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An Ethical Response to Disclosures of Suicidal Ideation or Behaviour

Helen M Stallman

Ethical Dilemma

Determining when a client is at risk of dying by suicide is a common dilemma for psychologists and other professionals who work in clinical settings. The subsequent task is to determine the intervention needed to keep the client safe. Overarching concerns are for the accuracy of the assessment of risk, client autonomy and self-determination, the therapeutic alliance, and intervention effectiveness.

Background Information

Thoughts of suicide are not an uncommon experience. The cross-national lifetime prevalence of suicidal ideation is estimated to be 9.2% (Nock et al., 2008). Of those who have suicidal thoughts, the probability of ever making a suicide plan is 33.6%. The probability of a suicide attempt amongst people with a plan is 56.0% but only 15.4% amongst those without a plan. In Australia in 2016, 2,866 died by suicide— a prevalence rate of 11.7 per 100,000 people (Australian Bureau of Statistics, 2017)—making it the 15th leading cause of death (Australian Bureau of Statistics, 2017).

Anxiety, stress, distress, and other unpleasant emotions are normal human experiences that require a coping response. The health-focused theory of coping considers all coping strategies and behaviours attempts to reduce distress (Stallman, 2018). Healthy coping strategies are those that are likely to reduce distress and improve coping self-efficacy without adverse consequences; unhealthy strategies are those that might help reduce distress initially, but are likely to have negative consequences (Sinha, Lacadie, Constable, & Seo, 2016; Stallman, 2018; Stallman, Ohan, & Chiera, 2017; Stallman, Ohan, & Chiera, 2018; Wilson, Thomas, & Furlong, 2017). Healthy coping strategies are grouped from independent to dependent—self-soothing (e.g., deep breathing, coping self-talk, positive self-talk, or being mindful), relaxing or distracting activities, social support, and professional support, if personal strategies are not effective. Unhealthy strategies groups are: negative self-talk, activities (e.g., emotional eating, aggression, alcohol and drugs, self-harm), social isolation, and suicidality. Suicidal ideation is a response to distress when healthy and other unhealthy coping strategies are inadequate and the person feels overwhelmed by their distress—it is the psyche's way of trying to find a solution to feel better (Stallman, 2017b). Like all frequently-used strategies, suicidal ideation may become a person's habitual coping response when distressed (Goldney, Smith, Winefield, Tiggeman, & Winefield, 1991).

In clinical settings, psychologists use science to help people learn to function better. Supporting healthy coping starts with the first contact with a client and continues throughout therapy. It involves helping clients build on their existing strengths (self-soothing, relaxing or

distracting activities and social supports) and connecting clients with additional professional supports if the client needs additional support between sessions (Stallman, 2018). Additional support can be low intensity, such as telephone helplines or chat-lines, through to higher intensity supports, such as more frequent psychology sessions, General Practitioners, or emergency services and hospital staff. For clients with few healthy strategies and who rely on unhealthy strategies—including suicidal ideation—to cope with unpleasant emotions, a strong professional support system is critical until they develop independent healthy strategies. As clients develop new strategies to function better over the course of therapy, they can add new coping strategies to their coping plan (Stallman, 2017c), reducing the need for professional supports.

Despite strong evidence showing that risk factors, individually or combined, are poor predictors of death by suicide at the individual level (Franklin et al., 2017), suicide risk assessment remains a core competency in psychology training (Australian Psychology Accreditation Council, 2018), ethical guidelines (Australian Psychological Society, 2014), and practice. Consequently, many clinicians and students across all disciplines feel ill-equipped to respond to people with suicidality (e.g., Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989; Pilkinton & Etkin, 2003) because their ability to accurately predict suicide risk is barely higher than chance.

Within the coping framework, when a client discloses suicidality they are in essence saying, 'I'm having difficulty coping right now; can you help me?' (Stallman, 2017a). It is an invitation for the clinician to be an immediate, temporary support for the client. When the clinician responds by doing a risk assessment, they ignore the reason behind the disclosure and focus on their own task of trying to calculate the likelihood of the client dying by suicide. Consequently, disclosing suicidality is often a traumatic and stigmatising experience for many people (Frey, Hans, & Cerel, 2016, 2017; Goffman, 1963; Sheehan, Corrigan, Al-Khouja, & Stigma of Suicide Research Team, 2017).

