Working with Self-Harm and Suicidal Behaviour

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Communicating with People Who Are Suicidal

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Introduction
Communication is essential for all therapeutic/helping relationships and in particular when engaging with people who are suicidal. The knowledge and interpersonal skills that the worker uses to communicate are essential aspects of helping to prevent the immediate risk of suicidal behaviour, while at the same time facilitating the development of a positive helping relationship. For the worker, this requires the use of a range of appropriate and effective communication as well as engagement skills. This chapter presents some of the interpersonal skills and interventions that can be used to help prevent the immediate risk of suicidal behaviour. The chapter will provide examples to illustrate how the different skills can be used in practice.

LEARNING OUTCOMES

By the end of this chapter, you should be better able to:

1. describe how your beliefs and attitudes about suicide might impact on your interventions with the suicidal person;
2. identify the characteristics necessary to facilitate the development of a positive helping relationship;
3. demonstrate an understanding of how communication skills/interventions can be used to help assess and prevent the immediate risk of suicidal behaviour;
4. apply interpersonal skills and interventions to help the person who is suicidal in the work setting.

Connecting with the suicidal person
As stated at the outset of the book, the extent of suicide has become a serious public health issue and a major global cause for concern (Pleischmann & Shekhar, 2013). Suicide and suicidal behaviour affect many people directly, in both a personal and professional capacity. For those working in mental health and other helping services, suicide prevention is obviously a priority. Being able to connect, engage and communicate with people who are expressing suicidal thoughts or behaviours is critical to maintain and promote the person’s safety and well-being. However, before being able to engage and communicate therapeutically with the person, it is important that the worker is aware of his/her beliefs and opinions about suicide and how they might influence their reactions.

Beliefs and attitudes about suicide
Over the years, societal beliefs and attitudes about suicide have varied tremendously; in many countries, suicide is no longer considered either a crime or a sin (O’Connor et al., 2011). Notwithstanding such significant changes, suicide remains a complex, emotive and difficult topic that produces a wide range of attitudes and responses from people, some of which may be pejorative and value-laden. In addition, the stigma associated with suicide, as discussed in Chapter 2, can influence people’s beliefs and opinions about suicide, which can differ between and within helpers, institutions, societies and persons at risk of suicide. Such diverse views may influence not only how workers respond to the suicidal person but also whether people at risk of suicide ask for help or tell people how they are feeling. Negative reactions by helpers can cause a person to feel that the worker is unsympathetic, unconcerned and uncaring, which is likely to have a detrimental impact on the person’s mental state (Flawton & van Heeringen, 2009). This in turn can put the therapeutic/helping relationship at risk and at the same time be detrimental to the person’s immediate safety and long-term recovery (Royal College of Psychiatrists, 2010).

As a subject, suicide rarely leaves people in a neutral position (Reeves, 2012: 541); it is therefore likely that workers’ views about suicide will be present in their therapeutic/helping interactions. Different beliefs about suicide can influence how a worker will respond to the disclosure of the possibility of suicide (Reeves, 2012). Being aware of one’s opinions and feelings about suicide is essential in order to be able to listen to the beliefs and views of the person who is suicidal. Furthermore, having an awareness of such views can also help the worker to identify and manage his/her beliefs and feelings that might hinder their willingness and ability to engage and provide first-aid help to the person at risk.

Misconceptions and myths about suicide
In the context of helping, workers may be exposed to many different beliefs or misconceptions about suicide. Such beliefs or ideas about suicide are often a reflection of a much wider societal view and can become so embedded with little evidence or logic to support them that they become common misconceptions or ‘myths’. The Irish Association of Suicidology (IAS) (2013) identified the following common ‘myths’ about suicide:

1. Most suicides occur with little or no warning.
2. Most suicides are caused by one single traumatic event.
3. Those who talk about suicide are the least likely to attempt it.
4. Talking about suicide encourages it.
5. If someone is going to complete suicide there is nothing you can do about it.
6. Suicidal people are fully intent on dying. They will do it eventually.
7. Suicide attempts are just cries for help – it’s a form of attention seeking.
8. Only mentally ill/clinically depressed people make serious attempts at suicide.
9. Once a person is suicidal, they are forever suicidal.
10. Suicide can be relief not just for the individual but also for those that surround the person.

