Suicide Prevention Through Social Work Intervention:

A study examining the applicability of crisis intervention theory using an ethnographic approach.

by

Diane J. Craig
BEd, BSW

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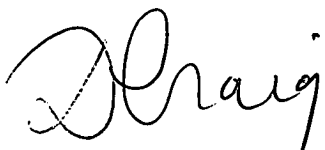

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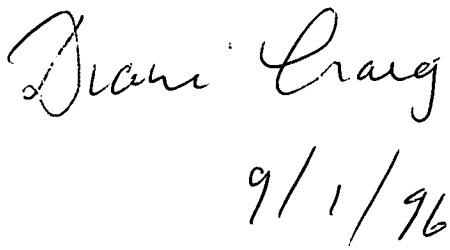

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ABSTRACT

Suicide is a concept that is socially constructed in that the intention of the deceased is inferred after the death has occurred. The implication underlying the use of the term is that such deaths are somehow problematic for society. Society therefore defines a role for professionals in the prevention of suicide. Psychologists, psychiatrists, general practitioners and nurses have written extensively on the subject and their role in the prevention of suicide is well articulated. There is a dearth of social work literature on the subject. Few studies that have researched the help-seeking behaviour of suicidal people have included visits to social workers in them and little has been written about the extent to which social workers encounter suicidal behaviour in clients or about the action they take.

This is an exploratory study which seeks to establish the extent to which social workers encounter suicidal behaviour in clients, how they assess level of risk and what kind of action they take to prevent suicide. The study aims to test out predictions about social workers' responses based on crisis intervention theory. A random sample of thirty qualified social workers who are employed in the Launceston area were interviewed. Social workers were found to lack consensus about how highly suicidal behaviour ought to be treated and differed in the action that they took to prevent it.

Social workers face a range of dilemmas about the extent to which they believe they ought to intervene to prevent a death by suicide. Just over half the sample (16 respondents) took non-directive action in that they offered choices, explored options or made suggestions and left the client to choose. The remaining 14 social workers argued that suicidal thinking is a process of constriction and this group intervened in a directive way. They acted to make the client safe and applied pressure to clients for consent for action to be taken. Dilemmas about action were particularly pronounced when the scenario involved a young adult or adolescent but action was more likely to be directive than non-directive.

The beliefs that social workers held about suicide, depression, mental illness and professional knowledge were found to determine, to a great extent, their response to clients deemed at high risk of suicide.

As a result of the findings of the study, explanations are generated for the split in opinions across the sample. A number of recommendations are made about the education of social workers and their needs in working with highly suicidal clients. Gaps that have been identified within the service delivery network in Launceston are discussed.

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CHAPTER 1

INTRODUCTION

1.1 SUICIDE JUST MEANS KILLING YOURSELF

Conventional wisdom would suggest that suicide is simply 'taking your own life'. However, a major problem with research into the extent and causes of suicide is one of definition. If suicide does mean 'taking your own life' then how do we know what the intention of a suspected suicide was. Did the young man who smashed his car into a tree die as a result of an accident or suicide? Defining the death as suicide is a social construction in that a meaning for the act will be sought by other people who will infer intention. The social meanings of suicide, the every day explanations, will affect the way the death is seen by other people (Douglas, 1967).

The definition of suicide is not a straightforward one but all definitions include the notion that there was an intent to die. Douglas (1967), for one, suggests several dimensions which are included in different combinations in all definitions. His dimensions are,

> the initiation of an act that leads to the death of the initiator; the willing of an act that leads to the death of the willer; the willing of self-destruction; the loss of will; the motivation to be dead which leads to the initiation of an act which results in death; the knowledge of an actor that actions he initiates tend to produce death (23).

Suicide is a term that has been used when there is a conscious effort to die and also when there is a lack of will to live. Some researchers apply the term suicide only when there is a deliberate act of self damage which the person committing the act could not be sure to survive (Novarra, 1979) or an intentional cessation of life (Pallikkathayil and Flood, 1992). Others including Stekel (1910) define it more bluntly as self murder (Halasz, 1992). A difficulty with the definition of suicide is that some researchers also use it to include the acts of those who are more passive in their action; for example long-term drug or alcohol abuse and refusal to comply with medical treatment (Lowenstein, 1985).

For the purposes of this study, the term suicidal behaviour is taken to include wishes or plans to take one's own life and acts of self-harm in which there is a conscious or unconscious wish to die. Attempted suicide is taken to be a form of suicidal behaviour in which there has been a conscious attempt to cause self-harm that the individual could not have been certain to survive. The definition of suicide which will be used in this research is the one proffered by Shneidman (1993). He defines suicide in this way

> Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which suicide is perceived as the best option (4).

There are a number of aspects to Shneidman's definition of suicide. He embeds his definition in a place and time. The whole meaning of a suicidal act for the person who did it and for those who witness

the event varies across time and cultures. The use of the word conscious means that the individual has some awareness about his or her action, and the word annihilation means that the intent is to reach a permanent state of cessation of consciousness. Deaths which result from long-term alcohol abuse for example, may have had a subintentional quality to them but would not be included in this definition of suicide. This definition also encompasses the way that the term suicide is used to refer to both the person who commits the act and to the act of annihilation itself. Further to this, the reason for suicide is suggested within the definition. Suicide is conceptualised as a solution that some individuals use for their problems.

1.2 SIGNIFICANCE OF THE RESEARCH TOPIC

The research topic is related to the practical problem of the prevention of suicide and is timely because of community concern about the disturbing trends in increased youth suicide. One way that suicide can be prevented is through the timely intervention of professionals and appropriate treatment. The results of this study will identify the extent to which social workers come into contact with suicidal individuals in their practice and will examine the action they take in the light of the recommended management written in the research literature. Results of this study will identify how the training of social workers can be improved so as to enhance their skills in the identification and reduction of suicidal risk in clients.

1.3 RESEARCH QUESTIONS

There is extensive information about assessment of suicidal risk and the management of suicidal behaviour. However, there is a dearth of social work literature on the topic. Most of the information has been contributed by members of the medical profession and psychologists, who suggest that non-psychiatric professionals often fail to identify suicidal individuals (Kreitmen, 1986; Lowenstein, 1985).

This is an exploratory study that will focus on the initial response of social workers to the suicidal crisis rather than on long-term interventions. There are two main phases in the management of the behaviour of highly lethal individuals. There is the initial phase which is aimed primarily at keeping the person alive and involves the employment of crisis intervention principles (Shneidman, 1993). When the level of risk has been reduced then long-term psycho-therapeutic interventions are begun. The emphasis is upon the first phase, responding to the suicidal crisis, because it is the most important. If the suicidal individual does not survive then there is no second phase of treatment.

This research aims to describe the extent to which social workers encounter suicidal behaviour in clients, how they assess level of risk and what kind of action they take. More specifically, in the light of our knowledge about suicide and suicidal behaviour:

1 how social workers decide the level of suicidal risk will be appraised;

2 the initial steps taken by social workers to prevent a potential suicide will be compared with the model suggested in the research literature; and

3 problems preventing the effective management of suicidal behaviour will be identified.

1.4 DESIGN AND LIMITATIONS OF THE STUDY

Little research has been carried out about how social workers conceptualise suicidal behaviour and the action they take in the context of their agencies in dealing with a suicidal client. How one defines the act will determine the action one takes. Exploratory discussions with colleagues suggested that social workers do not have an agreed definition of suicide. An intention of this research was to understand how ideas about suicide were linked to the action that would be taken. In order to understand the connection between ideas and action I decided that I needed a research design that would allow for the gathering of rich, contextual data while at the same time allowing flexibility to explore issues as they arose. Appendix B includes an interview schedule which illustrates the complexity of the data being received in answer to my questions. The schedule includes a number of probing questions I used to clarify and explore issues.

In the light of these aims I decided that a semi-structured questionnaire would protect the larger structure and objectives of the interview. Structured questions would enable me to cover the same terrain for each respondent, establish channels for direction

and scope of the questioning while at the same time allowing within the questions, scope for exploratory, unstructured responses.

I also recognised that collecting data through semi-structured interviews had its limitations. Launceston is a small city with 56 known social workers. The amount of data that could be collected and reported had to be weighed against concerns about the privacy of participants. Many of the people I would be interviewing would be colleagues and friends and I was unsure how this would affect the quality of the data I would receive. Given that I was a social worker interviewing other social workers there was a danger of 'over-rapport' and I needed to maintain an unambiguous social distance for the purposes of the interview.

I also wanted to collect data that were representative of the views of all social workers in this city. For this reason the sample of social workers was made by random selection. My hunch was that years of experience, the age and gender of respondents as well as the agency in which they were employed would impact upon the ideas that they had and the action they would take when counselling a suicidal client. It was important that the sample be large enough to assess the impact of all these variables upon action. In deciding to interview 30 social workers out of a total of 56, I believed that I would get a fair representation of views while being able to consider the impact that the above variables may have had upon the results.

Because the participants were all from the Launceston area, statistical inferences cannot be made to other areas in the state or country. However, Launceston is a city that is similar in many respects to

other urban areas of Australia (See Section 1.4.5) and many of the findings in this report about the problems social workers have in defining and preventing suicide are generalisable.

1.5 PARTICIPANTS IN THE STUDY

A comprehensive list of qualified (Bachelor of Social Work degree) social workers practising in Launceston was obtained from the Department of Social Work at the University of Tasmania. From this the names of social workers who were employed within the 003 area was selected. These names were then listed. (The names were written on slips of paper and drawn from an envelope. The names were then ranked in the order they were selected.)

Of the 56 names listed, the first 30 were selected as the sample to be interviewed. There were no refusals from those invited to participate in the research project. One social worker was unable to participate as she was on sick leave during the interview period. She was replaced by the social worker who was number thirty-one on the original list.

1.6 MATERIALS

A letter was sent to each member of the sample outlining the research project (see Appendix A). This was then followed up within two weeks, by a telephone call inviting the social worker to participate in a research interview.

A semi-structured interview schedule was prepared and used in each interview (see Appendix B). Pre-testing (discussed in section 1.4.3) led to a number of refinements of the original instrument.

Each interview was audio-recorded with the use of an unobtrusive cassette recorder after explicit permission was obtained from each participating social worker (see Appendix C). Interviews were later transcribed word for word by the researcher. The purpose of verbatim copying was to enhance data analysis and avoid making assumptions about the respondents' answers.

The decision was made to record the interviews for several reasons. The recording allowed for more flexibility within the interview and permitted the researcher to pursue points of interest outside the structured questions. It was considered that note taking would be an unnecessary distraction.

1.7 PROCEDURE

The interview schedule was prepared and received ethical approval from the Social Science Ethics Committee at the University of Tasmania. It was pre-tested upon social workers who were not employed within the Launceston area. During the first two trials it became apparent that the subject of suicide is an emotive one and that the interviewer needed to be more directive. The indication of these pre-tests was that social workers may not receive enough support themselves to deal with their responses in the aftermath of the suicide of a client. The interview itself, could be side-tracked if

respondents used it as an opportunity to debrief. These pre-tests also demonstrated that relevant questions had been excluded and that the order of questions needed to be changed.

The questionnaire was rewritten and a new procedure outlined in detail to participants in further pre-tests. It was explained to participants that the interview could result in personal and professional questioning for them and that in the interview, the focus would be upon questions related directly to the schedule. At the conclusion of the interview, time would be allowed to explore any personal issues or other questions that had arisen during the interview if the social worker being interviewed so wished.

The 30 social workers who had been selected as the sample to be interviewed were sent letters explaining the project. (The letters were not sent in one batch but were posted out in small groups over a four-week period.) After each letter was sent, it was followed up by a telephone call which invited participation in the project.

On average, five social workers were interviewed each week, over a six-week period.

To maintain confidentiality all names of participants have been changed in the report.

Analysis of the interviews was facilitated through the use of a software package called NUDIST 2.3. NUDIST is an acronym which stands for "Non-numerical Unstructured data Indexing, Searching and Theorising". It is a software system for managing, organising

and supporting research that requires qualitative data analysis (Richards and Richards, 1991). NUDIST 2.3 like many other software packages that have been developed for the handling of qualitative data is based upon a code and retrieve facility, which enables the user to organise, create and manipulate hierarchically-linked concepts.

A vast quantity of data had been collected in the form of interview transcripts. For the purposes of analysis, the data were organised into a system of categories and sub-categories. The organisation of data into groups or categories is conceptually the same as the methods used by qualitative researchers in pre-computer days. In the past, researchers developed a hang-file system into which they 'dropped' the text segments that were appropriate to the file or category they had created. NUDIST 2.3 enables the researcher to create these files on computer. As a result the data is more easily organised and managed.

The system of categories for this project was built in a series of steps. Prior theory gathered from the literature review gave me some ideas about information I was seeking; for example, how social workers assess level of risk, the action they take and problems encountered by them in the referral process.

Each transcript was thoroughly examined. On a sentence by sentence basis a label was given to the information contained within it. For example, the following comments in one interview were labelled as 'suicide as a choice' (node 3 3 1 1), 'worker impact' (node 2 6) and 'social work role' (node 3 4). (See Appendix D).

> I think it (the right to suicide) is their responsibility. That's how I deal with it for my own well-being and their well-being. It's their life and they can suicide if they want to but it is my responsibility as a worker to check out what the issue is.

At the end of several interviews many such labels had been generated. I needed at this stage to begin to sort the labels into a conceptual framework that would enable analysis of patterns at a later stage.

I began by sorting out what I considered to be descriptive data and placed these into a file, or in Nudist terminology, a 'tree' of their own. In Nudist 2.3 each tree can then be divided into a series of branches or 'nodes'. These nodes can be either simply listed, or organised into hierarchical trees of broad categories and sub-categories. The 'base data tree' held information about the age of the interviewee, years of experience, the type of agency, gender, client group and so on (see Appendix D).

The other concepts that had been identified and labelled at this stage of the coding process were sorted into the broad groups of 'experiences', 'ideas' and 'action'. These groups of concepts basically distinguished between what respondents had experienced, what they believed and what they did.

From this an early indexing system was begun that underwent numerous modifications and reshaping as more interviews were coded. Using the labels generated from the transcripts, the 'ideas' group for example, was organised into categories by sorting out what

topics social workers had expressed ideas about. These included ideas about mental illness, drug use, depression, suicidal behaviour, the causes of suicide, the managment of suicidal behaviour and values. Sections of text appropriate to each category were then indexed at the relevant node. Where the same section of text was appropriate for two or more categories it was indexed at all the relevant categories and then cross-referenced. The Nudist program cross-references text automatically.

When all the interviews had been indexed, the content of the categories was examined and separated into sub-categories. The sub-categories were specialisations in some sense of the parent concept. For example, one of the categories within the action tree was 'constraints' (See Appendix D). The text indexed at this point concerned a number of different types of constraints that social workers had discussed as inhibiting their preferred management of suicidal people. After examination of the text segments located in the 'constraints' category, I sub-divided these according to the source of the constraint, that is agency, client or worker. These sub-categories were then further sorted into more specific groups as illustrated in Appendix D.

The software enabled me to shift various nodes around the system so that they fitted logically into the emerging index system. This was a lengthy process because it was not merely a clerical exercise but involved theoretical considerations. For example after a number of interviews had been indexed, it became apparent that some social workers considered that depression could be mental illness and others did not. Initially I had placed ideas about depression as a sub-

category of ideas about mental illness. When interviewees did not define depression as a mental illness the ordering of the categories did not represent their beliefs accurately. Ideas about depression were then transferred into a category of their own with a sub-category that included beliefs about the relationship between mental illness and depression.

The process of moving depression away from its position under mental illness, then raised a number of questions in my own mind about the relationship between social workers' beliefs about depression and the action they took when they encountered a suicidal client who was depressed. This then became a question that I took to the data during the next stage of the process of data handling- that of data analysis.

When all the interviews had been indexed I was then able to build new nodes for the purposes of analysis. The basic analysis tools of the Nudist program are Boolean ones which search for intersection, union and negation of indexed text. An illustration of this process is the way that I determined that beliefs about rationality were linked with action taken. I selected the node 'suicide as a choice' (having collected sub-categories) which contained all references that had been made to the idea that highly suicidal people could be rational in their decision to die. I was able to use cross-references in the base data tree to identify the agency type, years of experience and other descriptive data of this group of social workers. Using intersection commands I was able to select only this group of social workers and find out what they believed about mental illness, what their experiences of suicide had been and what action they took when

confronted by a suicidal client. This information was then stored at a new 'working' node and compared with information about social workers who had stated that suicide by definition is irrational behaviour.

At times, some of the 'sub-sub-categories' I had developed during the initial indexing of documents were not helpful for the purposes of analysis. When this happened a 'collect' option allowed me to gather up the text indexed at this level and either recode it into more meaningful groupings without losing any data or use the collected information as a whole for analysis.

I continued the analysis until I was confident that the conclusions I was drawing could be checked and verified and that all deviant cases had been accounted for.

Building an index system is a challenging process. Richards and Richards (1994) warn of the futility of aiming for the perfect index system. They suggest that knowing when to stop refining the system is an important skill in qualitative research. Richards and Richards advise that, "the process of index construction should stop when the index system either has the nodes to ask the questions for which answers are required, or has the nodes to build them" (1994, 15).

After the index system had undergone considerable refinement, I was aware of some short-comings of the index system I had developed. However using the guidelines of Richards et al. (1994) as my rule of thumb, I had developed a system of nodes that enabled me to find answers to the questions I was asking of the data.

Although numerous textbooks were consulted for ideas about coding, indexing and theorising procedures I wish to acknowledge my three main sources of information. These were Strauss and Corbin (1990), Richards and Simon (1993) and Richards and Richards (1991).

1.8 DESCRIPTION OF THE SAMPLE

Of the 30 social workers who were interviewed, five were male and 25 female. Information about age was collected in age ranges from 21-30 years, 31-40 years, 41-50 years and over 50 years of age. Eighty-three percent of the sample were aged between 31 and 50 years. Only four social workers were aged 30 years or less and one social worker was in the 50 plus age group. Fifty percent of the sample were aged 31 to 40 years and a further 33% were aged between 41 and 50 years.

The social work experience of those interviewed ranged from 1 year to 25 years, with a mean of 8.8 years and a standard deviation of 7.2 years. The distribution of years of social work experience was positively skewed. Most of those in the sample (69%) had been employed as social workers between 1.5 and 16 years but over half of them (54%) had only graduated within three years.

The time spent in face-to-face contact with clients varied across the sample from five to forty hours each week, with the mean being 19.2 hours. Most of the social workers (69%) spent between 11.3 and 27.1 hours in direct client contact each week. The amount of time that

social workers spent in contact with clients was consistent over a range of agencies including hospitals, welfare agencies, community centres, schools and counselling services. However there was considerable difference in the extent to which social workers were able to engage in long-term follow-up of clients and this varied according to the type of agency in which they worked. Social workers in counselling agencies (33%) and those employed in the Launceston General Hospital in both generalist and psychiatric social work positions (23%) were more likely to have long-term contact with clients who sought assistance from the agency. Social workers in government welfare agencies such as the Department of Social Security (20%) were unlikely to have more than one or two sessions with an individual client.

1.9 DESCRIPTION OF THE AREA

Launceston is the second largest city in the state of Tasmania. The city is situated in the north of the state at the mouth of the Tamar River. The 1991 census indicated that almost 470,000 people reside in Tasmania, with 64,000 people living in the city of Launceston. Data from the 1986 census indicate that Launceston is a city that is similar in many respects to other provincial cities in Australia. Persons aged 65 years and over comprised 12.55% of Launceston's population compared with 10.65% elsewhere in Tasmania and Australia at 10.55%. There was a comparatively low sex ratio of .934 in the city's population with 107 females for every 100 males. The ratio for Australia was .99 with 101 females for every 100 males. Launceston had a slightly slower population growth (0.53% for the

period 1981-86) than Australia overall which was 0.89% for the same time period (Hanson, 1989).

Family structure and family breakdown in Launceston parallel national trends. Separation or divorce increased from 1981-86 at an average annual rate of 6.42% which was consistent with Australian trends. The proportion of lone-person households had increased by 1986 and those households comprised 21.37% of all dwellings in Launceston. The national percentage for lone-person households was 18.53 (Hanson, 1989).

The proportion of persons born overseas (not including UK or Ireland) is low compared with the national figures. In Launceston 5.67% of the total population were migrants whereas the Australian percentage was 15.5.

The rate of unemployment in Launceston in 1986 was 9.93% compared with 9.24% in Australia. Hanson (1989) draws the conclusion that in terms of function, role and employment opportunities Launceston is better placed in many respects than some equivalent mainland cities because it duplicates many higher order regional service functions. He argues that Launceston compares well with larger city centres in Australia such as Townsville, Geelong and Newcastle.

1.10 SUMMARY OF CONTENTS OF REMAINING CHAPTERS

Chapter Two outlines the statistical information about the completed suicide and attempted suicide rates. The difficulties in gaining accurate information are pointed out with the conclusion being that the suicide rate is inaccurate and is known to underestimate the extent of the phenomenon. Chapter Three looks at the causes of suicide from both structure and agency perspectives and suggests that in order to be understood, suicide must be seen as a multidimensional event, incorporating a range of theoretical perspectives. It follows then, that if suicide is a multidimensional malaise prevention of suicide will also have a number of facets to it. Chapter Four discusses the relationship between attempted suicide and completed suicide and using the literature, details a model of treatment for highly suicidal people based on crisis intervention theory.

The model of treatment recommended in the literature is then compared with the action taken by social workers in Launceston. Chapter Five explains the present study and its aims in light of research literature on the topic and in particular the theoretical framework of crisis intervention. Chapter Six outlines the extent to which social workers deal with suicidal people and the level of lethality they encounter in clients while Chapter Seven discusses the responses of social workers to suicidal clients. The responses of social workers were found largely to depend upon the ideas they held about suicidal behaviour, mental illness and their own role in the prevention of suicide. Chapter Eight analyses why some social workers responded to highly lethal clients in a way that was

consistent with the recommended treatment and others did not. Social workers were prevented in several ways from managing suicidal behaviour in an optimal manner. These are detailed in Chapter Nine.

Chapter Ten discusses the main findings. This chapter also includes a review of social constructionism because some of the results of this study had not been predicted in the research literature. Social constructionism is applied to these findings. The thesis concludes with a series of recommendations in the Eleventh Chapter.

CHAPTER 2

WHAT FACTS ABOUT SUICIDE?

2.1 COMPLETED SUICIDE

'The suicide rate' is written about as a fact; a measured and recorded indicator of the number of deaths that have occurred as a result of self-inflicted death in a particular time period. Given the difficulties involved in arriving at a definition of suicide and the subsequent problems in deciding when a death ought to be considered a suicide, it is no surprise to find that statistics about the rate of suicide are generally assumed to be inaccurate.

The statistics on suicide are thought to underestimate the real numbers of both completed and attempted suicides and are in fact, misleadingly low (Lowenstein, 1985). Estimates are that they are a quarter to a half as big again (Alvarez, 1971). There are a number of reasons which contribute to the under-estimation. Many suicides go unreported or unidentified and a number are purposely misclassified as accidents (Douglas, 1967). The coroner may err on the side of caution and not identify a suicide as such without substantial evidence. Miller (1979) reported that suicide amongst the elderly is often under-reported because in many cases deaths among this age group arouse little curiosity. Often it is in the financial or emotional interests of the family that a suicide be not recorded as such and as a consequence many coroners only record a suicide in the presence of a note or other direct evidence (Lowenstein, 1985).

Hassan and Carr (1989) say that the official suicide rate in Australia has remained relatively stable at about 11 per 100,000 people over the past 100 years with some fluctuations in the intervening years. The highest female rate of suicide recorded was 10.8 per 100,000 in 1965. This compares with the highest male rate of 24.0 per 100,000 in 1930 and the lowest male rate of 9.9 in 1944. The stability of the rate masks a number of changes within the population of people who suicide. In the 1880s there was a male to female ratio for suicide of five to one (Hassan and Carr, 1989). Statistics in the 1980s indicate that the ratio was three male to every one female (Hassan and Carr, 1989). However any conclusions about the male to female ratio must be drawn with caution. The most recent statistics available from the Australian Bureau of Statistics indicate that in 1992 1,820 males committed suicide compared to 474 females. This is a ratio of almost four males to every female. Data from the National Social Health Database (HealthWIZ, 1992) indicate that across age ranges, men were three to five times more likely to suicide than females (See Table 1).

Table 1: Suicide deaths for 1985-1989, numbers and direct age standardized rate (per 100 000), Australia

	Numbers		Rates		
Age	Males	Females	Males	Females	M/F Ratio
0-14	42	8	0.5	0.1	5.0
15-34	3589	736	27.3	5.8	4.8
35-49	1466	410	26	7.5	3.5
50-64	1909	656	25.5	8.9	2.9
65-74	663	242	28.6	8.7	3.3
75+	451	170	39.3	8.6	4.6
Total	8120	2222	21.3	5.6	3.8

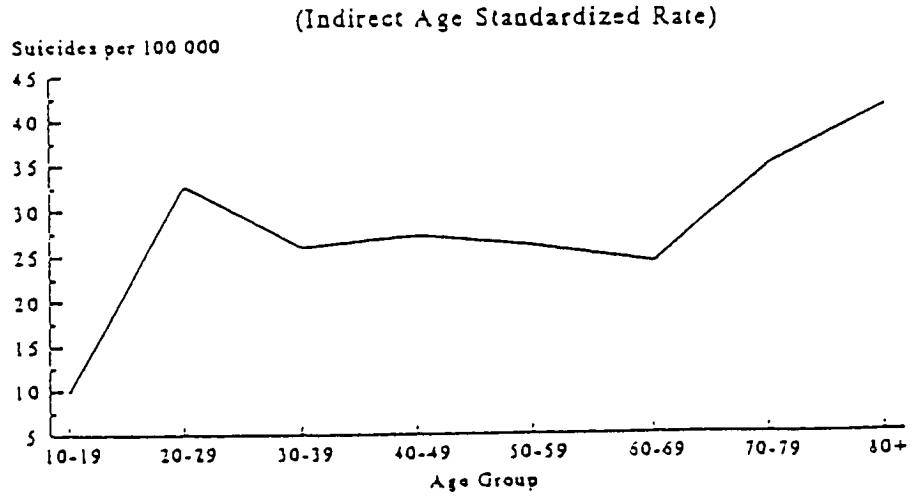
An indicator of the lack of reliability of official suicide statistics is a study conducted by Renwick, Olsen, and Tyrrell (1992). Their findings suggest that the real male to female ratio for completed suicide may be lower than the statistics indicate. In their study of 376 inquests in the New England region of New South Wales 53 deaths were recorded as suicides giving a male rate of 15.6 per 100,000 and female at 6.3. The male to female ratio was measured at 2.5 to 1.

Although the overall suicide rate is reported to have remained relatively stable there have been dramatic changes in the ages of those who are killing themselves. Like Canada, the United States and New Zealand, Australia now has a high rate of youth suicide and a relatively uniform distribution across all age groups over the age of twenty, if female and male deaths are grouped together (Cantor, 1992). In the past, age and risk of suicide were highly correlated, with suicide being primarily a problem in the older age groups. Hassan and Carr found that in 1961 there were four suicides by people aged over fifty for every single suicide under 25.

By 1984 this picture had changed significantly. "Suicide has increasingly slipped into the younger age groups so that there is little difference in the various age categories above twenty years" (Hassan and Carr, 1989, 230). The suicide rate had fallen in the older age groups, particularly for men, but for young men the reverse was the case. For men aged 20 to 24 years the rate had doubled and for adolescent males aged from fifteen to nineteen years there had been an increase from 6 per 100,000 in 1961 to 16.6 per 100,000 in 1985. The exception to the lowering rate in older age groups, appears to be among very old men aged 85 and over who have recorded a rise

from 37 to 51 per 100,000 in the years between 1980 and 1985. The rate for elderly women aged 70 and above also increased but peaked between the ages of 70 and 79 and then showed a decline in the older age group (Hassan and Carr, 1989). The high rate for elderly men contradicts the statement that there is little difference in the age categories above twenty years. Figure 1 which uses data from the National Social Health Database (HealthWIZ, 1992) shows the male suicide rate by age for 1985-1989 and illustrates the high rate of suicide amongst elderly men in Australia.

