Working with Suicidal Clients

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It's understandable that a therapist would experience some degree of trepidation when working with a suicidal client. Therapists have a profound responsibility when treating someone who is in such extraordinary pain. But the responsibility is inescapable: Statistically, every clinician is likely to encounter a suicidal client at some time in his or her career.[1] As a result, every therapist should be concerned about what the law expects of him or her when working with such a client.

This article discusses a number of key legal issues which are generally applicable when treating a suicidal client. The article also briefly discusses the topic of assessing and managing risk when working with suicidal clients.

KEY LEGAL ISSUES

When a therapist is aware that his or her client is at risk of committing suicide, courts have generally held that he or she has a duty to take "reasonable" or "appropriate" steps to prevent the client's suicide.[2] However, the definition of what may be considered to be "reasonable," depends on the facts and circumstances of the case. There is not a list of actions or interventions which can be uniformly applied to all suicidal clients, in all circumstances.[3]

The case entitled *Bellah v. Greenson* provides an example of what is generally expected of a therapist when he or she is working with a suicidal client.[4] In this case, the parents of an adolescent girl who committed suicide brought a lawsuit against their daughter's former psychiatrist, wherein they alleged that he was negligent in the care of her daughter because he failed to use reasonable care to prevent her suicide. However, in this case, the girl's parents also contended that Dr. Greenson was negligent **because he failed to inform them of the fact that she was engaging in high-risk behavior during the time that she was in treatment**.[5] [6] In its' decision, the Court of Appeal agreed that Dr. Greenson had a duty to exercise reasonable care in his treatment of the girl; meaning that he was expected to take **"appropriate preventive measures" concerning her risk of suicide.7 But, the court did not agree with the plaintiff's contention that Dr. Greenson had a specific duty to disclose his client's confidential information to her parents**.[8]

What did the court actually mean when they used the words, "appropriate preventive measures?" And why did the court disagree with the plaintiff's argument that Dr. Greenson was negligent because he didn't tell her parents about her high-risk behavior? In order to answer such questions, it may be helpful to briefly review the primary legal issues which are at the heart of a negligence (malpractice) lawsuit against a mental health professional.[9] [10]

THE ELEMENTS OF NEGLIGENCE

When a therapist is sued for negligence, the plaintiff must prove by a preponderance of the evidence:[11] **That the therapist owed a duty of care to him or her; that the therapist breached his or her duty by failing to meet the standard of care which was expected under the circumstances, and, that the therapist's conduct actually and proximately caused the plaintiff to be harmed**.[12] "Actual causation," means that "but-for" the actions of the therapist, the plaintiff would not have been harmed.

"Proximate causation," means that the alleged harm to the client was foreseeable to the therapist as a possible consequence of his or her actions.[13]

The Duty of Care

Courts have long recognized the fact that a psychotherapist owes a duty of care to his or her clients.[14] [15] Thus, if a client-therapist relationship existed at the time of the alleged wrongdoing, there was a duty of care owed to the client. Generally speaking, the duty of care is based upon the existence of a "special relationship" between the therapist and his or her client.[16] [17]

The Standard of Care[18]

The standard of care which is applicable in a given case depends on the actual facts and circumstances present in the case. In order to determine what the appropriate standard of care is, the court will usually require the opinion(s) of relevant experts. **The expert will provide his or her opinion as to what would be expected of a therapist who was exercising the reasonable degree of skill, knowledge and care that would ordinarily be exercised by other therapists, when practicing under similar circumstances.**[19]

What was the applicable standard of care in *Bellah v. Greenson*? Although the adolescent client in *Bellah v. Greenson* was at risk for suicide during the course of her treatment, the court was not inclined to rule that Dr. Greenson was *required* to disclose her confidential information to her parents. It wasn't that the court lacked compassion for the terrible loss that her parent's had suffered. The court recognized that, if every therapist was faced with a broad mandate to disclose confidential information regardless of whether it was clinically appropriate to do so, the disclosure itself could result in the rupture of the therapist-client relationship and potentially increase the client's risk of suicide. Furthermore, the existence of such a rule would be at odds with the fundamental privacy of a therapist-patient relationship. On this issue, the court of appeal also rejected the plaintiff's contention that the landmark case, *Tarasoff v. Regents of University of California*, created a "duty to warn" under the circumstances found in *Bellah v.Greenson*:

