A Process Model for Clinical Decision Making in High-Risk Outpatient Situations: The Therapeutic Alliance and Suicide

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Abstract

When a client is at risk for suicide, important counselling decisions must be made. In this article we present a process model for decision making in high-risk outpatient situations. We propose that counsellors attend to two key dimensions of these situations: the strength of the therapeutic alliance and the degree of suicide risk. Therapeutic actions are then directed toward strengthening the alliance, and toward implementing other risk-reduction interventions only when the risk cannot be adequately reduced via the alliance. Four case studies are presented to illustrate the application of the model to suicidal situations.

Résumé

Quand un client est considéré suicidaire, d'importantes décisions en counseling doivent être prises. Dans cet article, les auteurs présentent un modèle de processus pour la prise de décision dans des situations de malades externes à risque élevé. Ils proposent que les conseillers s'occupent des deux aspects fondamentaux de ces situations : la solidité de l'alliance thérapeutique et le niveau du risque de suicide. Les actions thérapeutiques sont alors dirigées vers le renforcement de l'alliance thérapeutique et vers la mise en pratique d'interventions visant à réduire les risques seulement lorsque ceux-ci ne peuvent être effectivement diminués au moyen de l'alliance. Cet article présente quatre études de cas pour illustrer l'application du modèle aux situations de suicide.

When life and death are at stake even experienced counsellors can find themselves distracted from the process of counselling by such concerns as whether to alert third parties of the threat, implement interventions outside of their usual repertoire, or otherwise to conduct counselling differently. This tendency is reflected in the professional literature by an emphasis on case management rather than counselling process (Fremouw, de Perczel, & Ellis, 1990). The intent of this article is to present a model for decision making when responding to an outpatient client at risk for suicide that is designed to help counsellors develop a clear counselling treatment plan that is effective, simple and justifiable. An earlier

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version of the model was developed by the authors (1995) for decision making when clients are at risk for violence against others, and through its application in a variety of life-threatening counselling situations we have refined and developed it further.

In addition to the concern that a suicidal client may actually die, counsellors also tend to become very worried about being sued. Legal liabilty in the case of suicide can arise out of any of three failures on the part of the counsellor: (a) failure to foresee the suicide; (b) failure to establish a reasonable treatment plan; or (c) failure to properly implement the treatment plan (VandeCreek & Knapp, 1993). Note that there is no requirement to "warn" anyone. There is a legal requirement that parents of minors be notified when their children are suicidal (Eisel v. Board of Education, 1991), and there certainly are circumstances where other individuals have to be involved in order to properly implement a treatment plan, but counsellors should not confuse their legal responsibility when a client is suicidal with their legal responsibility to protect third parties when a client is homicidal (Truscott & Crook, 1993).

It is the standard of foreseeability that presents the most serious dilemma for counsellors because any judgement of liability will be made in hindsight, in which case the suicide will appear more foreseeable, and because even the best suicide assessment will result in a false positive rate in excess of 95% (Bongar, 1991). It is prudent, therefore, to treat every expression of suicidal ideation or suicidal gesture as serious, without resorting to breaking confidentiality (such as initiating involuntary hospitalization) unless all other treatment avenues have been exhausted. In addition to being legally defensable, this approach is also consistent with the *CGCA Guidelines for Ethical Behaviour* (Canadian Guidance and Counselling Association, 1989) and the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 1991).

A strong therapeutic alliance is the cornerstone of a positive outcome in counselling (Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988; Orlinsky & Howard, 1986; Orlinsky, Grawe, & Parks, 1994; Sexton & Whiston, 1994). Since it is by virtue of the alliance that counsellors are able to influence life-threatening situations (Bongar, Peterson, Harris, & Aissis, 1989), it follows that in such situations we should focus our energies on this aspect of counselling because it has the greatest likelihood of success. Only if the risk cannot be adequately reduced via the alliance should therapeutic energies be directed toward other risk-reduction interventions that have a lesser likelihood of success. We propose, therefore, that counsellors in high-risk situations attend to two key dimensions: the strength of the therapeutic alliance and the degree of risk. Although both of these dimensions are obviously on continua, we have found it helpful to think of them in a 2x2 table. This table is presented in Figure 1.