Figure 1: Male Suicide Rate by Age



Hassan and Carr (1989) report a gradual increase in female rates of completed suicide among women aged 15 to 25 years with a rate of 3.6 per 100,000 in 1985. However, it should also be noted that Hassan and Tan (1992) report that although the female suicide rate in Australia rose steadily between 1901 and 1965 the overall suicide rate for females has been falling since then. This information suggests that the drop in the overall female suicide rate masks an increase in suicide among younger females.

The rise in suicide amongst young males appears to be still increasing. By 1989 the rate for males aged 15 to 24 years was reported to be 24 per 100,000 (Graham and Burvill, 1992). Graham and Burvill claim that by 1989 suicide was the cause of death of one in five Australian males aged 15 to 24 years. Suicides of men aged under 30 years outweigh female suicides at a ratio of 5 to 1 and Australia now has the second highest rate in the world for young men of this age group (Cantor, 1992). Like Hassan and Carr (1989), Graham and Burvill (1992) say that in the past decade male suicide rates in all age groups above 35 years have been decreasing. By 1988 there was one teenage suicide every 47 hours in Australia (Hassan, 1992).

A similar increase to that reported for young Australian males has been reported in other English speaking countries. Lowenstein (1985) reported that in the U.S. there is a critical epidemic of suicide among adolescents and young adults with the rate tripling in the past 25 years.

Because hospitals and prisons accommodate people in high risk groups for suicide, the rate is often higher in them than in the wider community. Pokorny (1983) reported high rates of suicide in psychiatric hospitals in the U.S. at 279 per 100,000. Grippin and Graff (1989) found in a review of the literature that 10 times more deaths by suicide occur in general hospitals in non-psychiatric services than in psychiatric units.

Suicide rates in American and Canadian prisons have been estimated at between three to sixteen times greater than the rate for the general population (Esparza 1973; Hayes, 1983, cited in Hatty, 1988). In an Australian study Hurley (1989) using records of deaths at Brisbane Prison over a fifteen-year period found that 45% of the deaths were by suicide, based on an average daily population of 501 male prisoners. Hurley calculated the suicide rate at the prison to be 266 per 100,000. His findings are consistent with the rather wide-ranging estimates cited in Hatty (1988). Using the average male rate in Australia for 1985-1989 of 21.3 (Table 1) Hurley's calculation of a rate of 266 per 100,000 is 12.5 times higher than the average male rate.

Hatty notes however, that statistics used in studies about suicides in prison have been largely unreliable because the researcher does not know how the statistics were gathered and has no way of estimating their accuracy (1988, 186). Coronial reports and the submissions of Boards of Inquiry "are oriented more towards the exoneration of correctional personnel than toward the explanation of suicide" (Burtch and Ericson, 1979 cited in Hatty, 1988, 187).

Information from the Australian Bureau of Statistics shows that in 1992, 96 people were recorded as dying by suicide in Tasmania. With a population of 470,000 this means that the rate of suicide was higher in Tasmania than in the rest of the country. One in 5,000 people died by suicide in Tasmania.

The difficulty of obtaining accurate statistics about the extent of suicide is illustrated by a suicide profile of Tasmanian data produced

at the Government Analyst Laboratory in Hobart. This profile shows that according to the coroner's records (which are also the source of information for the Australian Bureau of Statistics) in 1992 in Tasmania 120 people died "by their own hand" (Ryall, 1993, 1). The coroner later decided that insufficient evidence existed to find a verdict of suicide in some of these deaths and consequently the number was reduced from 120 to 96. This example shows how difficult it is to be precise about the actual suicide rate. One in five cases of suspected suicide were dismissed which is an error margin between the two sets of figures of 20%. In addition it should be remembered that many 'accidents' which are not suspected of being suicides are not included in these figures.

Of the 120 people who died by their own hand in Tasmania in 1992 93 of them were males and 27 were females. Most of these people were aged 35 or less. Of the 120 who committed suicide, 13 were aged between 16 and 20, 21 were aged between the years of 21 and 25, 14 between 26 and 30, and 14 between 31 and 35, a total of 72 aged 35 or less. Forty of these people were located in the 003 area of Tasmania and given that the 003 region has 27% of the population of Tasmania the suicide rate in the Launceston area was slightly larger than the Tasmanian rate. The more conservative ABS figures show that one-fourth (24 out of 96) of the deaths by suicide in this state were in the 15-24 age group. Thirty-eight out of the 96 deaths by suicide were in the 25-38 age group.

The 96 deaths represent an increase of almost 43% on the previous year with very little increase in the state population for the same year. In 1991, 67 people died by suicide in Tasmania and this is

typical of the rate for suicide over the previous five years and consistent with the national rate. Figures for 1993 are not yet available but until they are it is not possible to see whether the 1992 figures are an aberration or part of an increasing trend of suicide in Tasmania.

2.2 ATTEMPTED SUICIDE

Attempted suicide is particularly difficult to measure accurately. Once again the definition is problematic. At what level of intention to die is an act to be deemed an attempt at suicide? A further problem with determining the attempted suicide rate is that it is usually measured according to information from hospital admissions and as such does not record the total phenomenon in the community (Lindsay, 1978). Statistics regarding the number of people who attempt suicide vary considerably. De Braga (1989) concluded from a review of recent literature that the ratio of actual attempted suicide to the reported level could be anything from 50 to one through to 300 to 1. Hawton and Catalin (1982) in a UK study proffer lower figures. They suggest that the ratio between attempted suicide and completed suicide is 10.8 to 1, with a ratio for women (14 to 1) being almost double that of men (7.7 to 1).

There is little information about those who remain undetected after a suicide attempt. Davis and Kosky (1991) surveyed all patients who presented at the Royal Adelaide Hospital over a two-year period (1986 to 1987) and then compared their findings with the official figures for the hospital. They found that from 1986 to 1987, between one-fifth and one-third of persons who attempted suicide were not

recorded in the statistical division of the hospital. In 1988 two-thirds were not recorded. Their findings suggest that official rates for attempted suicide greatly underestimate the extent of the phenomenon. They estimated that the real rate for males in Adelaide was 180 per 100,000 compared with the official rate of 108 per 100,000. For females the estimated real rate was 250 per 100,000 compared with the official rate of 156 per 100,000.

It is generally assumed that the female to male ratio for attempted suicide is three to one (Hill, Murray and Thorley, 1986). Davis and Kosky (1991) cite a claim in a recent edition of *Synopsis of Psychiatry* which states that "women are four times as likely to attempt suicide as are men" (Kaplan and Sadock, 1988). The findings of Davis and Kosky (1991) indicate a lower ratio. They investigated the changes in the age and sex distributions of people who attempted suicide in Perth over a fifteen-year period from 1971 to 1987. They found that the rate of attempted suicide for males increased from 93 per 100,000 to 137 per 100,000. Most striking in their results was the increase of suicide in the age groups 15 to 19 years and 39 to 44 years. The rate for females decreased from 214 in 1971 to 195 per 100,000 in 1987. Their conclusions were that the 47% rise among males and 9% fall among females suggests that attempted suicide is no longer a behaviour more associated with women than men because the female to male ratio in 1987 was 1.4 to 1. "It is almost as common among males as females" (Davis and Kosky, 1991, 668). They found a similar ratio in Adelaide at 1.3 to 1. The findings of Davis and Kosky are important in that they do challenge the conventional view that female rates of attempted suicide are much higher than male rates, although the finding of 1.4 to 1 and the conclusion that attempted

suicide is almost as common among men as among women is somewhat debatable. Women are still attempting suicide 40% more often than men.

In conclusion, it is somewhat misleading to talk about a suicide rate or attempted suicide rate with any certainty. Given that completed suicide has a very low base rate and that we know official rates underestimate the phenomenon any conclusions about trends must be drawn cautiously. Attempted suicide is a behaviour that likewise suffers problems of definition and measurement.

CHAPTER 3

PRIVATE TROUBLES OR PUBLIC ISSUES?

In the introduction to this thesis the notion of suicide as a socially constructed phenomenon was briefly discussed. This is a crucial concept because differences in theoretical perspectives and problems in the measurement of the phenomenon of suicide can be directly related to a lack of agreed definition about what suicide is. In the definition fo suicide that was quoted earlier, Shneidman (1993) began by locating his definition in a time and place, "Currently in the Western world...". In doing this he is in effect saying that the meaning of the suicidal act changes across time and culture. The concept is not fixed.

How suicide is defined will determine any action to prevent it. When social workers in this study were asked about the course of action they ought to take when faced by an acutely suicidal client there was a lack of consensus amongst members of the profession. Their own notions of the causes of suicide were reflected against a backdrop of understanding about their own role, their responsibility towards a client, attitudes towards other 'ways of knowing' such as psychiatry, and the 'right' to suicide. These understandings are explored in Chapters Six through Nine of this thesis.

In order to understand why particular forms of management are recommended for suicidal people some overview of the causes of suicide is warranted. Theories about the causes of suicide tend to fall into two categories. They either emphasise the structural factors underlying individual behaviour or concentrate on the

characteristics of the individual who commits suicide. These will be discussed and compared.

3.1 STRUCTURAL EXPLANATIONS OF SUICIDE

Structural explanations of suicidal behaviour intimate social factors as the cause. Such theories view suicide as understandable given the position in life and the life situation of some individuals. Durkheim (1951(1897)) was the original proponent of a sociological theory of suicide. He identified a relationship between the suicide rate of a nation and the level of integration of individuals within it.

Durkheim grouped the causes of suicide as either altruistic, egoistic, anomic or fatalistic. Altruistic and fatalistic suicide were thought to have occurred as a result of an over-integration of the individual into society. Altruistic suicide was identified as being motivated by the wish to benefit others or to free them from burden. Such a person would be the elderly chronically ill person who does not want to be a burden on the family. Compliance with powerful social obligation, such as the ritual suicide occurring in Japan earlier this century, is also considered to be within the altruistic category.

Egoistic and anomic suicide were seen by Durkheim as resulting from an under-integration of the individual into society. Egoistic suicide applies when the individual cuts ties from others as a result of his/her own conduct. The isolation of the person with mental illness is an example. Anomic suicide occurs when the individual is isolated from others because of a societal structure which prevents the maintenance of social bonds between people. Unstable

populations in urban centres, for example, cause this kind of isolation.

Modern sociological theory has built upon the ideas of Durkheim in which the actions of individuals are explained as being a function of structural causes. The data that we have about suicide suggest that more men die by their own hand than women and that over the past century the male-to-female ratio has decreased.

A number of reasons have been suggested for the changes in the reported male-to-female ratio of suicide, over the past one hundred years and sociological theory has linked it to modernisation and women's emancipation. Hassan and Tan (1992) found a positive relationship between these two factors and suicide. They used an index to measure women's emancipation which comprised the female participation rate in the labour force, the urbanisation rate, the female-to-male education ratio and the female-to-male employment ratio. They found that women's emancipation was positively related to the male-female suicide ratio.

There is by no means a consensus on this finding. Krupinsky (1976) queried the link that some researchers had made between urbanisation, the female role and suicide rate amongst women. He found no significant relationship and contends that it is easy to find statistics in support of a range of sociological theories and that it is equally easy to find data which will reject them.

One explanation for the increased suicide rate of women could be that as women participated more in the work force their public

visibility increased which had the effect of increasing the difficulties faced by families who wanted to conceal the death by suicide (Hassan and Tan, 1992). Krupinsky (1976) attributes the increase in deaths amongst women over the years to the availability and usage of sedatives. Women use less lethal methods than men in their suicide attempts: the preferred method of women is drug overdose while most men who complete suicide use methods such as hanging, firearms, inhalation of car fumes and jumping from heights (Pallikkathayil and Flood, 1992; Roy, 1986; Miller, 1979).

The availability of sedatives could be expected to impact upon female rates because ingestion of drugs is the preferred method of suicide. This is supported by data which indicate that the rate of female suicide peaked in 1965 two years after which the pharmaceutical provisions in the National Health Act, which restricted the availability of a number of sedatives, were changed. There was a marked fall in female deaths by suicide from the mid-1960s onwards (Hassan and Tan, 1992). The fall in completed suicides amongst women must also be in part attributable to advances in intensive care technology which means that there is an increased chance of rescue and resuscitation for those who attempt suicide by drug overdose.

Lack of availability of a particular means of suicide may not have the same effect upon the male suicide rate as men tend to choose from a variety of lethal methods. A number of studies show that there is a strong relationship between gun ownership and suicide by guns (Goldney, 1992 b). Lester (1990 cited in Goldney, 1992 b) found, in a comprehensive review of these studies, that although the

availability of firearms was positively associated with suicide using firearms, it was negatively associated with the rate using other methods. That is, when firearms were not available, people tended to choose other lethal methods so that the suicide rate remained the same (Lester, 1990 cited in Goldney, 1992 b).

Unemployment is one factor which is considered to contribute to the increased level of suicide in certain age groups. Hassan (1992) found that over the past 30 years there has been a six-fold increase in unemployment among 15 to 19 year olds and a concurrent 50% rise in suicide. During the same time period those aged 20-24 years have faced a four-fold increase in unemployment and corresponding 86% rise in suicide for the same age group. Hassan (1992) noted that the increased unemployment level applies to both males and females but it is males who have reflected the increase in their suicide rate. She suggests that prolonged unemployment is associated with low self-esteem and insecurity but that unemployment may affect the two genders differently, with women perhaps being able to find meaningful activities within the domestic domain (Hassan, 1992, 6).

Long-term unemployment has more consequences for the individual than boredom and low income. Payment for work provides for the necessities of life but is also the primary source of personal satisfaction, social status, freedom and access to leisure activities. The unemployed are relegated to the status of non-citizens (Graycar and Jamrozik, 1989). It may be, as Hassan (1992) suggests, that women are able to find a source of status in unpaid employment more readily than men.

Employment is a sign of social integration and it has been found that the suicide rate generally reflects the quality of social relations in a population (Renwick, Olsen and Tyrrell, 1982). Renwick et al. were able to draw this conclusion after a comparison of coroners' findings in rural and metropolitan areas of New South Wales. Although lack of status may not contribute to suicide in women as much as men, the isolation of domestic duties could be a cause of suicide in women. Renwick et al. found that women aged 50 to 64 years in the rural New England region of New South Wales were more than twice as likely to commit suicide as their counterparts throughout the rest of the state. Eighty percent of the women had been listed as having an occupation of domestic duties.

However the linking of the suicide rate with employment status is a matter of correlation not causation. Given our incomplete knowledge about the extent of suicide and the low base rate of suicide, it may be that the connection between the two factors is a spurious one.

Data from the National Social Health Database (HealthWIZ, 1992) indicate that unemployment or not being in the labour force is a factor in relatively few male suicides. Many employed men commit suicide. Marital status, which is also an indication of both social support and social integration (Durkheim, 1951, 270) is an important variable to consider (See Figure 2, p. 35).

Structural explanations have also been generated about the high rate of suicide among the elderly. Portwood (1978) asserts that the elderly face certain problems more than other groups in society and for a

number of them there is a fear of prolonged life when the quality of life is no longer as the person wishes. Hassan and Carr (1989) concur with Portwood. They suggest that among the elderly economic, health and social problems can reach an unbearable level so that acts of suicide which are "planned and rational" result (p 230).

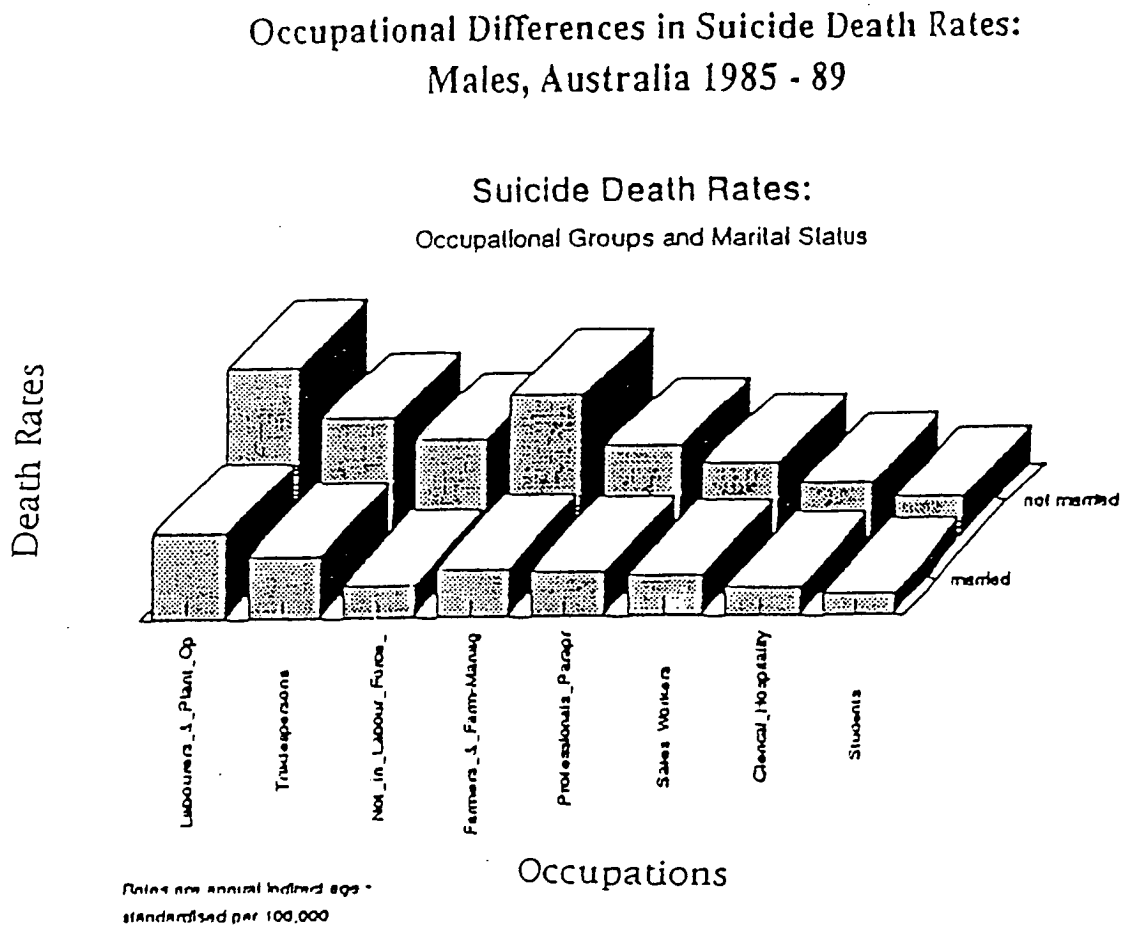
Social isolation was correlated with suicide risk by Renwick, Olsen and Tyrrell (1982) in their explanations of the comparatively high suicide rate among housewives in New England. Portwood (1978) argued that isolation is one of the problems faced by the elderly. However, one needs to question the degree to which a correlation between perceived isolation and the rate of suicide exists. Haines, Hart, Williams and Slaghuis (1992) say that isolation is more often given as a reason for suicide among the elderly than the young but that this may be due to a tendency to assume that young people have friends and are therefore not isolated. It may be that subjective feelings of isolation bear little relationship to the amount of contact with friends or family one has.

Sociological explanations have been sought for the dramatic increase of suicide among younger people. Sarri believes that in industrial and post-industrial countires of the world a serious youth crisis has emerged (1972, 15). One explanation for increased youth suicide which has been singled out is the change in family organisation. Hassan (1992) examined parent and child relationships in the light of changing family structure and organisation. He notes that the fastest growing family type in recent years is the single parent family. In 1981 in Australia, there were a quarter of a million single parent families. Research into the socio-economic attributes of parents

shows that these have also changed over the past three decades, with people marrying later, having increased educational and economic status (Hassan, 1992). Hassan hypothesises that parents generally expect more of their offspring in terms of educational attainment than did earlier generations.

FIGURE 2

FIGURE 2



Sociological explanations of suicide include analyses of social forces and their impact upon vulnerable individuals. Goldney (1989) examined the role that the media may play in precipitating suicide. He reviewed the 13 studies that had been published about media reports and suicide and drew the conclusion that there is an appreciable body of evidence supporting anecdotal claims of a correlation between the two. Ten of the studies found a significant relationship between reports of suicide in the media and an immediate increase in suicides. Goldney also makes mention of the fact that the remaining three studies reported similar results but not at a significant level. A disquieting finding was that even neutral reporting results in an increase. While such suicides are often thought to be caused by an imitation effect, Goldney suggested a different reason. He believes that any reporting leads to a subtle understanding that suicide may be a normal course of action and that the more it is reported, the more the behaviour is normalised. Goldney's findings about an imitation effect are consistent with some earlier research he conducted into a spate of jumping at a psychiatric hospital in South Australia where he concluded that the effect of suggestion may have been a contributing factor to the phenomenon (Goldney, 1986).

The correlation reported by Goldney (1989) between media reporting and suicide is of concern because it implies something of a 'Catch-22' situation. Publicity is needed to increase awareness of suicide so that services can be improved and vulnerable individuals helped. Increased publicity though, runs with it a proven risk of increased suicide because of the effects of media reports in normalising suicidal behaviour.

Durkheim's work aimed to explain why the suicide rate in a given country remained stable over decades. Since that time structural explanations of suicide have been concerned with an individual's relationship to, or estrangement from, his or her society. But on their own such explanations are not enough to explain why certain individuals commit suicide and others do not. In order to explain why particular individuals in high risk groups commit suicide one must consider the contribution of individual differences.

3.2 INDIVIDUAL EXPLANATIONS OF SUICIDE

Individual explanations of suicide can be divided into psychiatric and psychological theories. Psychiatric theories concentrate upon the notion of suicide behaviour as mental illness while psychiatric theories explain this behaviour in terms of the frustration of psychological needs. They have common ground in that they locate the reasons for suicide within the psyche of the individual. There is also some overlap between the theories, especially in the literature pertaining to depression. Rather than reviewing the psychiatric and psychological literature regarding depression separately I have combined it under the first section 3.2.1. Section 3.2.2 then goes on to describe the main characteristics of psychological explanations of suicide.

3.2.1 PSYCHIATRIC THEORIES

The principal assertion of psychiatric theories is that the act of suicide is best understood primarily in terms of mental illness or as a result of bio-chemical imbalances within the body (Shneidman, 1993). Suicide is explained as the symptom of an underlying disease brought about by a disturbed mental state that can be triggered by psychiatric illness or the effects of intoxication (drugs or alcohol). The rationale behind treatment is that only people suffering psychiatric disability will kill themselves and because of this, such individuals are not rational and must be protected from self harm while being treated medically for the cause of the illness (Kreitmen, 1986). Kreitmen holds that suicide does not occur among individuals with no psychiatric disability but qualifies this by adding that this applies only during normal peacetime conditions. (The conditions of war may lead some individuals, such as the kamikazee pilots, to suicide). He claims that special conditions operate in prisons and closed institutions which increase the risk of suicide in individuals who may not be psychiatrically ill.

An important contribution of theorists from the mental illness school of thought is in the relationship they have identified between suicide and depression. Depression has been identified as one of the most important factors which lead to suicide (Davis and Schrueder, 1990; Hassan, 1992; Garfinkel, 1990). Depression is used in two ways in the research literature. The word depression can refer to feelings of sadness or despair. It is also applied to an endogenous condition that is beyond the resources of the individual to control and which therefore requires medical intervention. Wilson and Kneisl (1988)

describe depressive disorders as being "characterised by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness that are not warranted by reality" and prescribe that "they should be differentiated from the normal sadness and grief resulting from some personal loss or tragedy"(427).

Various studies have sought to measure the relationship between suicide and depression and have produced a difference in figures. Researchers are not consistent in the way that they define depression and some do not define the way that they use the term in their research.

Lowenstein (1985) found that in the U.S. patients who have had a major depressive episode are thirty times more likely to die by suicide than non-depressed persons. These findings were supported by the research of Davis and Schrueder (1990) who found that 15% of depressives die by suicide. Sadler (1991) reported that in teenagers depression ranges from normal transient feelings of sadness to major depressive episodes. Amongst teenagers in the community she found that depression ranged from 1.5% with severe depression to 47% with self-reported depressive symptoms.

Teicher (1970) claims that the relationship of depression to suicide is unclear in adolescents but that 40-70% who kill themselves have a history of serious depression. However, she also goes on to note that 85% of depressed people (of all age groups) are not suicidal but most of the suicidal are depressed. Whether she is talking about endogenous "serious" depression or an affective mood of depression in the latter statement is unclear from the article.

Garfinkel (1990) estimated that 69% of all suicides among young people result from depression or from depression in combination with other disorders. Similar findings have been reported about youth suicide in this country. Birleson (1988) researched depression in adolescence in Melbourne, and reported that one quarter of the young people admitted to hospital after a suicide attempt met the criteria for depressive disorder, but three quarters did not. According to the coroners' records in South Australia during 1988 and 1989, 92 people under the age of 24 years suicided and of these, 86 had a history of depression and/or serious disturbance in their interpersonal life at the time of the suicide (Hassan,1992).

The rate of depression among younger people who die by suicide may not be as high as the rate in other age groups. Haines, Hart, Williams and Slaghuis (1992) found in a study of youth suicide in Tasmania that there was no evidence of a high incidence of psychiatric disorder in those who had died. In addition it was found that the younger group (19 years and less) were significantly less depressed in the days leading up to the suicide, than the older group (over the age of 55) which was being used for comparison. The findings of Birleson (1988) contradict those of Haines et al. in that they report a high level of depression among adolescents in general. His study found 50% of adolescents report the experience of severe depressive moods with 25% saying that this had happened often. He reported that seven percent of 15-year olds report suicidal thoughts. The difference in the findings of Haines and Birleson may be one of definition of depression but this is not clear from the research articles.

Graham and Burvill (1992) are clearer in their categorisation of depression and indicate high levels of diagnosed depression in adolescents and young adults who died by suicide. Cases were assigned DSM-111 categories and where depressive symptoms had been identified but were not severe enough to meet the criteria, they were categorised under the heading 'minor affective symptoms'. A psychiatric diagnosis was made in 52% of the cases of 15-19 year olds, 49% of the 20-24 year olds and 64% of an older comparison group of 45-59 year olds. When minor affective disorders were added the percentages increased to 92%, 95% and 97%, respectively. However it is unclear how many diagnosed as suffering psychiatric illness suffered depression specifically, although depression is listed by Graham and Burvill as the most common diagnosis.

Ninety percent of victims of suicide in a Brisbane study were found to have some mental illness, with depression affecting 50% (Cantor, Brodie and McMillen, 1991). This study was taken across all age groups and was not specifically measuring young people but the findings are similar to those mentioned above.

Renwick, Olsen and Tyrrell (1982) estimated that about one-third of people who suicide are suffering a mental disorder. In a study of suicides in the U.K. Barraclough (1987) found that 93 of the 100 cases were judged to be mentally ill with 70% having depression as the principal diagnosis. Of these, 33 cases had been referred to psychiatric services in the past.

Although the evidence is contradictory in terms of the extent of clinical depression amongst suicidal people, the literature clearly indicates that a substantial proportion of people who take their own lives are severely depressed. In addition, many more people have shown some symptoms of depression. In attributing causality, it is difficult to separate out one particular factor because generally, suicidal individuals show evidence of multiple factors occurring simultaneously.

3.2.3 PSYCHOLOGICAL THEORIES

Suicide is explained by psychological theorists, as being understood in terms of psychological pain, which arises from the frustration of psychological needs (Shneidman, 1993). Shneidman argues that the central issue of suicide is not death but the cessation of unbearable psychological pain. Suicidal individuals reach a point in their lives where they are suffering a high degree of psychological pain and decide that they can no longer tolerate it (Shneidman, 1993). He says,

> as a psychological disorder suicide relates specifically to unmet or frustrated needs such as the need for acceptance, achievement, dignity, self-regard, clear conscience, safety and succorance. There are many pointless deaths but never a needless suicide....Suicide is not only a reaction to unmet needs, but also the need for important psychological freedoms such as freedom from pain, freedom from guilt, freedom from shame, freedom from rejection and aloneness (22).

Psychological models accentuate that suicidal individuals are suffering great stress and as such, are not in the position to make rational decisions (Lowenstein, 1985; Novarra, 1979). The process is likened to a pathological narrowing of options where the person is ambivalent about dying. It is suggested that people who commit suicidal acts do not either want to live or die, but want to do both at the same time, usually one more than the other and that the will to commit suicide passes with the passing of the crisis which precipitated the decision to commit suicide (Lowenstein, 1985; Novarra, 1979).