Some of the above myths will be discussed further in relation to their impact on conducting a suicide risk assessment. For the interested reader, coverage of the facts concerning such misconceptions about suicide is available at www.ias.ie.

**Helpers’ responses to suicide**

Working with the suicidal person evokes a wide range of feelings, often occurring at the same time. For many workers, the presence of a discussion about suicide can be experienced as challenging and anxiety provoking. This can apply to both experienced and inexperienced workers. Reeves and Mintz’s (2001) small study found that counsellors and psychotherapists with varying post-qualifying experience found it difficult when working with clients who were potentially suicidal and as a result did not explore with the client the meaning of his/her suicidal thoughts or consider the degree of intent and the level of risk. The range of responses experienced by workers is often underpinned by certain beliefs as illustrated in Table 6.1.

<table>
<thead>
<tr>
<th>Responses</th>
<th>Beliefs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic</td>
<td>I don’t know what to do to help, I’m just a support worker and I’m not trained to deal with this type of situation.</td>
</tr>
<tr>
<td>Fear</td>
<td>I am afraid, what if I try to help the person ad then they harm or kill themselves.</td>
</tr>
<tr>
<td>Frustration</td>
<td>I am busy now, I don’t have time now to talk to the person about this.</td>
</tr>
<tr>
<td>Anger</td>
<td>I don’t know what else to do; I have done all I can to help.</td>
</tr>
<tr>
<td>Resentment</td>
<td>I feel I am being used; the person is just looking for attention – it’s doesn’t seem really serious to me.</td>
</tr>
</tbody>
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**Establishing a helping relationship**

Similar to any therapeutic/helping relationship, the relationship between the worker and the suicidal person is paramount (Briggs, 2008). One of the most important factors in preventing suicide is the presence of a supportive resource. The person at risk of suicide needs someone to connect with, particularly at the time when their feelings of hopelessness are strong (Reeves, 2012). In such instances, the person is likely to seek out and approach a worker whom they trust and feel able to connect with in some way. In fact in the context of helping, suicidal persons have a well-tuned radar, which can detect the extent of a helper’s interest (Royal College of Psychiatrists, 2010). Having a positive attitude towards those who engage in suicidal behaviour is therefore crucial to achieving any meaningful engagement and interaction. Exploring with the client the meaning of their suicidal thoughts and behaviours requires the worker not only to be able to connect with the person but also to demonstrate a willingness and ability to develop and remain connected with the person at risk. However, establishing a helping relationship does not just happen or should be taken as a given; instead, it is built with care, compassion and underpinned with certain core values, which are essential, particularly if the worker wants to develop, maintain and sustain a positive, supportive and therapeutic/helpful relationship with the person (Morrissey & Callaghan, 2011). Notwithstanding this, each helping/therapeutic relationship is unique and may be influenced by many factors; for example, the context of the helping relationship, the length...
of time the worker and the person know each other and, as stated earlier, the
worker’s beliefs and responses towards the suicidal person.

In any context of helping, being faced with a situation whereby a person
is expressing suicidal thoughts or behaviour can seem frightening and often
lead the worker to consider a range of behaviours and actions that might fall
beyond his/her capacity to work/help (Reeves, 2012). As stated earlier, such
fears can apply to both experienced and inexperienced workers. One way to
allay such fears is for workers to become familiar with their organisational
policies, procedures and practices concerning issues of risk, in particular, those
relating to persons at risk of suicide and self-harm. In most organisations, such
policies are in place to guide the workers in their role and to ensure that those
being helped are responded to appropriately (Reeves, 2013).

Principles and characteristics of a helping relationship

Every interaction with a suicidal person is an opportunity for the worker
to intervene by engaging into a supporting relationship and offering help to
reduce the person’s distress and potentially to save a life at that time (Cole-King
et al., 2013). A person-centred approach lies at the core of any helping rela-
tionship. Carl Rogers’ (1961) person-centred approach believed that if helpers
built relationships based on what he referred to as the three core conditions –
genuineness, acceptance and empathy – then the people they were attempting
to help would begin to understand aspects of themselves that were previously
unknown to them. For example, the person who is in a potential suicide risk
may begin to explore and understand his/her beliefs and reasons for wanting
to harm themselves or die at that particular time. Although each core skill will
be described separately, it is important to note that in practice all three core
conditions are interrelated, for example, in the context of helping one cannot
demonstrate empathy without being congruent and unconditional.