"We disagree with plaintiffs in their contention that *Tarasoff v. Regents of University of California*, created a duty on the part of the defendant in this instance to breach the confidence of a doctor-patient relationship by revealing to them disclosures made by their daughter about conditions which might cause her to commit suicide. In *Tarasoff*, the California Supreme Court held that, under certain circumstances, a therapist had a duty to warn others that a patient under the therapist's care was likely to cause personal injury to a third party…The imposition of a duty upon a psychiatrist to disclose to others vague or even specific manifestations of suicidal tendencies on the part of the patient who is being treated in an out-patient setting could well inhibit psychiatric treatment."[20]

Actual and Proximate Causation: Was the Alleged Harm Foreseeable to the Therapist?[21]

As stated above, in a negligence lawsuit, it must be shown that the harm in question was actually **foreseeable to the therapist as a possible consequence of his or her actions**. A therapist cannot be expected to implement preventive measures in a case where the potential suicide of his or her client was not reasonably foreseeable. Thus**,** in a case involving the alleged negligent failure of a therapist to prevent his or her patient's suicide, **one of the fundamental issues is whether or not the therapist was aware of facts from which he or she could reasonably conclude that the client was likely to self-inflict harm in the absence of preventative measures**.[22]

It is important to remember that, the information which is available to a therapist regarding his or her client, is related to the therapist's investment of time, energy and skill in collecting such information. **In other words: Did the therapist conduct an assessment of his or her client in accord with the relevant standard of care**? **A therapist may not be aware of facts from which he could reasonably conclude that his or her client was at risk of harming him or herself, if he or she failed to exercise the**

reasonable degree of skill, knowledge and care that would ordinarily be exercised by other therapists, when conducting an assessment of the client.[23] Ultimately, whether the therapist was, or was not, reasonably competent in conducting an assessment of his or her client depends on the facts and circumstances involved.

There is no list of questions which will be appropriate for all clients. One client may be relatively forthcoming when asked about his or her ideation. Another client may minimize his or her prior history of depression but have a history of psychiatric hospitalization, wherein, documentation may exist which could prove to be enlightening to the therapist, if he or she elected to request such records. Alternately, a consultation with a client's psychiatrist may provide the therapist (or the psychiatrist) with valuable diagnostic information, etc.

Identifying and Responding to Risk Factors for Suicide

There are numerous articles in the literature which discuss the topic of risk-management in clinical practice with suicidal clients.[24] The terms: "risk management," in this context, refers to a therapist's efforts to identify the risk factors for suicide which may be present in a given case, and his or her efforts to prevent the client from harming him or herself.[25] Such efforts may include, but are not limited to: facilitating the client's hospitalization; consulting with his or her psychiatrist; increasing the intensity of the client's treatment; asking the client to sign a no-self-harm agreement; attempting to increase the degree of social support available to the client; involving a family member or friend in the treatment plan, etc. However, no therapist is able to predict, with certainty, what his or her client will do in the future, nor can he or she control the actions of his or her client. The preventive measures which a therapist employs when working with a particular client, depends on the needs of the client, the surrounding circumstances, and any information which may be available to him or her regarding the client.

A therapist is not legally required to be correct in his or her assessment of a client's risk for suicide. Therapists are really no-better at predicting the future than anyone else. Thus, the fact that a suicide may occur does not, in itself, prove that there was a breach in the standard of care.[26] There is an expectation, however, that the therapist make reasonable efforts to obtain information about the client in order to determine the risk of suicide.[27]