Suicide is not seen to be rational because of the constriction or narrowing of the mind's focus which has been identified as typifying the suicidal state. Shneidman (1993) says that, "there is no such act as a rational suicide; but every suicide is a rational act - except possibly one committed by an actively psychotic person" (21). Although Shneidman's statement appears at first to be contradictory, the point he is making has important implications for the treatment of suicidal people. The process of constriction which leaves people thinking that suicide is the only option is deemed to be a logical thought disorder. However, he is acknowledging that the act of suicide makes sense for the person who is committing it, and is a solution for the unbearable level of psychological pain.

Suicide has been written about from various theoretical points of view. They are all perspectives with particular types of knowledge that can help in an understanding of the 'reality' of suicide. Even if we integrate the structural and individual explanations how does this assist us in the prevention of suicide? Structural contributions

to the prevention of suicide lie in their identification of high-risk groups and the identification of the structural variables that contribute to an under or over-integration of individuals within society. Strategies to prevent suicide focus upon structural initiatives. In contrast, micro-perspectives such as psychological theory address the issue of suicide prevention from the point of individual intervention. This research focuses upon individual interventions because it is specifically concerned with short-term action taken with suicidal individuals. Through a review of the psychological literature a model for working with suicidal people has been developed and is detailed in the following chapter.

CHAPTER 4

A CRY FOR HELP- WHAT DO I DO FIRST?

Given the wide-ranging explanations of the causes of suicide and the problems inherent in coming to any agreed definition about the phenomenon, one needs to proceed with caution in prescribing any particular course of action that ought to be taken to prevent it. Suicide prevention can take place at different levels of intervention, and this research focuses on one of them. Of particular interest is the action by social workers at the point when a client is deemed to be 'at high risk' of suicide.

Theoretical notions of suicide as a construct offer little assistance to the practitioner who wishes to engage a client in some form of action to prevent suicide. The professional role of social workers demands that they address the issue of suicide prevention in a practical sense. A finding of this research was that social workers take a psycho-social perspective in explaining the causes of suicide and this is detailed in Chapter Seven. Such a perspective is consistent with the knowledge base of social work which is derived from sociology and psychology. A psycho-social perspective means that suicide is explained as the result of an interaction between psychological and social variables.

It was explained in the preceding chapter that sociological approaches focus on structural intervention and that for the purposes of this research an emphasis upon individual intervention would be more appropriate. This is not to suggest that structural interventions are of secondary importance. On the contrary as Sarri

points out, "Early intervention using a variety of systems as well as individual approaches could produce far more effective results that 'treatment and control' after the fact" (1978, 8). This research concentrates upon action that is needed at an individual level because early intervention at a structural level has not been successful. Using psychological theory a useful model for assisting highly suicidal people will be outlined in this chapter. The model has been developed from the writings of experts in the field of suicide prevention. This model will serve as a guide against which the findings of this research about the action that social workers take to prevent suicide can be discussed.

4.1 SUICIDE AND ATTEMPTED SUICIDE

An important feature of any management model lies in the way that the difference between suicide and related forms of suicidal behaviour are conceptualised. The relationship between attempted and completed suicide is disputed amongst researchers. Some researchers (Kreitmen, 1986; Birleson, 1988; Hawton and Catalan, 1982) isolate the act of suicide from self-inflicted injury and argue a separate etiology for the two phenomena. By contrast, other researchers (Novarra, 1979; De Braga, 1989) reason that such acts are related so that there is a continuum suggested between suicidal thoughts, acts of self harm and suicide.

Shneidman proposes that much which has been written about suicide and associated behaviours is of little help in the practical sense. "There can be little meaningful practical research on suicide

until the obfuscating categories of 'attempted suicide' and 'threatened suicide' are eschewed and the continua of 'perturbation' and 'lethality' are understood and employed" (1993, 23). The ideas that Shneidman has proposed about seeing suicidal behaviour in terms of lethality and perturbation are supported by Appleby (1992). She contends that these concepts are important to assessment of risk. (1992, 11).

The level of perturbation refers to how upset or disturbed the individual is and the level of lethality has to do with the seriousness of the threat to die. These two aspects of general personality functioning can be juxtaposed and rated to determine level of suicide risk. Shneidman (1993) suggests that everyone is rateable on how disturbed or deathly suicidal he or she is (23). It could be that an individual is highly perturbed but not suicidal. A less frequent scenario may be that a person is lethal but not highly disturbed. A person at high risk of suicide would have a high level of perturbation and lethality.

Hawton and Catalan (1982) suggested that part of the management of people who have attempted suicide but appear to lack serious suicide intention, is in addressing the negative attitudes of professionals. Hawton and Catalan reported that professionals tend to differentiate between those they see as having been serious in their attempt and those whose action is attributed to other motives such as 'seeking attention'. Attitudes towards the latter are much less sympatheticand this increases the chances of further attempts and possibly ends in completed suicide.

An advantage of Shneidman's model is that other forms of suicidal behaviour such as attempted suicide, threats of suicide or self-destructive behaviours can also be rated in terms of lethality and perturbation and treated accordingly. This may go some way to overcoming the problem of labelling the less lethal expressions of suicide as 'attention seeking behaviour' rather than as real signs of increasing distress.

4.2 ASSESSMENT OF RISK

The management of suicidal people is clearly established within the literature. The initial, and arguably most important step, is in the recognition of suicidal risk and subsequent assessment of degree of risk. Assessment of degree of risk means that the right questions have to be asked (Murphy, 1986). It is necessary to ask if the person is thinking of suicide, what the plan is, if a time has been worked out, if the means have been obtained and whether a note is planned. (Appleby, 1992, 11). Eight out of every ten people who complete suicide have talked about it and will when questioned, discuss it with a practitioner (Lowenstein, 1985). Asking such questions is basically establishing the level of lethality.

Practitioners then need to assess how disturbed the individual is. This means looking for clues about any changes and variations in the levels of perturbation. Evidence of recent trauma, troubled relationships, stress as well as subjective judgements about the general appearance of the person and questioning whether suicide is

being considered should give clues about the extent of constriction of the thought processes (Shneidman, 1993).

It is the experience of Kreitmen (1986) that many non-psychiatrists fail to accurately diagnose high suicidal intent. Recognition of suicidal intent is enhanced by a knowledge of the chronic and acute signs of suicidal tendency (Lowenstein, 1985). The indicators of a chronic risk of suicide are severe depression, prior attempt, family history of suicide, alcohol or drug abuse, loss of socio-economic status, lack of social contact and a disabling or disfiguring medical condition (Lowenstein, 1985). Goldney (1992) adds to this list the availability of the means of self-destruction and increasing publicity about suicide. The indicators of an acute risk of suicide are feelings of hopelessness, helplessness or guilt, loss of self-esteem, disorganised thoughts, constricted thought processes, pervasive thoughts about death, delusions (reunion fantasies, plans to punish, visions of immortality) and formulation of a lethal plan (Lowenstein, 1985).

It is particularly important to act quickly if any indicators of suicide risk appear in an elderly person because older people tend to communicate their intentions less frequently than younger people, use lethal weapons more often and have less ambivalent attitudes towards suicide. That is, when an older person becomes suicidal there is often a strong intent to die (Miller, 1979).

Hassan (1992) believes that in order to lower suicide in young people, parents, teachers and counsellors need to be educated about how to identify suicidal tendencies in the young. The evidence is

that the risk factors for young people differ from those of adults. The risk factors for young people include previous attempts or threats; limited problem solving and coping strategies; unsupportable families; a history of separations, psychiatric disorders or substance abuse in the family; family history or culture of suicide attempts; family disorganisation or abuse or neglect; being male (increases possibility of a more lethal attempt); major relationship disturbances with social isolation and /or aggression; indicators of psychiatric disorders (depression, school refusal, self injurious behaviour, psychosis, substance abuse) and availability of guns or drugs (Birleson, 1988). Adolescent precipitating factors are listed as loss events (death, divorce, relationship break-up), disciplinary crisis and conflict, unemployment, loss of health, chronic illness, multiple stresses impacting over time and the anniversary of a loss (Lowenstein, 1985).

Sadler (1991) suggests that there are a number of aspects of the lives of teenagers which will elicit clues of suicidal behaviour. She says that overall appearance may be an important clue and that talking with the adolescent about their daily functioning, relationships and school experience is a way to begin. The aim is to gain information about the extent of suicidal ideation and lethality of plans because these give information about urgency and the type of care required.

An important aspect of assessment of risk lies in the identification of depression. Not all people who kill themselves have reached a level of clinical depression (Miller, 1979). Shneidman for one, clearly differentiates between symptoms of depression and characteristics of suicide and notes that an important difference is that they have

enormously different fatality rates. "One can live a long unhappy life with depression - not true of an acutely suicidal state" (1993, 54). Even so, an extensive body of evidence reports that endogenous levels of depression figure in a substantial proportion of suicide cases (Renwick et al., 1982; Cantor, 1992; Graham and Burvill, 1992). Chronic depression is an important and common form of perturbation.

Lowenstein suggests that doctors and other non-psychiatrists frequently make an error of omission in the assessment of depression. He reported that while depression is usually detected, its depth and consequent level of risk are overlooked. In addition, Lowenstein found that there is a rationalisation of depression which negates the real possibility of suicide. "I'd be depressed in that situation too" (1985, 61).

Lowenstein suggests that use of the Diagnostic and Statistical Manual of Mental Disorders (DSM-111) categories in the diagnosis of depression are the most appropriate. These include reduced appetite with weight loss or increased appetite with weight gain; insomnia or hypersomnia; psychomotor agitation or retardation; loss of interest in usual activities; fatigue or loss of energy; difficulties in thinking, concentration or decision making; feelings of worthlessness or guilt; and recurrent thoughts of death. Lowenstein warns that these symptoms of depression can be masked by drug abuse or perennial physical complaints and to be aware that subtle self-destructive behaviour, such as a series of 'accidents' or skipped insulin injections in a diabetic, may be a reflection of depression (1985, 61).

The diagnosis of depression in young people is often difficult to detect. As Halasz (1992) says, young people are rarely as articulate as Shakespeare's Hamlet in uttering "to be or not to be" in dealing with their profound life struggles. There is a tendency on the part of adults to trivialise their depths of despair because adolescents are generally not able to clearly articulate it. Halasz notes that as a matter of course practitioners should expect not to elicit suicidal despair. On the contrary it is recommended that they maintain an index of suspicion when risks of suicide are apparent.

4.3 SAFETY FIRST

If an assessment is made that a person is both highly disturbed and shows evidence of a high level of lethality then it is important to move quickly and ensure that a provision for safety is made. Crisis intervention principles apply (Garfinkel, 1990). These principles assume a temporary inability on the part of the person in crisis to think clearly and there is a recognition that the normal problem-solving techniques are rendered ineffective in dealing with the stressful situation (Hradek, 1988).

One means of making a suicidal person safe is through a short period of hospitalisation along with medical and perhaps psychiatric assessment. Certainly many researchers recommend this step (Garfinkel, 1990; Sadler, 1991; Hawton and Catalin, 1982). Some researchers recommend that in cases of serious suicidal intent hospitalisation and psychiatric assessment are always warranted (Murphy 1986; Lowenstein, 1985; Kreitmen, 1986; Halasz, 1992).

Shneidman notes that hospitalisation is a complicating event in the life of the patient but should be considered if lethality and perturbation remain high (1993, 28). Another way of providing safety particularly in cases of moderate rather than serious risk includes outpatient care when the individual has the support of family and friends and the person him/herself wishes to be treated as an outpatient rather than an inpatient (Halasz, 1992).

Perturbation drives lethality and so it is recommended that part of the initial process of safety provision is in lowering the level of lethality (Shneidman, 1993; Appleby, 1992). This is done by moving immediately to lower the level of perturbation and Shneidman says that when this is done, even to a slight degree the level of lethality drops and the risk of suicide is reduced accordingly.

> A psycho-therapist decreases the elevated perturbation of a highly suicidal person by doing almost everything possible to cater to the infantile idiosyncrasies, the dependency needs, the sense of pressure and futility, the feelings of hopelessness and helplessness that the individual is experiencing. In order to help a highly lethal person one should involve others; create activity around the person...and at least move in the direction of some substitute goals that approximate those that have been lost. Remind the patient that life is often the choice among lousy alternatives (Shneidman, 1993, 26).

A common recommendation is that family or friends ought to be contacted so that isolation is broken down, help is located and action that indicates concern is created around the person. With teenagers care will necessarily involve the support of parents because working

with parents is integral to suicide prevention work with young people (Birleson, 1988; Sadler, 1991; Halasz, 1992).

A final aspect of making someone safe, where possible, is to remove the means (Goldney, 1992; Shneidman, 1993).

4.4 FURTHER ACTION TO TAKE

Once an assessment has been made, provisions for safety organised and the level of perturbation lowered, the next step recommended is to widen the tunnel vision. At this point it is necessary to implement strategies that enable the client to consider other options to that of suicide (Hradek, 1988). Such strategies may include writing all the possible courses of action that the client may take including that of suicide, discussing the pros and cons of each one and then asking the client to rank order them (Hradek, 1988). In addition, given that the mental pain of the suicidal person relates to the frustration or blocking of psychological needs, the counsellor should move to help the person in relation to the thwarted needs (Shneidman, 1993).

When the level of risk is reduced long-term psycho-therapeutic strategies can be introduced. Treatment options after attempted suicide, or when a lower risk of suicide is suspected, can vary from referral to voluntary agencies, referral to a general practitioner or referral for psychiatric assessment, depending upon the level of intent to die (Hawton and Catalin, 1982). Therapies can include psychotherapy, drug therapy and group or family therapy (Garfinkel, 1990).

Because working with highly lethal clients is demanding it can result in personal and professional self-questioning (Lowenstein, 1985; Halasz, 1992). As a result of the demands of this kind of work and the potential consequences of it, Shneidman (1993) argues that professional supervision is vital and that practice has to be limited to few very lethal clients at a time (147).

Researchers make three further recommendations. Consideration ought to be given to using multi-disciplinary teams because the management of suicidal behaviour requires the skills of a number of professionals (Novarra, 1979; Hawton and Catalin, 1982). Careful consideration of the usual canons of confidentiality should be taken (Halasz, 1992; Shneidman, 1993). Therapy to reduce risk ought to include work with a partner or significant person in the life of the suicidal individual because a precipitant of the suicidal crisis is usually a dyadic event (Birleson, 1988; Halasz, 1992; Shneidman, 1993).

In conclusion, according to a psychological model of intervention, a series of steps needs to be taken to prevent suicide. Accurate assessment of risk should include some measure of lethality and perturbation, identification of depression or mental illness and a consideration of high risk factors. The person needs to be made safe so hospitalisation should be considered, medical assessment organised, family members or a friend contacted and where possible, the means for carrying out the suicide removed. Action should be taken to identify the stressors and lower the level of distress. As perturbation is reduced, lethality will drop. Strategies should then

be implemented that enable the client to consider other options to that of suicide. When the level of risk is reduced long-term psychotherapeutic strategies can be implemented. Counsellors should seek supervision when working with highly suicidal clients.

CHAPTER 5

THE PRESENT STUDY AND ITS AIMS

The purpose of this study was to ascertain how frequently social workers encounter suicidal behaviour in clients and to explore what action they take when faced by a client who is at high risk of committing suicide. The topic was chosen because this is an area which has largely been ignored in the social work literature. The design of the study was exploratory in nature because so little has been written on the nature of social work intervention in suicide prevention.

The literature tended to suggest that non-psychiatrists do not accurately diagnose depression and as a result do not always assess the level of suicide risk accurately (Kreitmen, 1986; Lowenstein, 1985). The literature also advises that the assessment of level of risk is the most crucial step in preventative action (Birleson, 1988; Garfinkel and Northrup, 1989; Halasz, 1992; Kreitmen, 1986). As a consequence, I decided to carry out a research study into how social workers assess the risk of suicide, which would be a useful contribution to social work knowledge.

Action taken to prevent suicide is an outcome of beliefs and knowledge about its causes. For this reason I began with a review of the literature about the causes of suicide and the frequency with which it occurs. Sociology contributes to our understanding of the structural causes of suicide but clearly does not attempt to offer a theoretical framework for dealing with suicidal individuals. For

such a framework, it was necessary to refer to the contribution of psychology and psychiatry on the subject. Psychologists have written extensively on the subject of suicide prevention and offer a very clear model of prevention. The framework I used for this study was a crisis intervention model. Chapter Four details the crisis intervention model of suicide prevention.

The principles of crisis intervention theory assume a temporary inability on the part of the person in crisis to think clearly and there is a recognition that the normal problem-solving techniques are rendered ineffective in dealing with the stressful situation (Hradek,1988). Scott and Stradling say that the goal of crisis counselling is to help clients to "get their bearings" (185, 1994) as they may be overwhelmed by events. The crisis is a time when normal coping mechanisms can break down.

The theoretical perspective that underpins psychological thought about suicide is that it is the result of a psychological crisis through which the person will pass if certain steps are taken to keep him/her safe. Psychologists suggest that the suicidal state is a temporary one that is characterised by a pathological narrowing of options so that, to the person in crisis, suicide is seen as the only option to end deep distress (Shneidman, 1993).

The literature therefore stresses the importance of an accurate assessment of risk in order to predict the onset of the crisis, followed by the implementation of crisis intervention principles. The theoretical assumption is that these people who are contemplating suicide are not in a mental frame of mind that will enable them to

think clearly about what they are doing so action needs to be taken to prevent them from self harm. Psychological theory also contends that a person thinking about suicide is not wanting to die, but wants to end pain and so there is always a measure of ambivalence in their actions.

In order to describe how one would expect the crisis intervention model to inform practice, a scenario follows that demonstrates the key tenets of the theory.

SCENARIO

Mary is a social worker at a non-government counselling agency. Her client Brian, who has been suffering depression after the break-up of his 15 year marriage, has arrived for a counselling session. He tells her that he feels much calmer today and that the depression has lifted somewhat. The week before, when she last saw him, Brian had been in a very agitated state.

Before asking questions of Brian about his state of mind, Mary suspects that Brian may be at risk of suicide. Her knowledge of the risk factors - that Brian is male, in his mid-thirties, socially isolated, recovering from depression, high alcohol user - alerts her that his apparent calm may in fact be the result of a decision to take his own life. Further questioning confirms her suspicions. She assesses Brian to be at high risk of suicide. He has a gun, a definite plan and tells her that he now feels better having made the decision to take his own life.

Despite the fact that Brian tells Mary he has made his mind up and has only come today to say goodbye and to thank her for her help, Mary assumes that Brian's attendance today for the appointment is in itself an act of help-seeking, that must be acted upon. Although he appears calm, she believes that his presence in the agency indicates a measure of ambivalence. She discusses this with Brian and tells him that she intends to take action that will keep him safe. Brian refuses to consider hospitalisation or referral to psychiatric services, but does agree to having some family members notified. Brian's brother is called in and a plan is discussed. The family will roster themselves and see that Brian is not left alone over the following three days. Brian contracts with Mary not to kill himself without talking to her first. Brian agrees to give his brother the gun and to begin intensive therapeutic work with Mary.

In the above scenario the social worker acted in accordance with the crisis intervention principles detailed in the previous chapter. The worker used her knowledge of suicide risk factors to alert her to the need for an assessment of suicide risk. She assessed the level of perturbation and lethality. The high level of lethality was confirmed by the client's plans. He did not appear to be distressed but this apparent calm masked a high level of perturbation.

The research literature detailed in Chapters 3 and 4 of the thesis is consistent in suggesting that there is no such thing as a rational suicide. Although a client may appear to be calm and have understandable reasons for wanting to die, suicide prevention literature informs us that there is always a measure of ambivalence

on the part of the suicidal person, to which the professional has a duty to respond (Appleby, 1992; Cantor, 1992; De Braga, 1989).

The suicide prevention literature also assumes that once a high risk of suicide has been assessed, the appropriate professional action to take is one that focusses upon the safety of the client (Garfinkel, 1990; Halasz, 1992; Hradek, 1988). Researchers recommend that if the suicidal client shows a reluctance to allow such measures of safety to be implemented, then the practitioner ought to consider the breaking of confidentiality (Shneidman, 1993). Because it is considered that the individual is in a state of crisis, and therefore is not able to think as clearly as he/she would under normal circumstances, it is recommended that the practitioner be, where necessary, quite directive in taking action of the part of the client (Hradek, 1988; Kreitmen, 1986, Shneidman, 1993).

As previously mentioned, the research literature tended to suggest that non-psychiatrists do not always assess the level of risk of suicide accurately. It also predicts, that once such an assessment has been made the above crisis intervention principles will be applied. In the conceptualisation of this research, I therefore decided to focus upon how social workers assess level of risk, and also to identify the way that they opted to ensure that the suicidal client could be kept safe.

Specifically in the light of crisis intervention theory, I was aiming to identify:

1 how social workers decide the level of suicidal risk,

2 what steps they take to prevent suicide, and

3 what problems they have identified as preventing the effective management of suicidal behaviour.

In the pilot interviews that I conducted, the social workers varied in their level of confidence when it came to assessing suicide risk. However, having made an assessment of high suicide risk they all implemented crisis intervention principles. The results of the pilot interviews confirmed the predictions in the research literature concerning both assessment of risk and subsequent directive action.

Chapters Six through to Nine will detail the findings of the study. Chapter Six outlines the extent to which social workers encountered thoughts of suicide, attempted suicide and completed suicide in their work. Chapter Seven then details how social workers assess level of risk. Chapters Eight and Nine examine social work ideology and the impact that this has upon suicide prevention practice. The findings of these chapters are then considered in the discussion in Chapter Ten.

CHAPTER 6

SUICIDAL BEHAVIOUR IN CLIENTS

Some research has been conducted into the help-seeking behaviour of suicidal clients and the conclusions have been that all too often, the professionals involved have not heeded the need. Lowenstein (1985) reported that more than three-quarters of patients who commit suicide have contacted their GP in the six months before death, two-thirds have done so within two months, 20% within 48 hours of death and 10% on the same day. Peck (1982) found that 30% - 50% of adolescents who suicided had seen a doctor within four months of death. Barraclough (1987) also reported a high level of help seeking from general practitioners when he found that of 100 suicides in his study, 59 had seen a doctor within a month of their death.

Little has been published about whether or not suicidal people are seen by social workers in the few months prior to death. One study which did measure help-seeking behaviour from social workers by people who had subsequently attempted suicide, was conducted by Hawton and Blackstock (1976). Of the 141 suicide attempters in their study, the vast majority had been in touch with some helping agency before the attempt. Thirty-six of the 141 people had seen a GP within a week of the attempt, and 63 within a month. Fifteen had seen a psychiatrist within a week and 22 within a month. Ten had seen a social worker within a week and 22 within a month and 13 had been to a voluntary agency within a week and 23 within a month. These data may not be predictive of current help-seeking behaviour because the study is 18 years old. It also refers to attempted suicide,

and no information is given about the level of lethality of the attempts or whether any of the subjects later completed suicide.

It was beyond the scope of this study to measure the extent to which suicidal people in Launceston seek help from social workers but data gathered from the participants indicate that working with suicidal behaviour in clients is common practice for social workers in Launceston. The types of behaviour encountered range from suicidal ideation to acts of self-mutilation, high risk-taking behaviour, suicide attempts and completed suicide.

6.1 THOUGHTS OF SUICIDE

During the interviews the participants were asked about their experiences of suicidal ideation in clients. Only one social worker, who does not have direct client contact had not had clients expressing suicidal thoughts. For the remaining 29 participants, dealing with suicidal ideation in clients was a frequent part of their work and was encountered on a weekly and sometimes daily basis (See Appendix E). As one participant (Christine) commented, "It's a constant theme really....the bread and butter of our work".

Frequency of such thoughts ranged from Bev's experience of it as a very common behaviour through to that of Jeff who rarely encountered it. When Bev was asked how many people talk to her about suicide she replied,

> about eighty percent. This agency has contact with hundreds of people a week. We see up to 300 a month just for welfare. Hundreds of all ages and circumstances come to us feeling suicidal.

Interviewees who work primarily with children, were the least likely to encounter frequent thoughts of suicide amongst clients. In the past six months one such social worker had received two referrals of adolescents who had stated that they were thinking of suicide.

> They presented as showing marked behavioural changes, depressed, dishevelled in their clothing, stating to staff members - not to myself initially, that they were thinking about suicide (Jeff).

Some social workers report that children express such thoughts at a young age. "From the age of five. At least I haven't heard it before then. Serious threats at nine. Threats where there is some design and ability to carry it through" (Denise). Denise's experience was echoed by those of Karen and Jim. "I have had four pre-adolescents talking of suicide. From nine to twelve years "(Karen).

> I am thinking of children from the age of eight and above. Some of the children we have interviewed in schools with disturbed behaviour will talk about killing themselves....They may very well exhibit that behaviour or behave in a way that will result in their deaths (Phil).

Valente describes the belief that children under the age of 12 are rarely suicidal as a myth and an area in need of further research (1991, 14). Some social workers in this study reported contact with

children expressing thoughts of suicide from the age of five years with serious threats at nine. Often feelings of despair in children are minimalised and their suicide attempts dismissed as 'accidents' (Teicher,1970; Valente, 1991). Social workers in this study did not belittle distress in children but the fact that suicidal children have been encountered has implications for the training of social workers because one of the most important barriers to assessment of suicide risk in children are attitudes and values that make it difficult to hear that a child is troubled with thoughts of suicide (Valente, 1991, 19).

The level of lethality expressed in the thoughts of adult clients ranged from minimal to highly lethal.

> I had one on Monday who had been planning it. He had thought it through and had actually sat in the car with a rifle. A lot of others tell you things like, 'I was in my car and thought how easy it would be' (Jim).

Thoughts of suicide are not necessarily indicative of any real risk that an attempt will be made but they are important because they are one factor to consider when assessing level of risk. The challenge for the professional lies in differentiating between those thoughts that are expressions of general frustration and those that indicate a high level of perturbation and lethality. Most social workers interviewed indicated that they were aware of the necessity for doing this.

> Sooner or later you are going to be wrong. I mean it is my biggest fear but so far I have got away with it and have been able to peg it OK, I mean sometimes I get people who say, 'I've had enough. Life is a shit and I want to be out of here. And I have instinctively thought that they are not saying that they really want to be out of here and I haven't wasted a

great deal of emotional energy on it but one of these days I am going to get caught" (Trisha).

6.2 ATTEMPTED SUICIDE

Acts of attempted suicide were found in this study to be common behaviour in clients who are seen by social workers. While not being encountered as frequently as suicidal ideation, such clients present on a weekly or monthly basis to many of the social workers in the sample. Twenty-eight of the 30 social workers said that they had worked with clients who had attempted suicide either prior to counselling or during the counselling process (see Appendix E). Workers in agencies who have clients in high-risk groups, such as the sexually abused, disturbed young people or the mentally ill, were more likely to report contact with clients who had attempted suicide while in contact with the social worker. Thirteen participants mentioned occasions of attempted suicide in clients who were being seen by the social worker at the time.

The difficulty in gaining an accurate picture of the extent to which attempted suicide is part of the experience of social workers, and how serious the attempts are, is one of definition. Analysis of the interviews indicated that social workers tended to categorise the behaviour according to the perceived strength of intent to die. Acts of self-injury and high risk-taking behaviour were contrasted with attempts which had involved more lethal plans. Social workers lack consistency in the way that they define attempted suicide. Some of

those interviewed considered self-injury and high-risk taking behaviour to be attempted suicide, and some did not.

> Some were taking enough pills to not quite overdose but to still have to go to hospital and be suspected of a suicide attempt (Bev).

> I have one who was disfiguring himself but it wasn't actually a suicide attempt (Cynthia).

> It has been more the cry for help stuff and they have obviously got some sense that this is not what they want to do (Jim).

> You get the Panadol overdoses and the 'I have taken five more Diazapan than I needed to' stuff. It's been two or three weeks since a completion but there have certainly been presenting parasuicides (Jack). (The term parasuicide refers to attempted suicide. It is commonly used by members of the medical profession.)

The statements above can be contrasted with the following examples of a broader definition of attempted suicide. Including cigarette burns, as the following social worker does, within a definition of attempted suicide is a very broad use of the term.