FIGURE 1

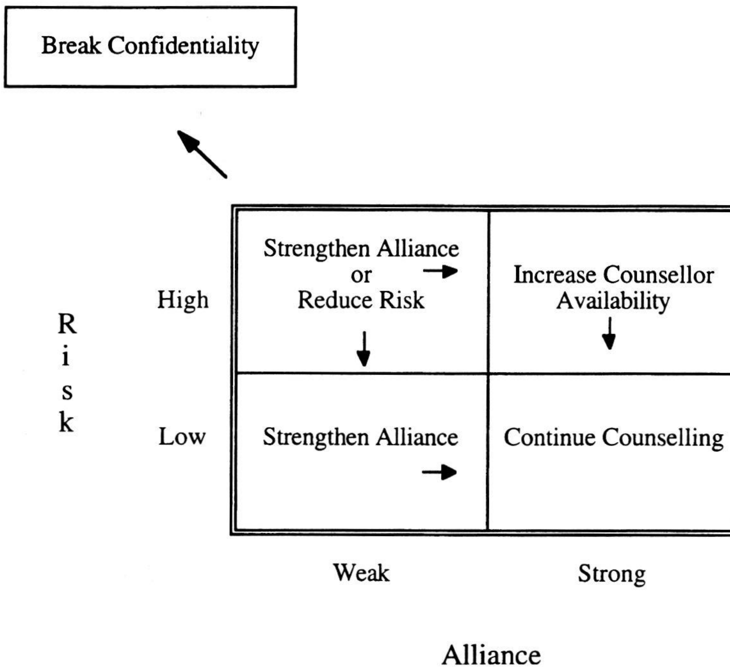

Figure 1. Model for decision making in high-risk outpatient situations.

Our model is relevant to crisis counselling in person as well as over the telephone where the counsellor has only the alliance by which to influence the client. Directives simply need not be followed by clients in such settings if they so choose. During crisis counselling in person clients can walk out. When on the telephone clients can hang-up, or kill themselves while talking to the counsellor. We think our model is especially useful for counsellors in solo practice and in suicide prevention centres where, in addition to the stress of having to deal with a life-threatening situation, they often do not have the opportunity to consult with colleagues before having to make the important decisions that need to be made.

Our model is not the first to be presented as a guide for decision making with suicidal clients. Shneidman (1981) recommends that the counsellor change the focus and context of counselling when dealing with suicide, going beyond the boundaries of the alliance to involve relatives, friends, coworkers, ancillary counsellors, and community resources. Once the suicidal crisis has passed, "ordinary psychotherapy" can be resumed. Fremouw et al. (1990) argue that this approach, of treating the suicidal crisis as an event isolated from the issues being addressed in counselling and in a manner different from how these issues had been addressed, does not take into account the trait-like qualities of suicide,

nor the reduction of future suicide risk. A model which does take these into account is the empathic method of Jacobs (1989), in which increased counsellor empathy during the suicidal crisis allows the client to explore his or her issues more deeply, rather than looking for ways of immediately alleviating pain. What we propose is an integration of these two models, drawing on the strengths of each. From Shneidman (1981) one learns case management strategies that can be implemented, while Jacobs (1989) presents a therapeutic stance. Our model provides a simple framework for deciding when to move from a therapeutic stance to case management by foremost assessing the strength of the alliance.

