PROFESSIONAL ETHICS: HANDLING SUICIDAL THREATS IN THE COUNSELING SESSION

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The extent of the problem of suicide is a current topic in the media. One poll showed that 12% of college students have seriously considered suicide (1983). The Suicide Prevention Center in Dayton, Ohio reports that suicide is the second leading cause of death among college students. It is estimated that the number of college students attempting suicide is 10,000 per year (1986).

The problem is equally as alarming among the general population. The American Association for Suicidology estimates that 35,000 people kill themselves each year, and might even reach 100,000 according to some reports. Evidence indicates that the incidence of suicide is on the rise. The Associated Press reported in *The Cincinnati Enquirer* that suicide among Americans increased 136% between 1960 and 1980 (1985).

The problem is practical and "real" for counselors and therapists. It is seen from a high level of perception by reality therapists. Many clients make direct or veiled references to suicide as indicated by such statements as: "I can't take it any longer"; "I don't think it's worth it"; "I can't go on"; "They would be better off if I weren't around"; and many others. This article is an attempt to describe appropriate counselor behaviors for discussing that suicidal threat with the client. Such behaviors are seen as congruent with the practice of reality therapy and comprise the current "standard of practice" which is the norm for professional ethical behavior. However, no attempt is made to outline the entire process of how to intervene outside the counseling session.

POSSIBLE COUNSELOR BEHAVIORS

When reality therapists hear such veiled threats or even more direct threats such as, "I'm thinking about suicide", they are faced with a practical decision: whether to discuss this negative, destructive behavior directly or whether to ignore it and to emphasize "positive symptoms" (Wubbolding, 1985). An argument can be made that the best way to deal with negative behaviors is to help the client replace them by positive behaviors. This argument is, at best, seductive and, at worst, dangerous or harmful. It is seductive in that it might be easier for the counselor to avoid an uncomfortable topic than to bring it into the open, and it could be very upsetting and threatening to the counselor to discuss this topic with a client. The therapist might even feel that a discussion of it will help the client perceive suicide in a more favorable light thereby making the choice more likely.

However, a closer examination of control theory and reality therapy reveals a well-grounded rationale justifying a direct and thorough discussion of the threat. It is sufficient to say that "Suiciding Behaviors", as described here, are primarily "thinking behaviors" which are seen by the client as the best behaviors available at a given moment. Suicide is also seen as a picture in the client's inner world. To ignore the threat is to avoid a major part of present behavior as well as a picture which is a high priority to the client. Also, there is enough known about suicidal clients to demonstrate that the best way to deal with the threat is to confront the decision or idea head-on by a calm, frank, open, and thorough discussion of it. Therefore, such a discussion will be described below and should be viewed as an effective way to apply the principles of reality therapy.

Finally, the "standard of practice" as indicated in the sources referred to below clearly states that counselors act ethically and appropriately when they handle the threat as suggested in the questions described in this article.

In general, the course of action to be taken by the reality therapist, or any therapist, is as follows:

1. Determine the lethality of the threat and
2. Use direct intervention, if necessary.

ASSESSING LETHALITY

Appropriate action first includes an open discussion of the decision so as to determine the lethality of the threat, i.e., the intensity of the total thinking behavior, and to assist the client to make a decision not to carry out such a decision, and to generate more effective need fulfilling behaviors.

Questions to ask:

1. "Are you thinking about killing yourself?" Gernsbacher (1984) states that the question should be asked bluntly, clearly and calmly. It should not be avoided or glossed over. If thoughts of suicide are brought into the open, clients often feel relieved that they can talk about them. They reply, "Yes, I've thought about it", or "The thought has passed through my mind", or some equivalent statement. Many times further questioning indicates that no such decision is imminent or even possible. Thus bringing the "threat" into the daylight often results in the removal of suicide from the inner picture album. And so, no further action need be taken. Nonetheless, the question, "Are you thinking about killing yourself" is the crucial first step in assessing the lethality of the threat.
2. "Have you tried previously to kill yourself?" Past attempts comprise the best predictor of suicide, and provide a measure of the seriousness of the present threat. If the person is thinking about suicide presently and has a history, especially a recent history, of attempts, the possibility of such a choice is increased. This "history" is not past, irrelevant behavior. Rather, it is linked to the present by way of current Total Thinking Behaviors, as well as, current Pictures in the Inner World.
3. "Do you have a plan? How will you do it? If the client has a plan for

suicide, i.e., a gun will be used, pills will be taken, the car will be driven into a tree, etc., the lethality of the threat increases.