> I have seen a number who have already attempted it, slashed their wrists and taken an overdose (Carol).

> The majority of clients I have would have attempted suicide at some stage. It ranges from feeling very suicidal to ending up in hospital with an overdose or whatever (Francis).

> Yes plenty of that (attempted suicide). There is a bit of a line between self-abuse and suicidal behaviour. Sometimes that

> is blurry for me. So you get a lot of slashing of wrists, cigarette burns and things like that (Mark).

It became apparent during the interviews that social workers have seen clients with high levels of perturbation and lethal plans. About one-third of the sample discussed incidents similar to the one described by Pat.

> I had a genuine reason to believe that things were dangerous. He had one suicide attempt in his past when he tried to hang himself and was interrupted. This time he had the whole plan worked out - the date, the time and he had gone and bought a gun.

The problems involved in identifying how serious the suicide attempts were are further discussed in Chapter Six. The responses that were given by some social workers indicate that there is no agreed definition of attempted suicide. When social workers say they have had clients who have attempted suicide this does not necessarily indicate that they are talking about people who have demonstrated a clear intent to take their own lives, rather that they may have considered doing so.

6.3 COMPLETED SUICIDE

Of the 30 social workers interviewed for this study, 18 of them reported contact with a client who had subsequently died by suicide (see Appendix E). The social workers who reported this tended to have been in the profession longer than those who did not report a suicide. Their years of experience had a mean of 10.0 years, a

standard deviation of 7.2 years and were evenly distributed rather than skewed towards the less experienced workers. One-third of these workers were employed in counselling agencies. Of the 18 who had been working with, or had recently interviewed a client who had subsequently suicided, ten social workers had had this occur only once, three on two occasions, four on three occasions and one social worker reported it happening "probably in the order of about ten" times.

These figures represent the known completed suicides. As discussed in the literature review the rate of suicide is known to be under reported. Social workers may not be fully aware of the number of clients who take their own lives. Nola indicated this when she said,

> In this position, dealing with men (going through a crisis) we have noticed in the paper about six months later clients that have died of a car accident or some other cause that we haven't known of. They have been fairly young. They haven't been elderly and they have died suddenly. So that could have been suicide that hasn't come to our notice....I think it has been too closely linked with their distress at the time and it could have been deliberate accidental death or suicide by smashing their car into a tree.

Much of the work that social workers have done is in relation to the aftermath of suicide. Some clients who were at risk of suicide had experienced the suicide of a loved one. In several cases suicidal clients had experienced the death of a number of people within their own family or circle of friends by suicide. One-third of the social workers interviewed had played a role in counselling the bereaved in the aftermath of a recent suicide. Some social workers like

Denise, who was counselling two bereaved children, provide on-going counselling, particularly around grief and anger issues. "The concern with these children is that they are feeling responsible. The grief and self-hate associated with it and the unanswerable question of why they (the father who died by suicide) did it" (Denise). Six workers said they were currently giving long-term counselling to bereaved relatives or friends after a suicide.

Sometimes however, the contacts with bereaved family members were brief and unexpected. One such story was related by a social worker in a government welfare organisation.

> I had three in one day once....There was one out there recently at the counter. A mother and her daughter. The two of them had gone out for a couple of hours and when they came back he (husband-father) was burning in the back yard and the other kids were coming home from school. The daughter was seventeen. So they basically put him out and he was dead and they wouldn't let the young kids see him. They were telling me this story out there in the office and I had only gone out there to let them know that I couldn't see them because I was too busy. Then they came out with this amazing story and it was so loud and everyone was just sitting there listening.

The information gathered during the interviews clearly indicates that social workers are sought out by some suicidal clients prior to the suicide attempt or completion. The majority of social workers interviewed have seen clients who have made a suicide attempt in the past and a little under half of the sample have worked with clients who have attempted suicide subsequent to time spent with the social worker. These 'attempts' vary considerably however, in

terms of their level of lethality. More than half of those interviewed discussed an experience when a client, known to the worker, had completed suicide. One-third of the social workers had acted as counsellors in the aftermath of a suicide. These results indicate that in future studies into help-seeking behaviour the experiences of social workers ought to be included. The dearth of literature on the topic suggests that their contribution has been under-researched.

Evidence from research into help-seeking behaviour has found that women are more likely to seek help from professionals than are men (Gibson et al., 1992; Good, Dell and Minz, 1989, Johnson, 1988) The findings of this research support the notion that the people most likely to seek help from professionals are women. Twenty-four percent of the social workers were employed in agencies that have exclusively a female clientele or see women more than 80% of the time. The remaining 76% see both men and women on a regular basis.

In general it was the experience of social workers that men had not sought help from them because they were feeling suicidal but were in the agencies for other purposes, for example, custody or marital disputes, to apply for Social Security benefits, assistance with accommodation, because they have been hospitalised or because they were clients of psychiatric services. Women were more likely to go to agencies for social support (neighbourhood houses, community centres) or for post-trauma counselling (sexual assault services, crisis intervention units, domestic violence counselling) as well as using the services consulted by men.

The evidence from the interviews indicates that young men are seen less frequently than women or older men. Social workers most likely to offer them assistance were in agencies such as Social Security, private welfare organisations and psychiatric services. The group of people least likely to be seen by social workers in this study were young men. There was little long-term involvement with this group. Five social workers said their main source of knowledge about young people was through familiarity with the friendship networks of their own children. Other social workers, with the exception of the four who work exclusively with children, had brief contact.

> Others who have suicided have been lots of young kids that we see for Youth Homeless Allowance. I hadn't been working closely with any of them. I just helped them with the claims and then you hear some time later about the suicide (Ellen).

Although two social workers mentioned previous outreach work with this group when working interstate, only one was involved in such work locally.

The evidence presented in the interviews leads to the conclusion that the clients who are considered to be at risk of suicide and seek help from social workers, are representative of a minority of those who are generally thought to be of high risk. Women are more likely to seek help from social workers than men and young men are least likely to seek such help. A group that did not feature in accounts given by social workers of clients who had subsequently suicided were the elderly, a very high risk group. Women are

considered to be at less risk of completing suicide than men. Young men and the elderly are the two groups who contribute to a substantial proportion of the suicides in this state.

A note of caution needs to be added to any conclusions drawn from the finding that women are the group more likely to seek help from social workers and the group least likely to complete suicide. The note of caution relates to the theoretical construction of suicide as primarily masculine behaviour (Kushner, 1985 in Hatty, 1988). This can lead to a denial of the incidence of women's self-destructive behaviour and underestimates their level of distress and consequent level of risk. Women injure themselves - independent of outcome - at a greater rate than men (Hatty, 1988). Even though less women than men figure in the 'completed suicide' statistics, many of them could still be assessed at high risk.

The experiences of social workers indicate that dealing with a range of suicidal behaviours in clients is a regular part of their work. Obviously a client who is casually expressing thoughts of frustration with life is going to require a different kind of response to someone deemed to be at high risk of suicide. The model of management outlined in Chapter Four refers to people who have been identified as extremely suicidal by virtue of a high level of lethality and perturbation. Social work intervention with highly suicidal clients is the focus of this research. Because suicidal ideation and acts of self-harm are common behaviours encountered by social workers, the first step is assessment of risk so that appropriate interventions can be matched with the corresponding level of risk.

CHAPTER 7

THE SOCIAL WORK RESPONSE: ASSESSMENT OF RISK

In order to understand the response of social workers to a suicidal crisis in a client some clarification of the theories they hold about the causes of suicide is necessary. As pointed out in Chapter Three the way suicide is conceptualised will affect the response to it. There was general agreement in the interviews that a multi-causal explanation for suicide was needed. Suicide was generally seen as resulting from an interaction between psychological and social variables. Variables, such as a history of trauma or abuse, an extended period of problems which were often exacerbated by a social crisis in the person's life, were identified as common threads.

When social workers described what they knew about the lives of suicidal people or those who had died by suicide it was apparent that for those whom they see, suicide is not an event that happens purely because of a crisis. In most cases social workers identified a long-term history of some kind of problem.

Some feelings were recognised by social workers as being common to all those who were suicidal. Feelings of intense isolation and a sense of hopelessness about their lives were common. A number of those interviewed understood the desire to suicide, as not a wish to die, but a need to end the pain. "The only way I can end this pain, these circumstances is to die, is to finish it" (Bev). "In many cases people tell you...'I didn't want to die' but they want to get away from the pain, to get away from the distress" (Christine). Suicide as escape from pain emerged as a common theme in many interviews.

Social workers distinguished between two emotions which precede the suicide or attempted suicide. Social workers have found that suicidal people present as either angry or depressed and that with both emotions it is often hard to identify whether the client is homicidal or suicidal.

> They are so distressed, I sometimes don't know which way they will go - homicide, suicide or both (Nola).

> Three of them would have been suicide-murder situations. Like as if they are looking at whether they can save someone from this terrible world stuff, and saying there is nothing for us to live for (Irene).

The views of social workers about the causes of suicide and the recognition that the build-up to a suicidal crisis is a process that has resulted in high levels of psychological pain from which the person wants to escape, are views that are consistent with a social-psychological perspective. Social workers identify the impact that structural factors have upon the individual psyche and recognise the resulting psychological pain.

In the descriptions that social workers gave of highly suicidal people, they differentiated between what they saw to be different causes of the behaviour. In other words, the social-psychological perspective they adopted could be broken down into groups of causes. Interview text pertaining to the causes of suicide behaviour was initially indexed together in one category (see number 332, p 195). Examination of the text segments indicated distinctions that social workers were making amongst types of suicidal behaviour. These

distinctions were then grouped into separate categories using the methodology explained in Section 1.7.

The categories were grouped according to the perceived cause of a suicidal reaction and the effect that it had had upon the suicidal individual. These are general categories only. Some suicidal clients could be considered under more than one category. The types are important in that they appear to have an effect upon the way social workers assess level of risk.

The first group were described as having become suicidal in a "straw that broke the camel's back"(Ellen) scenario (see Appendix F). Some social workers related stories of a client who had suicided or made a serious attempt after a build up of problems had exhausted their coping skills. An example of this is related by Jim.

> This was a case of a young person of about 30 who was in a relationship with a suicidal woman in her 40s. She was a reasonably sophisticated person. He had a country upbringing and was a very innocent type of fellow, trusting and a really nice person. She had been in and out of 1E (psychiatric ward at the Launceston General Hospital). He had had a difficult relationship before her and had been taken to the cleaners. Well there they were the two of them. Their relationship hit a difficult stage and he was all of a sudden suicidal. I would have thought it was the first time in his life that he had thought about it. However of all the people I knew he was the highest risk. He was the sort of person who was hard to ruffle. He had weathered enormous storms. He was stoic as well as trusting. This was different and he was reacting differently for the first time in his life and he was very vulnerable and I thought he could have done something impulsive. He was the one I thought I might lose.

It is to the people in this group that Irene refers when she says,

> They have often had lengthy periods of enduring the most awful circumstances and they are just plain worn out. It's like their pot has run dry and they are still being drained.

Concerns are expressed by Nola about the number of men she sees as "tipping over the edge" to homicide, suicide or some other destructive behaviour, at a stage of great emotional crisis in their lives. Christine describes these people as the ones who have developed tunnel vision and have

> somehow ended up in their lives where suicide seems the only way out. I think they would be able to see other options and solutions and somehow end up in a situation where they don't.

The second category of suicidal clients, named "inability to cope" (see Appendix F), were those who were recognised as having suffered a long history, usually from childhood, of violence and abuse. This was seen to result in a general inability to cope with life. These clients often have a history of multiple suicide attempts, have minimal coping skills and seek assistance from a range of services, including psychiatric services.

When referring to people in this group, social workers identified behaviours that ranged from subintentional death wishes to self-damaging behaviour and attempted suicide.

> There are people we see every week who generally have difficulty coping with stresses or rejection from others or all

> kinds of things and who come to you as suicide threats or suicide attempts (Christine).

These are the group who are sometimes labelled as having "personality disorders" as a result of the abuse they have suffered.

> There are people who will probably continue to do things like take overdoses and we will continue to have contact with them. It is to do with their personality that this is the way they behave and that this is the way they live. We get used to the fact....that this is a pattern of behaviour that we can't stop. This was the pattern with two of the ones who died and another one now who is still alive but we think may end up going the same way. If we can keep them alive long enough, we may be able to get them through it (Marion).

This is the group who Jacinta names "the permanently suicidal".

Results from this study indicate that people in this group are among those who do complete suicide but their problems were more likely to be minimised than those of other groups. These people were the ones least likely to receive a crisis intervention response.

> You know you just try and focus on something practical after you have got their mind off the grief. He will focus on something else that night and if he has a good cry then I won't see him for two weeks. Then he will be suicidal again (Jacinta).

There was some awareness of the problems faced by this group when their problems are labelled as attention seeking behaviour.

> Some are referred on the phone and labelled personality disorder and it's a case of 'we won't see them because we won't cater for them anyway'....I think that is a fault....It may be a pivotal episode for the client or a decisive episode in terms of ending their life (Jack).

The third category of highly suicidal people, labelled "guilt or shame" (see Appendix F) were those who were harbouring a great deal of guilt or shame that they were apparently unable to resolve. In these cases the guilt was inferred after the suicide had occurred but had not been identified prior to the death.

> He was the third in a series of male perpetrators who suicided....He had been interviewed by myself I think the day before in relation to child sexual assault in the family (Phil).

> The guy kept coming here and other issues started to surface. The issue that he couldn't talk to me about was the incest with his children (Jim).

> He identified his fears and I thought it was a big step for him to come and tell me this. Then his wife came bursting in on the end of our session and filled me in on his violent behaviour. The way that he had described it to me was that it wasn't that violent....but he hadn't explained the full extent of what he had been doing (Cynthia).

The fourth category of suicidal people, labelled as "hopelessness" (see Appendix F) were young people who were seen to have a pervasive sense of hopelessness and rebelliousness. They were identified as a separate group with special needs. In the interviews social workers gave examples of individual cases of suicidal behaviour but this happened less often when they were referring to cases involving young people. Young people were more likely to be

spoken about as if they were an homogeneous group than any other group. "Young people need..." or "Young people feel..." were common phrases used.

> It just felt by the time we got them at the farm where I was working, by the time we saw them at fourteen or fifteen it was too late. It was like this pattern, this socialisation, had been complete too much for us to then come in and say, you are worthwhile or whatever. It was too late and they rebelled against any form of authority....Underneath the rebellion was rejection and low self-esteem (Francis).

> The injustices and the hopelessness seem to be pervasive among most young people. They don't use the word 'hopeless' but when I introduce it they will grab it and use it. Maybe it is that they won't get the certificate they need, they won't get the apprenticeship they want, the job, the education. They will be on the dole. It's hopeless (Denise).

Social workers spoke of their experience of a 'suicide culture' amongst young people.

> Several of my son's friends have died by suicide. Sometimes I think it is like suicide is all around them (Jenny).

> It is hard because there is so much grief that they (young people) are constantly carrying, because so many of their mates suicide. Suicide follows them around like the grim reaper. They look over their shoulder and it is there (Jacinta).

One social worker who works with children expressed concern about the extent to which young people are exposed to suicide:

> In young people's minds, it does concern me that they do consider suicide as a viable option, as something they could do....They have experiences of people who have suicided and they have known people who have suicided. It has a big effect, doesn't it (Judith).

The final category of suicidal people were the mentally ill. Social workers who have been closely involved with this group of people were most likely to mention psychiatric disturbance as being different from the other categories. There was a recognition that the symptoms of psychiatric illness can lead to suicide. People in this group were seen to be suicidal when symptoms were acute, which when treated with medication would abate. They were also, however, seen to be highly at risk when well. The social workers who used this category of suicidal people were placed within health services and responded using crisis intervention principles. "A warning sign is when they become insightful and look at what their lot in life is...their quality of life, well it is pretty abysmal" (Leanne).

Social workers were readily able to identify with the first group of suicidal people where there had been a build-up of problems that had exhausted coping skills. In contrast, when people in the second category, the 'constantly suicidal', were discussed, social workers were more likely to minimise the pain and consequent risk of suicide of this group. The descriptions of behaviour where guilt or shame was inferred after death, indicated that in all these cases the social worker had failed to identify the level of perturbation.

The way young people were often described in the interviews as an homogeneous group has advantages and disadvantages for

treatment. Suicidal young people do have special needs and these were discussed in Chapter Four. However there is a danger in generalising about intense feelings of hopelessness or despair to all young people because abnormally disturbed adolescents may not be identified. Another problem of generalising is that this reinforces stereotyping about youth and can normalise suicide as a course of action for young people. Normalisation is a subtle understanding of suicide as a normal course of action and was one of the main factors identified by Goldney (1989) as contributing to increased suicide in young people. Suicide is a rare phenomenon and disturbed young people need help. A pertinent warning comes from Davis:

> In general there is ignorance about the prevalence of mental illness in adolescence, especially depression. This applies to family members, teachers, medical practitioners and other health professionals. In the community there is a tendency to consider adolescent experiences such as emotional distress, depression, binge drinking and drug abuse as 'normal' adolescent behaviour. This is usually far from the case and can result in troubled adolescents not gaining professional help when it is needed (1992, 100).

Social workers were asked about the warning signs they associated with an acute risk of suicide in order to gain more information about how they assessed level of risk. Warning signs that were identified as being associated with suicide risk were threats and plans, depression, acts of farewell, anger, unresolved grief or guilt, exposure to suicide either within the family or a friend, violence, a sense of hopelessness, threats to kill others, substance abuse and any sudden change in behaviour or attitude. A number of social workers also mentioned, particularly in relation to suicide rather

than attempted suicide, that they had noticed a sense of euphoria or decisiveness prior to the death.

> The danger zone is when they came back in and you ask how they are and they say 'I'm great'. It's an elation but it doesn't seem to be a true elation. I can't really describe it better than that (Francis).

> There was clear intent to kill herself, clearly articulated and immediately before there was a sense of euphoria (Irene).

> The calmness. They appear decisive when their history says they haven't been (Jack).

Almost all of those interviewed said that when they had cause for concern, they confronted the client to confirm the intent to suicide. "I name it up and ask them directly about their thoughts, and how they would do it and assess where they are at" (Irene). The experiences of those interviewed for this study was that people who are suicidal admit to their feelings if asked.

> I can't think of anyone I have asked who has said, 'No I am not' and I have had that feeling that perhaps they are not telling the truth (Jim).

Eleven of the eighteen social workers who had had a client who had completed suicide expressed surprise at one or more of the suicides they had encountered. They described in detail a total of twelve suicides in which social workers believed there had been an absence of warning signs. Pat's story was typical of them.

> She was a lady who was in a support group who gave everybody the impression of being bright and bouncy. She

> would discuss problems as other people did but she did not appear to show a great deal of distress, apart from the normal concerns about the problems she was facing. I saw her three days prior to the suicide and she appeared at the group to be no different to the other days. No warning signs that I picked up. I am still surprised about it and so was everybody else.

In Pat's description she was unable to locate high risk factors and three examples of suicide in other interviews indicated a similar response.

The descriptions of the other nine suicides about which the worker expressed surprise, indicated a high level of risk, as shown in the following example:

> She was getting treatment from a psychiatrist....The marriage had broken up. She had been profoundly depressed and had made a very serious suicide attempt (Christine).

An analysis of the suicides that were high risk and after which the worker had expressed surprise, can be broken down into three groups. The first group are the social workers who work with clients who are a high-risk group for suicide. Such workers were expecting a change in circumstances or mental state as an additional warning sign to indicate that suicide may be imminent.

Two of the suicides were found in retrospect to have shown a number of warning signs but these had not been apparent to the worker.

> I often find it hard to predict. A couple of years ago we had a suicide and we found out in hindsight that all the clients

> knew but didn't recognise it. He had done things like paid off his debts, given his possessions away. The other clients did not know what that information meant and they did not convey it to us. As staff (here in the agency) it came as quite a shock (Leanne).

In the remaining four cases the worker had not been prepared for a suicide. The common factor in these suicides is that they were all relatively brief contacts. Two examples of these clearly illustrate that although there was an acute level of risk indicated by the high-risk factors described and a probable high level of perturbation on the part of the clients, the social workers involved did not appreciate the level of risk.

> I only had one session with him for about an hour. He had a lot of stuff going on his head. A lot of uncertainty, a lot of fear about what was happening inside him and in his life in general. As he talked with me he identified some of those fears, fear of unfaithfulness by his partner and the need to keep an eye on her. Controlling I suppose, the need to control. And his low self-esteem. I thought it was a huge step for him to come and tell me this. So there seemed to be this big cry for help. 'There is something going on for me and I can't deal with it on my own.' His partner ...came bursting in on the end of our session and filled me in on his violent behaviour. The way he had described it to me was that it wasn't that violent. Just pushing her but he hadn't explained to me the full extent of what he had been doing. I tried to ask her to stay and talk about it and to ask her what support she had but she didn't want to. She just left. Because of the seriousness of the violence I really had very few places to refer him to...I don't work with violent men....That ended up being a suicide but he gave me no warning about that. He didn't tell me he was going to kill himself or anything (Cynthia).

> She was chronically, chronically depressed. Multiple suicide attempts. I cannot completely recall the conversation but if she had said, 'things are not too good' it would have been completely normal for her. She'd had a tragic history. She had been raped by her brother and then years later when she had decided to disclose it, the whole aboriginal community turned against her....She was drug addicted and there is nothing she could have said that was out of the ordinary anyway. She was virtually permanently suicidal. Everyday was an achievement for her. When she rang me some months later there was nothing in what she said except that she rang to ask me a really basic question. Something that anyone could have answered (Jacinta).

In both examples of the interviews from Jacinta and Cynthia lethality was not assessed and the risk of suicide not identified. Most social workers expressed confidence in their ability to assess the level of lethality.

The recognition of depression was identified in the literature as important for accurate assessment of risk. Depression has been found to be a high-risk factor and is one type of perturbation that ought to be assessed. As reported in Chapter Four Lowenstein's findings were that non-psychiatrists frequently overlook the depth of depression although depression itself is usually detected. In addition, Lowenstein (1985) found that there is a rationalisation of depression which negates the real possibility of suicide. 'I'd be depressed in that situation too' (62).

As predicted by Lowenstein, depression was detected by social workers and one-third of them described depression in a way that suggests a risk of inaccurate assessment. The data collected for this

study indicate that social workers are not consistent in the way they define and measure depression.

Two distinct schools of thought emerged from the data. Almost one-third of the sample (eight interviewees) made definitive statements about their understanding of depression as a mental illness. "I find it helpful to get medical input, because depression is a mental illness" (Denise). "I will ask a psychiatrist to review it. If there is any evidence of depression then medication may help" (Marion). Social workers in this group recognised a level of depression that is beyond the ability of the individual to control without medical help. Christine summed this up when she said,

> I have also seen lots of people who are suicidal because they have a depressive illness which I think social workers do not as part of their basic training have an understanding of, because the very serious depressive illness is not something that you see around in the community. It is the kind of illness where people just want to die. But if that is treated then they recover and come back to normal and are quite happy.

A further nine social workers described depression in terms of the clinical warning signs associated with it. Although they did not make a statement to the effect that depression was a mental illness, their use of the clinical signs of depression indicated an awareness of the distinctions to be made between normal sadness and grief, and a depressive disorder as described by Wilson and Kneisl (1988) as being characterised by exaggerated feelings of hopelessness and sadness that are not warranted by reality.

In contrast, nine social workers made statements that conveyed their understanding of depression as a feeling and not a psychiatric illness.

> Yes there is a role for the drugs when it is a bio-chemical problem but we are not really talking about mental illness here, just people who are very depressed although I know there is a bit of a cross over (Janelle).

> They have been whacked into 1E (the psychiatric ward at the Launceston General Hospital) when I don't really think they should have been....I think some of them were just severely depressed. I don't like it because they are often slapped with a label and left with the stigma (Karen).

> I don't believe that depression is necessarily a mental disorder. I see it as an emotion like anger, fear and all that stuff (Sharon).

This second group made distinctions about depression in a way that the first group did not. There was an underlying assumption in their statements, that there is a difference between depression that came around as a result of social factors and the depression that is associated with mental illness.

> Like one young woman who stands out. She has had multiple suicide attempts. She will tell you when she goes home on Fridays that she is worried whether she will be there on Monday. She has had a history of sexual assault and was mis-diagnosed as depressive. Yes she was very seriously misdiagnosed. I don't know how many more psychiatric theories were developed over that one about childhood depression and all that sort of crap. Of course she was depressed. It's like domestic violence. I have met people who are diagnosed as depressive and are on medication. They come in, and it comes out that they are in

> a violent relationship and what they are being diagnosed as depression for, would be very healthy adaptive behaviour for domestic violence (Jacinta).

The difference in the two groups, is that while the first group decided that depression moved into the realm of psychiatric illness when it reached a certain depth of despair, the second group was more likely to differentiate between psychiatric depression and non-psychiatric depression according to perceived causes. Social workers in groups one and two could also clearly be divided according to their years of experience as social workers. The 17 informants of group one had an average of 12.5 years experience. Six social workers in this group had been practising for less than ten years, and with the exception of one person, were all employed in Health Department agencies.

On the other hand, the members of the second group who described depression as a justifiable situational state rather than a clinical condition, had all been social workers for less than ten years. The average time since graduation for this group was 3.4 years. Only one of these workers was employed within health services with the other eight in welfare and counselling agencies. The remaining four social workers did not discuss depression in the interviews.

In conclusion, the interviews showed that according to the proposed model in Chapter Four, social workers have an accurate social-psychological perspective of the causes of suicide. Although respondents did not state that they were assessing lethality and perturbation, analysis of the interviews shows that this was the first stage of the assessment process. An examination of two examples of

highly suicidal clients who were not accurately assessed and subsequently took their own lives shows that in-service training about assessment of risk is warranted. In addition, the way that some social workers minimised the level of perturbation of some clients also needs to be addressed during in-service training.

The findings from this research about the way depression is defined and assessed shows considerable differences across the sample. Over half the sample (17 social workers) who had been practitioners for more than ten years or were workers in health services demonstrated an awareness of depression as an endogenous state. Almost one-third of those interviewed (nine social workers) did not differentiate between endogenous depression and depression as a normal feeling of despair or sadness. Social workers in the latter group, with one exception, had all been practitioners for less than ten years and were not employed by health services. They were employed in a range of counselling and welfare agencies.

This finding is of concern because it suggests that social workers who have been trained for less than ten years and who do not work in an agency such as the hospital are rationalising depression and not diagnosing it accurately. Why would this be so? One explanation could be that the training of social workers has changed over the past ten years and that social workers are now less likely to be trained in the use of diagnostic tools such as the DSM 111 categories of depression than were some of their counterparts who trained more than ten years ago.

As was detailed in Chapter Three the perceptions that social workers have about suicide can be expected to determine how they will react to highly suicidal clients. In this chapter it was demonstrated that social workers' perceptions of depression and 'suicidal types' directly affected their response to suicidal clients. Other important ideas that direct social workers' actions were found to include their concepts of mental illness and the professional role. These are the subject matter of the following chapter.

CHAPTER 8

"I AM NOT HERE TO TALK THEM OUT OF IT"

Social workers differ in the action that they take when faced by a suicidal client. To a great extent action is determined by the ideas social workers hold about suicidal behaviour, mental illness and about their own role in the prevention of suicide. This is further compounded by the ethical dilemmas they face about suicide as a choice. Social work is a profession that has a code of ethics which holds dearly to the notions of client empowerment and self-determination. Those interviewed in this study had drawn a wide range of conclusions about whether or not there was an inherent contradiction in social work ethics and the management of suicidal behaviour in clients.

The question of the right of a client to take his or her own life poses a number of dilemmas for social workers and is a complex issue because the age of the client, quality of life, perceived rationality and even the level of family responsibilities affect their response. In some cases, all of the above affect the extent to which social workers will intervene to prevent the loss of life. In answering this question, respondents tended to begin by acknowledging that for many people suicide is an understandable act in view of the extremely adverse circumstances and life problems faced by some clients. There was a recognition that many of these people face intense pain as a result of factors beyond their control.