ASSESSING ALLIANCE STRENGTH

A therapeutic alliance is present when the client trusts the counsellor, there is a positive affective bond between the client and counsellor, and they are working collaboratively toward shared counselling goals (Bordin, 1994). It is the client's perception of the therapeutic alliance that is especially predictive of counselling outcome (Horvath & Symonds, 1991; Luborsky, 1994; Whiston & Sexton, 1993) and should therefore be the focus of an assessment of alliance strength. The following client perceptions to be considered when assessing the current strength of the alliance are adapted from Bordin (1994), Gelso and Carter (1985, 1994) and Whiston and Sexton (1993).

Trust

Does the client trust you to place his or her best interest first and to continue to work with them in counselling no matter what those interests may be? Are you perceived as genuine and as an expert? Does the client have issues around trusting people in general, or counsellors in particular? Does the client feel confident that what is being discussed during counselling will be kept confidential? Do you trust your client?

Positive Affective Bond

Has the client expressed, explicitly or implicitly, positive interpersonal feelings toward you? Does the client perceive you as warm, supportive, concerned, empathic, compassionate, non-judgmental, and respectful?

Working Collaboratively Toward Shared Goals

What are the client's reasons and goals for seeking help? Are they consistent and congruent with yours? Does the client agree with the method proposed by you for solving problems? In particular, to what degree is the client committed to addressing personal problems in counselling? Has the client expressed any opinions about the helpfulness and benefit of counselling so far? Have any appointments been missed? If so, why?

ASSESSING SUICIDE RISK

The degree to which information about the risk of suicide can be obtained will depend upon the circumstances of the situation. Generally, an assessment of risk factors should be undertaken at intake if a client presents with issues related to suicidal feelings, thoughts, or behaviour. If concerns about suicide arise in the course of counselling, the counsellor should make every reasonable effort to obtain relevant information while at the same time attending to the client's change process needs and thereby not disrupting the therapeutic alliance. There is an extensive literature dealing with risk factors for suicide, but no established and generally accepted procedure for assessing suicide risk (Bongar, 1991; Rudd & Joiner, 1998). In particular, most of the literature deals with factors that cannot be changed, such as age, gender, and past history. The following simplification, adapted from Bednar, Bednar, Lambert, and Waite (1991), Bongar (1991), and Sommers-Flanagan and Sommers-Flanagan (1995), is not intended to be exhaustive, but rather as a guide to those factors that can be addressed in counselling.

Affect

Is the client depressed? If so, for how long? How intense are any feelings of hopelessness, helplessness, guilt, worthlessness, shame, anger, or self-loathing?

Suicide Ideation

Has the client been thinking about suicide or having self-destructive thoughts? If so, how often, long, or intensely? Are they related to any important anniversaries or events? Is it a passive wish to be dead (e.g., go to sleep and never wake up) or an active desire?

Suicide Plans

Has the client thought about how to commit suicide? How specific, lethal, and attainable is the plan? Have any initial actions being taken, such as hoarding medications or obtaining a gun or rope?

Self-Control

Does the client fear losing control? How has control been maintained in the past? Is the client under the influence of any psychoactive substance? What are the client's spiritual beliefs with respect to suicide? Is anyone available for support or to intervene if an attempt is made?

APPLICATION OF THE MODEL

The following cases illustrate the application of the model to situations in which the risk for suicide is high. If the risk is low, the counsellor

should address strengthening the alliance and shift the focus of counselling more specifically toward suicidal ideation and intention, and the psychological pain that is fueling it.

Moving from Weak Alliance, High Risk to Strong Alliance, Low Risk

When the therapeutic alliance is weak and the client is at high risk for suicide, the counsellor should make themselves more available through more frequent and/or longer sessions and/or 24-hour telephone access and direct his or her energies toward strengthening the alliance. If an alliance has not yet been established, this can be addressed by behaving in an affiliative, autonomy-granting manner, while refraining from responding in a hostile or controlling manner (Henry & Strupp, 1994). The counsellor should listen with empathy, genuineness, and warmth (Hill & Corbett, 1993; Orlinsky & Howard, 1986) to the client's narrative of their affect, ideation, and plans (if any) in order to engender a positive affective bond. While the information gained via this process can be helpful when it comes time to formulate risk-reduction interventions, the primary task of the counsellor at this point is to let the client know they have been heard, understood, and accepted.

