correlated across pretty much all psychopathological diagnostic categories, a basic understanding of diagnosis is useful in helping counsellors to understand any increased suicide risk.

Sommerbeck (2003) discusses the importance of counsellors at least having an awareness of diagnostic structures, even if they are not actively implemented in their work:

- Counsellors will often receive questions from clients about diagnoses they have been given: 'It is important that the therapist is able to accommodate such a request for information in a qualified way when he deems it appropriate' (p. 33).
- In psychiatric and medical settings, diagnosis is the dominant language, 'and the client centred therapist must be able to communicate in the language with other staff and professionals when working in this culture' (p. 33).

- Counsellors need to be aware of the range of treatments that might be offered clients, and 'the client centred therapist will quickly experience the necessity of psychiatric diagnostics for many treatment modalities, especially for the psychopharmacological treatments that help many clients, in combination with psychotherapy, or without psychotherapy' (p. 34).
- Diagnosis is often central when considering the liberty of a client under mental health legislation, and a counsellor needs sufficient awareness of this to contribute usefully to that discussion, particularly in relation to client suicide potential.

As is the case with training competency, counsellors arguably need to interact more actively with basic concepts around psychopathology and diagnosis, congruent to their model of practice, to support their work with suicidal clients.

### Research awareness

The context of working with suicide risk has been so profoundly informed by research that it is essential that counsellors have some awareness of the relationship between their practice and what the research says. As will be highlighted in other chapters, research has been pivotal in the development of an understanding of risk factors, and as a consequence in the development of the plethora of risk assessment tools, questionnaires, inventories, scales, and so on. Counsellors are traditionally not research aware, as for many decades training has tended to focus on skills development rather than research competency. As counselling training has increasingly moved into further and higher education settings, in addition to the many training programmes that are independent, research awareness has begun to change as trainees have been required to complete small scale research studies as part of their programme of study.

The work of organizations such as BACP in trying to make links between practice and research has resulted in research more and more appearing on the agenda of the counsellor. The push towards evidence-based practice, and the publication by the Department of Health in the UK of *Treatment Choice in Psychological Therapies and Counselling: Evidence-Based Clinical Practice Guideline* (2001), a document that identified preferred interventions based on research evidence, made research awareness a greater imperative.

However, many counsellors remain wary of and intimidated by research, believing it to have little relevance for their practice. Cooper however argues that 'research findings can be like good friends: something that can encourage, advise, stimulate and help us, but also something that we are not afraid to challenge and argue against' (2008: 1). This is certainly true for the research evidence in relation to suicidal potential. Understanding the evidence can certainly 'encourage, advise, stimulate and help us' when we are trying to make sense of another's suicidal experience, and the likelihood of them acting on their thoughts, but neither should it be a given that we feel unable to 'challenge and argue against' it. As stated elsewhere, there is a tendency to presume that risk factors in themselves are the panacea when working with suicide risk, whereas in truth they are but a starting point, a context, within which much more information and detail need to be gathered and interpreted.

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### Knowledge of relevant policy

The need for counsellors to be aware of policy that informs practice is essential across all aspects of professional work. Specifically in relation to suicide risk, there are a number of important documents that inform and shape the expectations of counsellors and other mental health practitioners. These are discussed more fully in Part II, 'The Prediction-Prevention Model, Policy and Ethics'. I am not aware of research that tells us whether social policy adequately addressed within counsellor training. It is likely that counsellors will have awareness of policy directly relevant to their working context, but whether knowledge and understanding are achieved in a transferable way is less clear, e.g. a counsellor working in higher education understanding the practice implications of the *Suicide Prevention Strategy for England* (Department of Health, 2002). The need for counsellors to understand how practice is shaped and informed by policy is an important skill, given that intervention decisions are likely to be benchmarked against policy and good practice parameters at some stage.

My questionnaire survey asked course leaders to comment on whether they believed professional organizations adequately supported their members in acquiring knowledge of key policy documents, and their implications for counselling. The majority of respondents did not feel that professional organizations adequately met the information needs of counsellors in such important areas. Such initiatives can be essential in informing members about key practice and contextual changes across a range of topics. If such organizations are not providing information at a time of change in mental health legislation and policy development, they are potentially failing their members. However, it might be that such information is made available but that counsellors do not read or access it.

At the time of the study, the Department of Health (1999a; 1999b) had published important policy documents that created imperatives in mental health policy development and professional responses to risk. Guidance issued by professional organizations might not be reaching all the membership or might not be perceived by the membership as relevant for their practice. A proportion of respondents did not express confidence that appropriate or sufficient information was being provided by professional organizations in these areas. The nature of information that counsellors might see as relevant to their practice and the means of dissemination warrant further enquiry.

This is not a 'sexy' area for many counsellors. For other professional groups, such as social workers and nurses, social policy is an integral component of their core training curricula. This arguably allows for a greater critical awareness of the development of social policy, and a greater understanding of the implications of policy for the professional tasks in which they are being trained. However, social policy does not appear to be generally incorporated into counsellor training. During the workshop I developed for supporting counsellors in their work with suicidal clients, policy was the point at which many participants became 'glassy eyed' and were clearly switching off!

