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How to Determine Whether a Client Might Hurt Herself

Just as the last chapter explored the idea that we might sometimes ignore thoughts that *we* could be in danger, so we must start this chapter by addressing the powerful wish to avoid thinking that another human being might deliberately take *her own* life. Yet, as we all know, suicide—quite literally—happens every day.

Some of those people who die every day might be acquaintances or friends or even relatives of ours. They could also be acquaintances or friends or relatives of our clients—or they could *be* our clients. If we accept that unthinkable thought as within the realm of possibility, then where should we begin, as therapists, to think constructively about the idea that someone we are interested in, care about, and wish to help might one day feel so desperate or hopeless or rageful as to take or attempt to take her own life? How do we realistically assess how much we can do to prevent such a terrible outcome?

First we must accept a sad but utterly truthful fact: Any person who truly wants to end her life, other than a very young child or a completely incapacitated adult, will find a way to do so. You may wish to change that, you may try to change it, you may believe you have changed it, but you may fail. That is a fact.

Having accepted that reality, you should know that there is a great deal you can do and *should* do and will *learn* to do that

can significantly alter a client's feeling that life is not worth living, or that no one cares if she lives or dies, or that she cannot solve the problems that are making her consider suicide as a solution. The purpose of this chapter is to help you recognize those sentiments in a client, face them with her, and protect her from them as much as is humanly possible.

This chapter will explore how to assess and respond to suicidal thoughts and actions in both adults and children. If this last idea—that children can have such sadness or hopelessness or anger or fear within them that they wish to die—makes thinking about suicide seem overwhelming, then perhaps some facts repeatedly documented by research will be helpful. Let us begin with children and move chronologically along the spectrum of suicide.

Deliberate suicides have occurred in children as young as four years old, but in general suicides under the age of 12 are uncommon.

Among adolescents, girls are considerably more likely to *attempt* suicide; however, boys are considerably more likely to *complete* a suicide.

The most frequent suicide *attempts* occur in *women under 30*; then the incidence of attempts begins to decrease. Also, women tend, in general, to use less reliably lethal methods of trying to kill themselves, such as overdoses of pills or slashing their wrists.

The most frequent *completed* suicides occur in *men over 45*, and the risk factor continues to grow—particularly in white males—culminating in the greatest rate of completion after age 65. In addition, men use more certain methods, such as guns, hanging themselves, and jumping from high places.

Those are the bare-bones statistics about the *populations* most at risk. It is hoped that these statistics—like all statistics—are reassuring because they are verifiable and relatively neutral. However, as a therapist you must also recognize and think about the powerful *myths* society has concerning suicide, two of which have been proven over and over again *not* to be true, but persist anyway, even among therapists—sometimes with fatal consequences.

The first myth is: *A person who is thinking about killing herself will never tell anyone.*

The *fact* is that *most* people who take their own lives have given some sign of their intentions to at least one other person—and often to several other people—within the last few weeks or months. That sign may be verbal and quite direct—whether said in a joking manner or quite seriously. For example, a person may say, "I wish I was dead," or "I think I may kill myself," or "What do you suppose it's like to be dead?" or some other clear statement indicating to those around her that she is having thoughts about ending her life.

Or it may be said less directly, for example: "I'm so tired I wish I could sleep for years," or "Nothing interests me anymore," or "What difference does it make if I failed that exam?" or many other variations that suggest despondency, or hopelessness, or a lack of interest in the future or in her own well-being. Or it may be expressed as anger and a wish for revenge against another person who has disappointed her, or threatened her feeling of being loved, or humiliated her, such as "I'll show him who can leave. . . ."

In addition, there are many nonverbal ways in which a person might indicate to others that she is thinking about hurting herself or that she is losing interest in staying alive. She might stop eating, or give away some possessions, or have her telephone disconnected, or start taking drugs, or go to a doctor for a physical symptom.

Finally, the most dramatic and significant way in which a person might indicate that she is thinking about suicide is by making an attempt on her life that is not fatal or even necessarily very dangerous in and of itself. The purpose might be to see how others respond or to "practice" not caring what happens to herself. In either case, a suicide attempt should certainly be regarded as a foreboding sign.