If a therapeutic alliance had already been established and has been weakened or strained, the counsellor should openly identify and nonjudgmentally discuss the client's perception of the alliance, clarify any misperceptions, explore any core interpersonal themes that are impacting on the therapeutic relationship, facilitate the client's expression of what they want in and from counselling, and make any necessary adjustments to the therapeutic tasks or goals (Safran & Muran, 1995). Once a strong alliance is present the counsellor can then work with the client to reduce the risk of suicide by addressing the source of their desperation and collaboratively developing and implementing risk-reduction interventions. These interventions will usually be directed toward limiting the client's access to the means for carrying-out any plans they may have made (e.g., removing knives from their home or disposing of hoarded medications) and/or increasing the client's self-control by making arrangments to be with someone who cares about them (e.g., friend, relative, church member). The key process, however, is collaboration with the client.

Case 1. Mr. R was a 17-year-old high school student who was referred by his mother because he had been voicing suicidal intentions. He had severely restricted his food intake and was engaging in other self-destructive behaviours such as riding his bicycle in a reckless manner, resulting in a near-fatal accident.

Mr. R presented to counselling looking lethargic and depressed. He confirmed that he did want to kill himself, but had not devised a plan. He described feeling a profound sense of anomie and worthlessness, and was afraid to the point of panic that others would abandon him if they knew how worthless he was. He

stated that he did the opposite of what his parents wanted because "it hurts them more than it hurts me." At the insistence of his father he had seen a psychiatrist, who had prescribed anti-depressant medication which the client did not want to take.

The counsellor focused on establishing a therapeutic alliance by taking steps to convey to the client that he understood and accepted him. He did this by acknowledging and validating his need for control over his life and his fear of abandonment. The counsellor avoided invasive probing to prevent reactance and in order not to exacerbate the client's sense of worthlessness. Mutual trust was addressed by allowing him to dictate the pace and content of the counselling, and by respecting his wish to not rely on medication. The client agreed to discuss his difficulties with the counsellor and to contact the counsellor if he felt an urge to act on his thoughts of harming himself.

By the fifth session the alliance was felt and believed to be strong enough to ask the client if he wanted to continue counselling. He stated he did not know, and that he would think about it. He returned the following week more alert and happy. He stated that he did want to continue counselling and that he felt he could attend school for himself rather than his parents. He reported feeling a sense of self-responsibility and an awareness that he was sabotaging himself.

After a six-week hiatus, the client returned with greater feelings of control and the alliance intensified as he emotionally explored his relationships with his parents and friends. He began to eat, exercise, and make efforts to become more independent from his parents. As he worked through his anger with his parents and became more aware of his strengths, his depression and self-destructive tendencies abated.

Moving from Strong Alliance, High Risk to Strong Alliance, Low Risk

If the therapeutic alliance is already strong and the risk is high, counsellors should increase their availability and interventions for risk-reduction should be developed and implemented collaboratively (as described in the previous section).

Case 2. Mr. E. was a 34-year- old fish and wildlife officer who was severely injured while attempting to apprehend a poacher. He was depressed in reaction to the loss of his job which was central to his self-concept and was his primary source of self-esteem. He became embroiled in a bitter dispute with his employer regarding returning to work because he was unable to meet the physical demands of his pre-accident job, but did not want to accept a lower status position.

During the 86th session of counselling, Mr. E. presented as extremely agitated in response to being told he had to accept a position as a janitor, which he considered to be demeaning and insulting. He stated that he was "tired of fighting" and "ready to give up." He reported that he had always slept with two handguns under his pillow and that he intended to kill himself. The counsellor assessed him as being at high risk for suicide and engaged him in exploring his feelings, images, thoughts, and beliefs about taking his life. Daily telephone sessions were scheduled and he promised to refrain from harming himself between sessions.

