A solution-focused approach to working with clients who are suicidal

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ABSTRACT Self-harm and suicide are amongst the most challenging and frightening problems that therapists and counsellors can encounter in the course of their work. The risk of clients harming themselves in the course of treatment can debilitate the therapists from acting creatively and collaboratively, and make their actions defensive, focused solely on risk assessment rather than therapeutic change. Yet it is precisely a creative and collaborative response, such as that engendered by solution-focused therapy and other models, that is the most likely to facilitate change and re-empower clients to take back charge of their lives. This article describes a solution-focused approach to working with suicidal clients that can be used in conjunction with traditional approaches and which focus on establishing safety as well as assessing risk. Working from this model the clinician shifts to identifying client strengths and coping skills, to collaborating with the client to establish meaningful goals and to helping the client envision a positive future. Arguably, such an approach can increase collaboration between therapist and client and lead to a more client-centred safety plan.

Introduction

Solution-focused therapy (SFT) is a collaborative and non-pathological approach to therapy developed by de Shazer and others in the 1980s and 1990s (Berg, 1991; de Shazer, 1988, 1991; de Shazer et al., 1986; O’Hanlon & Weiner-Davies, 1989). Belonging to the social constructionist school of thought, the approach questions the usefulness of many of the traditional assumptions about psychotherapy such as that problems need to be always understood before solutions can be reached, or that symptoms mask underlying deeper problems which have specific causes, or that real therapeutic change takes time and is invariably resisted by clients. From a postmodern perspective such assumptions are not true or false. They do, however, direct the course of the therapeutic conversation, selecting what therapists listen to and guiding the thrust of their questions and therapeutic techniques.
SFT proposes that strengths-based assumptions are more useful in guiding therapeutic conversations. For example, in contrast to the above assumptions it is arguably more useful to conceive that solutions need to be understood and elaborated rather than problems, that therapeutic change can be brief and pivotal, and that ‘resistance’ only occurs when therapists misunderstand the client’s individual way of co-operating.

In practical terms, SFT is a reorientation from a problem-focused to a solution-focused approach to therapy. The focus is on working with client strengths, rather than deficits, on analysing positive exceptions rather than problem patterns and on elaborating preferred futures and goals rather than problem pasts. In a nutshell, the focus is on where clients want to go, rather than where they have been. The role of the therapist is to clear his or her head of hypotheses about the nature of the problem (or the solution) and to adopt an ‘unknowing position’ viewing the client as the expert. From a stance of respectful curiosity towards clients and their life situations, the therapist asks questions that aim to facilitate the client in generating their own solutions to the problems that brought them to therapy.

Solution-focused therapy and suicide?

Self-harm and suicide are serious problems which affect large numbers of people in the western world. Particularly alarming are the recent increases in suicide among young men (Cantor, 2000). Far from being resistant to help, some studies have shown that over half of those who attempt suicide are already in contact with mental health services (Hawkes, et al., 1998). This puts an onus on mental health professionals to find therapeutic ways of reducing the risk of the many suicidal and depressed clients who come to the attention of services. Traditionally, this response has consisted of risk assessment and management, followed by treatment interventions such as medication or psychotherapy (Carr, 1999; Hawton & van Heeringen, 2000). Alarmingly, there has been little empirical research to suggest that either medication or psychotherapy-based interventions, in their current format, are effective in reducing the risk of suicide, when compared to a non-treatment control group (Heard, 2000; Verkes & Cowen, 2000). (This is partly due to the ethical and practical difficulties in conducting such research.) In addition, many of the techniques used by practitioners, such as entering into a no-suicide contract with clients during treatment, are not as effective as commonly believed. For example, in a postal survey of clinicians, examining the rates of suicidal attempts following treatment, Kroll (2000) found that 41% of respondents had treated people who committed or made a serious attempt after entering into a no-suicide contract with the clinician. While these data tell us nothing of the efficacy of contracting relative to no contracting, it does indicate that no clinician should take excessive comfort from the fact that a suicidal person agrees to contract for safety. Indeed it suggests that we should continue to be searching for more effective ways of working with this high-risk client group.