The core conditions are the following:

- Empathy
- Congruence
- Unconditional positive regard.

The skill of empathy

The skill of empathy is widely recognised as a key component for all therapeu-
tic/helping relationships (Roth & Fonagy, 2005). Its use is advocated as
a potent and powerful skill, which contributes to the achievement of effective
outcomes for the person being helped. Larson and Yao (2005) argue that work-
ers who are empathic and compassionate are more likely to encourage those
being helped to disclose more about their concerns, symptoms and behaviour,
which is ultimately more effective when helping the potentially suicidal per-
son. At its simplest, empathy refers to ‘the ability to perceive the world from
another person’s viewpoint and to take on that perspective while not losing
one’s own’ (Stevenson, 2008: 112). According to Rogers (1961), this means

that the empathetic helper will sense or pick up on the person’s feelings but
will not lose what he calls the ‘as if’ component, that is ‘as if’ you were the
other person. When conveying empathy, the ‘as if’ factor helps to protect the
worker from being overwhelmed by the emotions and distress of the person
being helped. This then helps the worker to be able to ‘step back’ and be
more objective when offering therapeutic help to the person in distress. Being
empathic requires the worker not only to tune into what the person is saying
and describing but also to be able to convey that understanding to the person.

In many everyday communications, a sympathetic response, that is an
expression of concern, comfort or consolation, is conveyed by the worker
with regard to the person’s distress or situation. However, while empathy is
not sympathy, expressing sympathy is a first-level empathetic response, which
acknowledges and validates the person’s situation and is therefore also recog-
nised as important for connecting with the person and developing rapport and
trust in all helping relationships (Freshwater, 2003). Examples of sympathetic
responses are as follows:

I am really sorry to hear that you have had such a difficult time

I am sorry you feel so upset

I am sorry that things have been really hard for you recently

Conveying empathy

Conveying the skill of empathy and its various components can be a chal-
llenging task for the worker. Rogers (1990) admitted that he was not always able
to achieve these qualities in the helping relationship. Therefore, similar to most
acquired helping skills, learning how to use empathy effectively demands time,
practice and the ability and willingness to reflect on one’s application of the
skill with different people in different contexts throughout one’s working life.
Since each person and helping relationship is unique, there are no universal
or magical empathetic sentences that will meet the needs of all persons at risk
of suicide; as with most therapeutic/helping skills, ‘one size does not fit all’
(Stevenson, 2008: 109).

REFLECTIVE EXERCISE

Think of a person that you worked with or helped who expressed suicidal
thoughts or behaviour and answer the following questions; illustrate your answer
with examples.

1. What challenges did you encounter listening to the person talk about suicidal
intentions?
2. What feelings did it evoke for you at the time?
3. How did you respond to the person at the time?
4. On reflection, how might respond now – the same or differently and for what
reasons?
Notwithstanding the challenges for workers, connecting with the person and conveying empathy is essential in order to help save lives and requires the worker to, or at best, make every effort to implement the following:

- Be fully present (physically and emotionally) with the person.
- Stay in the here-and-now with the person.
- Listen attentively, with interest and at the person's pace, to gain a deeper understanding of the person and his/her situation.
- Be mindful of the tone of your voice and your body language; for example, non-verbal behaviour, for example, facial expression, eye contact, posture should reflect what and how the message is being conveyed verbally.
- Acknowledge that you can never truly understand the person's experience, for example, 'I can only imagine how difficult it must feel for you at this moment, when you think everything is hopeless'.
- Be aware of your own thoughts (judgements) and feelings towards the person who is suicidal and how they might be hindering your ability to be fully present for the person.
- Stay with the person's frame of reference, that is his/her perspective and experience and not your thoughts, feelings and expectations.
- Check frequently with the person as to the accuracy of what you are sensing or picking up and be guided by the responses you receive; for example, Worker: 'so life has been so difficult for you of recent that you want to end it... because you think it will stop the emotional pain you are feeling', is that how it is for you? Person: 'I don't want to die... I just want the pain to go away; I am tired of feeling miserable'.
- Empathetic statements should be tentative and used sparingly; when overused they can sound very contrived, false and not real or genuine.