These are some of the common ways by which to recognize that the first myth about suicide—that most people who are going to kill themselves do so without any warning—is simply not true. It is hoped that this clarification will go some way toward reassuring you that if a client of yours is thinking about killing herself there is a very good likelihood that you can get some indication, provided you know when and how to ask and are able to both listen and talk about suicide yourself.

This brings us to the second myth about suicide: *If you talk about suicide, that will put the idea into a person's head and she will kill herself.*

The facts are that *talking about suicide does not cause suicide* and that *not* talking about suicide with someone who is thinking of hurting herself can sometimes be a fatal mistake. Nevertheless, most of us need some help in knowing what to say, what to ask that might be helpful, and how and when to bring up the subject. So let us start with the last question: how and when you would consider raising the subject of whether or not a client you are seeing, especially for the first time, might be considering suicide.

Again, you would begin with the existing record on that client, starting first with the *diagnosis* and looking up the criteria. As in the case of violent tendencies, you are looking in both children and adults for diagnoses that include impulsivity, poor judgment, antisocial or suicidal tendencies as part of the criteria for the diagnosis itself. If there are no indications of any of these, then you would next be alert to any diagnoses that suggest depression or intense anxiety. However, as with all diagnoses, the absence of such criteria is never in and of itself a reason to rule out the possibility that a client might be thinking about or even planning to hurt herself.

Next turn to the *mental status exam*, paying particular attention to the previous questioner's comments on the client's suicidal ideation at that time. This lets you know if the client has told someone before that she was thinking about hurting herself. In addition, be alert to the person's predominant mood at the time the MSE was formulated and to any thoughts that were preoccupying her at that time, so that you can assess, as you do *your* mental status exam, whether or not this person

Remember

- **Talking to a client about her suicidal thoughts makes it *less* likely that she will kill herself.**

continues to be "stuck" on the same unhappy or unrealistic thoughts she was having then. Further, note any history of delusions, depersonalization, or hallucinations—especially command hallucinations ordering her to hurt herself or someone else.

Focus next on her written history, looking for three essential elements. First, ascertain whether the client is a *substance abuser*, because, as was mentioned in the previous chapter, alcohol and drugs engender behavior that people might not otherwise do. That is, they are "disinhibitors" which both physiologically and psychologically limit the user's capacity to think logically, to move steadily, and sometimes to appropriately protect others and herself. Drugs, alcohol, or both have been implicated in at least half the known suicides in the United States; they figure even more prominently in adolescent suicides.

In addition, read the written record for any *family history of suicide* or suicide attempts. Is suicide seen in this client's family as a means of problem-solving? Has suicide ever been used as a way of relieving medical or psychiatric suffering? Whatever the reason, any previous suicide in your client's family places her at higher risk for suicide.

The last critical factor for which you would examine the record is *a history of previous suicide attempts by the client*, since the single most reliable predictor of a suicide attempt in the future is a suicide attempt in the past. If that suicide attempt has occurred within the last year, the client is in the highest risk group for another, possibly fatal attempt.

If you saw such a profile in the written record of a client, you might feel that you did not even wish to see her. That is certainly an issue you should discuss with your supervisor, because it is important and useful for you to explore your own personal experiences related to the issue of suicide and to think ahead about your feelings concerning such a client, just as you would before any first interview.

However, it is also important for you to realize that people who come for help are people who have problems, many of which they have not yet found a way either to resolve or to tolerate. What that means in practical terms is that at some time in your career you are certainly going to have a client who has made a suicide attempt—whether that information appears in the written record or not. And just as certainly, you are going to find it

necessary at some juncture to evaluate a man, woman, or child for the possibility that one of them is presently thinking about, or planning, to kill him or herself.

So the first thing you need to do for yourself is to get comfortable with the idea that you are going to be talking to people from time to time about suicidal thoughts and behavior. You are going to find out what procedures exist in your agency for managing potentially suicidal clients. For example, who are you to speak to if such a scenario occurs? What telephone number do you call? Where do you ask a person to wait if you need to consult with a colleague? What have other people on the staff done in such situations?