> There is a man I am seeing presently who has a sister who has been in two relationships where she was a victim of domestic violence. The ex-husband is a very violent man and is constantly breaking restraining orders. He is threatening to kill this girl in the family who is only fifteen and one day he probably will and the whole family as well. Like one time he attacked the girl and crisscrossed her stomach with a knife and he just won't keep away. The kids have had fifteen years of this stuff. The woman (my client's sister) has a new partner who has a steel plate in his head because this guy took to him with a pick axe. So this client I have, who is a very gentle man and a fairly fragile person has always tried to keep this family intact and to be there for them. He has a 60 year old mother who is an alcoholic. He now lives with the 15 year old girl and looks after her because she was sexually assaulted by the mother's new partner. He has got nothing in his life and no-one who is giving to him.

As Jeff says,

> I mean people tell you their life stories and you think 'Oh shit'. Rejection from their parents, no social networks at all, total despair and no hope of getting anywhere much. I think suicide is pretty understandable given the context of their lives.

As a consequence of hearing about such experiences, and the belief that it is understandable why some people want to end their lives, suicide is not seen as the action of people who are 'crazy'.

> With the people I have seen come through here, well they are not crazy. I don't believe for one minute that they are crazy but they do feel very bad about themselves (Jim).

Even the mentally ill are not necessarily seen as irrational.

> A warning sign here is if they suddenly become insightful into their condition and look at what their lot in life is....The way I have rationalised it for myself is that I think they were quite mad at the time (that they suicided) then I just wished they had waited until they were more clear thinking. If they do it when they are more clear thinking then basically I don't have a problem with it (Leanne).

Social workers showed considerable reluctance to label suicidal behaviour as psychiatric unless accompanied by recognisable signs of psychiatric illness such as a thought disorder or in some cases, depression. This reluctance is consistent with the social-psychological theoretical perspective that social workers hold.

> The ones I referred to psychiatric services were the people who came in here who were off with the pixies. They were in such a state of depression, immobility, scrambled thought wise (Irene).

> Sometimes you come out of a session and your head is spinning. You know it is not you. It is the client. You know you need the help of someone who is a lot more skilled in dealing with mental illness (Nola).

Many social workers, however did emphasise that while suicidal behaviour may well be understandable and was not a symptom of psychiatric illness, the suicidal crisis is accompanied by confused thinking. Confused thinking, tunnel vision and an inability to think through options clearly was seen as limiting the extent to which any client could make a rational choice under such circumstances.

> I believe that we can only make choices if we know all our options and there are various times when we are not able to make free choices because our options are shut down to us. It's similar to being blind and you can't see the traffic coming when you cross the road (Irene).

When clients showed evidence of extensive confused thinking then some social workers commented that the delineation between mental illness and suicidal behaviour blurs.

> I think the behaviour comes out from a depth of feeling which can amount to disordered feeling sufficient to be within the category of mental illness (Phil).

> If you believe that suicide is about some kind of confusion for the suicider, then mental illness is also about confusion, by definition almost (Jack).

Even if most social workers were not prepared to suggest like Phil and Jack that confused thinking could be considered mental illness, they generally conceded that at this point in a person's life the individual might make choices that wouldn't normally be made.

> I don't think suicidal people are necessarily unstable or deranged at the time that they are suicidal but there is a chance that they are not thinking as clearly as they might be and that somewhere down the track they might regret that sort of action (Judith).

Sixteen of the social workers suggested however, that clients could reach a stage whereby a rational choice to suicide could be made and that this in fact was their right to do so.

> I tell the clients it is their right to take their life and that I am not here to talk them out of it (Francis).

> If a person who in their own right and their own self-determination had made that decision, I would explore options with them but if they have decided that this is the best way out for me, and I don't have their permission to get any help for them, well that is their decision (Mary).

This is not to suggest however, that all social workers agreed that clients could be rational and make such a choice. Just under half the sample, 13 social workers, indicated that they were not convinced that this was the case and that the mere fact that the client had sought help indicated that they were ambivalent about death.

> If they were rational about it I don't think they would be here telling me about it anyway. They would probably just go ahead and do it. I don't think there is anything I could do but I would do my best to see that they didn't (Karen).

Social workers who did not accept that clients could make a rational choice about suicide argued that empowerment and self-determination are principles that do not apply in this situation.

Of the social workers who did believe that clients could make a rational choice to die, only two were prepared to concede that young people could make such a choice. The assumption behind the decision that an adult could make a rational choice was that adults could think clearly about the information they were given and could choose to reach out for support or services if they needed them. Young adults and children were seen as different from adults in a

range of ways that limited the extent to which they could think clearly about information and reach out for support.

In some cases it was argued that the ability to make choices is a developmental process that is not fully developed until adulthood.

> They are not as mature, not as developed as adults. There comes a point where you as a worker make a distinction between the degree of real choice that I feel an adult has as against that of a child. I would be tending to be more concerned for children in that situation than for adults who have had a range of choices to get to the point where they are at (Phil).

Young people were seen by some workers to be more impulsive than adults, more vulnerable, more emotional and less likely to think through the decision:

> I believe they have more chance of carrying it out because of the make up of adolescence and the being here and now; the huge highs and lows and not a lot of thought about the future (Trisha).

> There is more life to be lost. They don't have an adult awareness or appreciation of their circumstances. They are more likely to be swamped by their circumstances (Mark).

> With young people it is not always that easy to reason with them (Melanie).

> I just sense they are more impulsive. I was more impulsive at that age (Lisa).

> I think they are more vulnerable for a whole range of reasons. Maybe they are not but I happen to think that way (Jim).

> It pushes buttons for me when it is a young person. For an older person they can rationalise. For me when they are young it is a more emotional thing (Carol).

A belief was expressed by two social workers that there is more capacity for change in young people.

> At that age, although they might be quite rational I might be able to put back some hope into their situation. If they had some hope, they might change their thinking (Mary).

The 16 social workers who believed suicide could be a rational choice, unless confused thinking or mental illness was apparent, intervened in a non-directive way. They offered choices, explored options or made suggestions and left the client to choose. Social workers in this group were more likely to be employed in community-based organisations, some counselling agencies and welfare agencies. All of this group said they would recommend medication in cases of severe depression and also indicated that if the client were a young person they would be more likely to take directive action.

Action taken by social workers in this group was to explore strategies for safety with the client, and to contact family or friends if requested. As the following quotations indicate, they were less directive in that they would take no further action unless specifically requested to do so by the client and tended not to apply pressure to the client to make a decision:

I think it is their responsibility. That is how I deal with it for my own well-being and their well-being. It's their life and they can suicide if they want to. It is my responsibility as a worker to check out what the issue is. I talk to them about the effect it would have upon the other significant people in their life and always check out how they can make their lives more safe if they need to....I think it would be quite different if I was working with teenagers (Lisa).

I would be confronting them with the fact that they are very suicidal and asking their permission to get some supports for them. I don't think I have ever, if someone has been really suicidal gone off behind their back. I think that in the end if they are going to do it , they are going to do it. I would do all I could to see that they were going to be followed up with their permission. If a person, in their own right and self-determination has made the decision (to die) I would explore options with them but if they have decided that this is the best for them and I don't have their permission to get any help, well it is their decision (Mary).

The last time I saw her she was feeling very hopeful....She said she had some strategies in place, mainly with the doctor who she couldn't speak highly enough of. She made it clear she was grateful to the people who were assisting her to hold on while she knew that she was doing everything to not hold on. Well not everything obviously, because she was reaching out. Therefore I didn't take any (action to prevent the suicide). There were no other supports that she hadn't already been working with that I could offer, other than myself, which I did....Yes it's interesting and I haven't actually thought about it before, but at no point did I think it was up to me to force her not to kill herself. I never had any responsibility around that at all (Suzanne).

In contrast, the 13 social workers who saw the suicidal crisis as a process of constriction whereby clients were unlikely to be able to fully consider the options available to them intervened in a directive way. Seven social workers were willing to break the confidence of a client in order to make that person safe. They acted to make the client safe and applied pressure to clients to gain their consent for action. Social workers in this group were employed by the Health Department, in children's services and some counselling agencies.

Medication from a general practitioner was recommended if necessary and some kind of contracting was made with the client. The action taken ranged from contacting family members to initiating hospitalisation procedures. As two workers stated:

> Certainly you try and use whatever is there. For example with a young person, or with anyone actually, I would probably bend confidentiality things in trying to seek their permission to talk to someone in their family or go with them to talk to the family....One time we had a young person who did not want to go into hospital but he agreed to wait until we got the family in. Now the family actually rostered themselves for two weeks and just never left that person alone. He was so close to suicide (Irene).

> We actually put him in a car and took him home to his parents who lived 45 kilometres away. We knew there was a safe environment there. He spent the weekend and reconnected with his parents (Jim).

Even in agencies where consent was necessary to initiate further action, some social workers pushed clients as much as they could to obtain such consent as the following quotation shows:

> Recently I saw a young person who I considered at risk. He did not want anybody to be contacted and I insisted. I don't have any legal right, and nor does anybody else, to make the contact if that person doesn't want to but if I think it is serious enough then I will say over and over again, 'Look I think this is serious and I am really concerned. I don't think we can allow you to go home unless you give us permission to contact somebody to make sure you are safe'. And I say this over and over again until this person says OK. It really is a matter of making that quite clear. Sometimes people walk out and you can't stop them but I think one needs to be far more direct about things than social workers are often used to being (Christine).

The 13 social workers in the latter group are acting in a way that is consistent with the recommendations made by experts about the management of suicidal behaviour (See Chapter Four). Apart from the issue of consent there is a congruence in the way they treat suicidal adults and suicidal young people. They implement crisis intervention strategies with both groups.

The first group of social workers, 16 in total, who responded in a non-directive way were not identifying the process of constriction that is part of suicidal thinking. Clients who have ended up thinking about suicide and completed suicide may appear to have had logical reasons for doing so, but this does not mean that at the time of the suicidal crisis they were thinking through the range of options that were open to them other than suicide. Bateson, Oliver

and Goldberg (1989) claim that the calmness of some highly suicidal people may be confused with rational thinking. Being non-directive does not take account of the poor motivation of many clients who show signs of suicidal behaviour, to seek further help or follow up referrals.

> It is now well established that many clients who have attempted deliberate self-harm are poorly motivated towards further contact with either psychiatrists or social workers and that nearly 50% fail to attend subsequently when offered out-patient appointments (Bateson, Oliver and Goldberg, 1989, 474).

This raises the issue of the role of a social worker or any professional in the prevention of suicide. An important aspect of suicidal thinking is ambivalence. Part of the person wants to end the pain but another part is resisting the move to end consciousness. One could argue that it is the resistant part that is seeking help, leaving clues, wanting to be rescued. If the suicidal individual has become highly ambivalent the response of the practitioner or professional could tilt the scales either way. Shneidman (1993) argues that in not actively preventing a potential suicide by, for example, preventing someone from leaving your office with a gun, the professional is actually giving the client a "latent message that you are encouraging the suicide" (147).

Three concepts that emerged as themes during the interviews were suicide as understandable behaviour; suicide as rational behaviour; and suicide as a choice. At times some social workers used the terms as if they followed in a logical sequence:

> The woman who did kill herself, well the risk was high, but she was conscious and rational about the whole situation....At no point did I consider that she did not have a right to kill herself (Suzanne)

According to the psychological model of suicidal behaviour suicide is both understandable and is rational in that it makes sense to the person who is considering it. Suicide as a choice is a particular value position that is not automatically implied in acceptance of suicide as understandable or rational. The whole notion of suicide as a choice is a complicated philosophical and moral question that is beyond the scope of this research to examine but the issue at point is not the right to die by suicide, but what the role of the professional ought to be in responding to suicidal individuals. There are limits to what any professional can do in the face of a determined suicidal person. However, the issue is that we are talking about people who are seeking help and who have given an indication of their suicidality to social workers. This implies a measure of ambivalence to which social workers have a duty to respond.

One needs to question why young people should be treated differently from adults. Some social workers who replied with comments like, "It pushes my buttons", "young people are more open to change than older people", "there is more life to be lost" or "I think they (young people) are more vulnerable" are differentiating between young people and adults in an inconsistent manner and in a way that does not do justice to the desperate situation faced by suicidal adults.

Like the notion of suicide as a choice, the ethic of confidentiality is linked to social workers' perceptions about their professional role in the prevention of suicide. The ethic of confidentiality was strongly adhered to by members of the social work profession. The decision about whether or not to break the confidence of clients was found to be related to the agency in which social workers are employed. The only workers who could conceive of a time when they may have to break the confidence of clients were employed in health services, counselling agencies or agencies for children. Even so, unless children were concerned such decisions were made reluctantly. Exceptions were often made when the life of another person was at risk. In these cases a number of social workers confided that they would be prepared to 'bend confidentiality' to prevent a potential homicide.

During the interviews many social workers discussed strategies that had proven successful in keeping suicidal clients safe but the key to these strategies seemed to be gaining the co-operation of the client involved in the first place. Almost half of the social workers admitted to applying considerable pressure to clients who were reluctant to accept any form of assistance but the experience of these workers had been that in most cases clients welcomed the assistance and minimal pressure was needed. In most circumstances social workers varied in the amount of pressure they would apply, but did not break the confidentiality of clients. Given that experts (Halasz, 1992; Shneidman, 1993) in the treatment of suicidal behaviour recommend that consideration be given to breaking the ethic of confidentiality, more debate needs to be carried out at an agency and

professional level about what the response of social workers ought to be to this issue.

The agency in which the social worker was employed appeared to have been a key factor in determining the response of the social workers. Years of experience, age or gender did not appear to have an effect. Only two of the 16 agencies covered in this research had a suicide protocol in place to direct the action of workers. Twenty-three percent of the social workers in this study said that they were prohibited legally by the privacy regulations of their agencies and could not initiate any action without client consent. Having a suicide protocol in place within agencies may lead to a more consistent response by social workers across a range of agencies and resolve the sticky issue of confidentiality. Development of the protocol allows for debate about philosophical and ethical issues that ought to be clarified by the time the suicidal client appears in the agency.

We need to ask what effect this lack of consensus has upon the practical problem of suicide prevention. The results of this study show that suicide prevention is not a straight forward issue and cannot be separated from the subjective value and ethical dilemmas of professionals. Clearly, the comments of many social workers in this study indicate that all too often action results from personal opinions that have not had the benefit of considered reflection.

CHAPTER 9

"HOW ELSE DO YOU MAKE THEM SAFE?"

One course of action that social workers may consider is that of referral of the highly suicidal person to another agency. Whether or not referral was considered as an appropriate course of action was found to be a function of an interplay between ideological and practical realities.

Social workers who decide that referral of a suicidal person is the preferred course of action, could refer to psychiatric services, a general practitioner or to other non-psychiatric services in Launceston. All social workers were prepared to make referrals to general practitioners and this was usually done when signs of deep depression were apparent.

All of the social workers interviewed could see a positive role in the use of medication for depression. Drugs were seen to be needed, "to engender enough energy to even start looking at what (clients) are feeling and why" (Denise) and "to reverse the spiral they are in " (Mary). Concerns were expressed however, by a small number of social workers (one fifth of the sample) about what they saw to be the on-going use of heavy medication to treat depression. The ones most likely to express such concerns, were the social workers who did not define acute depression as mental illness. Lisa's comments represent the views of such social workers:

> It seems to me that whenever you prescribe drugs they are monitored all the time, depending on your moods. The women tell me that their drugs are never in sync. They are always a week behind or a week in front. I just feel that the women in those situations, well their feelings are often quite masked. They can never really get a grip on what is going on for them...and that is what I think prevents healing - taking drugs for it (Lisa).

The concerns about perceived over-medication illustrate conflict between a number of social workers and psychiatric services over the management of clients.

9.1 DISPARITY OF VIEWS ABOUT PSYCHIATRY

Thirteen social workers expressed great reluctance to refer to psychiatric services. Five of the 13 social workers could not imagine any circumstances under which they would make such a referral. However, 18 social workers in total discussed the negative impact that labelling and stigma have upon clients who are treated by psychiatric services. Karen related the concerns of many social workers when she said:

> I would refer if I thought they were going to hurt themselves or someone else. I don't like to do it because I have heard such dreadful stories about it by the women themselves. They have been whacked into 1E (psychiatric ward) when I don't think they should have been....I don't like it because they are often slapped with a label and left with the stigma. But at the same time I believe it has a place. What else can you do? You can't guarantee someone's safety unless they are in a place like that. How else do you make them safe?

Some of those interviewed believed that suicidal behaviour was managed by psychiatric services because no other professional groups were seen to offer alternative management strategies:

> If I was honest about it, I would explore all the other avenues first and see if there was a reason for this behaviour and when you get to the reason refer onto that specific area. If I can't come up with anything then maybe it is psychiatric by default (Trisha).

> I think the reason that suicide is seen as a mental health problem is because nobody else sees themselves as having a grasp on that type of behaviour....I guess handing it across to somebody who is prepared to accept the work, psychiatrist or psychologist, well that's the way it goes (Jack).

Another theme about the perceived results of psychiatric intervention that was found in one-fourth of the interviews was loss of control. Several social workers objected to an observed disempowerment of personal rights on the part of clients of psychiatric services. As one stated:

> One of the biggest things has been that every client I have had contact with who has had contact with psychiatric services has been incredibly afraid to re-establish contact. It has been about a fear of losing control of what is happening to them and the labelling and stigma. But mostly the loss of control. Once they are in there it is like a trap, never regaining what they had (Kate).

The concept of control was taken by a few social workers and applied to the model of psychiatric intervention. It was suggested that psychiatry is only one way of approaching a problem that could be

"just an alternative reality" (Francis) on the part of the client. Psychiatry was conceptualised as a dominant paradigm against which there were alternative methods of treatment as the following quotation indicates:

> I don't know how helpful psychiatric intervention would be in the long term. It would be interesting to look at their success rate....Maybe it isn't all that helpful for a lot of people. They feel out of control because someone else has put a label on them because that is their interpretation of what is going on for that person....I don't think psychiatry is totally negative but I do think it has tended to own a lot of knowledge about working with people and understanding people and I don't think that is necessarily a good thing. I think it is always good to have alternatives (Cynthia).

The five social workers who could not imagine any circumstances under which they would make a referral to psychiatric services and saw psychiatry as a dominant paradigm, disputed the existence of mental illness. They perceived it as a label for adaptive behaviour and described mental illness as a different reality from that of the majority. These social workers believed that the psychiatric services are generally unhelpful and create more problems for their clients than they resolve.

There was a perception, especially amongst those social workers who were concerned with the negative impact of stigma and labelling, that psychiatrists use medication more than other forms of treatment and lack an understanding of the social dimensions of illness:

> I had a young lady in here a couple of weeks ago who had been diagnosed with reactive depression or something. She had been contemplating suicide for a long period and had been involved with a psychiatrist for some time. Now the psychiatrist had sedated her and medicated her but hadn't actually spoken to her about the abuse that had gone on throughout her childhood which was really fresh for her. You just lose a bit of faith in them if all they do is medicate them to oblivion. I mean that is one thing but they never seem to confront the issue and work through that. I get sceptical about what psychiatrists do (Mark).

Mark was one of nine social workers who mentioned that stories from patients were a primary source of information about psychiatric services. Sharon added to this view:

> I do have a healthy sense of scepticism because of the stories I hear. More than 50% of the people I see here have had some involvement with the psychiatric system...and it hasn't always been a successful enterprise for them in their healing....So I am not committed to the idea of psychiatric help (Sharon).

Despite any expressed reluctance to refer, 25 of the 30 social workers who were interviewed had made a referral at some time to psychiatric services, although not necessarily because a client was suicidal. Sixteen social workers said they would refer to psychiatric services if there was a high risk of suicide. Nola's comments typify the attitude of the social workers who believed that psychiatric services are essential to the management of some clients:

> I would refer clients at risk of suicide to a psychiatrist if I thought I could no longer handle them or if I thought it was something way beyond my control or my scope. If I was

> dealing with someone who I thought had a definable mental illness or was not rational at all I may refer them. I recognise my limitations.

The split across the group of social workers into those who expressed concerns about the intervention of psychiatrists and those who willingly made such referrals either in the case of a suicidal person or when someone was exhibiting psychiatric symptoms appears to be related to how long they have been social workers and the type of agency in which they were employed. Graduates within the last ten years who were not employed by the Health Department were more likely to dismiss the reality of mental illness and to question the role of psychiatry in the maintenance of mental health. It should be noted that this was a trend to which there were two exceptions. Two social workers who had graduated within ten years and who were not employed by the Health Department did not hold these views. More recent graduates were also more likely to discuss the impact of psychiatric services in terms of a perceived power structure that inhibited the rights of clients and the power that clients were able to exercise over their own lives.

The question arises as to whether the split across the sample regarding attitudes towards psychiatric services is due to a change in the education of social workers or whether experience itself leads to a change in attitudes. It seems that familiarity with psychiatric services which may have come through training or through work experience is an important factor in attitudes towards these services. From this research it is not possible to identify the extent to which length of time as a practitioner is itself a factor, regardless of training. It may be that the longer one is a social worker, the more likely one

is to have contact with the seriously mentally ill and, therefore, be more predisposed to seeing psychiatric services in a favourable light.

Information from the interviews suggests that the changing focus in social work education may explain some of the differences in attitude. The change of focus in education was reflected in the experiences of social workers in this study. Many of the social workers who have been practitioners for more than fifteen years described having input from psychiatrists during their training. They said they attended lectures given by psychiatrists and also attended classes which were located in mental health facilities. Part of their education involved an opportunity to become familiar with various diagnostic instruments that were used in psychiatric services. These experiences are not part of the training of recent graduates in Launceston. On the other hand, recent graduates were far more likely to show a sensitivity towards the adverse effects of involvement in the psychiatric services. One could hypothesise that this is a result of the change in education practices.

The findings about less experienced social workers being reluctant to refer to psychiatric services, may only be a reflection of the social work course here in Launceston. Of the social workers who participated in this study, one-third (10) trained interstate and two-thirds (20) trained in Launceston. Only three of the social workers who trained interstate had been qualified for less than ten years and although these three social workers readily made referrals to psychiatric services, the sample was not big enough to draw conclusions about the differences in the Launceston social work course as compared to courses elsewhere in the country. Social work

courses in the rest of the country may have produced different attitudes amongst graduates regarding psychiatric intervention.

Concerns about the problems faced by clients of psychiatric services are justified in light of the recent findings of the Human Rights and Equal Opportunity Commission and ought not be underestimated. This report entitled Human Rights and Mental Illness found that

> people affected by mental illness are among the most vulnerable and disadvantaged in our community. They suffer from widespread, systematic discrimination and are consistently denied the rights and services to which they are entitled (1993, 908).

However, these concerns need to be balanced against the importance of providing a safe environment for, and accurate mental assessment of suicidal people. Experts in the area of suicide prevention stress the importance of psychiatric assessment because in their experience mental illness is a major cause of suicide and one that is all too often unidentified by non-medical professionals (Lowenstein, 1985; Davis, 1992). Statements made by some social workers, particularly some of the more recently graduated, suggest an antipathy towards psychiatric intervention which may be putting suicidal clients at further risk.

9.2 MAKING REFERRALS

In their role as social workers in agencies, all of those interviewed, received and made referrals as part of their practice. When asked about the referral procedure as it applied specifically to suicidal clients the social workers differed in the action that they took. "Referral" here means that social workers referred to other agencies to take charge of the management of the client. (All social workers would refer to a general practitioner if they felt that medication was warranted.) Twelve of those in the study referred clients on to other agencies when clients showed evidence of suicide risk. These workers typically had short-term contact with clients and sought medical intervention for them. Two of the workers engaged in long-term counselling but made referrals if a risk of suicide was imminent. As one of them commented:

> I have had occasions where I have kept someone here until someone could come. We have had five admissions directly to 1E (public psychiatric ward) from here and one directly to St. Vincent's (a private hospital). People don't mind that. I mean we have never had to hold anyone down or anything like that (Irene).

Four social workers regularly received referrals of suicidal people from other agencies. They were able to continue long-term counselling with clients and were in the position to initiate procedures for involuntary hospitalisation. One of them claimed that:

> The other option that we have if the person is regarded as a suicide risk is that they might need to be admitted....Part of my job is ...organising involuntary admissions if need be and as an authorised officer I can sign one of the forms together with a physician (Christine).

The remaining 13 social workers (one social worker had no client contact) who had had contact with suicidal people did not generally refer clients to other agencies specifically because they were suicidal unless it was considered that the client was mentally ill or confused in his/her thinking. With the exception of four social workers, this group typically had long-term contact with clients and most were prepared to engage clients at risk of suicide in long-term counselling.

With two exceptions, the twelve social workers who were most likely to refer a suicidal client were either employed in agencies that did not allow for long-term contact with clients or in agencies in which a protocol was in place which stipulated that referral was the action to be taken. Social workers in this group were more likely to be directive in their action and seven of them were willing to break the confidence of a client in order to make that person safe. Social workers less likely to refer were those employed in counselling agencies where long-term contact with clients was common.

9.3 BUT WHERE TO REFER?

Whether or not social workers referred suicidal clients did not only depend upon their willingness to do so. The referral process was identified by most of those interviewed as one that was fraught with

difficulty. Almost one-fourth of the sample were restricted by agency regulations and were unable to make a referral without client consent. One interviewee pointed to this problem:

> Our agency is restricted by our privacy regulations. I cannot make any referrals or take any further action without the consent of the client. It is agonising and frustrating when you have determined through your interactions that this person is at risk of suicide and if they are resistant to any suggestions I have made then I have to accept that as a choice, as a decision (Kate).

A further third of the sample contended that, provided mental illness or thought disorder was not evident, referrals could only be made with the consent of the client involved. The following quotations demonstrate this:

> With adults I am looking at suicide as a real choice. I name that up with them....if you don't want psychiatric services then let's look at the other options. You've got the counselling services, the health department services, you've got self-help groups. Encouraging an individual who is reluctant to be involved in such services if they don't want to be and I would be making sure that they knew the range of options such as Life Link or their own networks....But if they were still not interested then I guess I wouldn't be doing much more (Phil).

> If they don't want a referral it won't be made (Jack).

Client resistance to proposed referrals was generally identified as a major constraint upon action. Even when social workers were prepared to break the confidence of clients to seek help for them,

client resistance would prevent further action from being taken as these comments show:

> If you press a referral it will happen. There are a couple of factors that influence that. Whether or not the client wants to see a psychiatrist and whether the doctor is treating them is keen for them to see a psychiatrist or feels that it is only a reaction to a social situation and should be left (Carol).

> It really depends on the client's willingness to come back. I can't force them to come back (Christine).

> I find getting someone admitted to psychiatric care is very difficult if they don't want to go. The one time I had to work really hard to get someone admitted it was quite exhausting. It took a few days to talk this person around and in the end he went as meek as a lamb (Jim).

> What I do is consult with colleagues about what I should do and it is a bit like you can't really do anything if a person doesn't want you to. You can't suddenly call in the police about something that they may do. It's very, very difficult (Pat).

Another problem which was identified by most social workers was that of a shortage of agencies to which one could refer the suicidal person. When asked about the response of other agencies in Launceston to referrals Pat's was a typical response:

> They are all too busy. They pass the buck beautifully. They don't really want another case load. I am being pretty ungenerous here because that is not always the case but for instance with this man I had a genuine reason to believe that things were dangerous. Three-quarters of the day I was on the 'phone trying to get some help and I just couldn't seem to get onto anybody to call me back in a reasonable space of

> time. You go through a process of twisting arms to get them to take him on.

It was generally acknowledged in the interviews that there was a shortage of agencies to which men and young people could be referred. This was particularly the case if violence or aggression was a part of the problem. Several interviewees pointed to this:

> M.O.V.E. (Men Overcoming Violent Emotions) was the best place to send them but it has not been refunded. Now I just try for one or two counsellors I know who used to be involved with M.O.V.E. (Jenny).

> It is politically correct at the moment to be pro women and children and to be very anti-male. I would say it that bluntly. It shows in funding and service provision (Bev).

> For older people, older aggressive alcoholics there is bugger all support. For homeless people there is nothing....I find the lack of resources in Tasmania immoral (Jack).
> For young people I don't think there is much at all. ....Oakrise do the best they can but they don't have enough people. There is hardly anything here and that's why I did some education for myself (Trisha).