No two clinicians are alike and every therapist will employ his or her own style or approach to gathering information about a client (e.g., taking a psychosocial history), conducting an assessment of the client and arriving at a diagnosis and treatment plan. When the therapist suspects the possibility of suicide risk, he or she should take care to directly ask the client whether he or she is experiencing any suicidal ideation, and if so, to describe it. It is important to inquire about any history of prior treatment, and the client's history of problems with depression, including any prior suicidal ideation or attempts. When the client has been treated previously in an inpatient setting, it is also generally a good idea to seek authorization from the client to request a copy of his or her prior treatment records. If the client was recently treated in an inpatient setting, and/or, if he or she is admitted to an inpatient program based upon a severe risk of suicide, a therapist should make reasonable and appropriate efforts to communicate with the relevant inpatient staff, including the attending psychiatrist if possible.[28] And of course, in cases where there is a risk of suicide, it is advisable for the therapist to consistently and thoroughly document his or her treatment efforts and corresponding clinical rationale, including the client's degree of cooperation with any recommendations given.

The treatment plan or specific intervention which is best suited to a given client is a function of that client's needs, and the surrounding circumstances, including the resources which are then-available to the therapist.[29] As an example, the therapist may believe that a partial-hospitalization program would be ideal for a particular client. But if there is no such program in the community where the client resides, or if the available program is filled to capacity, then the therapist has to consider the next-best choice(s) for that

person, and create a plan which is based upon the existing, rather than most-desirable treatment alternative. So, the client who would be well-served by the therapeutic intensity and support offered in an all-day treatment program, may not have such an option available to him or her and will need to consider an alternative plan, such as meeting with his or her therapist more frequently, with the ongoing collaboration of a psychiatrist. But, as every practicing therapist knows, if "plan B" isn't an option, then it's necessary to move-on to the next available treatment options, and so on. This is why a therapist can only be expected to do what is reasonable, under the circumstances.

There is a large body of information available to therapists on the topic of identifying risk factors for suicide.[30] There also appears to be a fair amount of information available concerning the range of actions which should be considered by a therapist in this area.[31] The actions which may be appropriate in some circumstances, with some clients, may be unnecessary or inappropriate in others. A therapist should strive to implement a course of action which he or she considers to be reasonable and appropriate for his or her client, at that point in time. Some of the key factors that a clinician may consider when assessing his or her patient's suicide risk include, but are not limited to the following:[32]

1. When there is a severe risk of suicide, it is necessary to consider the need for hospitalization in order to stabilize the client's symptoms, and for the protection of the client.[33]

2. When evaluating a client, it is important to consider any preexisting risk for suicide, including the client's history of depression and suicidal behavior.[34] Previous suicide attempts are associated with an increased risk for suicide, especially when there is a history of two or more attempts. [35]

3. There is evidence that clients face an elevated risk for suicide during the first year following an admission for inpatient psychiatric treatment, especially during the first few months after discharge.[36]

4. Depending on the client's diagnosis, there may be a need to refer the client for psychiatric evaluation. When a referral to a psychiatrist is indicated, the therapist should make a reasonable effort to consult and collaborate with him or her regarding the client's treatment.

5. The presence of a major mood disorder is a significant risk factor for suicide.[37] Borderline personality disorder and antisocial personality disorder are also associated with an increased risk of suicide.[38]

6. Numerous studies have reported that a client's experience of hopelessness is a substantial risk factor for suicide.[39]

7. A history of alcohol or drug abuse is associated with an increased risk of suicide.[40]

8. A history of impulsive behavior is associated with an increased risk of suicide.[41]

9. The availability of a support system for the client is a key consideration in assessing suicide risk and treatment planning.[42]

The Use of No-Suicide Contracts

The use of no-suicide contracts by clinicians working with high-risk clients is common practice in both in-patient and outpatient settings.[43] The phrase "no-suicide contract" is somewhat inapt, as this device is intended to serve as a therapeutic tool rather than an enforceable legal contract. Also referred to as a "no-self harm" agreement, a no-suicide contract is an agreement between the clinician and his or her client,

wherein the client agrees not to harm him or herself, and to seek help from the therapist or other identified person, when he or she experiences suicidal urges.[44]

In spite of their prevalent use, there is little empirical evidence that no-suicide contracts are effective in preventing suicide, in the absence of other treatment efforts.[45] Various criticisms have been levied against the use of no-suicide contracts, including:[46]