In recent years many practitioners have been exploring how solution-focused therapy can apply to work with clients who are suicidal or who have a history of self-
harm (Calcott & MacKenzie, 2001; Hawkes et al., 1998; Softas-Nall & Francis, 1998a). In particular the authors have explored how solution-focused ideas, particularly scaling questions, can be used to enhance traditional approaches to suicide risk assessment in order to establish a safety plan with clients and their families. Though there is a growing body of research for solution-focused therapy in general (George et al., 1999), there is at yet no empirical evidence for the effectiveness of the approach with suicidal clients. There is however some evidence that the strengths-based orientation that SFT engenders may be a fruitful one. For example, Malone (2000) studied 84 depressed individuals, many with a prior history of suicide attempts. Depressed individuals who had no history of suicide attempts had greater survival and coping beliefs, more moral objections to suicide, and more reasons for living. While being far from definitive, these results suggest that rather than exclusively carrying out risk assessment, clinicians should also spend time doing the things that might prevent depressed individuals from attempting suicide such as highlighting their coping skills, exploring their reasons for living and helping them envision a more hopeful and optimistic future. These are the areas where SFT can make a contribution.

SFT is not unique in engendering a strengths-based collaborative approach to working with suicidal clients and the ideas strongly resonate with other brief interventions, particularly those from the cognitive–behavioural tradition. For example, the SNAP programme (Miller et al., 1992), a cognitive–behavioural intervention for adolescent suicide attempters and their families, resembles SFT in that it focuses on establishing practical goals, encouraging strengths-based communication between family members and using scaling questions to assess risk and to establish safety plans.

Some people have expressed caution about using the solution-focused model with suicidal clients, especially given its lack of emphasis on risk assessment. Indeed a strict application of solution-focused principles without taking into account the dangers that clients could be in would be an unethical way of practising as clearly there will be times when the therapist has to take unilateral action to ensure a client’s safety (such as informing other family members, the family doctor or arranging an involuntary in-patient stay). However, there are also dangers from being excessively problem- or risk-focused in that this can close down the possibility of therapy. Clients will simply not talk to you if they feel you are going to react in a specific way without consulting or listening to them first. For example, many people will not disclose just how depressed or hopeless they feel for fear someone will ‘lock them up’. Ironically, it is these clients, who are without a person with whom they can supportively communicate, who are at the most risk of harming themselves. In their model combining the benefits of the solution-focused approach with the caution of risk assessment, Hawkes et al. (1998) have recommended using the standard solution-focused therapeutic interview as the starting point of engagement with the client. Safety can be explored using some of the model’s techniques, notably scaling questions (as we shall see later). If concerns still exist about safety, for the therapist or client, then the therapy stops and a management plan is negotiated. The overriding concern is the safety of the client.
Interventions of solution-focused therapy

In the remainder of this article, we describe a number of solution-focused interventions, notably: (1) listening for strengths, (2) moving from problems to goals, (3) finding exceptions, (4) exploring how clients cope, and (5) using scaling questions. The interventions are illustrated with sample session dialogues (based on an amalgam of case examples) as to how they can be applied to working with suicidal clients and their families. We conclude the article with the important area of how suicide risk can be assessed and managed from a solution-focused perspective particularly using scaling questions.

Listening for strengths

Central to the practice of SFT is the focus on client strengths, skills and resources. The aim is to harness these resources (many of which are forgotten, neglected or undervalued) in the service of positive change. As in all psychotherapy, empathic listening that ensures clients feel understood, respected and not judged is critical in SFT. When solution-focused therapists listen, however, they acknowledge not only the pain and suffering of clients but also their strengths and resilience in response to the problems they have. When therapists reflect back how they have understood what clients have said, their words are passed through a ‘strengths-based filter’ that frames understandings in ways that open up possibilities and choices. The aim is to hold up a positive, reflective mirror to clients of their own abilities and strengths. While the client may feel despairing, the therapist holds on to his or her belief in the client and in the potential of a collaborative therapeutic alliance to move things forward. A gentle, affirming, non-impositional but persistent listening style characterises this approach.