Services designed to meet the needs of suicidal people were found to be lacking by social workers. Psychiatric services were found to be difficult to access, particularly for clients who did not have a psychiatric history and these services were also seen generally as unsuitable for the majority of suicidal clients, as the following examples demonstrate:

> The youth are not serviced in any way. There are no services that reach out to people where they are at. To have to come

> to a psych service, well they are not crazy, they are distressed. They are not able to utilise the existing service and it is not really geared up to meet their needs. Their depression is unique too and doesn't fit in with the system. A lot of their distress is situational but it slips into the clinical and there isn't a service that is acceptable to them that deals with that. They don't want to go to a psychiatrist. Nutters do that so if they do go into the system they are probably unresponsive to it anyway (Leanne).

> The agencies are set up for specific problems like sexual assault, domestic violence, homelessness. If you have a suicidal person who has one of those problems then you can refer there, but if they don't where can you send them? We need just a general crisis service that can respond quickly (Jenny).

It has been the experience of many social workers that services in Launceston are unable to respond quickly when a referral is made for a suicidal client. This is discussed in the following quotations:

> The worst time is January. It's just awful. I mean even accessing a psychiatrist in town was dreadful, hopeless....But now I do have a couple of psychiatrists who will make themselves available pronto and that has been a lot quicker than 1E (public psychiatric ward). Certainly if someone has got private health cover I tend to go that way because I can have a psychiatrist come up here and have someone admitted to St. Vincent's (a private hospital) a lot quicker than I can mobilise 1E. But we have had times here like recently when it took about five hours to get any help for one guy and he was very agitated too. We kept him here and we were trying to get him onto 1E (Irene).

> Referrals have not been so good if it is an emergency type situation. Psychiatric services have been fairly prompt and have been able to see the person within a couple of days. I

> have called in a GP a few times and they have come straight away. I send a few who can afford it to private counsellors but most people here don't have that sort of money (Karen).
>
> There has always been an element of frustration in referring to agencies in Launceston. Well, not always if I am really concerned about someone, well, most services seem to have been able to help out. It can be frustrating if I am really concerned about it to get them to share that concern unless they know the client. If they don't know the client it is harder. The thing with people in crisis is that it is important that the service is put into place very quickly or you lose them.....I think sometimes that it is just impossible (Carol).

The results of this study suggest that social workers experience difficulty in obtaining prompt and appropriate assistance for clients at risk of suicide. These results are consistent with the findings of the Human Rights and Equal Opportunity Commission that "the existing relationship between the public and private psychiatric systems militates against optimal patient care. Private inpatient care (for the mentally ill) is virtually unobtainable by people who do not have private health insurance" (1993, 909). In the interests of equity for all clients an inter-agency response is needed. Clients who lack medical insurance are disadvantaged. Clients who are violent, aggressive or not actively seeking help are unlikely to receive the services they need.

In conclusion the reality of social work practice regarding suicide prevention results from a combination of beliefs that social workers hold and practical issues. It is not surprising that some social workers were very reluctant to enter into a form of partnership with psychiatric services when they saw psychiatry as diametrically

opposed to their own understanding about the nature of illness. Numerous social workers reflected upon well-documented problems that result for some clients who become part of the psychiatric 'system' while noting that at present, "You can't guarantee someone's safety unless they are in a place like that" (Carol). In addition, social workers identified a range of practical problems which inhibit the type of referrals that they may like to make. There is a shortage of agencies to which one can refer suicidal clients and agencies that may be able to accept referrals are unable often to respond quickly.

These findings represent the end of the 'results section' of the thesis. The findings detailed in Chapters Six through to Nine will be discussed in the following chapter. Chapter Ten offers an explanation as to how some of the unorthodox findings of this study may have come about. Chapter Eleven makes a series of recommendations in the light of the Discussion Chapter.

CHAPTER 10

DISCUSSION

The discussion begins with an overview of the main findings, including the extent of suicidal behaviour in social workers' clients and a review of the social work response to this behaviour. The response of many social workers to suicidal behaviour in clients was unorthodox, and was not predicted in the research literature or by myself when I used crisis intervention theory in the conceptualisation of this study. In order to explain the results, I use the theory of social constructionism. The discussion contains an overview of social constructionist theory, which I then apply to the results of this study.

10.1 SUMMARY OF MAIN FINDINGS

A review of the literature on suicide prevention identified the dearth of social work contribution on the subject. As a result the purpose of this study was to generate information about the extent to which social workers encounter a range of suicidal behaviours in their practice and to document how they intervene to prevent self-harm. The research questions were specifically centred around the appraisal of suicidal risk, preventative action and problems impeding effective management of suicidal behaviour.

For 29 participants in this study suicidal ideation in clients was encountered on a weekly and sometimes daily basis. Those social workers who work primarily with children were the least likely to encounter frequent thoughts of suicide amongst clients whereas

social workers employed in crisis services were the ones who were more likely to encounter such ideation on a daily basis.

One-third of the sample discussed incidents of attempted suicide in clients where there had been evidence of a high level of perturbation and lethal plans.

Completed suicide in clients was reported as a rare phenomenon. Eighteen participants reported contact with a client who had subsequently died by suicide but for the majority (ten participants) this had only happened on a single occasion.

An unexpected finding was that sixteen social workers believed that clients could reach a stage whereby a rational choice to suicide could be made and that this in fact was their right to do so. If suicidal clients were seen by this group of social workers to be rational in their thinking then the clients' right to self-determination was the principle they adhered to, even to the extent of respecting their decision to take their own life.

As stated previously the purpose of the study was to document how social workers intervene to prevent self-harm. However, after analysis of the interviews it became apparent that an unexpected social work response to the phenomenon of suicide had occurred. In the formulation of the research, it had not been anticipated that a substantial proportion of social workers would adopt an ideological position that would result in a non-interventionist approach to suicide prevention.

In view of these findings, it is important to provide an explanation of such an unorthodox response to the threat of suicide in clients, as well as describing the extent to which social workers encounter such behaviour.

10.2 THE EXTENT OF SUICIDAL BEHAVIOUR

The findings about the extent to which social workers encounter suicidal behaviour in clients was not unexpected. These findings are consistent with the facts as we know them about suicide (Birleson, 1988; Hassan and Carr, 1989; De Braga, 1989). Suicidal ideation, that is, thoughts of being tired of living, of wanting to be dead, or the use of the word suicide by individuals who are in a state of distress, forms a frequent part of the work of social workers.

There have been few studies measuring the extent of suicidal ideation amongst the general public and none measuring the extent to which social workers encounter such behaviour. Kosky et al. (1990) found that 1.4 percent of all adolescents (average age 15 years) express suicidal thoughts. The same study found that 12.7 percent of adolescents in remand centres express such thoughts. Birleson (1988) cites a study (Rutter et al. 1976) which found that 7 percent of all fifteen year olds report suicidal thoughts.

Given that social workers work with disadvantaged and distressed people it is not surprising that they encounter suicidal ideation on a very frequent basis because such ideation is usually an expression of distress rather than of a real risk of suicide. Thoughts of suicide in themselves are not necessarily a problem. "There is nothing

intrinsically wrong or aberrant in thinking about suicide; it is abnormal only when one thinks that suicide is the only solution" (Shneidman, 1993, 21). None the less, the findings are important in their implications for social workers who need to be skilled in distinguishing the genuinely suicidal from the distressed.

These findings about the extent to which completed suicide in clients is encountered by social workers can also be reconciled with the suicide rate in Tasmania. In 1992, 40 people died by suicide in the area of Tasmania in which this study took place. This study confirmed that completed suicide appears to be a rare phenomenon faced by social workers.

Of the entire sample just over half reported contact with a client who subsequently died by suicide. These social workers, on average, had been in practice for ten years. In that time, ten had had this occur only once, three on two occasions and four on three occasions.

10.3 THE SOCIAL WORK RESPONSE AND IDEOLOGY

Although completed suicide may be a rare event, suicidal behaviour presented as a common problem to social workers. As thoughts of suicide and acts of self-destructive behaviour occur frequently within the community (Hawton and Catalin, 1982; Davis, 1992) one could expect that social workers would encounter them in their work. The focus of the literature on the subject of suicide prevention is upon the problems inherent in assessment of risk and recommends a clearly defined course of action when a high-risk assessment has been made (see Chapter Four). For that reason the

focus of this research was on how social workers assess level of risk. However, it was entirely unexpected that having assessed a high level of risk, just over half the sample did not necessarily implement crisis intervention principles and act to make the client safe (see Figure 3).

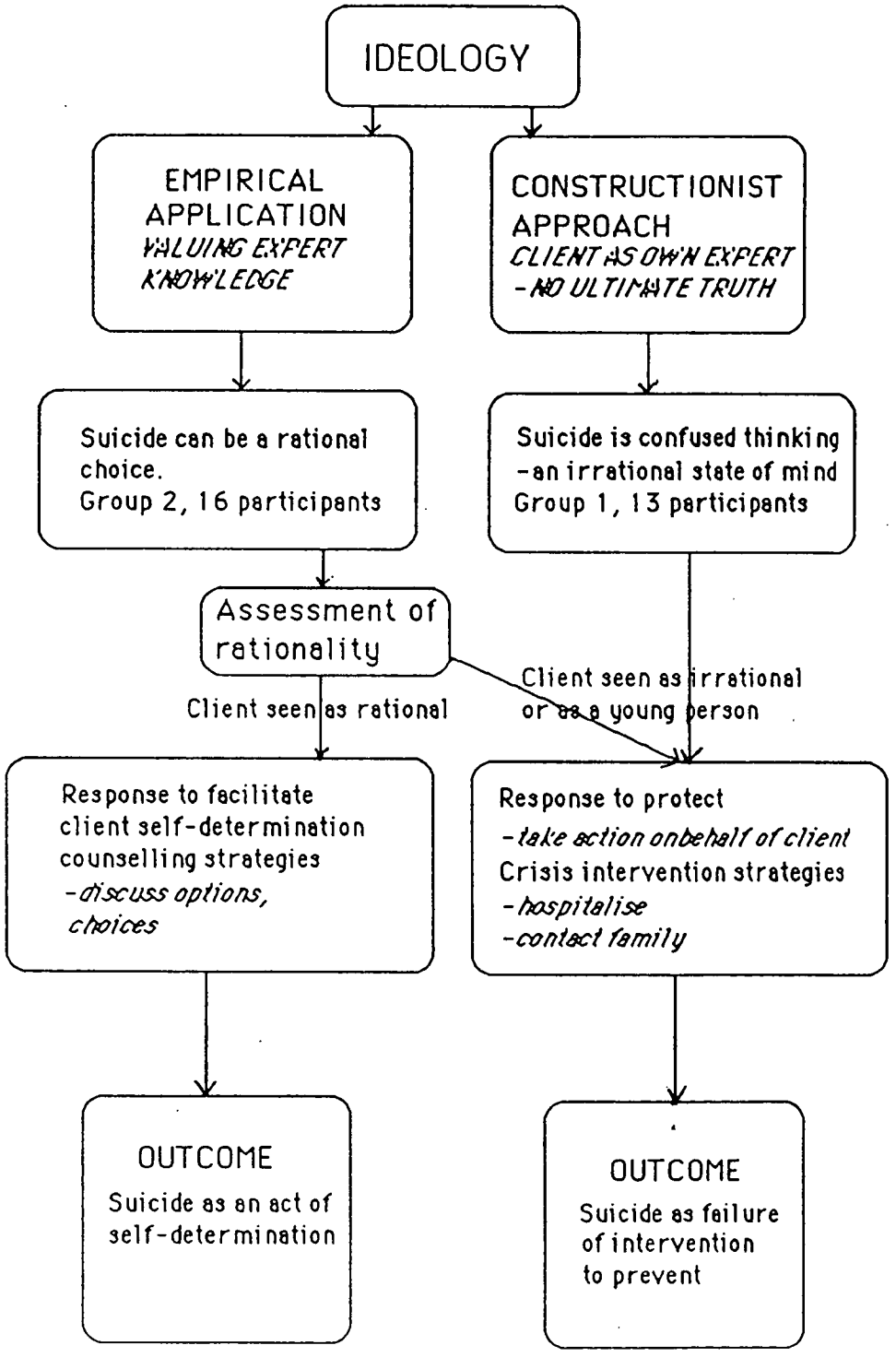
Thirteen participants did take direct and/or directive action whenever they assessed a high level of suicidal risk. They instituted hospitalisation procedures or contacted family members of the client and set up a support network to ensure the safety of the client. These social workers took the view that the fact that the client had contacted the social worker was in itself a sign of ambivalence that warranted directive action. In addition they argued that acutely suicidal clients are not in a state of mind to allow the principles of self-determination to apply. It was seen that the constriction of thoughts which accompany the suicidal client meant that the person was by definition 'irrational' and therefore in need of protection from themselves.

These 13 participants adhered quite closely to the view expressed in the literature on the subject and was the response predicted by myself when designing this study. That is, that once an assessment of high suicide had risk had been made a subsequent crisis intervention response would be implemented.

The unexpected response came from 16 participants. They began their intervention with a process of assessing risk. This process was centred around the notion of rationality. If clients were deemed to be 'irrational', that is, they were not thinking clearly, were

Figure 3

Social Work Intervention After A High Suicide Risk Assessment



psychiatrically disturbed or highly distressed - then these social workers like the 13 participants described above, implemented crisis intervention strategies and acted to make the client safe.

However, if the client was deemed by them to be rational, that is thinking clearly and able to exercise a choice in the course of action they could take, it was determined by these social workers that principles of self-determination and empowerment should apply. This meant respecting the right of clients to have control over their own destinies even if this included taking their own lives. Suicidal behaviour was not seen to be irrational by definition. These social workers gave examples of times when they had explored options, discussed feelings and so on with clients who they saw to be at high risk of suicide but took no further action with them. On the contrary, they affirmed the right of the client to make such a choice.

This was an unexpected response because nothing in the literature that I had read had prepared me for such a finding. That is not to say that there is no debate about suicide as a rational choice for some people. But the philosophical position that "the right to die must be implicit in the right to life" (Flew, 1981, 48) is applied to those people who are terminally ill. The concept of euthanasia or assisted suicide for the terminally ill is becoming more widely accepted by society as a humanitarian act to relieve chronic pain and suffering (Andrews, 1992; Baume and O'Malley, 1994; Charlesworth, 1993; Stewart, 1992). The concept of rational suicide is not normally applied to those who do not have a terminal illness and yet indeed, this was the position to which many social workers in this study adhered.

Rationality was assessed by the ability of the suicidal client to weigh up the pros and cons of his or her situation and to exercise a choice about whether to live or die. If a client was seen to be doing that then he or she was exercising a 'rational choice'. For example, this view is well exemplified by the following response from a social worker:

> If somebody is distressed and they are sitting here spinning out, then you have got a real life circumstance to respond to. You have to do something. If someone is sitting there and they are fairly calm...I have difficulty with that. This person is still making choices and they have to make them one way or the other. We have to provide them with enough information and support and to point out to them the kind of supports they need, but that is it (Jim).

It could be argued that anyone who is considering making such a choice in a dispassionate manner cannot be deemed rational and that is the assertion in the literature on suicide prevention (Appleby, 1992; Shneidman 1993). In other words although the act of suicide makes sense to the person who is contemplating it because it is a solution to ending pain, it cannot be considered a 'rational' act as such, because rationality involves the ability to think clearly and choose among several viable options. Suicidal perception is linked with a constriction of the individual's thought processes and a focussing on only one seemingly possible solution, that is suicide. For this reason Shneidman says, "There is no such act as a rational suicide; but every suicide is a rational act- except possibly one committed by an actively psychotic person" (1993, 21).

Why then are many social workers taking the position that one can rationally choose to die? In order to explain this unorthodox response I needed to find an alternative to psychological theory. These social workers must have been using an alternative theory to inform their practice. Johnson argues that there is always a link between theory and practice although the former may be explicit or implicit (1987, 7-11). If theory is implicit then Johnson suggests that it may be unacknowledged by the person because he or she may be unaware of the assumptions being made.

Lecomte supports Johnson's proposition, in writing:

> We contend that the real issue is not whether practitioners operate from theory, but rather 'what' theory they use and how they should evaluate its usefulness for practice. For it seems evident that those who feel that they can operate entirely without theory are usually basing their behaviour on vaguely defined 'implicit theory'.
>
> (Lecomte, 1975: 208-9)

Plant (1970) believes that the theory underpinning practice may be a moral one rather than a scientific one. In which case as Lecomte suggests, problems may result for practitioners and their clients: "It is the theory used by a practitioner without knowing he is using it that is dangerous to practitioners and their clients" (Lecomte, 1970, 209).

It was beyond the scope of this study to determine the exact nature of the theories that were underpinning the practice of those social workers who endorsed the concept of rational suicide. This is clearly an area ripe for further research. However, the findings do tend to indicate that some of these theories have a moral rather than a

scientific component to them. The action of some of these social workers was based on beliefs about mental illness, depression and psychiatric intervention that are not supported by empirical research (See Chapters 6-8). Nevertheless the suggestion that the actions of all social workers who supported the notion of rational suicide was always based on moral rather than scientific theory does not hold true either. This group of social workers was not uniform in being 'non-scientific'.

How then to explain the results? To do so, I turned to social constructionism. In recent years there has been a resurgence of social constructionism in the social work literature. For example, a recent edition of the *Journal of Teaching In Social Work* (Vol 8, 1993) was solely devoted to revising a social constructionist approach to social work knowledge and practice. Social constructionism will not enlighten us as to the precise theories underpinning the practice of social workers but it will help explain how such differences have come about. Social constructionism explains how alternative perspectives are generated and how members of one profession can "occupy different experiential realities" (Fisher, 1991, 4). I will now overview its key tenets in the next section.

10.4 SOCIAL CONSTRUCTIONISM: A BRIEF OVERVIEW

A constructionist perspective sees reality as subjective rather than objective and has its roots in the philosophy of the Skeptics who asked, 'How is it that anyone can claim to know anything at all?'. Constructionism was first developed as a comprehensive theory by Berger and Luckmann in 1966. They focussed on the processes by

which any body of knowledge comes to be socially accepted as reality. The term reality as it is used by Berger and Luckmann (1966) refers to the process whereby people continuously create through their interactions a shared understanding that is experienced as objectively and subjectively meaningful.

Berger and Luckmann (1966) claim that people both create the reality of their society and are created by it. This is explained by them as an on-going dialectical process which comprises "moments of externalisation, objectification and internalisation" (78-9). Externalisation is the process by which individuals generate the social world by creating new social realities and re-creating existing institutions through an on-going recognition of them. Objectification refers to the way that human beings apprehend everyday life as an ordered, pre-arranged reality which is seemingly independent of themselves. Internalisation is a process whereby individuals, in the form of socialisation, 'take on board' the perceived objective realities. In other words, that which appears to us to be an objective fact has originally been created by ourselves to make sense of the world, objectified and then internalised by us as something separate from ourselves.

The dialectic process that Berger and Luckmann (1966) outlined described the relationship between subjective and objective reality as a two-way process. The creation of knowledge or an understanding of reality occurs at several levels. There is, according to Berger and Luckmann (1966) an accumulation of a social stock of knowledge that is passed from generation to generation through the medium of language. In complex societies, it is necessary for knowledge to be

socially distributed. It would not be possible and is unnecessary for us all to have a complete understanding of the social stock of knowledge for our society. Consequently Berger and Luckmann (1966) say that knowledge becomes socially distributed. Professions and institutions operate as 'sub-universes' (102-6) and have control over types of knowledge. Individuals have access to this knowledge through their membership of professions or institutions. Sub-universes are carried by a particular collectivity, and conflict or competition can exist between groups who have all developed a variety of perspectives about the nature of reality.

At an individual level there is a subjective knowledge of the norms and roles associated with the various types of knowledge. Individuals develop an awareness of their own consciousness as they move between and negotiate a system of roles. For example, one person can be a mother, friend, social worker and student.

Social institutions, which are themselves the product of the consciousness of individuals, in turn shape the consciousness of individuals. However, individuals are not passive beings locked into clearly articulated roles. The construction of reality involves a reflective ability on the part of human beings. We constantly assess and reflect upon the input we receive from the outside world. Individuals within various sub-universes develop particular perspectives that will be in line to some extent with the greater knowledge stock to which they adhere and yet will have aspects to their understanding that are quite unique.

Since the early 1980s there has been a resurgence in the social work literature of constructionist ideas. Laird (1993) says that the epistomological debate has focussed upon a re-exploration of the ideas of Gregory Bateson (1972). The resurgance came about as a number of researchers became discontented with what was perceived as an "hegemonic, positivist emphasis" in research and practice and a desire to explore "alternative ways of knowing" (Laird, 1993, 2). Constructionist thinkers:

took issue with the idea that a real world exists that we can discover, measure, or know objectively. These constructivist thinkers were not denying the existence of such a world; rather, they argued, we only ever come to know it through our bumping into it, as it is filtered through our perceptions, our languages (Laird, 1993, 84).[1]

This reformulation of approach has taken place within the post-modern era that has swept through the social sciences in the past two decades. Laird reflects upon the changes from modernism into post-modernism (1993, 4). She claims that modernism seemed to

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1 Laird uses the terms constructionism and constructivism, interchangeably and does not differentiate between the two. Constructivism, or personal construct theory, as it was formulated by Kelly (1955) is not usually used synonymously with constructionism. Constructionism refers to the process by which people create a shared understanding of reality that is both objectively and subjectively meaningful. Constructivism is a theory that suggests that reality is experienced by people through an intricate network of bi-polar constructions through which events and ideas are interpreted.

represent order and clarity. It supported the notion of an objective, 'scientific' approach to our understanding of the world. In contrast

> Post-modernists teach us that history itself is a changing narrative, open to endless recasting, that experiences are not 'real' until they are interpreted, given meaning in language; meanings themselves are contextual and intersubjective, co-created in dialogue with others (Laird, 1993, 4).

Set within the context of post-modernism the revived constructionist paradigm contains several assumptions. The first lies in the rejection of the concept of an objective reality. Constructionists contend that reality is invented, largely out of the meanings and values of the observer (Allen, 1993, 32). The premise is that each of us occupy different experiential realities so that our knowledge of the world is "derived from an interplay of shared and interpretive processes" (Delia, 1977, 74).

A second assumption of the constructionist perspective is that language is crucial to the construction of reality. As Allen says, "language is a mediating influence in all constructions, from our ideas, concepts, memories, to our very sense of self. We bring forth our realities, our worlds, through conversations with others" (1993, 32). Out of language we conceptualise our world through a process of categories and patterns. These are fluid and are continually influenced by the communities to which we belong" (Dean, 1993, 58).

The categories and patterns through which we interpret the world become standardised in the form of rules and roles. Constructionists argue that a problem arises when we cease to see them as

constructions but as somehow separate from ourselves as a 'real' world. "Thus an essential paradox of human life is that we live in a world of our own construction but we treat it as though it was constructed by powers outside ourselves" (Weick, 1993, 12).

The role of language in the construction of reality leads to a third assumption of constructionism. This is that there is an inevitable link between knowledge and power (Allen, 1993, 32). It is argued that some knowledge is privileged while some is subjugated. This comes about because those in power are able to determine which definitions and categories are legitimised. The powerful are then able to determine how reality will be seen within a given society (Dean, 1993, 60).

Because of the link that is seen to lie in the relationship between knowledge and power, constructionists believe that knowledge is treated as a valuable commodity that has served to divide people (Weick, 1993, 14). One way that this has happened has been through the process of professionalisation that Weick argues has been connected to a drive for status within universities. "By developing jurisdiction over large areas of human experience, professionals created a new power relationship based largely on their claim of having expert knowledge about the human condition" (1993, 15).

There are implications for social work practice if the assumptions underpinning constructionist thought are applied to this profession. Constructrionists suggest that social work practice has an implicit ethical and political basis because of the link between knowledge, power and the creation of reality. Those whose knowledge has been

subjugated are involved in a "giving over process" whereby the individual is expected to relinquish the power of interpreting his or her own life in favour of the judgement of the professional (Weick, 1993, 15). Fisher (1991, 15) argues, that given the premise that each of us occupy different experiential realities, we can assume the status of expert when it comes to understanding our clients' problems. Therefore he says, we cannot pre-suppose what it is like to be poor, or to be disadvantaged but that we need to produce conditions that the client is able to use to bring about change in his or her life.

The issue of power also needs to be addressed in practice and Laird (1993) proposes that the client-therapist relationship ought to be a co-evolutionary process in which the emphasis is on collaboration. In challenging the role of the professional as expert, constructionists such as Anderson and Goolishian (1988) suggest instead that clinicians should take a "not-knowing", de-expertised position. Laird asserts however, that this de-expertised position does not mean that we can be neutral observers. Rather, we have a responsibility to help those "who have been excluded from certain types of 'knowledges', their voices silenced and experiences invalidated" (Laird, 1993, 89). There is a responsibility she believes, for constructionist clinicians to:

> be an 'expert' on relationships of power and domination, on the social construction of social discourses that shape individual meanings, and, when necessary, to make those worlds of meaning accessible to our clients (1993, 89).

10.5 THE RESULTS OF THIS STUDY IN THE LIGHT OF SOCIAL CONSTRUCTIONISM

How does the theory of social constructionism help us to understand the social work response to suicidal behaviour in clients? The action taken by social workers, in this study, depended upon how they construed the concepts of rationality and self-determination. Sixteen participants viewed the concept of self-determination in almost absolute terms. It remained a right provided that the conditions of rationality were met. If a client was irrational then this was seen to reflect the need for protection rather than self-determination to apply.

In contrast, 13 participants argued that in the case of highly suicidal clients, principles of client self-determination do not apply. Self-determination was construed as a value or ethical position rather than as a client right and one that in the case of suicide risk could be waived. These social workers did not apply the construct of rationality to their understanding of self-determination and so automatically took action to prevent death.

The understanding that one can make a rational choice to die stems in part, from an perception developed from the sociological understanding of the relationship between free will and determinism. Sociology forms part of the knowledge base of social work and a major theme that runs throughout the sociological literature is that of the relationship between free will and determinism (Boguslaw and Vickers, 1977; Bilton, 1987). Structural theories proposed by sociologists such as Weber, Spencer Marx and

Durkheim hold a deterministic view of human behaviour because these macro perspectives see human behaviour as the result of broad social forces over which individuals have little control. These forces include class, gender and race. Other sociologists such as the ethnomethodologists and symbolic interactionists stress the creative, unpredictable nature of human interaction. They believe that human beings create their world and are constantly making choices (Bilton, 1987; Boguslaw and Vickers 1977).

Social workers use their understanding of the construct of determinism and its counterpart - free will - in their practice. A belief in determinism assumes that structural forces are at work in the lives of individuals shaping the way they see the world and themselves. Conflict theory, out of which feminism has developed, has reasoned that these structural forces legitimate particular kinds of beliefs and values over others through a process of hegemony or of the control of ideas. As a result power is seen to be distributed unequally in society and various groups of people are considered to be disadvantaged as a result.

The understanding of social workers is that power works to protect the powerful. This is officially sanctioned in a recent document published by the Australian Association of Social Workers. The AASW Competency Standards (1994) describes the function of the social work profession as being "...to act as an agent of social change and contribute to the redistribution of power, resources and opportunities towards more disadvantaged individuals, groups and communities" (p5).

If social work has this ideology underpinning it then it should be no surprise that the framework for practice that arises from it emphasises processes that lead to conscientisation and empowerment (White and Epston, 1990). It follows that the aim of social work intervention is to challenge the beliefs and assumptions that restrain individuals from using free will, that is gaining more control or power over their own lives.

In the context a label such as 'craziness' or 'irrationality' is not seen as an objective assessment, but as a result of the dominant medical paradigm which labels in this way in order to exercise control over deviant individuals. This may be why so many social workers in the group who applied the notion of self-determination spoke of a choice to suicide as an exercise of power in the lives of clients. Below are two such typical responses:

> I often find that 'irrational' or 'crazy' people are reacting to an environment. I think that our society finds it easier to say there is something wrong with this individual. Whereas I think this individual may not be functioning in an acceptable manner but they are part of a family part of a society and it is all interrelated. So when I work with them I do it on an individual level, then in relation to their family and then to women in society and what is put on them. A lot of 'crazy' women have been abused as children...So I think it is a way to get some power over your life by suiciding' (Lisa).