Examples of empathetic statements:

- 'You appear very distressed; I wonder if you are hurt by your father's response to your overdose?'
- 'I get the sense that things are really difficult for you and have been for a long time and that at this moment you cannot see any reason to live?'
- 'Listening to what you said, I get the sense that you have been hiding your fleeting thoughts about killing yourself for fear that your mum and dad would get very upset?'

**Congruence**

Another important core condition in the context of helping is congruence. Being congruent refers to the worker being genuine or real in their therapeutic/helping skills and relationships. This means that the worker relates to the person in a genuine manner and does not hide behind a uniform, medical jargon or the organisation. It means being as open and honest as possible with the other person about one's thoughts and feelings.

**Unconditional positive regard**

Unconditional Positive Regard (UPR) refers to accepting the person for who she/he is; no matter what his/her behaviour, feelings or condition is (Rogers, 1961). This means being non-judgemental and being able to demonstrate that acceptance to the person. This does not necessarily mean approving or accepting all behaviours; in fact, there may be some situations whereby the worker does not approve of the person's behaviour. In such situations, the worker strives towards separating the person from their behaviour and valuing them as an individual, which in practice can be challenging as illustrated in the following case.

**CASE SCENARIO 6.1**

Ruby is a senior counsellor working in a large school. Part of her role involves facilitating trainees from different helping professional backgrounds to get the most from their placement in an educational setting and maximise their professional learning. Ruby is particularly interested in helping trainees to develop their knowledge and practice especially concerning working with adolescents and young adults who are suicidal. On meeting Jade, a new trainee, Ruby asks her the following question. What issue(s) has been the most challenging for you to date and for what reason(s)? Jade stated, '...I am a mum of two teenage boys, yet I find it hard to empathise with some students particularly when they "threaten" suicide to manipulate their parents and cause them much distress. I think about how I would feel if it was one of my sons.' After some discussion, Jade acknowledged that she also found it hard to separate the behaviour from the person, for example, the taking of frequent overdoses. On reflection, she began to realise that she needed to 'tune in' more to what the person was saying and pay less attention to her own views and judgements about the person's behaviour.

**Assessing the risk of suicide**

As well as engaging into a compassionate, caring and trusting relationship, the worker also needs to undertake a comprehensive risk assessment with the potentially suicidal person. Suicide risk assessment and management are of major importance in reducing the risk of a completed suicide (Royal College of Psychiatrists, 2010). As described in Chapter 3, undertaking a suicide risk assessment requires the worker to be familiar with the evidence-based risk factors, warning signs and protective factors for suicide, all of which need to be taken seriously. Notwithstanding their importance, the worker also needs to be aware that just as each person has a different way of coping with stress, the person may also experience and behave differently when they are considering suicide. Therefore, appraising factors associated with a high risk of suicide also needs to be individually focussed as illustrated in the following case.
CASE SCENARIO 6.2
Rupert is a 54-year-old solicitor, married with two grown-up daughters, presented at the Emergency Department having taken a serious overdose. According to his daughter Libby, Robert is happily married, enjoys his job and has no financial difficulties. He has no history of mental illness and there is no known family history of depression or suicide. Libby is both shocked and distressed, and cannot understand why her dad might want to end his life.

CASE SCENARIO 6.3
Gertrude is an 84-year-old widow who lives alone in the country. Up until recently, she enjoyed a very active social life with various family members, friends and neighbours. Over the last six months, she has begun to notice that she tends to forget things. She fears that she might be getting Alzheimer’s like her parents, whom she looked after for many years. She has begun to think about suicide before her health deteriorates further. She does not share her thoughts with her family or friends for fear that they might try to change her mind.

CASE SCENARIO 6.4
Krystal is a 20-year-old student who was recently discharged from hospital following a serious overdose. Krystal regresses her behaviour and feels embarrassed that she caused so much distress for her family. Krystal has a history of self-harming behaviour as a teenager but has not cut herself for the last year.

REFLECTIVE EXERCISE
Answer the following questions, illustrating your answer with examples.