How this is done is often very subtle depending a lot on both the verbal and non-verbal communication the therapist employs. Consider the differing impacts of the two following opening statements from a therapist to a client in a post suicide attempt interview:

Therapist: What made you do what you did?

Therapist: You must have had a pretty good reason for doing what you did.

The first question can inadvertently communicate a judgement or make the client feel defensive (he may be surrounded by lots of family and friends asking him this question). The second opening comment is more disarming, non-judgemental and implicitly assumes a positive view of the client (e.g. that he acts reasonably and with good cause). In this way strengths-based listening has begun and the client is gently invited to tell more of his story. Consider another example of strengths-based listening, taken from a different client:
Therapist: How did you pull back at the last moment [from the suicide attempt]?

Client: (thinks) Well I thought of my children

Therapist: I see, what did you think about them?

Client: I thought of how alone they would be if I killed myself, of how much they need me.

Therapist: Sounds like you have a lot of love for them. . . that you really want to be there for them.

Client: Yes (a little tearful).

Therapist: What does that say about you as a person . . . that you want to be there for your children . . . even despite the pain you feel yourself?

Client: (pause) . . . It means that I want to be the best mother I can be for them.

Therapist: I can really see that.

The shift to a strengths-based conversation starts with the therapist thinking positively about the clients and their actions and beginning to reflect this back to them. For example, when faced by a family who have come to therapy because of a suicide attempt, rather than seeing them simply as having ‘dysfunctional communication patterns’, the therapist can reflect about the courage and organisation it took to come to therapy and state:

Therapist: You’re the type of family that doesn’t sweep problems under the carpet, but faces them bravely and takes steps to sort them out . . . I think it also shows a great willingness to change and learn, the fact that you all got here today.

Or rather than reflecting about the action of a suicide attempt, the therapist can reflect back to the client the underlying motivation that underpins it, stating, for example:

Therapist: I’m struck by how desperately you must want things to change for the better, given that you were prepared to consider ending your life.

The focus on strengths, skills and resources is not about simple ‘positive thinking’ or about denying or minimising the problem. SFT is not problem or pain phobic. Clients need to feel that their problems and difficulties are taken seriously, that their
suffering is acknowledged and that they are not blamed for the problem. A good solution-focused therapist communicates this empathic understanding, while also communicating a belief in the strengths of the client and in the possibility that they can make things different. Therapy should both provide the client with compassion and understanding about their difficulties as well as encouragement about their strengths and inspiration that things could be made better.

Moving from problems to goals

Suicidal thoughts and suicide attempts are serious problems but they are not goals. Indeed suicide is more of a means to an end than rather the end or goal in itself. Clients who see suicide as an option desperately want things to be different in their lives, whether this is ending the hurt they feel or ensuring other people take notice. Though it is a drastic course of action, they feel hopeless and believe that suicide is the only way to achieve these goals. The aim of therapy is to uncover with the client the positive goals and intentions which underpin their suicidal actions and to explore with them how they can achieve these by other means. Consider the following example:

Therapist: Things must have been really difficult for you, for you to consider harming yourself . . . You must really want things to be different in your life?

Client: Yeah, I want an end to the pain I’m feeling.

Therapist: I see . . . you don’t want to feel this pain anymore . . . you’d love to feel better?

Client: Yeah.

Therapist: How are things for you when they are better?

Client: Well, I wouldn’t wake up with this dark cloud over me . . . I’d wake up and feel lighter.

Therapist: So when things are better, you wake up in the morning feeling lighter . . . maybe rather than a dark cloud there would be . . .

Client: sunshine

Therapist: Ahh . . . so you would like more sunshine in your life?

Client: Yeah that is it.