> Well our policy here ...is that if a person is suicidal well we don't let them leave. I personally have a dilemma with that as a worker. My dilemma is bottom line stuff that if I have done everything that I can, information and support etc., then really I should have no control over that person and what they do when they leave here. I have a dilemma around have I the

> right to do this against their wishes. People are the best experts in their own lives... We cannot tell them what to do (Francis).

The notion of rationality was also applied by many in the sample to their understanding of depression. As reported in the literature review, depression has been identified as one of the most important factors which lead to suicide (Davis and Schrueder, 1990; Hassan, 1992; Garfinkel, 1990).

Depression resulting from trauma was seen by one-third of the respondents as a 'rational response' which should therefore not be treated as a psychiatric disorder because psychiatric illness is by definition 'irrational'. One third of respondents assessed depression as being a justifiable situational state when there had been a history of trauma or abuse rather than as a depressive disorder. As a result they would be unlikely to see it as warranting psychiatric intervention. They distinguished between depression that could be explained in terms of the history of the problem and depression that they saw to be psychiatric in origin. When psychiatric intervention was used, for example, with women who had a history of sexual abuse, these social workers were likely to see the situation in ideological terms- that is one group exercising power over another. In this case psychiatrists were seen to be asserting their power over disadvantaged women by labelling the behaviour as 'crazy' rather than as an understandable response to trauma. The following response from one social worker exemplifies this:

> They see it (psychiatric services) as such an alien analysis of their problems. Irrelevant, absolutely irrelevant...For example, take that girl who was suicidal and was admitted when she was

> a teenager. She would be put in, she would be OK when she was in there, then later she would slash her wrists to get back in. But no-one thought to enquire about incest and the fact that she was trying to suicide every time she went home...She was very seriously misdiagnosed. I don't know how many psychiatric theories were developed over that one about childhood depression and all that crap. Of course she was depressed. It's like domestic violence. They are diagnosed as depressive and are on medication. They come in and it comes out that they are in a violent relationship and what they are being diagnosed as depression for, would be very healthy adaptive behaviour for domestic violence (Jacinta).

The thirteen participants who expressed a reluctance to refer clients for psychiatric assistance, and particularly the sub-group of five participants who could not conceive of a situation in which they would make such a referral, discussed psychiatric intervention in terms of the disempowerment of individuals. The knowledge base of psychiatry was viewed by some as a dominant paradigm and mental illness as an alternative reality. For these social workers, psychiatry has acquired its status through the power it has been able to exert over other alternative explanations for highly unusual behaviour in individuals. They question whether it is any more valid to label this behaviour as 'mental illness' than to call it an 'alternative reality' that is construed by some individuals. In this way these social workers, using Berger and Luckmann's term, are seeing the psychiatric knowledge base , as a sub-universe of knowledge (1966, 104).

Berger and Luckmann see a sub-universe as a social edifice of meaning which is carried by a particular collectivity, in this case psychiatry. Over a period of time one collectivity achieves

dominance over others as an explanation of human behaviour. As Berger and Luckmann explained:

> The increasing number and complexity of sub-universes make them increasingly inaccessible to outsiders. They become esoteric enclaves...to all but those who have been properly initiated into their mysteries...An illustration may serve for the moment. It is not enough to set up an esoteric sub-universe of medicine. The lay public must be convinced that this is right and beneficial and the medical fraternity must be held to the standards of that sub-universe. Thus the general population is intimidated by images of the physical doom that follows 'going against the doctor's advice...To underline its authority the medical profession shrouds itself in the age-old symbols of power and mystery from outlandish costume to incomrehensible language, all of which, of course, are legitimated to the public and to itself in pragmatic terms (Berger and Luckmann, 1966, 105).

Seeing mental illness as an alternative reality and psychiatry as a dominant paradigm rather than as a legitimate explanation of human behaviour, are examples, in my view, of an unorthodox way of construing psychiatric illness. The theory of social constructionism explains how such beliefs may have developed. Part of the process of making sense of our world is one of coherence. Coherence means that as we try to make sense of the world, we actively fit current events into our pre-existing frameworks (Fisher, 1991 p37). These thirteen participants and more particularly the sub-group of five partcipants have developed a frame of reference that is more likely to filter out the valid contribution that psychiatry has made to our understanding of human behaviour.

Social constructionism as it was developed by Berger and Luckmann is only one part of a "major epistemological revolution in the arts, humanities and social sciences" (Laird, 1993) that has sought to challenge the view that there can be an objective positivist understanding of reality. The debate has been spearheaded by those who call themselves post-modernist, social constructionist or deconstructionist thinkers (Laird, 1993).

Those social workers in this study who supported the idea that clients had a right to commit suicide if they were rational in their thinking, used a constructionist perspective to support their stand. That is, they raised the issues suggested by Laird (1993) as being essential to a critical perspective inherent in the constructionist approach. These included, a search for the meaning of our own experiences rather than having meaning imposed by others; attention to issues of power, domination and subjugation of certain 'knowledges'; a sensitivity to the power of language to shape what we see and hear; and a search for collaborative and empowering approaches to work.

While the theory of constructionism allows for mulitple realities that are equally valid, this does not mean that all realities are equally acceptable (Fisher, 1991 p17). In other words, social constructionism suggests that we do not have to pursue whether or not one person's perspective is right or wrong, but that we can examine the consequences of adhering to such a perspective. In the case of suicidal clients such a perspective is likely to have adverse consequences for clients (see scenario below). Endogenous depression is unlikely to be diagnosed and referrals to psychiatric

institutions- at present our best option for keeping people safe- are unlikely to be made.

As discussed in Chapter Three, there is a substantial body of evidence which indicates that feelings of normal sadness and grief should be differentiated from "depressive disorders which are characterised by exaggerated feelings of sadness, melancholy, dejection, worthlessness, emptiness and hopelessness" (Wilson and Kneisl, 1988, 427). The latter form of depression is considered by many experts to be an endogenous state which requires drug therapy to change it (Birleson, 1988; De Braga, 1989; Garfinkel, 1990 and Davis, 1992). Although all social workers in this study said that they would refer to general practitioners if drugs were needed for depression, the statements of one-third of the sample suggest that they are unlikely to assess such a level of depression in practice. A consequence of beliefs about depression as a justifiable situational state regardless of depth of despair is that clients are unlikely to be referred for drug therapy.

10.6 A SCENARIO OF INTERVENTION WITH HIGHLY SUICIDAL CLIENTS

In order to illustrate the consequences of the way that social workers conceptualise suicidal behaviour a scenario of the two basic types of conceptualisation will be presented. Social worker A, let's call her Amy, is one of the 16 participants who believe that suicide can be a rational act and that when it is deemed to be rational then client self-determination will be upheld. Social worker B, named Bronwyn, is

one of the thirteen participants who believe that highly suicidal clients are by definition irrational and that client self-determination is not warranted under these circumstances.

Amy is likely to be employed in a welfare agency or a community-based organisation. A thirty-six year old client named Jane comes to see her. It is apparent to Amy that Jane is at high risk of suicide. Jane discusses her intention to take her own life in the near future. She has a clearly defined plan and the means to carry it out. Amy discusses with Jane why she wants to take her own life and the consequences that this will have for her family and friends. Amy decides that although Jane is very likely to attempt suicide in the near future she is clear in her thinking. She is able to articulate her reasons for wanting to end years of psychological pain. Jane was sexually abused by her father during her childhood and has had a series of disastrous relationships. She has reached the point where she no longer wishes to live and can see no end to a life of poverty and emotional pain. She has numerous counsellors over the years and saw a psychiatrist once who did not talk to her about the abuse. Her only child is now an adult and has left Tasmania.

Amy sees that Jane has good reasons for wanting to end her life. The way that she is able to discuss calmly the reasons for her decision and the consequences that it will have indicate rational thinking to Amy. Amy sees that she has a history of trying to 'work through' her problems. If Jane had been much younger or in a highly distressed state then Amy would have considered calling a family member or contacting the hospital. Given that Jane is not an adolescent, is able to rationalise her decision and has good reasons for wanting to die,

Amy affirms Jane's right to control her own destiny, even if this includes self-induced death. Amy tells Jane that if she wants to discuss the issue any further she can call her for an appointment. Jane leaves Amy's office and no further action is taken by Amy.

The death of Jane by suicide, is a logical outcome of Amy's intervention.

Instead of going to see Amy, Jane makes an appointment with Bronwyn. Bronwyn is likely to be employed by the Department of Health Services, in children's services or perhaps a counselling agency. Jane tells Bronwyn her story, and Bronwyn assesses her to be at high risk of suicide. She explains to Jane that she believes Jane is unsafe and that she has an ethical obligation to do her best to ensure that Jane does not take her own life.

Bronwyn does not make an assessment of Jane's level of rationality as she believes that Jane is in a state of crisis and that her apparent calm is a result of having made the decision to die. Her suicidal state in itself deems her to be irrational. Bronwyn believes that the fact that Jane is in her office indicates a measure of ambivalence about her decision to die. Bronwyn takes the calmness as an indicator of high suicide risk. Bronwyn tells Jane that she is going to seek help for her and will recommend either hospitalisation or a place of safety until the crisis has passed. Bronwyn will also offer Jane on-going counselling in addition to making her safe.

If Jane then goes on to take her own life it will be seen as a failure of the intervention to prevent the death.

Using a constructionist framework to understand the actions of both groups of social workers, means that we do not have to conclude which is the most valid reality. However, the consequences of adhering to the first rather than the second perspective means that suicide is more likely to occur.

10.7 DECISIONS ABOUT RATIONALITY

Given the importance of rationality, the question arises as to how social workers determined whether or not a client was rational and consequently what particular course of action needed to be taken. The assessment of rationality was a crucial component of the decision as to whether or not the client would be allowed to exercise self-determination by 16 of the social workers in the sample. In this way, an assessment of their rationality was the 'audition' that the client had to pass.

Rees (1978) used the concept of clients 'passing an audition' when they were being assessed by social workers. The audition would then determine the kind of intervention they would receive. Rees saw the audition as an assessment of the degree of 'moral character' displayed by the client. Unlike Rees social workers in this study were not so much assessing the moral character of their clients but the level of rationality.

One indicator of rationality was that of the notion 'responsibility'. Responsibility was shown to be a multi-layered construct in this

research. The relationship between responsibility and rationality requires further research as it was not explored in this study. However, this research does indicate that the concept of responsibility held by social workers included the notion of being adult. That is, to make decisions concerning one's own life, in a level-headed way one could not be an adolescent or child.

The linking of responsibility with adulthood explains the apparent inconsistency of social workers' actions when they were intervening with a young person at risk of suicide. Of the 16 social workers who did believe that clients could make a rational choice to die, only two said they would be non-directive in their actions with young people. There was a great reluctance among those sampled to be as non-directive with young people as they were with adults even though the young people may be as 'rational' in their thinking as adults and like them have understandable reasons for wanting to end their lives. Responsibility was generally seen as an outcome of a developmental process that is not fully granted until adulthood.

However, rationality as it was used by social workers is more than a consideration of responsibility. The mental state of clients was assessed in terms of what could be expected according to the way in which they were categorised. This categorisation or typification was explored in Chapter 6 of the thesis. Typification is a process that Berger and Luckmann (1966) believed people use to enable them to organise information about others and thereby make sense of the world. They suggest that:

> The reality of everyday life contains typificatory schemes in terms of which others are apprehended and 'dealt with' in face-to-face encounters. Thus I apprehend the other as 'a man', 'a European, ...'a jovial type' and so on. All these typifications ongoingly affect my interaction with him... The typifications will hold until further notice and will determine my actions in the situation (1966, p.45).

Berger and Luckmann describe the process of typification as a reciprocal situation in that both parties, in this case social worker and client, typify each other in interacting schemes. They suggest that there is a 'double sense' in the encounter in that the other is seen as a type and is set in a situation that is itself typical. This then determines the set of actions to be taken.

Social workers weighed up the presenting state of the client with their history. A client would then be loosely categorised. For example, one suicidal type was seen to be those who had suffered a build-up of problems that had exhausted their coping skills. They were 'normal, well-balanced' people who had had an overload of problems and had been 'tipped over the edge'.

This typification was then interpreted according to the ideological position of the social worker. The first group of social workers who were always directive in the case of high suicide risk would see this as a suicidal crisis through which the person would pass and given support would resume their former state. The second group of social workers also saw these individuals as non-psychiatric clients who no longer wanted to live with an overwhelming number of

problems. These problems were reframed in ideological terms, with the client's right to self-determination paramount.

Social workers, particularly those who supported self-determination for rational suicidal clients, were reluctant to see themselves as experts who would 'diagnose' and treat a client's problem. They were critical of professions such as psychiatry who responded to suicidal people in this way. They believed that to understand suicide, one had to place the act within the broader socio-political context.

Constructionism supports the contention that clients are the experts on themselves. Like these social workers, Anderson and Goolishian (1992) have challenged the conception of the mental health professional as an 'expert', but suggest instead that the practitioner ought to take a "not knowing" de-expertised position . Gergen and Kaye (1992) also support a de-expertised approach in which practitioner and client collaborate together. They argue that the traditional psychoanalytically-informed therapies

> furnish the client with a lesson in inferiority. The client is indirectly informed that he or she is ignorant, insensitive, wooly headed, or emotionally incapable of comprehending reality. In contrast, the therapist is positioned as all-knowing and wise- a model to which the client might aspire. The situation is all the more lamentable owing to the fact that in occupying the superior role, the therapist fails to reveal any weaknesses.
>
> (1992, 171)

In contrast to the traditional conception of the practitioner as expert, the one who "possesses privileged, esoteric knowledge" (Weick, 1993, 19) Weick suggests that the role of the practitioner ought to be to activate, support and honour people's ability to know their own knowing. When the professional models the expert role Weick (1993) sees it as a "giving over process", in which the person is "expected to relinquish the power of interpreting his or her own experience in favour of the judgement of the professional" (17).

During the interviews a number of social workers alluded to psychiatry as 'another way of knowing' or as a 'dominant paradigm'. These comments also reflect a constructionist paradigm which stresses a link between knowledge and power, "particularly in the political sense that some knowledge is privileged and some is subjugated. One person's or a profession's knowledge may become more valued, more 'true' than another's, depending upon socio-political context" (Allen, 1993, 33).

Weick (1993) discusses how in the nineteenth century the emerging professions cordoned off the "world of common experience" (14) and competed with each other in order to achieve status". By developing jurisdiction over large areas of human experience, professionals created a new power relationship, based largely on their claim of having expert knowledge about the human condition" (Weick, 1993, 15). Bledstein (1976) contends that professionalism replaced "common-sense, ordinary understanding" and that "clients found themselves compelled to believe, on simple faith, that a higher rationality called scientific knowledge decided one's fate" (94).

It seems that the concerns expressed by social workers about the importance of minimising any power imbalances with clients, especially that which results from a defined expert status, is supported from a social constructionist perspective. Does this then imply that constructionists would adopt a view similar to that of the social workers in this study who sought to facilitate client self-determination with regard to suicide? The answer is a resounding no.

Laird (1993) is emphatic when she says that while therapy may be likened to a dialogue in which no-one is an expert, this is not to say that the therapist is irresponsible or condones behaviour that is harmful to self or others (89):

> We are not neutral observers...What *is* the responsibility of the constructionist clinician, I believe, is to be an 'expert' on relationships of power and domination, on the social construction of social discourses that shape individual meanings, and, when necessary, to make those worlds of meaning accessible to our clients (89).

In saying this Laird implies that it is irresponsible to act as a neutral observer and that the clinician is under an obligation to share with the client an alternative understanding of the situation. Allen also writes that the key assumptions of constructionism preclude the ethic of objectivity and neutrality which belong to an empiricist tradition.

Constructionists identify the link between the observer and the observed and "acknowledge the active role they play in creating a

view of the world and interpreting observations in terms of it" (Efran, Lukens, and Lukens, 1988, 28).

When social workers said that they did not actively prevent a suicide they were adopting something of a neutral position. That is, the client has made up his/her mind, is clear in his/her thinking and has understandable reasons for suicide to be an option. This overlooks the way that in their very interaction with the client they are both creating meaning together. The social worker cannot be in a neutral position. As Shneidman says, non-intervention is in itself giving latent message to the suicidal person (1993, 147). By not taking preventive action this in itself is creating meaning for the client that suicide is an acceptable course of action. Logically, this may mean that the client is more likely to commit suicide after leaving the social worker than before seeing him/her.

As Allen (1993) suggests, the clinician will effect change. For this reason she says that practitioners must acknowledge their active participation in "creating images of their clients, their problems and their possibilites for change" (31). The processes of typification and assessments of rationality that have been described in this discussion are an example of social workers creating images of their clients and their possibilites for change.

Like Laird, Allen (1993) argues that the clinician needs to shed power but not responsibility. Her argument is that the therapeutic role is to bring forth "subjugated knowledge" (Foucault, 1980) in the personal, family and social lives of clients. In other words, social workers have a responsibility to facilitate a process through which clients are

better able to understand their own lives and are therefore able to take action to change them. Constructionists argue that the role of the practitioner is about facilitating change in a way that is respectful of clients (Allen, 1993, 35). "Sometimes this means actively trying to change rigid definitions about the client and the problem that actually impede needed change" (Allen, 1993, 40).

The unorthodox response of many social workers in this study is not consistent with psychological theory. However, the theory that underpins the practice of this group of workers is not obvious from this study and is an area for further research. Social constructionism will help to explain the unexpected findings and to state a position on them. While all the views expressed about suicide are equally valid they can be compared in terms of their outcomes for clients. A non-interventionist approach is more likely to have a negative outcome for clients than will an interventionist approach. One cannot be a neutral observer. Adopting a de-expertised position with clients still carries a responsibility to facilitate change in clients.

10.8 METHODOLOGY OF THE STUDY

The findings need to be considered in light of the methodology used in the study. As stated in Chapter One, those interviewed were a random sample of social workers in the Launceston area. The findings are only applicable to social workers in this area of Tasmania and cannot be generalised to other areas of Australia.

Self-reporting of respondents may lead to the allegation of bias in the results. However, the self-reports of social workers about the extent of suicidal behaviour in clients is supported by the facts as we know them. As discussed in the thesis (Discussion, Section 10.2) suicidal ideation is common behaviour. Given that social workers deal with disadvantaged and distressed people, it is not surprising that they encounter suicidal thoughts in clients, on a frequent basis.

In contrast, completed suicide is a rare phenomenon at about 11 per 100,000 people in Australia (Hassan and Carr, 1989). Self-reporting of social workers in this study indicated that completed suicide suicide in clients was a phenomenon they rarely faced. Of the entire sample just over half reported contact with a client who subsequently died by suicide. These social workers had on average, been in practice for ten years. Ten of these workers had experienced this on one occasion, so these findings are consistent with statistical evidence.

This study was designed upon a framework of crisis intervention theory. The design was generated by the the findings of research literature on the subject. Analysis of the interviews indicated that this framework was inadequate for understanding the responses of some social workers to a high suicide risk assessment in practice. As a consequence, there was a limit to the extent to which I could explore the framework of practice adhered to by those interviewees who held unorthodox views about their role in suicide prevention. This anomaly was not apparent until part-way through the analysis of interviews. As a result, I was only able to report these results and discuss them in the light of social constructionism. I was not able to fully explain them.

10.9 FUTURE RESEARCH

The main finding of this study that social workers may have an ad hoc response to suicide prevention, which is not consistent with research, warrants further investigation. In order to understand this response it would be useful to explore how social workers conceptualise suicide, attempted suicide and thoughts of suicide. If suicide is not seen as psychological crisis, then alternative ways of perceiving it need to be fully explored in the light of an overall framework for practice. Further to this, these alternative ways of perceiving suicide need to be examined in terms of social work theory. Do these views result from a verifiable theoretical base, or are they the result of beliefs that are not supported by research?

The assumption in the literature is that professionals have a duty to care in suicide prevention, so further research could also investigate how social workers who take a non-interventionist approach reconcile this ethic with their practice.

Because this study was limited to social workers in the Launceston area, further research could establish the extent to which the findings are relevant to social workers elsewhere in the country.

CHAPTER 11

RECOMMENDATIONS

11.1 TRAINING

Given the extent of suicidal behaviour encountered by social workers there is a need to consider suicide-specific training in the Tasmanian social work course. Understanding of the suicidal process as an affective and cognitive constriction, of depression as an endogenous state and familiarity with psychiatric interventions would assist newly graduated social workers in identifying, assessing and lowering suicidal risk in clients.

Of course there is a limit to how much skill-specific training can be incorporated into the social work course but given the large increase in recent suicide statistics in this state and the extent to which social workers deal with the behaviour there is a case to be put for some suicide-specific training to be included.

Most social workers who were included in this study supported the notion of suicide-specific training for social work students. When asked what they recommended for the training of social work students in the light of their own experience, 22 respondents suggested that more emphasis needed to be placed upon the development of skills and knowledge specifically about the management of suicidal behaviour. Many participants commented that although there are time constraints in the course, the frequency with which social workers encountered suicidal behaviour and the subsequent stress such work engendered in them, suggested that

more time spent in the development of relevant skills would be beneficial.

Of the 22 social workers who suggested that suicide-specific training would be helpful, 16 recommended that practical skills in assessment and management of suicidal behaviour be incorporated into the course. The following examples underline this view:

> Concrete work. Like what is suicide about, what are the range of options in terms of the theory behind it and the practice of it (Sharon).

> I don't know what they get at the moment....but I think you should start operating on automatic when you are with a potential suicide so that you have this format of questions that you ask, and you should be listening for the nuances so that you get some sort of leader and break that pattern of thinking up a little (Jack).

> You have to have some basic knowledge of the area...because those are the things that really stress people out. The consequences of dealing with someone who is threatening suicide are really major both for yourself and for them (Carol).

The remaining social workers in this group emphasised a need to more fully explore the values of confidentiality and the ethics of social work practice as they relate to the management of suicidal behaviour.

> We also need to look at ethical things as well. I know the Australian Psychological Association has some definite rules set down about how you should respond and what you must

> do with suicidal people and I think those are issues that are very important for social workers (Judith).

In light of the findings of this research, suicide specific training would need to prepare social work students for the likelihood of encountering suicidal ideation on a frequent basis. They need to have the skills to distinguish the genuinely suicidal from the distressed. From the findings, it is also apparent that suicidal behaviour and the accompanying thought processes need to be placed within the theory of crisis intervention in order to be understood. Placing them within this theory is consistent with the recommendations of the research literature.

As discussed in Chapter Ten of the thesis, an ideology of empowerment does not mean that seemingly rational clients have the right to take their own lives. The ethic of empowerment needs to be addressed in light of the ethic of 'duty to care'.

In addition, I recommend that social work training ought to challenge beliefs about mental illness, depression and psychiatric intervention that are not supported by empirical research. Perhaps in the light of these findings more exposure of social work students to psychiatric services is warranted.

Because the social work profession takes a clear stand on its role in redressing power imbalance in society, the social work course could also explore the notion that taking a 'de-expertised' position does not imply being a neutral observer in suicide prevention. Rather, it

necessitates taking a position that enables clients to understand and fight against forces of oppression in their lives.

In conclusion, given the views and experiences of social workers on the matter and the findings of this research in terms of the social work response to people facing a suicidal crisis there are strong arguments for the inclusion of further suicide specific training in social work education. In addition because many social workers in this study were found to be working with suicidal, mentally ill people, the following recommendation from the Human Rights and Equal Opportunity Commission should also be considered.

> Education authorities should examine the mental health education and training system in order to identify deficiencies and clearly define the specific training needs of mental health professionals and allied staff working with people with mental illness (1993, 912).

11.2 SUICIDE PROTOCOL

A suicide protocol in place in agencies would assist social workers to respond appropriately to suicidal clients. The setting up of such a protocol enables debate about philosophy and ethics among workers within the agency. Consideration can then be given at this level to issues of confidentiality so that there is a consistent approach from all workers in the same agency. Within a protocol, there can be guidelines about assessment of risk, action to be taken and a system organised for making and accepting referrals promptly. Guidelines

can also be included that will ensure that social workers have access to appropriate supervision, support and in-service training.

An important benefit of incorporating a suicide protocol into agencies is that of clarifying issues of accountability and possible legal liability. A protocol could detail the types of records to be kept about suicidal behaviour in clients. Systematic record keeping, a task according to Gelman (1992, 73) that is "rarely approached with enthusiasm" by social workers is a key to measuring the extent of suicidal behaviour in clients and assessing the social work response. Gelman reported that client access to records, whereby clients are informed about their contents and given access to them, led to a qualitative improvement in those records and a higher level of client satisfaction with the agency (1992, 75-76).

11.3 MULTI-DISCIPLINARY TEAMS

The development of multi-disciplinary teams to manage cases of potential suicidewithin counselling agencies is recommended by experts in the field of suicide prevention (Shneidman, 1993). Multi-disciplinary teams would enhance the services that are currently available because ideally social workers would then have access to the experience and knowledge of other professionals. Of particular benefit would be teams that included either a general practitioner or a psychiatrist and a psychologist. Social workers who already work in such teams find it a valuable source of assistance. As one worker stated:

> Each of us have our professional knowledge and as we work together as a team we build it up. We always have team discussions and if any of us is working with a suicidal client then that would be the case for discussion. Because we have three meetings a week to allow us to that, we can get some very quick input from the other team members. Otherwise you just go and knock on the others' doors (Jan).

11.4 PROFESSIONAL SUPPORT

If highly suicidal clients are to receive the support that they need, the professionals working with them also require support and supervision. Arrangements need to be made at an agency level to facilitate this. Professionals require support because such work is demanding both professionally and emotionally. Professional supervision is considered to be vital when working with highly lethal people (Shneidman, 1993). Only five social workers mentioned during the interviews that they sought supervision when working with a suicidal client. It may be that a greater proportion of the sample do indeed seek it but because they were not asked they did not say so during the interviews. They were only asked about the action they took when interacting with a suicidal client. Even so, the fact that supervision was not mentioned by most of the sample indicates that it is not a high priority.

One-fifth of the sample commented that there had been a lack of support for them as workers when a client had suicided or when they had been working with a suicidal client as the following two examples testify:

> When a client of mine died there was absolutely no support for me at all as a worker (Jim).

> It bugs me that there is no outside debriefing and support for me as a person dealing with this stuff. So that if some of the work I am doing with a family is triggering off something for me about my own life I have to go and pay someone to work that stuff out. People say, well you have OAS (Occupational Assistance Service) but I don't feel comfortable going there. I have to pay for debriefing but I have to do it because if I didn't then I couldn't do this job. Sometimes I think my employer should pay for that because it isn't fair that I should have to. Private stuff is so expensive. I think there should be more recognition of the stresses on people that work in this area. You can't just go home and forget about it. We debrief with the workers here but you can only do that to a point. I need to go outside of my work place to really let it all out because I feel vulnerable exposing it all at work. Also I am aware that the people here are not here as my therapists (Jan).

11.5 SERVICE DELIVERY NETWORK

There is a need to evaluate the service delivery network in Launceston so as to identify gaps in the service delivery system. This study found that clients who are poorly motivated or resistant are unlikely to receive the help they need. More accurate information needs to be gathered about the help-seeking behaviour of suicidal people in Launceston and an effective inter-agency referral system developed.

The majority of social workers in this study felt that while psychiatric services may, if accessible, provide a place of safety other options are also needed to assist people in crisis. Some of the interviews indicated that there are members of the medical profession who agree that psychiatric services are not appropriate for 'situational suicidal crises'. When asked about her impression of the referral process to the psychiatric services Carol replied,

> It has its problems....There are a couple of factors that influence that. Whether or not the client wants to see a psychiatrist, whether the doctor who is treating them is keen for them to see a psychiatrist or feels that it is only a reaction to a social situation and should be left.
>
> What sometimes happens is that the referral has to be decided by a doctor and there is a tendency, I think not to want to get people labelled. So they are not referred....Even if you get them to Cas (Casualty Department) you might get a bit stuck because the medical officer says ' I think it is OK' and then they can get discharged (Melanie).

Identifying gaps in the service delivery system and setting up services to assist suicidal people more adequately, will require a multi-disciplinary and inter-agency effort. Such a co-ordinated response is more likely to address the needs of the seriously suicidal in Tasmania.