Next you are going to explore in detail what your legal obligations are. For example, if someone reports to you that she is seriously thinking about or has a plan to kill herself, what rules of confidentiality, if any, apply? Who must you notify, and when? What kinds of notes do you need to keep during the session? What kinds of forms do you need to fill out after the interview? To what agencies and governing bodies are you required to report such a discussion? What follow-up, if any, is necessary?

In other words, you are going to get as much practical information as you can, because practical information is extremely helpful in overcoming the tendency to deny that someone you are with might be having thoughts or fantasies about hurting herself. When you are actually face-to-face with a client, regardless of what has been said or what you know about that person, if you have the *slightest inkling* that she might be suicidal, you must rely on that inkling enough to slowly but surely explore with the client whether or not she has had, or is presently having, any thoughts about killing herself.

The operative words here are "slowly but surely." That is,

REMEMBER

- **You must find out what your legal obligations are if a client tells you she is thinking about killing herself.**

you are going to ask questions in a deliberate and calm manner, reminding yourself at such times of two crucial facts: first, that people who are having thoughts of killing themselves are both relieved and grateful to have someone else bring it up; and second, that many people *think* about killing themselves from time to time but most of them neither wish to die nor actually take their own lives.

So where do you begin if you are having some feeling of unease about this client? The answer is: with a broad question, such as, "How are you feeling?" or "How are things these days?" What you are listening for in the answer is despair, despondency, or hopelessness. For example, as you explore a little with the client, does she express any feeling that things in her life are unbearable? Or that she feels unable to go on? Or that she is so lonely for someone who used to be in her life but is no longer that she cannot imagine the future without that person?

These kinds of feelings are more easily articulated by adults than children. If you are interviewing a child, particularly under the age of nine or ten, you will need to help her describe how she is feeling and the seriousness of the feelings she is experiencing. Therefore, when you are trying to assess the possibility of suicidal thoughts or feelings of despair in a child, always give her something by which to measure them. For example: "Do you think you feel more happy or more sad today?" "When you are sad, are you so sad you cry?" "Do you cry in the day and the night?" "Do you cry when you are alone, or when there are other people around?" Use a similar technique for angry feelings, or feelings of missing someone important who has died or gone away recently, or feelings that she has done something wrong.

Once you have begun to get a sense of the broad parameters of the client's mood, you want to find out if, when she is feeling that badly, she ever has any thoughts about hurting herself. Obviously, the answer you are wishing and hoping for is "Never," or "Are you kidding?" or "I'd be too scared to do something like that," or "I could never do that to my children," or just plain "No." However, as much as you might wish for one of those answers, eventually someone is going to say "Yes," and no matter how many times you have practiced such a scenario in your

head or talked about it with your colleagues, you are still going to feel frightened.

At first, you will be tempted—despite all your preparations—to try and talk the client out of having those thoughts, rather than exploring them with her. You may find yourself wanting to say, "You shouldn't be thinking about things like that," or "Don't be silly, you have so much to be grateful for," or some other variation on these themes. The younger the client, the more likely you are to feel the temptation. But you are going to have to resist it.

What will help you to do so is to again remind yourself that lots of people *think* about killing themselves at one time or another. Also remind yourself that, because the client has acknowledged having such thoughts, you now have a mandate to explore them with her and to rule out the possibility that she might go beyond just thinking about suicide. Therefore, regardless of when this subject comes up in an interview, and regardless of what else you might have on your calendar to do after this interview, you should make a practice—both for the client's well-being and your own—of never letting a client leave your office until you have used all necessary resources to satisfy yourself that she is not at imminent risk of trying to kill herself.

Let us return to the moment at which you inquire about whether or not a client ever has thoughts of hurting herself and the answer is "yes." In clinical parlance, this is what constitutes *suicidal ideation*. When you uncover the presence of suicidal ideation, two things are required of you: First, if you are not already doing so, you must start taking notes, as carefully as possible. Second, once you have established the existence of some form of suicidal ideation, you need to know what the *content* of that ideation is. So you are going to ask the client some

Remember

- **Most people who are thinking about killing themselves don't really want to do it.**

question like, "When you think about hurting yourself, how do you imagine doing it?" The response you get to this question will be somewhere on a spectrum between, "I don't know, I never really get that far," to "I think about jumping off the roof of my building," or some other comment that suggests thoughts of a specific mode of suicide.