Therapist (curious): Tell me then, what would you be doing differently if there was more sunshine in your life?
Client: Hum . . . I guess I would be able to go back to work. It has been a while since I went to work . . . feeling so down and all.

Therapist: What else?

Client: Well, I guess I would not feel like ending it, I would feel like there was something to live for.

Therapist: Like?

Client: That people cared, you know, I would know that people cared; it just seems that they don’t anymore.

Therapist: So it is pretty important for you to know people care . . . When was the last time you had that feeling?

The therapist attempts to help the client articulate clear, positive goals, defined in terms of things the client wants rather than what he or she doesn’t want. For example, it is not sufficient to know that the client does not want to be depressed anymore; the therapist wants to know what will be present in his or her life when the depression is gone—what will the client be feeling or doing when the depression is gone? The more concrete and detailed the goal is, the better. The aim is to help the client envision a future where the problem has been eliminated and to describe this in detail. A useful way to do this is with imaginative questions such as the miracle question (Berg, 1991; de Shazer, 1988) as follows:

Therapist: Suppose you leave here and a miracle takes place tonight where the problem that brought you to therapy disappears and life is much more manageable. But you don’t know this miracle has taken next place when you wake up. So what would be the first thing you’d notice, as you wake up, that would tell you the miracle has happened, that you are coping much better than before?

The miracle question works best when it is followed up with lots of questions to generate as much concrete and meaningful detail as possible. The more richly described the goal is, the better. Questions such as the following can be helpful in doing this:

Therapist: How would you feel/think differently? What would other people notice about you that would tell them the problem was gone? What would other people notice about you? What else would you notice? What else? What else?

Goals for the therapy. As well as uncovering the positive goals that underpin clients’ suicidal intentions, the solution-focused therapist is interested in establishing an
agreed goal for the therapy with the client. The question is not ‘what problem brings you to therapy?’ but ‘what would you like to achieve by coming to therapy?’ Or as Iveson (2000) frames it, ‘what is your best hope for these meetings?’ Generally psychotherapy works best when a clear, positive and client-centred goal has been established and this is major contributor to an effective alliance (Garfield & Bergin, 1994; Hubble et al., 1999). Indeed, much confusion is caused in the therapeutic process when goals are ‘assumed’ rather than clarified, or imposed rather than agreed with the client. Establishing positive goals isn’t easy and can take time with clients, especially when they are immersed in a serious and frightening problem like suicide but it is an important stage and marks a critical step towards change.

Therapist: What is your best hope for these meetings?

Client: Well I’ve been very depressed recently and a few weeks ago . . . I felt so low that I tried to kill myself.

Therapist: I’m sorry to hear that . . . things must have been pretty bad for you.

Client: They were.

Therapist: (pause) And that caused you to think about coming to therapy?

Client: Yeah . . . I don’t want to do anything stupid like that again.

Therapist: I see . . . so you’d like to find other ways of dealing with things when you feel low, other than trying to kill yourself.

Client: Yeah, I would.

Establishing therapeutic goals with family members, or a couple when one person is suicidal, can be very helpful as it can help the client access support from their family which can be key in helping them work things out. Consider the following sequence taken from a family session with a teenager who had attempted suicide.

Therapist: (addressing whole family) So what would you hope to get out of coming to these meetings?

Father: We’re here for Tina.

Therapist: You’re here for your daughter.

Father: I don’t want anything bad to happen to her . . . I want to help her.
Therapist: You want her to be safe and well . . . and you want to find a way of helping her.

Father: Yeah.

Father: What do you think of what your Dad is saying?

Tina: (shrugs) Dunno!

Therapist: (addressing Tina) What would you hope for coming down to this meeting?

Tina: I just wish everyone would stop making a fuss and leave me alone.

Therapist: Yeah . . . you’d like some space?

Tina: Yeah, I wish they’d trust me again.

Therapist: You’d like your parents to trust you and give you some space?

Therapist: What do you think (addressing the mother)? What would you like to happen?

Mother: I’d just like to get the old Tina back.