1. The use of a no-suicide contract may create an illusion of safety.[47]

2. The refusal of a client to agree to a no-suicide contract does not necessarily mean that he or she is at imminent risk of suicide.[48]

3. The willingness of a client to agree to a no-suicide contract does not necessarily mean that the risk of suicide has been lessened.[49]

4. The presence of psychiatric symptoms, such as severe depression or psychosis, may impede a client's mental capacity to enter into such an agreement.[50]

5. The client may be willing to sign such an agreement simply to placate the therapist.[51]

6. The therapist is asking a client to enter into an agreement with life and death consequences, even thought he or she may have had little time to develop genuine rapport with the client.[52]

7. The client who feels amendable to entering such into the agreement at one moment in time may feel quite differently after leaving the therapist's office.

No-suicide contracts should not be relied-upon by themselves as a sufficient preventive measure, and a therapist should exercise his or her clinical judgment as to when, and if, a no–suicide contract is of value in a particular case. Yet, in spite of its shortcomings, a "no self-harm or "no-suicide" agreement may have some clinical utility as part of a therapeutic plan. When used cautiously, depending on the circumstances and the client's needs, the possible benefits of a no-suicide agreement include: [53]

1. It may help facilitate honest and direct communication between the therapist and his or her client. [54]
2. It expresses an expectation that the client actively participate in his or her treatment.[55]
3. It defines a process for handling emergencies.[56]
4. It may help alleviate some of the client's anxiety by providing a structure to follow.[57]

Communicating With Others: Relevant Exceptions to Confidentiality

When dealing with a client who is a danger to him or herself, a therapist may determine that it would be helpful or even necessary, for him or her to communicate with a third-party in order to provide appropriate treatment for the client. For example, the therapist may wish to speak to the client's physician, family member, spouse, etc., because he or she believes that such communication will yield critical information, or, that it is necessary in order to prevent the client from harming himself. In another example, a therapist may determine that calling the police is an urgent necessity in order to prevent the client (or some other person) from being seriously harmed. In such circumstances, a therapist is permitted to disclose confidential information about his or her client, pursuant to the following sections of the California *Civil Code*:[58]

Section 56.10(c)(1) of the *Civil Code* clearly states that: "The information may be disclosed to providers of health care, health care service plans, contractors, or other health care professionals or facilities for

purposes of diagnosis or treatment of the patient…"[59] (This means that a therapist would be permitted to communicate with a client's physician, or with another mental health care professional (to name just a few examples) without a release, if such communication was for the purpose of diagnosing or treating the client.)[60]

Section 56.10(c)(19) of the *Civil Code*, specifically states that a psychotherapist can disclose confidential information about the client, "…if the psychotherapist, in good faith, believes the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a reasonably foreseeable victim or victims, and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.[61] [62] (This means that a therapist would be permitted to communicate with a third-party, if the therapist believed that such communication was necessary in order to prevent or lessen a serious or imminent threat of suicide).

The Bottom Line: Preparation is Key

Not all therapists want to work with a suicidal client, or are competent to provide ongoing therapy to a suicidal client. But, in light of the frequency of suicide, especially among particular age-groups such as adolescents and young adults, it is important for every therapist to have sufficient competency in the assessment of suicide risk, so that he or she can exercise reasonable care under the circumstances to prevent the suicide from occurring. As stated earlier, it is reasonable for a therapist to experience some degree of trepidation about working with a client who is suicidal. If, upon self-reflection, a therapist finds that he or she is *more than a little* anxious about this topic, it may be the appropriate time for him or her to seek-out additional training, or to explore the possibility of having consultation from a colleague who is well-trained in assessing and treating suicidal clients. Finally, it is suggested that every therapist take the time to become aware of the relevant treatment resources in his or her community, such as intensive treatment programs, as well as psychiatrists who would be available to evaluate a client, or to facilitate the hospitalization of a client if need be. It may also prove to be very helpful for a therapist to determine whether there are other therapists in the area who would be willing to accept the referral of a suicidal client, if necessary.