1. What are the warning signs, risk factors and protective factors for suicide in each of the above cases?

When undertaking a suicide risk assessment, the person who is contemplating suicide or who has tried to take their life is likely to be feeling distressed at that time. Although it might seem frightening, the worker can help the distressed person by staying calm, acknowledging their current problem/distress and conveying acceptance, while at the same time provide the person privacy and offer a space to talk about their thoughts and feelings. The best caring response at that time is a non-judgemental approach and active listening (Cutcliffe & Stevenson, 2007). Listening actively is one of the most important helping interventions and means giving your full attention, physically, mentally and emotionally, to the person who is talking (Arnold & Underman Boggs, 2003). While listening to the person, the worker may be able to draw the person into a supportive relationship and away from self-destructive thoughts at that moment. This intervention can also provide a safe period of time until other forms of help can be obtained.

Suicide risk is determined by thoughts of death (suicidal intent), hopelessness, the methods considered, development of a plan (the degree and seriousness of that intent), risk factors and specific warning signs (O’Connor et al., 2011). Although undertaking a suicide risk assessment can be potentially life-saving, the assessment is dependent on what the person chooses to disclose or not to the worker. For the worker, determining the level of suicide risk is reliant on the person’s disclosure of their suicidal thoughts. Cole-King (2010) points out that such disclosure must not be underestimated, which in itself can act as a protective factor. However, while some people may talk openly about their suicidal thoughts, others may find it difficult and painful and will not talk about them or instead might refer to them through the use of metaphors or ambiguous statements. For example, the person might say:

‘I just can’t take it anymore’
‘No one would miss me’
‘I feel like I am stuck in a very black hole’
‘I am causing my family so much worry’

It is important that the worker recognises and responds to such potential messages along with other things that he/she might observe and pick up, for example, the person’s body language or change in behaviour, all of which might be invitations from the person to help prevent suicide. It is therefore important that the worker asks openly about suicide, for example:

- ‘Have you ever thought about suicide?’
- ‘Have you sometimes felt like harming yourself?’
- ‘Have you thought about ending your life?’

Exploring the suicide question
For many workers, one of the biggest fears when working with the risk of suicide is that discussing suicidal thoughts may directly lead to an increased rate of suicide (Cole-King et al., 2013). As stated earlier, the belief that talking about suicide encourages it is a myth (IAS, 2013). If the person is experiencing suicidal thoughts, the worker needs to ask further questions to gain as much information as possible. Moreover, in order to undertake a comprehensive suicide risk assessment, it is essential that workers are not afraid of asking questions about suicidal thoughts and exploring the subject in depth. Given that many potentially suicidal people are reluctant to begin talking about suicide, workers must talk openly about it; in fact by doing so, it is more likely to reduce rather than increase the risk of suicide.

Asking suicide questions
When posing questions about suicide they should be clear, direct and unambiguous. The most useful forms of questions are open-ended and begin with
'When?'; 'what?'; 'how?'; 'who?' or 'where?' Asking an open-ended question invites a full descriptive response. The following questions are examples of how to gain as much information as possible about the person's suicidal thoughts and other relevant information when undertaking a comprehensive suicide risk. The questions are by no means intended to be exhaustive or prescriptive but instead aim to provide the general principles for the use of each skill presented. It is important to remember that when used in practice, they will be used together with the skills of listening actively and non-verbal communication (Table 6.2).

The following skills should at best be avoided:

- Closed questions: these limit the other person's options and often only allow a response of 'yes' or 'no', for example, 'Do you have suicidal thoughts?'
- Leading questions: these involve imposing your own perspective or being suggestive, for example, 'So you must have felt very upset after getting a diagnosis of depression?' rather than 'How did you feel after receiving a diagnosis of depression?'
- Why questions: these tends to invite an answer rather than a description or an exploration and the use of 'why' may appear interrogative and as a result may evoke a defensive response. For example, 'Why do you want to end your life?' rather than 'What has happened that makes you want to end your life?'

For workers, the prediction of suicide evokes much anxiety and concern, yet it is fraught with difficulty and the level of accuracy (Briggs, 2008). Nevertheless, people communicating suicidal thoughts is often a cry for help; therefore any statement, a vague comment, a gesture, or a very small change in the person's typical behaviour must be taken seriously and met with compassion and a constructive response in order to engage positively with the person. If the worker can engage into a supportive helping relationship and help the person to talk about their thoughts and feelings, it can help them to look beyond their immediate situation and avail of potential short-term solutions and resources that are available and can be put into action.