Therapist: What do you like about the old Tina?

Mother: Well she’d smile a lot more.

Therapist: I see, you’d like to see a lot more smiles.

When the client sees suicide as the goal? Establishing goals with clients often isn’t easy and it can be especially challenging with clients who have felt so immersed in their problems that they attempted suicide. However, therapeutic progress is severely curtailed unless on some level a positive goal, that the client is motivated about, has been established. Consider the following example where the client who is in an in-patient ward feels very hopeless and sees no other way out but suicide:

Therapist: So what are your best hopes for these meetings?

Client: I dunno, I don’t see any other way out. I just can’t bear the pain anymore.

Therapist: Things sound really hard for you at the moment.
Client: Yeah, I just want to end it all. And that is what I’m going to do when I leave here. They can’t keep me in forever.

Therapist: You’re pretty serious about trying to kill yourself?

Client: And I don’t think coming to meet you can change my mind.

Therapist: You’re not sure yet what we can achieve in these meetings (pause).

Therapist: Can I make a proposal to you?

Client: OK.

Therapist: I’m sorry that you are in so much pain, so much so that you feel like ending your life. And I’d like to be of help to you, but I don’t want to see you killing yourself. Would you be interested in talking with me about how things could be different, how you could end the pain without ending your life? You can then decide if it is helpful to you. Even if we don’t come up with anything new, you can still go back to your old option, but I think we might be able to find something helpful. Would you like to give this a try?

The aim is to invite clients into conversation about alternative perspectives on the problems they are facing and to open up the possibility of a future where life is better for them, with suicide sidelined as a potential method of moving forward.

Finding exceptions

An essential aspect to SFT is the belief that there are always exceptions to problems (de Shazer et al., 1986). Problem patterns are never rigidly fixed through time and different situations. There are always times and situations when the problem occurs slightly less or even not at all. Indeed, the fact that a person is aware that there is a problem suggests that they are making a comparison to another time or situation when the problem did not exist. For example, a woman who feels depressed only knows this if she has a sense of other times when she was happier.

These exceptions are often forgotten, ignored or considered to be ‘flukes’. Solution-focused therapists, however, believe that exceptions deserve the closest attention in therapy. They signify examples of ‘micro-solutions’ already occurring within clients’ experience and ways in which clients have applied their existing resources. They can be conceived of as chinks in the armour of the problem. If understood and explored they can be amplified and repeated, ultimately leading to the eventual dismantling of the problem. Consider the following questions designed to elicit exceptions:
A solution-focused approach to working with suicidal clients

Therapist: You were saying that you didn’t always feel suicidal, that it has only come upon you since autumn . . . How were things different for you then, say during the summer before the problems started?

Therapist: You were saying that the weekends are the worst for you . . . that then you feel all alone, and the negative thoughts get in on you . . . (client nods) . . . so presumably things are a little better for you midweek . . . so how are things better then?

Once an exception has been identified it should be explored in detail with follow-up questions such as: in what way are things different for you then? What do other people notice? What else? What else? The more concrete and meaningful the detail to the client, the more likely it is to facilitate change. Consider the following sequence:

Therapist: When over the last few months has the pain lifted, even a little bit?

Client: (silence) I don’t think it ever lifted . . . well maybe a bit, after my boyfriend found the pills, I just had them hidden in case I needed them, I hadn’t taken them yet, but Ben he found the pills and went mad, well first he went mad and then he started crying and told me how much he loved me and that he wouldn’t know what to do if I was gone. It was really strange, but for a while after that I felt better . . .

Therapist: You felt better . . . how do you explain that?

Client: I guess, because I know he cared that much about me, it made a difference . . . I think I felt closer to him after we talked.

Therapist: So when you talk to your boyfriend or when you feel cared for, that can make a real difference to you . . .