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References

1 For example: In 2009, 13.8% of U.S. high school students reported that they had seriously considered attempting suicide during the 12 months preceding the survey; 6.3% of students reported that they had actually attempted suicide one or more times during the same period. Among 15-24 year olds, suicide accounts for 12.2 % of all deaths annually. Center for Disease Control, "Suicide Facts at a Glance," available on the Internet at: http:://www.cdc.gov/violenceprevention/pdf/Suicide_DataSheet-a.pdf.

2 *Bellah v Greenson*, (1978) 81 Cal. App.3d 614; *Jacoves v. United Merchandising Corp*., (1992) 9 Cal. App.4th 88; *Kockelman v. Segal*, (1998) 61 cal.App.4th 491*; Gross v. Allen* (1994) 22 Cal.App.4th 354.

3 A therapist is not expected to be able to predict, with certainty, whether his client will commit suicide. This issue is further discussed in the section of this article entitled, "Identifying and responding to risk factors for suicide." There are numerous publications which address this issue, many of which are accessible via the EBSCO database, in the Psychology and Behavioral Sciences Collection. The EBSCO database is accessible to CAMFT members via the members-only section of the CAMFT website at www.camft.org. Use of the EBSCO database is a benefit of membership in CAMFT.

4 *Bellah v Greenson, Id.*

5 *Bellah v. Greenson, Id.*

6 The argument of the parent's on this issue was premised on their belief that they could have prevented their daughter's death, had they been informed of the fact that she was associating with heroin addicts during the time that she was in treatment.

7 *Id.*
8 *Id.*
9 *See*, *Jacoves v. United Merchandising Corp*; *Kockelman v. Segal*, *Gross v. Allen*, *Supra.*
10 A malpractice lawsuit against a health care provider is a lawsuit for negligence.
11 The standard of proof in a negligence case is preponderance of the evidence. In other words, the evidence must reflect that it was more likely than not that the defendant was negligent.
12 Black, H.C. (1990). *Black's Law Dictionary*, St. Paul MN: West.
13 Kionka, Edward, J.(1993) *Torts*, St. Paul MN: West.
14 *Bellah v.Greenson*, *Supra*.
15 Although *Bellah v. Greenson* and similar cases concern the actions of a psychiatrist, as a general rule, the basic issues related to duty of care, etc., are applicable to other mental health professionals.
16 *See Also*, *Nally v. Grace Community Church*, (1988) 47 Cal.3d 278 (no duty found where counseling was provided by pastoral counselors).
17 A legal duty is an obligation, recognized by the law, which requires a person to conform to certain standards of conduct. Black, H.C. (1990). *Black's Law Dictionary*, St. Paul MN: West
18 In the law of negligence, the standard of care is the degree of care which a reasonably prudent person should exercise in same or similar circumstances. If a person's conduct falls below such a standard, he may be liable for injuries or damages resulting from such conduct. In malpractice cases, a standard of care is applied to measure the competence of the professional. Generally speaking, a health care professional is expected to exercise the reasonable degree of skill, knowledge and care that would ordinarily be exercised by other professionals in same or similar circumstances. Black, H.C. (1990). *Black's Law Dictionary*, St. Paul MN: West
19 *Jacoves v. United Merchandising Corp*., *Supra.*
20 *Bellah v.Greenson*, *Supra*., at 620-21.
21 The issues in a negligence case which concern causation will generally involve "proximate" causation, rather than "actual" causation. Proximate causation requires foreseeability of harm.
22 *Jacoves v. United Merchandising Corp*.; *Supra*; *Bellah v. Greenson*, *Supra*.
23 *Id.*
24 I am referring to publications on the subject matter which may be found in professional journals, articles, books, etc. Much of the information utilized in this article was accessed via the EBSCO database (Psychology and Behavioral Sciences Collection) which is available to CAMFT members via the members-only section of the CAMFT website at www.camft.org.
25 "Risk-factors" are really those facts from which the therapist could reasonably conclude that his or her client was at risk of harming him or herself in the absence of preventative measures.
26 Berman, Alan, L., "Risk Management with Suicidal Patients," *Journal of Clinical Psychology in Session*, Vol. 62(2), 171-184(2006)(Published online in Wiley InterScience).
27 *Id.*
28 *See Also*, *Gross v. Allen*, *Id.* (psychiatrist liable for failure to communicate patient's high suicide risk to another psychiatrist who admitted patient to in-patient eating-disorder program where she committed suicide).
29 *See Generally*, Raue, Patrick, J., Ph.D, Brown, Ellen, L., Meyers, Barnett, S., Schulberg, Herbert, C., Ph.D, Bruce, Martha, L., Ph.D, MPH, "Does every allusion to possible suicide require the same response?" *The Journal of Family Practice*, Vol. 55, No.7, July, (2006); Overholser, James, C., Ph.D, "Treatment of Suicidal Patients: A Risk-Benefit Analysis," *Behavioral Sciences and the Law*, Vol. 13, 81-92 (1995)(Published online by Wiley InterScience); Maltsberger, John, T, "Calculated Risk Taking In the Treatment of Suicidal Patients: Ethical and Legal Problems," *Death Studies*, 18:439-452 (1994)(Taylor & Francis); Kaplan, Margaret, L., Asnis, Gregory, M., Sanderson, William, C, Keswani, Lata, De Lecuona, Juan, M, & Joseph, Sunny, "Suicide Assessment: Clinical Interview vs. Self-Report," *Journal of Clinical Psychology*, *March*, 1994, Vol. 50, No.2.
30 Much of the information utilized in this article was obtained via the EBSCO database (which is accessible to CAMFT members as a benefit of membership), on the CAMFT at website at www.camft.org.
31 *See Generally*, Bryan, Craig, J., & Rudd, M. David, "Advances in the Assessment of Suicide Risk," *Journal of Clinical Psychology in Session*, Vol. 62(2), 185-200 (2006) (Published online by Wiley InterScience); Packman, Wendy, L., J.D., Ph.D, Marlitt, Rebecca, E, B.A., Bongar, Bruce, Ph.D., & O'Connor Pennuto, Tracy, O., J.D., M.A.,"A Comprehensive and Concise Assessment of Suicide Risk," *Supra*.
32 The factors which are listed are a sample of those mentioned in the literature. They are not listed in any hierarchical order and are not intended to serve as a comprehensive list.
33 *Id.* "Severe risk," in the opinion of the evaluating clinician.
34 Brian, Craig, J. & Rudd, David, M., "Advances in the Assessment of Suicide Risk," *Supra*.