For people considered at risk of suicide, the most common intervention is 'safety planning' to mitigate an identified risk. Safety planning involves clinicians developing a stepwise plan for clients to use when they have suicidal thoughts (Stanley & Brown, 2012). This approach encourages the client to become hypervigilant for a suicidal crisis. Paradoxically, this may in fact maintain suicidality. Through a process known as ironic process theory (Wegner, 1997), the antidote (i.e., safety planning) can act as the poison when clients are instructed to constantly monitor their thoughts and behaviours in relation to suicide. The intervention focuses the client's attention on the very thing that the clinician wants to prevent (i.e., suicide). Suicide therefore, remains a predominant coping strategy. Distressed people, such as those experiencing suicidality, are most susceptible to this process (Wegner, 1997).

Both suicide risk assessment and safety planning focus on a single end-point, death by suicide. Although help-seeking is widely promoted to prevent suicide (Stallman & Ohan, 2018), people who ask for help are often denied acute services because they are deemed 'not at high-risk of suicide' (Allen, Forster, Zealberg, & Currier, 2002). Having exhausted all attempts to reduce distress—including help-seeking—some people subsequently die by

suicide to make the distress stop (e.g., Woodburn, 16 Jan 2017) (Stallman, 2017b). In this not uncommon scenario, however, the needs of the client, as expressed through seeking help and disclosure, have been neglected, with catastrophic consequences (Stallman & Ohan, 2018).

In contrast to risk assessment and management, which is clinician-centred and suicide-focussed, a needs-based framework is person-centred and coping-focussed (Stallman, 2018). There are three steps in a needs-focussed approach. The initial step is to recognise that asking for help is a healthy coping strategy that the client has used (strength). The clinician's task is to be supportive and listen to understand why the client is distressed (care). The second step is to assess and support coping (collaborate). The final step is to assess the client's need for additional professional support and connect them with appropriate supports as needed (connect). Because anxiety, stress, and distress are universal experiences, the Care · Collaborate · Connect approach is an approach to support all clients—not waiting until a client is considered 'at-risk'—thereby promoting coping and ultimately preventing suicide.

Relevant Ethical Principles

- Autonomy
- Nonmaleficence
- Beneficence

Relevant Ethical Standards

- A.2.1 Respect
- B.1.1 Competence – Maintain appropriate skills and learning
- B.2.1 Record Keeping – Make adequate records
- B.8.1. Cooperate with other professionals for the benefit of clients
- B.8.2. Benefit, enhance and promote the interests of clients
- B.3. Professional responsibility
- B.12. Conflicting demands
- B.13.4 Psychological assessments – Use valid procedures and research findings when interpreting psychological data
- 3. Risk assessment
- Mental Health Acts

Ethical Decision Making

1. Identify individuals and groups potentially affected by the decision.

   All clients with psychological disorders are likely to have problems coping with anxiety, stress, distress, or other unpleasant emotions.

2. Identify the problem, including the relevant ethical and legal issues and clinical practices.

   a) How to respond therapeutically to clients at risk of dying by suicide, both those who do and do not disclose suicidal thoughts, plans, intent, or attempts?

   b) What to do when the latest science is contrary to organisational operating procedures?

3. Consider the significance of the context and the settings.

Most clients who seek psychological services, irrespective of context or setting, do so because they are having emotional or behavioural difficulties. For many people, these result from coping strategies that are ineffective and/or who have impoverished coping resources. People with few or generally unhealthy strategies may experience suicidal ideation.

4. Identify and use relevant legal, ethical, and professional resources.
   - Code of Ethics (Australian Psychological Society, 2007)
   - Ethical guidelines relating to clients at risk of suicide (Australian Psychological Society, 2014)
   - Care · Collaborate · Connect: Suicide Prevention training (Stallman, 2017a)
   - Mental Health Act 2009

5. Develop and consider alternative solutions to the problem.
   a. Conduct a suicide risk assessment.
      Advantages: It is an established practice.