Or you may first get a response from the client like, "I'm not really gonna kill myself," or "I was just kidding," or some other reaction intended to change the topic of conversation or minimize the seriousness of this very serious subject. At this point, or whenever it seems most appropriate, let the client know that you are glad to hear that she isn't really going to kill herself, because you don't want anything to happen to her.

This is a very powerful message, and its purpose is twofold. It is a reassurance to a person of any age that someone else is concerned about her and that—were she, in truth, actually giving serious thought to taking her own life—someone else cares whether or not she does so. Second, it demonstrates that you take everything she thinks and feels very seriously, particularly any thoughts she might have about killing herself; therefore, you are going to need to ask a few more questions to make absolutely certain that she is safe.

You next want to find out *when* the client last had a thought about hurting herself. Obviously, a response such as "this morning" is more significant than "two years ago when I broke up with my boyfriend." In either case, however, pursue information about *how frequently* those thoughts occur or occurred. For example, if the answer was "this morning," then you would want to know whether the client had these thoughts yesterday, and if so, how many times. And if she had them yesterday, you want to know when she started having these thoughts and whether they are happening more or less frequently than before. Also, when she is having these thoughts, are they fleeting? Or do they seem to be coming with greater *intensity* and interfering more with her life?

When you have ascertained those impressions from her, you need to find out *how comfortable* the client is with those thoughts when she does have them. For example, you might ask her how she feels when she has those thoughts. The response you are h[illegible]g for is one that suggests that they "scare the hell

out of me" or "they really upset me." However, if there is any suggestion in the client's response that these thoughts are soothing or seem like a solution to all her problems, or promise reunion with a loved one, then that would significantly affect your evaluation of the state of imminent risk to this client—unless the client is a child.

Very young children are the most significant exception. Children under the age of seven or eight may *appear* to be comfortable with the idea of dying because they probably don't know in any real sense what it means to be dead. Therefore, if a child says that she wants to be dead so she can see her grandfather, you need to find out whether she thinks she could talk with her grandfather if she were dead. Could she go out and play? Or bring her grandfather back home with her? If the child demonstrates a clear understanding that death is a real ending of her life, that all the bodily functions cease, and that the separation from her caretakers is real, then you must believe that her wish to die is quite serious.

Once you have explored how clearly the client understands the idea of dying, and how comfortable that idea seems to her, turn your attention to whether or not the client has ever tried to kill herself. If she has, how did she do it? While she is explaining that attempt to you, ask yourself: Was this last attempt not completed because the client's own better judgment or wish to live intervened? Or would this person be dead now were it not for ignorance on her part of what actually constituted a fatal dosage, or someone showing up unexpectedly, or some other piece of sheer luck?

At this point—or perhaps even earlier, depending on what the client has already told you—you may have decided that you are going to need a second opinion on whether or not this client is in imminent danger. Once you have begun to think that is necessary, the question then becomes: Why would you continue to explore this subject with the client, rather than leaving that to someone with more expertise or experience?

The reasons are twofold. First, once a client has begun to share such information with you and to feel your concern, she may be more willing to go into details or share her plans with you than with someone else. In fact, in a subsequent interview, she might deny that she has any thoughts of hurting herself.

Therefore, the more specific, detailed information you can share with the other interviewer, or team of people, the more likely it is that the client will get the level of care she needs to guarantee her safety.

Second, depending on the setting in which you work and the severity of the client's danger to herself, getting that level of care may entail having your supervisor join you and the client, or arranging for the client to be interviewed by your staff psychiatrist right then, or contacting your local emergency room and taking the client there, or waiting with the client until a member of her family is available to come and get her. However, it might also require that you call the police to take the client to a hospital or that you present your findings to a team of psychiatrists who will use that information as part of their deliberations on whether or not to hospitalize a client involuntarily. So the thoroughness of your interview not only is good practice but may also be crucial to protecting the client's safety—and her rights.