35 *Id*.
36 *Id*.
37 *Id*.
38 *Id*.
39 Brian, Craig, J. & Rudd, David, M., "Advances in the Assessment of Suicide Risk," Id.; Berman, Alan, L, "Risk Management with Suicidal Patients, *Supra*.
40 *Id*.
41 *Id*.
42 *Id*.
43 Weiss, Andrea, M.D.,"The No-Suicide Contract: Possibilities and Pitfalls," *American Journal of Psychotherapy*, Vol. 55, No. 3, 2001; Rudd, David, M, Mandrusiak, Michael, Joiner, Thomas, E., Jr., "The Case Against No-Suicide Contracts: The Commitment to Treatment Statement as a Practical Alternative," *Journal of Clinical Psychology in Session*, Vol. 62(2), 243-251 (2006)(Published online by Wiley InterScience).
44 *Id*.
45 *Id*.
46 *Id*.
47 *Id*.
48 *Id*.
49 *Id*.
50 *Id*.
51 *Id*.
52 *Id*.
53 Rudd, et.al, *Id.*
54 *Id*.
55 *Id*.
56 *Id*.
57 *Id*.
58 Calif. *Civil Code*, section 56(c).
59 *Id.*, section 56.10(c)(1).
60 It is important to reiterate here, that the facts and circumstances of a given situation are always critical factors in a determining whether or not a particular exception to confidentiality applies. CAMFT members may call one of the CAMFT staff attorneys for consultation as a benefit of membership.
61 *Id*., section 56.10(c)(19).
62 California *Evidence Code*, section 1024 also provides that there is no psychotherapist-patient privilege in circumstances where the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.