      Disadvantages: It has poor validity. It has the potential to cause harm to the client and disrupt the therapeutic relationship. It does not respect the goals of the client in disclosing suicidality. It may decrease the likelihood of the client asking for help in the future.

   b. Conduct a coping assessment, however, record it as a risk assessment for organisational purposes, for example, record high needs for professional support as high-risk for suicide; low needs as low-risk.

      Advantages: Coping planning aligns the clinician's responses with the client's goals and needs. It would meet the documentation requirements in organisations that require risk assessments.

      Disadvantages: It maintains the use of a procedure that has been shown to have poor validity and harmful effects on clients. It does not meet the ethical guidelines for managing conflicting demands.

   c. Implement coping planning

      Advantages: Coping planning aligns the clinician's responses with the client's goals and needs. It meets the clinician's ethical obligations to their client. It focuses the client's attention on 'what to do' not 'what not to do.' Service provision is based on needs for support, not likelihood of death by suicide, intervening long before many people feel hopeless and with no other option than suicide.

      Disadvantages: The clinician needs to complete training to develop appropriate skills to implement the approach. The approach may put the psychologist into conflict with their organisation if it uses risk assessment.

   d. Use a 'no-suicide' contract

A 'no-suicide' contract is a verbal or written agreement by a client that states that he/she unequivocally agrees not to die by suicide. Sometimes the contract is for a specified duration.

Advantages: It is simple to implement. It provides the clinician with a sense that it is a legal document that will protect them in the event that the client breaks the contract and dies by suicide.

Disadvantages: There is no empirical evidence to show that 'no-suicide' contracts prevent suicide and indeed as many as half of clients who sign one attempt suicide or die by suicide. Such a 'no-suicide' contract is also, of course, not actually a legal contract. The client may not have the skills to use any alternative coping strategies. Clients may agree to them to avoid more intensive interventions, such as involuntary detention, or not agree to them to gain the treatment they perceive they need, such as hospitalisation. The false sense of reassurance they provide to clinicians can result in decreased attention and concern about a patient's risk for death by suicide.

6. Choose and implement the most appropriate course of action—note why this was noted is the chosen action.

Alternative C is best chosen for clients indicating suicidal ideation or behaviour when possible. Clients choose to ask for help, when to ask for help, and whom to ask for help from. When they ask for help, it is done with the belief that the person they ask will be able to help them.

Coping planning, using the Care ·Collaborate · Connect steps, aligns with meeting the needs of the client, respecting their autonomy and competence to make decisions.

As listening and caring is the intervention for acute distress, this intervention meets the ethical principle of beneficence.

The collaborative and supportive framework minimises the likelihood of harm (nonmaleficence). Psychoeducation that presents all coping strategies as normal human responses to attempt to reduce distress, means clients are not labelled as "suicidal people"—suicidality is conceptualised as a coping strategy rather than a personal defect or trait, thereby minimising stigma.

Collaboration, rather than management, minimises traumatic experiences. Even with clients who need immediate more intensive professional support and who are unwilling/unable to voluntarily consent to it, the process is described using a supportive framework. For example,

*You're having a lot of trouble coping right now. You're usual strategies aren't working, which is why those suicidal thoughts are fairly intrusive at the moment. The paramedics and hospital staff will be able to give you the extra support you need, just at the moment, until you're feeling a bit better… If you need to be stay at the hospital*

*for a while, our usual appointments will continue after you have been discharged… Shall we call them together?*

This approach also enables the clinician to meet their ethical and legal responsibilities to prevent harm to the client where foreseeable.

The documentation of coping planning includes details of:

i) the client's distress and triggers of the distress
ii) a systematic assessment of the client's current healthy and unhealthy coping strategies, including suicidal thoughts, plan, intent, and behaviours;
iii) the client's response to psychoeducation about coping;
iv) whether and how the client was able to strengthen his/her coping plan;
v) the assessment of the needs the client has for additional professional support;
vi) the Mental Status Examination;
vii) consultation with other professionals;
viii) the process of connecting the client with additional professional supports; and
ix) the plan for the next contact with client (Stallman, 2017a).