Very often, though, clinicians feel uneasy—particularly in those settings where they are the client's primary therapist—about pursuing an interview when they realize that the client is telling them information that will need to go outside the confines of the confidential relationship between the two of them. Somehow, it begins to feel sneaky, or underhanded, or manipulative to ask further questions when you know you cannot keep the answers to yourself.

SIX THINGS YOU NEED TO FIND OUT IF A CLIENT TELLS YOU SHE IS THINKING ABOUT KILLING HERSELF

1. **When did she last have a thought about killing herself?**
2. **How often does she think about killing herself?**
3. **How comforting do these thoughts seem to her?**
4. **Has she made a previous suicide attempt?**
5. **Does she now have a plan to kill herself?**
6. **Can she carry out the plan?**

Should you reach this juncture with a client who is describing thoughts of killing herself, two ideas are useful. First, anyone willing to tell you her feelings, or thoughts, or plans to kill herself is almost certainly doing so because she wants you to help her not to. Second, if that is not the case, and she truly does want to harm herself, then a human life is at stake and you must certainly act to protect her.

Having ascertained a history of her previous attempt or attempts, turn your attention to whether or not this client presently has *a plan* to kill herself. If she had previously indicated some thought such as, "I'd jump off the roof of my building," return to that comment and explore it further. For example, ask her if she has actually gone up on the roof recently or, if the client is a child, whether she can actually get to the roof on her own.

If she has made no previous comment suggesting a plan, then ask some simple, straightforward questions such as, "How would you do it if you were going to kill yourself?" Again, you are hoping for the vaguest possible response suggesting the least premeditation. But if the client says, "I would take a bunch of pills," or "I would shoot myself," or "I would jump out a window," then you need to proceed in a very deliberate manner to evaluate the issue of *access to means*, which will, in turn, help you to determine the *level of premeditation*. For example, if a person says, "I would take a bunch of pills," ask what kind of pills she would take. She may say, "I have no idea," or "I don't know, maybe a bunch of aspirin"; both of those answers are quite different from saying, "I got a bottle of uppers put away," or "When my mother died, I kept everything she had in her medicine cabinet."

Clearly, the latter two responses suggest that this person has been thinking about the possibility of ending her life for some time. The same would be true of someone who has access to someone else's gun, such as a child or adolescent who reports that her father has a gun in the top drawer, or to an adult who tells you she has recently purchased a weapon.

With all clients but especially with children, listen for and explore the temptation to some more impulsive, although somewhat premeditated, form of suicide. For example, if a child tells you she would jump out a window, find out if she knows *what*

window she would jump out of. If she says, "the one on the stairs at school," find out if she ever has gone near that window when it was open, whether or not there is ever a time when she can go near that window without being seen, and whether or not she has ever actually climbed out on the sill.

Obviously, by this time you will have reached a conclusion about whether or not this person might do something dangerous to herself and made a decision that someone else needs to be informed. However, before you raise that subject, there is one more piece of information you want to garner, particularly with a child. That is *why* she wants to kill herself at this time, although you are not going to phrase it that way. Instead, you are going to ask the person something about what she thinks will happen if she tries to commit suicide. If you don't already know, you may hear an answer that will help illuminate for you what current conflict is making the client feel so desperate. For example, "My mommy will feel sorry she hit me yesterday," or "I won't really die, I'll just scare everybody," or "I won't have to worry about my ex-husband's bills," or "My boyfriend will be sorry he dumped me and we'll get back together again," or "My sister will come home and find me."

Whatever the answer, respond to it by telling the client, in one way or another, that there are many other solutions to the problem that is making her feel so badly at the moment, but that your first concern is making sure that she doesn't hurt herself. Especially if this is a new experience, you should always err on the side of caution if you have any doubts about the need for a second opinion.

You should have discussed well in advance with other members of the treatment team what the procedure is in your agency; this is the time to implement it. Once you have done all that, you should feel a great sense of relief and of accomplishment.