REFLECTIVE EXERCISE

Reflecting on your suicide risk assessment skills, answer the following questions:

1. What do you consider the most challenging when communicating with a person who is expressing suicidal thoughts?
2. Identify two therapeutic engaging skills/interventions that you would like to develop further to help you to be more effective when undertaking a suicide risk assessment.

Managing the risk of suicide

For many people, periods of feeling suicidal may be short-lived; while for others their suicidal thoughts might be always present, in fact knowing that they have the option to end their life may be enough to keep the person alive. Suicidal thoughts can and do also change over a very short period of time. Having
undertaken a suicide risk assessment, the worker needs to appraise the person’s responses and determine the extent of the person’s suicide risk. Different actions will be taken by the worker depending on the seriousness of the person’s suicidal thoughts and intent to die, together with their ability to delay a possible suicidal act and the presence of protective factors at that time. The worker may involve professional intervention with a possible admission to hospital or in some situations ‘co-create’ support to keep the patient safe in their home and community.

Developing a safety plan

Working collaboratively, the worker can help to develop a safety plan with the suicidal person, and in some situations with the person’s permission engage his/her family/friends. A safety plan aims to keep the person safe during the immediate period and in the future by helping the person to connect with people close to them and in their community. Developing a safety plan requires time and the worker has to listen actively to the person, so that they can co-create a plan that is tailor-made to the individual’s needs and resources at that time. The person should feel comfortable with their safety plan and agree to interventions outlined in it, particularly those concerning times when the person might feel the most vulnerable, for example at weekends or late at night. Table 6.3 identifies the specific issues that need to be identified when co-creating a safety plan along with examples of possible questions that can be asked by the worker.

Training

There are a range of training initiatives relating to suicide prevention and mental health promotion. The ASIST short training programme is designed to suit the needs for all kinds of caregivers/helpers including volunteers and is currently the most widely used and researched intervention training programme in the world. The following provides a brief outline of the programme; for further information, see www.livingworks.net/AS

ASIST: Applied Suicide Intervention Skills Training

ASIST is an internationally recognised skills awareness programme in suicide prevention. It was developed in the 1980s by a team of mental health professionals in the fields of psychiatry, psychology and social work, in collaboration with the state governments of Alberta and California. As a suicide prevention programme, it was developed in response to growing concern at the time about suicide in the region. Originally developed for the Canadian province of Alberta, Canada, since then the programme has been delivered through networks of registered trainers in Canada, the United States, Australia, Norway, Ireland and Scotland. The Canadian-based LivingWorks Education Inc is the central organisational body for ASIST.

ASIST is designed for all front-line care givers from all disciplines and occupational groups including the general public. The aim of the ASIST workshop is to help caregivers/helpers to be more prepared and able to provide practical suicide first aid to persons at risk of suicidal behaviour. ASIST is a two-day intensive, interactive and practice focussed workshop designed to help helpers to recognise risk and learn how to intervene to prevent suicide. As an interactive workshop, participants examine their attitudes to suicide, learn how to recognise and review the risk of suicide and develop their skills through simulations and role-playing in order to become more ready, willing and able to help people at risk of suicide.

Conclusion

This chapter has outlined the different interpersonal skills that are used when communicating to the potentially suicidal person to help the person stay safe.
Being able and willing to engage into a positive compassionate helping relationship is paramount when working with the suicidal person. This requires the worker to be aware of his/her beliefs and opinions about suicide and to give serious consideration to how they might influence their reactions in order that they can adopt a compassionate and non-judgemental approach when working with the suicidal person.

REFLECTIVE QUESTIONS

1. How would you respond to a colleague who stated, 'people who talk about suicide never actually carry it out?'
2. Reflecting on your own work experience, have you ever experienced a situation whereby your own values or position on a client's suicidal behaviour challenged you in your work with this person? If so, what was the issue and how did you reconcile it?
3. How might the person who is suicidal know that you are listening actively to him?
4. What open questions would you ask to help a person to talk about their suicidal thoughts and intentions? Illustrate your answer with examples.

REFERENCES