A referral to the stepped-up care provider (e.g., emergency department) using the coping planning framework can enhance and promote the interests of the client by identifying the problem as "difficulty coping", rather than "risk of suicide" and the referral request as "provision of more intensive professional supports", rather than "risk assessment and management".

7. Monitor and assess the outcome chosen.

The Care · Collaborate · Connect approach is a positive and empowering experience for clients. Because mood and coping reviews are done at the beginning of each session for all clients, the client continually feels cared about and supported. Psychoeducation about the coping continuum and why some people sometimes have thoughts about suicide, normalises the client's experience and reduces the likelihood of the client feeling stigmatised.

The client receives positive reinforcement (attention) for using healthy coping strategies (what to do), rather than mentioning the word 'suicide' (what not to do), which promotes healthy coping.

Using this approach, every client develops and maintains their own coping plan (Stallman, 2017d) to promote coping and coping self-efficacy. High-intensity professional support is on everyone's coping plan, further normalising the use of these services when personal healthy coping strategies are ineffective. Because professional support is considered a healthy coping strategy, the approach maintains the therapeutic alliance even if involuntary inpatient treatment is needed.

An ethical dilemma for psychologists using this stepped-up care approach in community settings, may be the discrepancy between how they present hospital-based treatment to the client—telling them that the more intensive services will provide the additional temporary support they need to cope—and the reality when patients have previously had distressing experiences in hospital emergency departments and inpatient units. These may have included not being treated with respect, not being talked to, not being listened to, and not being involved in treatment decisions (Allen, Carpenter, Sheets, Miccio, & Ross, 2003). For clients who have previously had distressing experiences in these settings, and yet still need the additional support so as not to act on their suicidal thoughts, psychologists can empathise with them and highlight that they understand that it is not the client's ideal option, but that it is remains a better option than dying by suicide.

<u>Personal Reflection</u>
The best way to prevent deaths by suicide *in the future* is to:
    a) support and promote coping in the present
    b) address the client's *current needs for additional professional support*
    c) help the client develop and maintain a range of healthy coping strategies over the course of therapy
    d) help the client address the underlying biopsychosocial causes of their emotional distress.

The focus on the client's immediate needs *respects* the client's trust in the psychologist when he/she asked for help and disclosed suicidality and/or other unhealthy coping strategies. Collaborating with and supporting are client-centred, which means *acting in the interests of the client.*

The needs-based approach to working with people who are distressed, including those with suicidality, is consistent with legislation that aims to: a) ensure the highest level of treatment and care for people with serious mental illnesses with the goal of improving their functioning as far as is possible; and b) do this enabling the client to retain their freedom, rights, dignity and self-respect as much as possible (e.g., South Australia Mental Health Act 2009).

Because mood and coping reviews are the first steps in every clinical session for every client, it:
    a) normalises distress and coping
    b) promotes a framework for the client to think about their distress and how to respond by thinking about how they will cope
    c) continues to promote coping by focussing on "what to do" rather than "what not to do"
    d) identifies any barriers the client has implementing their coping plan
    e) provides an opportunity to help the client refine their coping plan so it remains effective
    f) includes an assessment of the client's need for additional professional support between sessions and connections with additional services as needed
    g) makes it easier to have conversations about stepped-up care where necessary because it is part of the ongoing discussion about having an effective coping plan.

This process aligns the clinician responses to the client's goals and needs and the clinician's legal and ethical obligations. By focussing on the continuum of coping, rather than the single end-point of suicide risk, psychologists have a greater chance to contribute to suicide prevention.


Example Details Statement

While no specific example was provided in the above ethical dilemma examination, many different instances where this approach can be applied can be imagined and indeed will confront psychologists in their work. Not only do psychologists find themselves working with those presenting suicidal ideation and behaviours but they also find themselves working in various workplaces that may be using practices not supported by research; such as the use of a 'no-suicide' contract or simple risk assessments. In such situations, it may be ethical for practitioners to present this current caring and collaborative manner of helping clients in distress.

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