However, regrettably, it is not always that simple to assess whether or not a client might hurt herself, since those who have the most serious plans or are the most depressed or without hope are often the least communicative. You have to fall back on your own inklings or sense that the client is withdrawn, or angry, or threatening, or despairing to the point where it is not even worth talking about. Or you may be alerted by exactly the opposit[illegible]henomenon. That is, feelings of serenity or good hu-

mor in a person who has only recently been very depressed and whose present state of tranquility may indicate that she has finally made a decision to end her life. In all these cases you will seek a second opinion—even if your suspicions are based only on a disquieting hunch.

When you have done all this, you will have used all your resources, insight, and courage to raise the possibility with your client that she might be thinking of taking, or preparing to take her own life. But you must be realistic about your own limitations. If a client wishes to die, she will find a way to do so, despite your best efforts.

Ultimately, she is the person responsible for preserving—or taking—her own life.

Assessing a Client for Risk of Suicide

This form begins with questions you should ask yourself in *every* interview. If the answer to some of these is "yes," then you should follow up with the client to find out whether or not the client has any suicidal ideation or intentions.

Questions for yourself

1. Is the client in a group that is statistically at high risk for suicide?
2. Has the client unintentionally gained or lost more than 5% of her body weight in the last month?
3. Has the client reported any marked change in sleeping habits?
4. Does the client appear sad or withdrawn?
5. Does the client sound despondent?
6. Has anyone else reported that the client is despondent or sounding hopeless?
7. Does the client seem extremely angry or hostile?
8. Does the client report a sudden improvement in mood or lifting of a longstanding depression?
9. Has the client recently experienced the loss of a significant person in her life through death, divorce, removal, or abandonment?
10. Has the client reported any recent suicide among friends or family?
11. Has the client reported any history of suicide in the family?
12. If so, does the client's family talk about the suicide or is it a secret?
13. Is the client approaching the anniversary of a family member's suicide?
14. Is the client about to be the same age or in similar circumstances as the family member who killed him/herself?
15. Has the client reported to you a previous suicide attempt?
16. Has the client made any comments—joking or otherwise—suggesting that death would be preferable to life?
17. Has anyone else reported that the client talked about killing herself?
18. Has anyone found a note, poem, or printed literature involving death or suicide that was written by or belongs to the client?
19. Does the client report giving away possessions?
20. Does the client have a history of impulsivity, poor judgment, or antisocial behavior?
21. Does the client have a history of recurrent depression, intense anxiety, or panic attacks?
22. Does the client have a history of a serious mental disorder, especially auditory hallucinations commanding her to hurt herself?
23. Does the client have a history of substance abuse?
24. Is the client frequently involved in "death-defying" or high-risk behavior?
25. Does the client frequently pick fights with people who are much larger or more dangerous?
26. Is there a current crisis in the client's life, such as illness, job loss, divorce, school failure, or suspension?

(continued)

Questions to ask the client

The list begins with general questions designed to establish whether or not a client is having suicidal ideation. You may or may not need to use these questions to establish the existence of that ideation; however, once ideation is reported, you should pursue the subsequent information in as much detail as possible.

1. You seem upset. Just how badly *are* you feeling?
2. When you feel badly, do you ever have any thoughts about hurting yourself?
3. Do you ever wish you were dead?
4. When you wish you were dead, do you ever think about killing yourself?

   If the answer to these questions is yes:

5. When did you start having these thoughts?
6. What was happening when you started thinking about hurting yourself?
7. How often are you having these thoughts?
8. Are you able to stop these thoughts once you start having them?
9. When you think about killing yourself, do you think a *lot* about it?
10. Do these thoughts upset you or do they make you feel better?
11. What do you think would happen if you tried to kill yourself?
12. Who do you think would try to prevent your suicide?
13. Have you told anyone that you're thinking of killing yourself?
14. What do you imagine death would be like?
15. When you have thoughts of killing yourself, how do you imagine doing it?
16. When you imagine it, do you complete the suicide? If not, who or what stops you?
17. Do you imagine writing a suicide note? Have you actually written a suicide note?
18. Where do you expect to get the [gun, pills, knife, etc.] with which to kill yourself?
19. When you feel this way, do you talk to anyone about it?
20. Is that person a comfort?
21. Is there anyone who is so important to you that that person could keep you from hurting yourself?