One explanation for this might be that as counsellors are not trained to think in policy terms, or to integrate policy information into their practice, they therefore do not value it as highly as interpersonal information, in which they receive extensive training. The consequences of this however are that many counsellors effectively practise in the dark – unaware of policy initiative and how practice is

subsequently shaped by it. Alternatively, many counsellors do not appreciate the importance of using a political/policy process to support practice. This is the case in working with suicide potential: many counsellors will be expected to use risk assessment tools (developed through research and integrated into policy), and will feel that they influence their practice negatively. However, the more aware counsellors are of the context of such tools, the more they are able to use that information to support what they do, rather than let it change it, as is discussed in other chapters of this book.

## Counsellors should work with suicidal clients

Why should counsellors continue to work with suicidal clients, particularly in the light of the potential difficulties around training, knowledge of psychopathology, lack of research awareness and lack of training about social policy? Essentially, because we are very, very good at it; and also because counselling offers suicidal clients a choice that goes far beyond traditional psychopharmacological or psychiatric interventions.

So why do I believe that 'we are good at it'? Primarily because the focus of the work of counsellors is relatively uncorrupted by extraneous factors, such as context. In many ways this is a difficult statement to make. I believe that it is essential that all counsellors think systemically in ways they currently don't. It is arguably impossible to help the whole person if they are continually viewed outside of their cultural, social or demographic context, for example. It is difficult for a client to really feel better about who they are if they live in squalid, uncaring surroundings. It is impossible to understand a client's suicidality if it is not viewed in the context of relationships, physical health or abuse, for example. So, I am not arguing here that counsellors should not think systemically, or encourage their clients to do so. However, by 'uncorrupted by extraneous factors', I mean that counsellors are perhaps in an almost unique position by comparison to many other mental health professionals to focus entirely on the 'self' of the client, using communication skills effectively and in a facilitative way to enable the person of the client to really explore who they are and how they feel.

Our theories and working models, regardless of orientation, are arguably designed to specifically facilitate the narrative of the client *for its own sake*, as opposed to then fit it into another box we might have waiting for it. However we construct personality, counselling is ultimately about giving voice to the client so that they can begin to make change through awareness, or perhaps remain unchanged but in awareness. This is particularly important when working with suicidality – enabling another person to begin to articulate their most difficult, painful thoughts in a way that ultimately aims to use those same thoughts as a means to moving on. Almost paradoxically, we are helping clients to use the awareness of their suicidal potential to begin to move away from it.

Having worked in secondary care for many years, I have met too many clients who have been treated by psychiatric or medical models for decades, without having had the opportunity to really talk about their problems. Isobel, whose suicide I described in the preface, said to me early on in our relationship, 'I've never really talked about this y'know. I've been in and out of hospital countless times,

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but have never really been asked about how I really feel.' That is not to say that the choice of counselling is necessarily an easy one: for Isobel it was perhaps the hardest (or most liberating?) thing she ever did. Also, the choice of counselling does not have to be one that excludes other interventions. For example, few might deny the benefits of counselling in conjunction with medication for depression, for example.

This is essentially why I passionately believe that counsellors should continue their work with suicidal clients: because it can be a lifeline when no others seem to exist. The other things – training, knowledge and research – we can change (and arguably are changing through the development of core competencies, for example). It is also because I believe counselling to be such an invaluable resource for people contemplating ending their own life that we need to do it as 'right' as we can.

### The structure of this book

This book is structured across seven parts, each dealing with an aspect of working with suicide risk pertinent to practitioners. Part I, 'Contextual Aspects of Working with Suicide Risk', considers suicide in context. For example, it looks at how the emergence of the medical model and psychiatry has influenced not only the way in which suicide is understood, but how it might be responded to. This is pivotally important for counsellors, given that we don't work in a vacuum. The emphasis in many counsellor training programmes is on the understanding of the individual, the 'self', with less emphasis placed on 'self' in context. This is understandable and, in many ways, important. It is vital that new counsellors can fully understand a number of theories of psychotherapy and personality in order to be able to work effectively with people in a therapeutic relationship. However, if we can incorporate into our thinking and understanding the 'self' in relation to relevant historical developments, other forms of helping and understanding, and the ongoing evolution of counselling as a professional activity, we can begin to understand the distressed 'self', and indeed the suicidal 'self', in a three-dimensional way.

Part II, 'The Prediction-Prevention Model, Policy and Ethics', builds on Part I by exploring how these different aspects come together to inform intervention choices. More specifically, it looks at how the work of suicidologists has considerably informed and shaped our response to risk, through the development of risk assessment tools, questionnaires and inventories based on suicide risk factors. What I will call the 'prediction-prevention' culture of working with suicide risk is a direct consequence of a factor-based approach to understanding suicidality. While it is important to acknowledge the value of integrating an understanding of risk factors into our work, I will argue that for many counsellors a dialogic approach (as opposed to one based on questionnaire or statistical analysis) is not only much more congruent with how we work, but also probably more likely to help us and our clients understand suicidality in a much deeper way, gaining a better idea of the risk of suicidal thoughts being acted on. Finally in this part I will provide a brief consideration of some of the factors that counsellors cite as problematic for them in working ethically and appropriately, such as managing confidentiality with suicidal clients, and understanding the implications of terms such as *capacity* and *consent*.