4. "Do you have the means to kill yourself? If the client has a gun, possesses pills, habitually drives recklessly, etc., the danger of suicide escalates.

5. "Will you make a unilateral contract not to kill yourself accidentally or on purpose? For how long?" If the client will consent to make this a *written*, firm contract even for a short time, e.g., 2 weeks, the lethality is lessened and the therapist can be less inclined to take further action. This contract should not be seen as merely a negative or a "stop-behavior". Rather, it is a positive beginning step along the way to more effective living. The Behavioral System will, of course, continue to generate other Total Behaviors. And so, caution is urged, i.e., no absolute statement can be made that a written contract eliminates the possibility of direct intervention. Previous questioning might have indicated that a serious threat is present thereby requiring counselor action.

In describing additional questions to ask clients, McBrien (1983) states, "There is *no cut-off* score to reply on: it requires clinical judgment based on the training and experience of the counselor, especially empathy and active listening skills". I would add that such judgment also depends on the reality therapist's skill in building on this initial contract by assisting the client to examine wants and to insert other pictures into the inner world, as well as to develop more effective need-fulfilling Total Behaviors.

More specifically, the decision should be reviewed at the next session and further contracts made until the danger has passed. The firm written contract should be "unilateral". In other words, it is not a contract made to the counselor. The therapist does not ask the client to promise him/her (the therapist) not to commit suicide. Rather, it is made as a self-generated plan for which the client assumes total responsibility. If the client refuses to make such a commitment, the therapist clearly should take "appropriate action". Such appropriate action involves intervening outside the counseling relationship, i.e., informing parents, spouse, physician, school authorities. This should be done with discretion and in consultation with another professional person. Written records of consultations should be kept. The value of the contract is described by Drye et. al. They report that of 600 patients making no-suicide contracts, none committed suicide. Unfortunately, not every client chooses to formulate a clear contract not to kill him/herself. Therefore, if the clinical judgment of the therapist is such that the threat is serious, direct intervention should be taken as stated above.

ETHICAL PRINCIPLES SUPPORTING AND REQUIRING DIRECT ACTION

The purpose here is to describe the ethical considerations as they relate to counselor behaviors. Though much latitude remains, various codes of ethics of professional groups make it clear that there are times when the counselor must intervene directly and take action. The American Association for Counseling and Development has stated, "When the

client's condition indicates that there is clear and imminent danger to the client or to others, the member must take reasonable personal action or inform responsible authorities". Similarly, The American Association for Marriage and Family Therapy says that confidentiality should be maintained unless "there is clear and immediate danger to an individual or to society". Likewise, the Standards for the Private Practice of Clinical Social Work of the National Association of Social Workers emphasizes that "the clinical social worker in private practice may find it necessary to reveal confidential information disclosed by the patient to protect the patient or the community from imminent danger". And finally, the American Psychological Association states that information should be revealed to others only with the permission of the client "except in those unusual circumstances in which not to do so would result in clear danger to the person or to others".

Clearly there is ethical basis for taking action in the case of serious threats. Yet the admonition of the AACD should be kept in mind, "the assumption of responsibility for the client's behavior must be taken only after careful deliberation".

The above questions represent the ethical "standard of practice" and comprise a schema for determining whether such direct intervention is necessary.

SUMMARY

The purpose of this article is to describe in the context of control theory and reality therapy the ethical considerations in determining the lethality of the suicidal threat, as well as the need for direct intervention. It is important to note that much latitude remains in developing further questions from those provided above. Consultation should be utilized each time the counselor determines that the threat is serious. Finally, effective reality therapy should be used to help the client gain better control through plans which enhance involvement with others, increase a sense of accomplishment, make life more enjoyable, and provide a feeling of independence. Such plans should be short-range, specific, and attainable.

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