Two days later Mr. E. reported that he had decided to pursue legal action to resolve his dispute and that he no longer intended to kill himself. Counselling continued for two more months, and one year later he reported that he was doing well.

Moving from Weak Alliance, High Risk to Weak Alliance, Low Risk

If the alliance cannot be established or strengthened sufficiently, risk-reduction interventions (as described above) can be implemented indirectly by involving significant others with whom the client already has a sufficiently strong alliance (e.g., family members or other health care providers) after obtaining the client's permission. Under these circumstances the counsellor may have to "coach" the significant other in implementing interventions and is responsible for follow-up to ensure that the client has been contacted and the risk addressed.

Case 3. Mr. H. was seen at the request of his insurance case manager. She was about to confront him with the news that he his benefits had been terminated for reasons of fraud. She had concerns that he may become suicidal because he had previously told her that he had sizable gambling debts and had taken money from his wife's personal bank account, that his wife had insisted he leave their home until he returned the money, and that he was feeling desperate.

The counsellor was invited into the interview room after the insurance adjuster concluded her discussion with Mr. H. He was tearful and visibly upset. Counselling was offered but declined. He would not directly answer questions about suicide risk, but responded vaguely that "I have no choice" and "I know what I have to do." He did, however, agree to visit his trusted physician who had an office one block away, and to not attempt to harm himself before talking it over with his physician. He did grant permission for the counsellor to contact his physician to relay the concerns about suicide. Mr. H. left and the physician was contacted.

Upon follow-up one hour later, the physician reported that he had seen Mr. H. and that the risk had been addressed.

Moving from Weak Alliance, High Risk to Breaking Confidentiality

Only if the alliance cannot be strengthened and risk-reducing interventions cannot be implemented within the boundaries of the therapeutic alliance should third parties be involved without the client's consent. Civil commitment proceedings should be considered, even if there is some doubt as to whether or not the client meets the appropriate criteria. If time and circumstances permit, the limits of confidentiality and the steps that will be taken should be discussed openly with the client. When third parties are contacted, only that information necessary to prevent the suicide attempt should be divulged.

Case 4. Mr. K's father contacted the counsellor to request assistance for his son who was expressing suicidal intent. The counsellor contacted Mr. K. by telephone, who reported that he did indeed intend to kill himself, that he had stockpiled medications in order to do so, and that he had already consumed a great many of them. He angrily stated that he did not want to talk to the counsellor or anyone else about his situation or decision. He then shouted into the telephone that he was going to "finish the job" and hung up.

The counsellor then telephoned Mr. K.'s father to advise him to go to his son's home and to obtain Mr. K.'s address. The counsellor then contacted emergency

services who went to Mr. K.'s home and found him in an unconscious state. He was taken to hospital and revived. During his stay in hospital arrangements were made for outpatient counselling, which he attended upon discharge.

CONCLUSION

The purpose of this article has been to present further a model for decision making in risky therapeutic situations (Truscott, Evans, & Mansell, 1995). The present paper applies the model to situations where the risk is that clients will harm themselves. The model involves attending to the therapeutic alliance — weak or strong, and the risk — high or low. We have simplified it and encourage the reader to visualize it geometrically as a 2 x 2 table with therapeutic alliance on the bottom, weak to the left (-) and strong to the right (+); and risk on the left, high above and low below, with the goal being to get to the bottom right-hand corner (see Figure 1).

The ideas contained in this article may appear somewhat intuitive and simplistic. We see this as a strength. Important decisions with life and death consequences are made more easily with fewer errors when we have an intuitive and simple model in mind that is based upon sound counselling process principles.

References

Bednar, R. L., Bednar, S. C., Lambert, M. J., & Waite, D. R. (1991). *Psychotherapy with high-risk clients: Legal and professional standards.* Pacific Grove, CA: Brooks/Cole.