In Part III, 'Organizations', I will consider how organizations influence and shape counselling generally, and more specifically in work with suicidal clients. This is particularly important given the numbers of counsellors now working in statutory and non-statutory agencies, where practice is often directed by a risk policy or procedure. We will consider how counsellors can negotiate working within a policy that might contradict personally held views on suicide. Additionally, we will look at what factors might be usefully considered when developing a suicide risk policy, or when reviewing an existing policy.

Part IV, 'The Client Process', will consider in some depth the ways in which clients might explore their suicidal thoughts in sessions, or indeed might consciously or unconsciously avoid them. This is, of course, vitally important to counsellors given that we rely on the ways in which our clients are able to articulate their narrative, and how we can facilitate a greater understanding of it through therapeutic 'talk'. It could be argued that *how* clients talk (or don't talk) about their suicidal thoughts has direct implications for the nature of the therapeutic discourse. In the context of these implications, we will consider what skills and relational factors counsellors might keep in mind to help maintain and sustain therapeutic contact in the face of potential client self-annihilation.

Part V, 'The Counsellor Process' is perhaps of greatest importance for any counsellor who works with suicide risk. Over many years of research and reading into working with suicide risk, I have found that the practitioner process is consistently overlooked in favour of statistical trends, risk factors and other more generalized aspects of the work. Yet, and particularly in the context of a dialogic approach to suicide risk assessment, the *understanding* of what we hear from suicidal clients will be profoundly shaped by our own subjective position. Our own experiences of having been suicidal or of suicide within our family, our spiritual or religious beliefs, our responses to the particular client in question, for example, will all shape what we allow ourselves to hear, and then how we subsequently respond. Telling ourselves that, despite our personally held views, we will always be able to reach objective conclusions about a client's level of risk is at best a professional arrogance and at worst a disregard of the complexities of suicidality that might leave our clients at great risk at a time when they needed our intervention the most. For example, how easy is it to really hear what is being said and what is not being spoken from a place of our own fear and terror?

Part VI, 'Key Aspects of Counselling with Suicidal Clients', will attempt to draw these factors together and provide a consideration of what we should do when a client talks of feeling suicidal. This includes self-care, and ensuring that our practice and practice decisions are grounded in a secure knowledge base as well as an ethical context. Part VII offers my concluding thoughts and makes suggestions for future development.

I hope that you find this book helpful in supporting you in your work. Ultimately, the aim here is not to provide a book of answers, because in working with suicide risk there aren't concrete ones to be had. Instead, the hope is that you will find many aspects in this book that will facilitate further thinking, and provoke you into personal and professional reflection. The book is deliberately written in a non-model-specific way. My belief is that it is not the model or training orientation of the counsellor that will best lend themselves to be able to work effectively with

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people who are suicidal, but their willingness to listen, to question, to explore, to go to unknown and often difficult places, and ultimately to be able to sit with their not knowing.

My personal experience is that I have encountered most problems when searching for something concrete, realizing that in the absence of it I am left with my anxiety and fear. It is these feelings that I find I take into the counselling relationship (even though I am convinced that I don't!). As soon as this occurs, I cease to be of value to the client who is in a suicidal place because I parallel their chaos or struggle in the absence of my own 'grounding'.

### My own view

I think it will be helpful here to be transparent about my own position in relation to suicide – though it must be said that this is inevitably a dynamic and changing one (as I suspect will be the case for you in reading this book). The chances that my perspective will have changed by the time this book appears in print, or by the time you read it, are extremely high.

Essentially I believe that as individuals we should all hold the choice to end our own life if we believe it is no longer worth living. I see this as an essential 'human right', and not one I would like removed from me. I believe that this 'choice' should be informed, and reached with capacity and consideration. However, many people have come to see me as a counsellor who have talked of wanting to end their own life but who, in my view, did not have the capacity to reach that decision clearly or in an informed way. That is to say, their level of distress was such that it was difficult or impossible for them to see beyond their distress. They had lost a sense of hope, and my role, as their counsellor, was to hold that hope for them in the event of change. I believe that mental health distress, or mental illness if you choose to call it that, can impinge on capacity and that as a counsellor I should provide my clients with opportunities to make *informed* rather than impinged decisions.

Of course, this logical argument becomes entirely redundant when applied to my own friends and family. Can I defend this contradictory stance, this ridiculous incompatibility between these two positions? No, clearly I can't. My position evidently has 'one rule for one, and a different rule for another'. It is hypocritical and nonsense. However, it is true for me ... at the moment. Such is the nature of our own positions *vis-à-vis* suicide that we all must work through what they are, and the contradictory places we might take ourselves. The fact is that it is probably impossible to stand in a concrete place until we know what that place might be. Certainly, for many, spiritually or religiously held beliefs will be profoundly important in reaching a 'position' on suicide. The task of managing these dynamics when working with a suicidal client can be daunting.