the risk of suicide after bereavement

ALTHOUGH MANY BEREAVED PEOPLE, AT THE HEIGHT OF their grief, would agree that "life is not worth living," or "I wouldn't care if I died tomorrow," the proportion who actually kill themselves is very small indeed. Nevertheless there is a significant minority who make suicidal attemps and some of these will be fatal. It is, therefore, vitally important that every Cruse counsellor knows how to assess the risk of suicide and what to do about it.

The experience of grief is sometimes so painful that it can make life intolerable. The bereaved may view suicide as an escape from misery, as a move towards reunion with the lost person or as an expression of rage against God, the family, or their own self. To them grief may seem unending, a permanent state which they have entered rather than a process through which they will pass.

To the Cruse counsellor grief is a painful but necessary part of the total reaction to bereavement. Our aim is to help the bereaved to find their way through grief in the expectation that they still have a worthwhile life to lead.

PARASUICIDE

Some people (particularly young women) threaten suicide, take overdoses or otherwise harm themselves without any real intention of killing themselves. It is tempting to react in a hostile way to these manipulative acts. Nevertheless such behaviour is usually better seen as a "cry for help" and should be treated as such. Occasionally parasuicide may be accidentally fatal!

ASSESSMENT OF SUICIDAL RISK

Contrary to popular belief we should not assume that "those who talk about suicide won't do it." In fact the majority of successful suicides have told somebody of their intentions beforehand.

Never be afraid to ask "Has it been so bad that you thought of taking your own life?" and to follow this up, if necessary, with further questions about how, where and when. The counsellor need not be afraid that they will put the idea into their client's head, anyone who is that unhappy is bound to have thought about suicide.

Further discussion will soon elicit just how serious is the risk and how urgently action needs to be taken.

On balance older widows (and widowers), living alone, who either have no family or are at odds with their family, are at special risk, particularly if they are also in poor health.

WHAT TO DO

Whenever suicidal intention is thought to be present there are two people who must be informed without delay, the client's General Practitioner and the counsellor's supervisor. It is also important to discuss the situation with a member of the client's family since suicide is an event which affects the whole family.

The law regarding suicide is clear. Although it is not illegal to kill oneself it is illegal to assist a suicidal act. Whether it is also illegal if a counsellor, knowing of serious risk of suicide, takes no action, is less clear. The policy of the Council of Cruse on this issue, however, is unambiguous. We believe that it is the responsibility of the counsellor to do his or her best to prevent suicide even if this necessitates a breach of the confidential relationship between counsellor and client.

In most instances clients are quite willing to talk to their G.P. or a psychiatrist and it is the counsellor's first duty to persuade them to do so. If it is necessary for the counsellor to break confidence the client has the right to know why. Most will understand that there are times when our concern and care for our clients overrides our obligation to keep silent.

Out of these consultations a plan for support should arise which will ensure that the necessary steps are taken to prevent a suicidal act. In some cases it

How should a counsellor respond to the threat of suicide?

DR. COLIN MURRAY PARKES, MD DPM FRCPsych, Senior Lecturer in Psychiatry at The London Hospital Medical College and Chairman of Cruse, sets out his statement on this issue.

may be sufficient to mobilize family support, as we have seen, some suicidal threats are cries for help. In other cases antidepressants or other psychotropic drugs may be prescribed, but it will be necessary to ensure that the client is not left alone with the means to suicide near at hand until the danger is past.

In view of the frequency with which overdoses are the means of suicide it is always worth checking whether or not there are stocks of drugs in the house. If so, the counsellor could offer to dispose of them or pass them to a responsible family member.

Many suicidal acts represent "end of tether" behaviour. It helps to offer the client something to do as an alterative to taking an overdose. A telephone number (your own if you think it safe or that of the local Samaritans) to 'phone if things get too bad, will sometimes save a life and will seldom be abused.

In many instances psychiatric referral is advisable and the counsellor may be able to pave the way by reassur- the client that nobody thinks they are a "nut case" and that even if hospital admission is needed, it is rare for anyone to stay in a psychiatric unit for very long nowadays.

In the event of referral to psychiatrist or G.P. it is tempting for counsellors to breathe a sigh of relief and back off leaving the "experts" to take over. Sometimes this is the right thing to do. From now on the responsibility is the doctor's and the counsellor is under no obligation to remain involved unless invited to do so. But there are times when it is a mistake to back off too soon. Not only will some clients fail to take the doctor's advice, but even when they do, the doctor may not be able to devote the time and unqualified attention to his patient that a counsellor can offer a client. I have known a widow to lose the support of a counsellor, a social worker and a neighbour as soon as she was referred to a psychiatrist, simply because each was afraid that they might"interfere with the treatment." In this instance the "treatment" comprized no more than a bottle of pills which the client did not take!

Having said this there is no doubt that the final responsibility for the care of suicidal people lies with the doctors, and for this reason alone it is essential for counsellors to notify the client's G.P. whenever a suicidal risk is suspected. If we fail to do this we run the risk of serious criticism from the family and even the coroner. Having made the referral, any further help which the counsellor provides should be with the doctor's knowledge and approval for he will have to bear the blame if things go wrong. In the end it is the problem behind the suicidal threat that need to be tackled rather than the suicidal threat itself. And this requires the same principles of counselling which we adopt in all our work - concerned, non-judgemental attention with tolerance of emotional expression and a minimum of advice.

But it can be more than usually hard to withold judgement and tolerate emotions when we ourselves feel threatened and threats of suicide often feel like threats against the counsellor. Because of this the counsellor too will need and should not hesitate to ask for support. It is the responsibility of the Counselling Sub-Committee of each branch of Cruse to ensure that every person who counsels the bereaved in the name of Cruse has easy access to an experienced and trained supervisor.

IF SUICIDE OCCURS

It is all the more important that the counsellor receive support in the rare event that a suicidal threat has been successfully carried out. Here the team must rally round without delay to ensure that the surviving family get help and to provide them with opportunities to talk through the perplexing and bitter feelings which arise.

Support for the family bereaved by suicide will be the topic of a later article in this journal. Suffice it to say at this point that the best care in the world will not prevent some people from killing themselves. And perhaps, for all we know, that may be as well.