Exploring how clients cope

Suicide attempts and depression are serious problems and can have a devastating impact on individuals and families. Though solution-focused therapists take these problems seriously, they are less interested in exploring the effects or damage inflicted by the problem and more interested in exploring how clients have responded to and coped with what has happened. Such a focus can be more empowering in helping clients identify strengths and resources to manage the problem more effectively. To identify coping skills the therapist can use questions such as the following:

- How do you get through the times when the suicidal thoughts are bothering you?
• How do you cope with your depression?
• What keeps you going on a daily basis?
• Who is your greatest support, when faced by a bout of depression? What do they do that is helpful?
• What gives you the strength to keep going?

Searching for the client’s coping responses to their problems can often require a gentle persistence on the part of the therapist. Immersed in the grip of the problem, it is easy to forget how one has coped in the past. The role of the therapist is to help clients ‘remember’ and reaccess these coping skills and often this can lead to unexpected strengths and resources. Consider the following example:

Therapist: How have you managed to deal with your depression on a daily basis?

Client: Well I don’t think I have, I feel like I’m falling apart, it has been so hard.

Therapist: I understand it has been really difficult . . . Yet you still got here today . . . Somehow you have been managing even though it is pretty tough . . . What has helped?

(Silence)

Client: Well my friends have been good, I mean they all know I’ve been down and they call and send little text messages to me, sometimes this helps and sometimes . . . I don’t know, it’s too much.

Therapist: So sometimes their support can be too much, but other times it can be helpful . . . When is it helpful?

Client: I guess, when they don’t push too much, when they simply are there for me.

Therapist: Which friend is best at doing this?

Client: I think Alison is.

Therapist: So Alison is a good support . . . What other things in your life are a support to you?

Client: Sometimes I like being on my own and just writing. I have this journal that I’ve been keeping, poetry and things like that. It helps, when I want to be alone and just think and write, it keeps me sane.
A solution-focused approach to working with suicidal clients

Therapist: Really? Tell me more about how the diary helps.

Client: I feel like I can get it out, you know get out the madness in my head and just write it out. It helps me and I hope it will help others one day, I have this idea that my writing might help other girls who have been through what I have.

When we explore clients’ coping we can often discover that they have engaged in many creative ways of managing their problems, some of which are recommended by various therapeutic models. In the above example the therapist discovered that the client’s kept a journal as a way of coping, a technique which is suggested by many therapists for different problems (e.g. Dolan, 1991). Setting out to first discover clients’ own methods of coping rather than suggesting new ones is much more effective as these are much more likely to be built upon and carried out on an ongoing basis.

Using scaling questions

In SFT, the therapist is interested in discovering how change happens in clients’ lives and in helping them understand and build on this. Scaling questions provide powerful and versatile ways of measuring change and breaking goals down to small achievable steps and are used in many other therapies and models such as cognitive–behavioural therapy (e.g. Miller et al., 1992). Consider the following example:

On a scale of 1 to 10, where 10 is the happiest you ever felt (or where you have achieved your goal for therapy), and 1 is the worst you ever felt, where would you say you are now?

Depending on where the client places herself, the therapist has series of important follow-up questions to elicit progress and plan next steps. For example, suppose a client says he is at 3 on the scale, the therapist can ask:

- What has got you to 3 on the scale?
- What is different being at 3 rather than 2? (What else is different? What would other people notice?)
- What is the highest point you have reached on the scale? (What was that like? What were you doing then?)
- What would be different if you moved to 4 on the scale?
- When was the last time you were at 4?
- What needs to happen so you can move to 4?

When working with families or couples, scaling questions can very useful in helping family members communicate positively and to identify what they want from one
another (Softas-Nall & Francis, 1998b). For example, suppose a teenage girl, who had attempted suicide, rated herself at 2 on the scale (where 10 was ‘feeling happy and safe’) but she had in the past been at a 6; the therapist could explore how the family could help in the following way:

Therapist: What was happening when you were at a 6? What were things like in your family then? What were you doing differently? What were your parents doing differently? What did you feel about those times?