Bongar, B. (1991). *The suicidal patient: Clinical and legal standards of care.* Washington, DC: American Psychological Association.

Bongar, B., Peterson, L. G., Harris, E. A., & Aissis, J. (1989). Clinical and legal considerations in the management of suicidal patients: An integrative overview. *Journal of Integrative and Eclectic Psychotherapy, 8,* 53-67.

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath, & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 13-37). New York: Wiley.

Canadian Guidance and Counselling Association. (1989). *CGCA guidelines for ethical behaviour.* Ottawa: Author.

Canadian Psychological Association. (1991). *Canadian code of ethics for psychologists.* Ottawa: Author.

Eisel v. Board of Education, 324 Md. 376, 597 A.2d 447 (Md. Ct. App. 1991).

Fremouw, W. J., de Perczel, M., & Ellis, T. E. (1990). *Suicide risk: Assessment and response guidelines.* New York: Pergamon Press.

Gelso, C. J., & Carter, J. A. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *The Counseling Psychologist, 13,* 155-244.

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41,* 296-306.

Henry, W. P., & Strupp, H. H. (1994). The therapeutic alliance as interpersonal process. In A. O. Horvath, & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 51-84). New York: Wiley.

Hill, C. E., & Corbett, M. M. (1993). A perspective on the history of process and outcome research in counseling psychology. *Journal of Counseling Psychology, 40,* 3-24.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61*, 561-573.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139-149.

Jacobs, D. G. (1989). Psychotherapy with suicidal patients: The empathic method. In D. G. Jacobs & H. N. Brown (Eds.), *Suicide: Understanding and responding: Harvard Medical School perspectives on suicide* (pp. 329-342). Madison, CT: International Universities Press.

Luborsky, L. (1994). Therapeutic alliances as predictors of psychotherapy outcomes: Factors explaining the predictive success. In A. O. Horvath, & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 38-50). New York: Wiley.

Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from psychotherapy? Predicting therapeutic outcomes.* New York: Basic Books.

Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 311-381). New York: Wiley.

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy - Noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 270-376). New York: Wiley.

Rudd, M. D., & Joiner, T. (1998). The assessment, management, and treatment of Suicidality: Toward clinically informed and balanced standards of care. *Clinical Psychology: Science and Practice, 5*, 135-150.

Safran, J. D., & Muran, J. C. (1995). Resolving therapeutic alliance ruptures: Diversity and integration. *In Session: Psychotherapy in Practice, 1*, 81-92.

Sexton, T. L., & Whiston, S. C. (1994). The status of the counseling relationship: An empirical review, theoretical implications, and research directions. *The Counseling Psychologist, 22*, 6-78.

Shneidman, E. S. (1981). Psychotherapy with suicidal patients. *Suicide and Life-Threatening Behavior, 11*, 341-348.

Sommers-Flanagan, J., & Sommers-Flanagan, R. (1995). Intake interviewing with suicidal patients: A systematic approach. *Professional Psychology: Research and Practice, 26*, 41-47.

Truscott, D., & Crook, K. H. (1993). *Tarasoff* in the Canadian context: *Wenden* and the duty to protect. *Canadian Journal of Psychiatry, 38*, 84-89.

Truscott, D., Evans, J., & Mansell, S. (1995). Outpatient psychotherapy with dangerous clients: A model for clinical decision making. *Professional Psychology: Research and Practice, 26*, 484-490.

Vandecreek, L., & Knapp, S. (1993). *Tarasoff and beyond: Legal and clinical considerations in the treatment of life-endangering patients* (2nd ed.). Sarasota, FL: Professional Resource Exchange.

Whiston, S. C., & Sexton, T. L. (1993). An overview of psychotherapy outcome research: Implications for practice. *Professional Psychology: Research and Practice, 24*, 43-51.

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