11.6 CONCLUDING NOTE

Social workers in Launceston responded to this research project with enthusiasm. All social workers who were approached agreed to participate and many rearranged busy schedules to make time for the interview. The fact that there was not one refusal is indicative of the concern that social workers have demonstrated about the suicide trends in this country. As one respondent (Bev) commented, "I think all the workers in human services are desperately trying to stop suicide. You can see that very clearly". In the interviews social workers answered the questions with honesty and frankness. They are to be congratulated for their professionalism and willingness to reflect critically upon their own practice. This research has shown that social workers in Launceston have made a substantial contribution to the well-being of the clients with whom they have worked.

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APPENDIX A

Letter sent to each participant inviting him or her to participate in the research project.

UNIVERSITY OF TASMAN

Department of Social Work
GPO Box 1214
Launceston
Tasmania 7250
Australia

Dear

I am researching the role of social work in the prevention of suicide as part of my Masters in Social Science. I am gathering information from social workers who are employed within Launceston and am writing to you in the hope that you will participate in a research interview.

The interview takes 30- 40 minutes to complete and the questions will cover your experiences with suicidal clients, your impression of the extent to which services in Launceston meet the needs of such clients and recommendations you have regarding social work training.

Every effort will be made to ensure that what you say in the interview remains confidential and no identifying information about you or your agency will be used in the results. If you would like a summary of the results or access to the thesis, that will be arranged.

From the interviews I would like to document the practice wisdom of social workers in the management of suicidal behaviour and would greatly value your contribution. I will contact you in the near future to see if you are able to participate. Please feel free to call me on 243253 if you want any further information before you decide.

Regards,

Diane Craig

APPENDIX B

Appendix B contains an interview with Sebrina. This interview has been included with the consent of the respondent concerned. When it was decided to include a complete interview in order to illustrate some points made during the thesis this respondent was approached and asked for her consent. She was given a copy of the transcript and asked to delete all identifying information about herself and her agency. Where such deletions have been made an 'XXXX' has been used to indicate this. In order to preserve confidentiality it was necessary to remove individual words and some sections of the document. For the purposes of analysis in the research the unedited transcript was used. The edited version contained within this Appendix has been given another pseudonym.

Questions from the original questionnaire have been printed in **bold** type and follow-up or exploratory questions have been printed in *italics.*

Sebrina, age XXXX, agency type XXXX, hours contact 25, years of experience XXXX.

I am interested to know about your experiences with clients who are at risk of suicide. Have you ever had a client who has attempted or completed suicide?

I personally have had clients who have attempted suicide. There have been clients who have used this service who have completed suicide and died. We probably average three a year who die of suicide. We are dealing with suicidal people on a weekly basis just about.

How do you recognise they are suicidal and how do you assess level of risk?

Generally how it has worked with me is that people are very up front about saying that. The type of work that I do is counselling and

the people who come here are often in deep spaces anyway. They are in deep spaces of being very distressed, very sad, very fearful or very angry. Alot of the work I do is with people who are in deep emotional spaces. Because of that it seems that it is a very normal thing. Suicide is just talked about in that context. Most people I talk to who are suicidal are either sad, incredibly sad or incredibly terrified. Very much linked to those two emotions. I haven't worked with many people who have attempted suicide who have been angry. Just very deep states of sadness or terror.

What have you noticed about the difference in those who have attempted isuicide and those who have completed it?

I think the main difference with those who have completed it and have died were incredibly terrified of being XXXX. In fact the people that I know who have died were not safe from XXXX. Its like dying was the only way to be safe.

Is the terror always to do with XXXX ?

XXXX.

What are the warning signs that you look for in a client that he/she may be at risk of suicide?

With some people its when they think that they need to go into 1E. Another is when they say that they don't think they can get a break from the trauma of the XXXX. Constant nightmares, constant flashbacks, the constant terror and there is no break to it. Other considerations-are when someone comes to see me and says goodbye. That's a big message. It's also just general comments like I may as well end it all. And that real desperate sense of I don't know what to do. When I work with people I really try to connect them with what resources they have available to them. Looking back and seeing when you have been in similar situations what have you been able to do to survive it. When none of that has worked and they say I just don't know what to do and I haven't got it any more, then I get really worried because I haven't got it either. I haven't got

the will to keep somebody else alive. I can say to someone-I want you to stay here. I don't want you to die but I can't make them want to live.

Have you noticed anything in particular about the warning signs that young people give out?

Most of the people I know who have been suicidal have been young people. It's the isolation of young people, particularly isolation from their families.
XXXX
...but that real sense of detachment from the ideal parents. That the parents that I thought that I had aren't really like that. I've got people in the family that don't believe me, I've got people who have thrown me out, or labelled me as schizophrenic or psychiatrically disturbed. They are not willing to hear me and I can't have the Mummy I want and I can't have the Daddy I want. That is just so totally devastating and when that realisation hits, people can really lose it around that. One of the big things is around family breakdown stuff.

When you say 'hook people into their resources', what sort of things do you do?

I go through stages. First if someone is talking about suicidal stuff but they are not actually saying goodbye to me, if its before goodbye. I talk to them about if they have felt like it before. When I get a background on that I get people to identify what kept them alive that time.

XXXX.

Just challenge the beliefs that are there and to look at what resources you have got, what was there then, why isn't it here now. It is, why are you still believing that you should die. I start off quite gently.

XXXX.

If someone is being very resistant then I get very challenging. I don't get too directive. I just ask lots of questions.

XXXX.

I have to be respectful of people's knowledge of themselves. Sometimes I want to get in there and rescue them. When they get to suicide, maybe their knowledge of themselves isn't as acute as it could be so I look at how I connect them to knowledge about themselves.

What do you mean by the word resources?

When I am talking with people who are at the point of ' this is it, I am going to pull the plug' it is not often about those issues of physical resources. That is not what they are concentrating on. Its not I am here because I don't have a job, have housing or whatever, it's because they don't have something that is much more intrinsic to themselves. That's why I connect them to the resources they have themselves. That's what it missing. Its like there is alot of stuff missing from around out there, XXXX the huge grief and gap between what is their reality and what other people perceive their reality to be. And that is so intangible in a sense. Its so real and yet so intangible. That's the level that I work at. The gutty heart of it. Real internal stuff.

What do you do when they say goodbye?

The alarm bell goes 'shit'. I get scared, really scared and I think really quickly and I go over material like, "Have you thought about how you are going to do this? Who is going to be the first person to see you after you've died" and if that is going to be a close person, I say "How do you think they are going to feel seeing you with your brains all over the wall"? I am really confronting with that stuff. "Are you going to leave a note"? If they say "no" I say, "Well you're leaving a message to the world with your death. They've really stuffed up on trying to understand you before so how are they going to understand you this time around?" What I try and do is get the

reality of their actions closer. So do they really know what they are doing? They may in one sense be taking care of themselves in a reframed way by suiciding, but do they recognise the responsibility that they have with their actions for other people? I am also very aware that someone's suicide has a tremendous impact upon other people. And I believe that we have a responsibility for what we do for ourselves and our lives. We are not responsible for other people's lives. However, I believe that we do have a responsibility for the relationships that we enter into and the people on the end of those relationships. It's almost like our relationship is a contract if you like, and I break it by dying. If none of that is working. trying to get the reality of this stuff home, then I ask questions like, "Are you sure that you want to die, or do you want another life"? I really try and look for the other side. If they say "Look Sebrina, I did really just come to say goodbye to you", I haven't had anyone say that to me thank goodness who has actually died, then I would just check out, who else do you need to say goodbye to and what other business do you need to finish? Have you said goodbye to your kids? How are you going to do that? It's just another thing to try and grab hold of and if they are going to die, well I know that they are going to die. I will hate it. I will not call the police. I will not call an ambulance unless at some point in that dying process they rang up and said they needed help then I would call. They have to ask first.

XXXX.

I would try everything in my power.

Social work places great emphasis upon the rights of the clients and upon encouraging clients to be autonomous and self-directing. How does being a social worker set boundaries for you as far as managing suicidal behaviour is concerned?

I think it is something that really needs lots and lots of thought. On the one hand there is the stuff about these people have the right to decide how they will live their lives.

XXXX.

I recognise that on one level. On the other level, I think its a pretty powerful thing to be alive and I believe that I work in a way that connects people to that sense of the power that there is in being alive. But if someone is at a point where they say 'This is right for me, inherently I know this", then I think I'd have to give it up.

Are there any differences in working with men who are suicidal as opposed to women?

Yes, when I work with men I work at a very cerebral level and that's because that's the place where they are. I follow them. They go straight into their heads and they talk an enormous amount. I find it very difficult to get a word in edgeways. Men tend to talk alot, some don't but most do. I have to get very intellectual and I think that the same approach works with women who are very suicidal. I find I have to try and bring them back up to their heads. Out of their hearts, out of the pits of despair and into thinking. I'm not saying they are not irrational, but let's start putting the pieces together because this is your adult level. This level is working overtime (ie heart) and this level (head) when its in tune with your heart can get you going. I do that with alot of people at anytime that they are in crisis. They go where they need to go but at some point I bring them back because that will keep them safe. The thing is with men I am there straight away. Men tend to use alot of words and I don't always understand what they mean and alot of words to justify their behaviour and what I notice with men, well I haven't worked with men who have been suicidal but they have been very self-destructive in the sense of taking enormous risks to their health like sharing needles, unsafe sex, playing chicken with car drivers, also using drugs. XXXX. I.V. drug users and they do alot of unsafe stuff. Alot of them have been pretty sick physically with that but haven't actually said, "I'm suiciding". They don't see that as a form of suicide. I will at some point name that up and suggest that what they are doing is a form of suicide. That's a bit confrontative and I don't usually go straight for the jugular but work up to that point as the relationship develops. There have been a couple of men who have been in a deeper space but it's often like when they go there

they go so deep they can't talk. They go so deep they get lost in the void. The emotion is quite scary to them, its scary to be feeling so lost and so vulnerable. What I do find hard when I talk to men is how I relate them..With women I can use a lot of symbolism that we both share as women like "this is like going through the birth process". It's different to say it to men.

What are the things that restrict whether or not you are able to work with someone who is contemplating suicide?

If they were being violent toward me and I have a strict contract with my clients of non-violence towards me. I have said to them if you assault me I will do something with that. It would make it difficult if there was a threat of that violence and I have worked with people who have been psychotic, almost flipped out, like they are not there and there is all this other stuff just seething there. What I do is stay there as long as I can and take safe precautions, stay close to the door, have somebody else in the building and if I need to I have somebody else work with me. I try to be creative. It may be that there is somebody else that is linked in with that person and I get that person in to work with me as well. It's happened once that somebody felt OK about saying goodbye to me and then I went and got this other person to say goodbye to and they got along so well that he decided not to die.

It's hard work with someone who is suicidal but I have never contemplated not working with someone. I have set limits. They are voluntary clients here. If anyone here is resistant then I tell them they are free to go anytime they want. And they are. That's the way this place works. They know they can terminate the appointment. When people come here and tell me they are suicidal then that process is very different to being a worker doing an outreach worker rolling up at someone's home and finding them with a knife at their throat. It's very different.

Would you ever refer a client to a psychiatrist and under what circumstances?

If there had been previous psychiatric intervention and that had worked I would. That's the only circumstance I have used so far. I have not actively sought psychiatric help for someone who is suicidal.

XXXX.

I do have a healthy sense of scepticism, because of the stories that I hear. More than 50% of the people I see here have had some involvement with the psychiatric system and it hasn't always been a successful enterprise for them in their healing. Sometimes it has and that's fine. Whatever works is OK but as for a number of them it has been quite disastrous and so I'm not committed to the idea of psychiatric help. If I felt out of my depth perhaps but it hasn't happened yet.

So, if you identified symptoms of mental illness you wouldn't automatically refer?

Yes, I don't believe I could assess mental disorder and I don't. I don't believe that depression is necessarily a mental disorder. I see it as an emotion like anger, fear and all that stuff. I work with people who have been diagnosed as schizophrenic and think, "How come you've been diagnosed as that?" And often they say, "How come I've been diagnosed as schizophrenic? I don't think I am. I can't stand living in this". Yeah it's a different perspective I guess.

XXXX.

You have an assumption of rationality?

We have a very strong sense that people are able to think and act responsibly for themselves. Workers here have questioned whether mental illness even exists and therefore given that they have had that particular philosophy, suicide is not seen as something that is in the mental health domain. It's seen as a normal reaction to XXXX- It's normal being suicidal or believing like some clients do, that they have three personalities. Some people are almost phasing out

because of (their pain). Their bodies are there but they are not. Seeing that as very normal XXXX.

Have you ever made a referral to psychiatric services?

No.

What has your impression been of the response of other services in Launceston to the needs of people facing a suicidal crisis?

There is a huge gap in being able to meet people's need when they get to that crisis point. Particularly in a generic sense. XXXX. In terms of after hours care, there is not much in a generic sense for people contemplating suicide. Where do you go? Lifeline is not for everybody. With some people I know when I have suggested that as an avenue for them not knowing who the person was, has been an issue.

XXXX.

It's like if I'm suicidal and I just want to talk to you while I die how do I know you are not going to call the ambulance or the police? So I see a gap there and I don't know how resourced the sector is to deal with it either. It's a freaky thing and I don't know that there is alot of training made available for people.

How helpful was your social work training in skilling you for assessment and counselling of suicidal clients?

Not alot. In terms of a concrete response to suicide I didn't get it. If it happened I missed it. Most of the skills I have learned have been through being in the agency and talking to workers. The second day I was here, my first job, two days out of uni, I had a client who was suicidal. It has been the issue that has plagued me in this place. I freak out at suicide. I'm better at it than I was. My second day at work and I had this person who was so close to the edge. I drew on some resources that I had got when I did my Youthline course years ago and I did all that and I remembered someone mentioning at one

point about contracting and so I thought, "Great. Contract with this person to stay alive". I thought, "Oh shit what am I going to do"?

I wasn't given the practical stuff on what to do and why. Why would this work and nothing else work? When I think about the things I do, I know why I am doing them. I'm not doing them because there is 'a suicide response' but that the philosophy behind it is that I am trying to get this person in touch with resources within them. I am trying to challenge their perceptions of the reality of death and I am trying to get this person to start getting some control over their life rather than let their life have control over them. I use a range of creative questions around that. That's the means to do it and that's the philosophy behind it. So that if those questions don't work I can still be thinking I can try to get this person connected to this and there is another question I can ask. The questions aren't set. They are not textbook. Knowing why is so important, so that I have a direction that I'm heading to.

What training have you had since then that has been helpful? In what way was it helpful?

I did a course with Amanda Kamsler and her line of work is very similar to Heather McGregor. Heather works in domestic violence on the mainland. She did some training on response to suicidal behaviour using creative questioning. They gave me some ideas. Other stuff has been general reading like Steve Levine's work and talking to people in the field. And talking to the workers here because the workers here at that stage had alot of experience in working with suicidal people. I got heaps from them. They talked about their experiences, what they had learned and what had worked. It became a bit institutionalised in this place. There are things that have worked before and that's what we use.

What recommendation would you have to improve the training of social workers so as to enhance their skills in the prevention of suicide?

One thing in the course would be to have issue specific training. I know there are time limits, but it would be possible to get a number of issues that are prevalent in social work and look at some concrete interventions around that. Some training around that. Like suicide, sexual abuse, HIV. Concrete work. Like what is suicide about, what are the range of options available in terms of the theory behind it and the practice of it. And giving them some chances to have a go at it. It is so disempowering as a worker to be in here when this is your first time and you haven't done it before. So that you can convey to your client that you know what you are doing. Gives them a sense of security with you. Role plays . And investigating with people their willingness to work with people who are suicidal. It is hard work and shocking work and some people may not be comfortable with doing it and need to recognise that before they get in there.

With the notion of empowerment suicide challenges that. You need to come to terms with what that means in practice. Is my empowerment about people having the right to determine their lives or is it about the power of staying alive?

In what situations does empowerment apply? There are huge questions in that. You tie yourself in knots if you don't have some understanding of that and getting that value stuff clarified. I clutched at straws when I first started. I just clutched at stuff. I wasn't thinking, just responding.

XXXX.

Do you have any questions you want to ask me or any other comments that you would like to add?

XXXX.

APPENDIX C

CONSENT TO PARTICIPATE IN RESEARCH INTERVIEW

Dear Colleague,

Thankyou for agreeing to participate in an interview during which we will discuss you experiences with suicidal clients, your impression of the extent to which services in Launceston meet the needs of such clients and recommendations you have regarding social work training.

What you say in the interview will remain confidential and no identifying information about you or your agency will be used in the results. If you would like a summary of the results or access to the thesis, that will be arranged.

Some people find that an interview about suicidal behaviour can be quite distressing. There will be time at the end of the interview to debrief if you would like, and I have a list of counselling agencies that would be available if you would like to talk through any issues that arise for you.

Of course, you are free to discontinue participation or to withdraw consent at any time.

If having read the above statement, you agree to being interviewed please sign the following declaration:

I (the participant) have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this interview. I also agree that research data gathered for this study may be published, provided that neither my name nor that of my agency is used.

---------- ----------

participant date

APPENDIX D

Initial list of nodes generated from interview transcripts.

For ease of reading, the broad groupings are listed in capital letters with bold type. Within these the main categories have been listed in standard letters with bold type. Sub-categories are in standard letters with no bold type and any division of these into sub-categories is in italics.

The categories have been listed in numerical order. In order to visualise the hierarchical nature of the index system a pictorial representation of the 'action' group of categories follows the numerical listing.

1 BASE DATA
11 /age
111 /21-30
112 /31-40
113 /41-50
114 /50 plus

12 /years experience
121 /two or less
122 /3-5
123 /6-10
124 /more than ten

13 /hours client contact
131 /0-5 hours
132 /5-10
133 /10-20
134 /20 plus

14 /agency type
141 /child
142 /hospital
1421 /psychiatry
143 /counselling
144 /govt welfare
145 /private welfare

15 /client group
151 /youth
152 /adult
153 /general
154 /female only
155 /other workers

16 /gender worker
161 /male
162 /female

17 /contact with clients
171 /long term
172 /short term
173 /mixture

18 /training
181 /Launceston
182 /interstate

2 EXPERIENCES
21 /suicidal behaviour
211 /suicide in clients
212 /no suicide in clients
213 /attempted suicide
214 /suicidal ideation
215 /aftermath

22 /client behaviour
221 /age differences
2211 */not identified*
222 /gender differences
2221 */not identified*
223 /patterns
224 /co-operativeness
225 /parental response
226 /help-seeking

23 /precipitating events
231 /loss of children
232 /shame
233 /loss of significant other
2331 */relationship breakup*
234 /personal crisis
235 /substance use
236 /recent suicide
237 /hospital discharge

24 /pre-existing conditions
241 /trauma
2411 */receiving abuse*
2412 */on-going battle*
242 /homelessness
243 /isolation
244 /mental illness
245 /perpetuating violence
246 /substance abuse
247 /immaturity
2471 */rebellion*
2472 */no deal emotions*
2473 */no concept death*
248 /no purpose
249 /previous attempts
2410 /self esteem

25 /warning signs
251 /threats
252 /acts of farewell
253 /depression
2531 */sudden change*
2532 */euphoria*
254 /anger
255 /guilt
256 /fear
257 /decisiveness
258 /violence
259 /hopelessness
25 10 /absence of

26 /impact worker
261 /debriefing
262 /isolation
263 /personal questionning
264 /shock

27 /re services
271 /conflict over management
272 /personal networks
273 /hospital
2731 */psychiatric services*
27311 */LGH*
27312 */private*
2732 /attitude after attempt
274 /non-hospital referrals
275 /protocols
276 /speed of response

3 IDEAS
31 /depression
311 /as illness
312 /as feeling
313 /role of drugs
3131 */positive*
3132 */negative*
314 /rel. to mental illness

32 /mental illness
321 /causes
3211 */organic*
3212 */social*
322 /role of psychiatry
3221 */expertise*
3222 */alternative paradigm*
3223 */labelling*
3223 */only alternative*
3225 */loss of control*

33 /suicidal behaviour
331 /suicide

3311 /choice
33111 /limited
331111 /age
331112 /responsib
331113 /rationality
3312 /confused thinking
33121 /mental illness
332 /causes of
3321 /environmental
33211 /overload
33212 /isolation
33213 /social crisis
3322 /trauma
33221 /abuse
3323 /guilt
3324 /hopelessness
33241 /no purpose
33242 /rebelliousness
3325 /mental illness
3326 /role of age
3327 /role of gender
333 /definitions
3331 /rationality
33311 /irrationality
3332 /suicide as escape
3333 /suicide as revenge
3334 /suicide as waste
3335 /suicide as self abuse
3336 /suicide as behav patt

34 /social work role
341 /micro
342 /macro
343 /limitations

35 /values
351 /confidentiality
3511 /break
3512 /maintain
352 /conflict with
353 /need for guidelines

36 /training
361 /macro perspective
362 /prior experience
363 /personal growth
364 /preparation
3641 /unhelpful aspects
3642 /helpful aspects
365 /supplemented by
3651 /supervision
3652 /colleagues
3653 /team approach
3654 /courses

3654/1 /problems in
3655 /experience
3656 /reading
366 /recommend
3661 /counsel techniques
3662 /opportun. observe
3663 /sui specific
3664 /in mental health
3665 /own work
3666 /assessment skills
3667 /other

4 ACTION
41 /assess risk
411 /minimising
412 /confirm intent
413 /assess plans
414 /assess concept death
415 /assess hi-risk behav
416 /mental health
417 /background

42 /refer
421 /non-medical
422 /thru parent
423 /to GP
424 /psych services

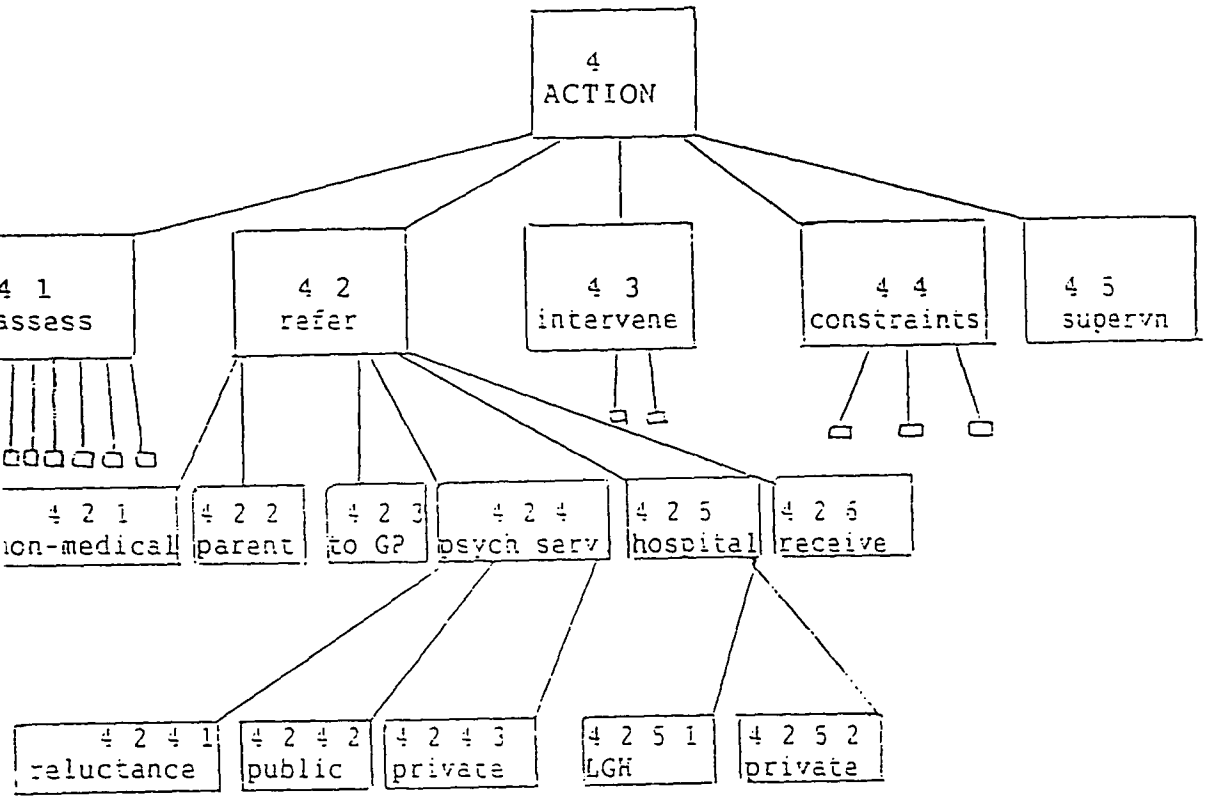
4241 /reluctance to
4242 /public
4243 /private
425 /hospital
4251 /LGH
4252 /Private
426 /receive from others

43 /intervention
431 /short term
4311 /prompt response
4312 /break confidentiality
4313 /restrain
4314 /make safe
4315 /call family
4316 /locate resources
4317 /contract
432 /counselling
4321 /defining needs
4322 /offering choices
4323 /break depression
4324 /conscientisation
4325 /build trust
4326 /behav modidcn
4327 /grief work

4328 */personal growth*
4329 */anger management*
43210 */work with relatives*
43211 */into heads*
43212 */into feelings*
43213 */externalisation*
43214 */problem solving*
43215 */other*

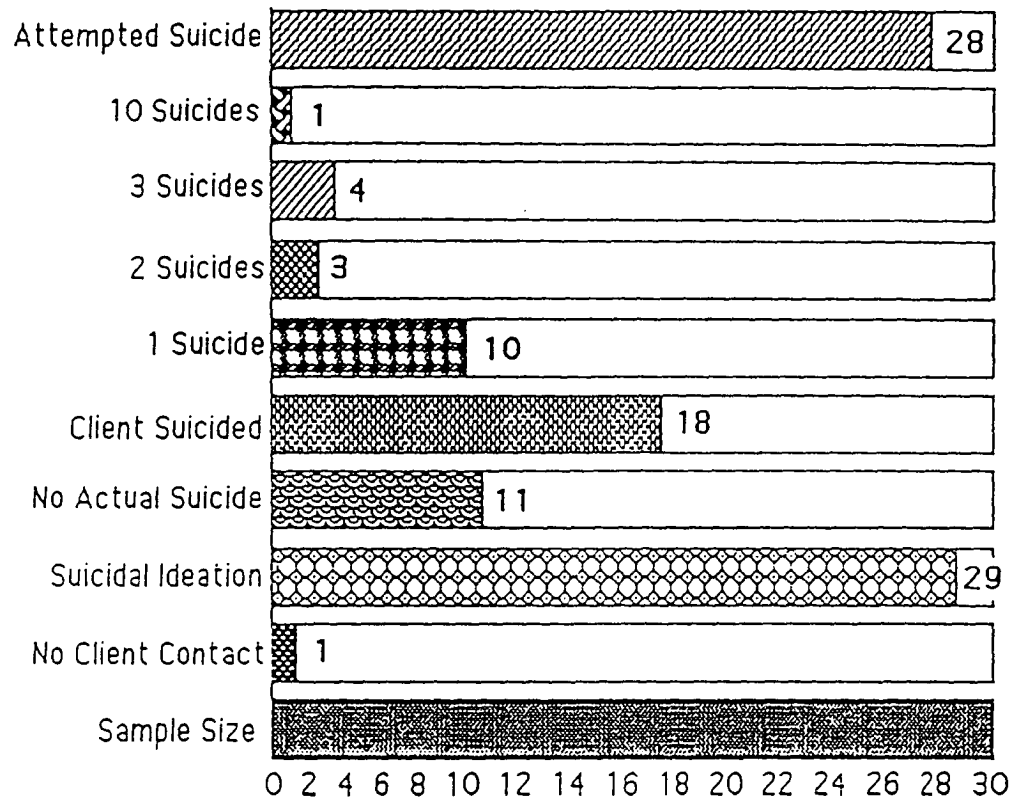
44 /constraints
441 /agency
4411 */consent*
4412 */inter conflict*
4413 */time*
4414 */facilities*
4415 */guidelines*
4416 */ownership*
442 /client
4421 */age*
4422 */drug use*
4423 */resistance*
4424 */preferences*
4425 */resources*
443 /worker
4431 */reluctance*
4432 */inaction*
4433 */inexperience*
4434 */role*
4435 */gender*
45 /supervision

Pictorial representation of part of the ACTION group of categories.



APPENDIX E

Number of Social Workers Reporting Their Experience with Clients



APPENDIX F

Number of Social Workers Describing Suicidal Types