In addition, the therapist could ask the parents corresponding questions:

Therapist: What do you remember about the time when things were 6 in the family? What did you notice about your daughter then? What was she doing differently? What were you doing differently?

Even if a client scores very low on the scale, follow-up questions can be used to elicit what next steps need to be taken. For example, if the client states they are at 1 on the scale—the lowest point they have ever felt—the therapist can respond:

Therapist: I’m sorry to hear things are so low for you at the moment . . . Supposing things were to be a little better for you, say you were to move one point (or half a point) forward on the scale . . . What would that be like? What would you first notice, that would tell you that things were beginning to improve?

Assessing safety using scaling questions

As distinct from working with other clients we have a responsibility, when working with suicidal clients, to assess the suicide risk and to take action if clients are in danger. Some therapists have explored how solution-focused therapy can complement more traditional forms of risk assessment, by using scaling questions to collaboratively establish with clients the level of risk and the safety action needed (Calcott & MacKenzie, 2001; Hawkes et al., 1998; Softas-Nall & Francis, 1998b). Useful questions are as follows:

Therapist: On a scale of 1 to 10, how confident are you that you will be able to get through the weekend without attempting to harm yourself, where 1 means you feel you have no chance and 10 means you are totally confident? What makes you that confident? What needs to happen to make you more confident . . . to move one point forward on the scale?

Therapist: Suppose over the weekend your mood drops two points on the scale, what will you do to ensure you get back on track? What would help to get you back up to 6 on the scale?
Where appropriate, other family members should be involved in safety discussions, and often they can provide great resources in helping the client be safe. Questions can be addressed to them as follows:

Therapist: On the same scale, how confident are you that your son will be safe this weekend? What makes you that confident? What needs to happen to make you more confident . . . to move one point forward on the scale?

In order to work safely in a therapeutic contract, clients ideally should be able to give some sort of guarantee that they will not harm themselves between sessions. If this is not the case, therapists may need to consider other options. Consider the following example:

Therapist: On a scale between 1 and 10, when 10 is you can 100% guarantee me you will be able to keep yourself safe until we meet again and 1 is that after our meeting you think you are definitely going to end things, where would you say you are now?

Client: 2.

Therapist: What would help you feel more confident that you would be able to be safe until next week?

Client: Don’t know, I guess I just feel so out of control again, I had been doing really well, but recently it is just scary . . . Maybe I have to go back into the hospital, I hate to say this, but it would be the only place I would feel safe at the moment. If I am on my own, I just couldn’t promise anything.

Therapist: It sounds pretty scary at the moment. Should we call your GP and see if he can arrange for you to go in hospital?

In the above example, although the therapist has to take action (i.e. contacting the GP) to ensure the safety of the client, this is done in as collaborative a way as possible to preserve the client’s sense of self-efficacy in deciding the resources needed to protect him or herself. If the client was not able to co-operate and demonstrated a high level of risk, then the therapist would have to consider taking unilateral action (e.g. in extreme cases arranging for client be detained involuntarily). It can be acknowledged with the client that you cannot simply do nothing if they intend to harm themselves, that you have a duty of care to protect them and do what you can to preserve life. As Hawkes et al. (1998) state, this is point where therapy should stop and case management should begin, though this should be done in as respectful and collaborative a way as possible.
Conclusion

Traditionally, professional responses to suicidal and self-harming clients have consisted of risk assessment and management, followed by treatment interventions such as medication or problem-focused psychotherapy. In recent times there has been a growing interest in exploring more collaborative and strengths-based approaches to working with this client group. In this short article we have outlined some of the principles of solution-focused therapy and how they can be applied to working with clients who are suicidal and/or at risk of harming themselves. Given as yet the lack of empirical evidence for SFT with this client group, we must be cautious about abandoning traditional approaches to risk assessment and management. Rather the approach can be best conceived as enhancing and complementing other therapeutic approaches in order to reorient the therapy away from an exclusive focus on the problem and to help clients envision a positive future where suicide is not an option.

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A solution-focused approach to working with suicidal clients


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