Suicide and Hastened Death:
Toward a Training Agenda for Counseling Psychology

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Despite the high frequency of suicide and its ubiquity in the caseloads of practicing psychologists, several sources of evidence converge to suggest that the training of mental health professionals in this critical area is woefully inadequate. For example, surveys of psychology training programs suggest that only 40% offer formal training in working with self-destructive clients (Bongar & Harmatz, 1991), and only about half of psychology trainees report receiving even minimal training in suicide intervention (Kleespies, Penk, & Forsyth, 1993). When such training is offered, it is typically limited to a recitation of risk factors and a cursory discussion of "no harm" contracts, coupled with the ethical necessity to report and prevent client self injury. Needless to say, this leaves trainees substantially unprepared for managing the complexity of actual suicidal crises, to say nothing of their preparedness to engage emerging challenges in the practice of counseling psychology, such as consultation regarding the appropriateness of hastened death in the presence of intractable terminal pain and debilitation.

In the face of this general inattention to issues of suicide and hastened death, Westefeld et al. (2000 [this issue]) and Werth and Holdwick (2000 [this issue]) have performed an important service in systematically summarizing the dauntingly complex literatures in both areas and sketching their implications for the practice of counseling psychology. Indeed, the impressive scope and balance of their respective reviews pose a challenge to the prospective commentator charged with critiquing or extending their survey of these cognate fields. Because of the comprehensiveness of their coverage and my general agreement with the tenor of their conclusions, I will focus on augmenting the implications of the two foregoing articles for training in counseling psychology. In doing so, I will draw particularly on my own experience as an educator of professionals, graduate students, and paraprofessionals in suicide intervention, as well as my collaborative research on the development and assessment of competencies in this area of practice.
SUICIDE COUNSELING: A TRAINING AGENDA

One of the ironies of contemporary training in psychology is that specialization has tended to "crowd out" attention to dimensions of human experience that are not easily circumscribed to particular client types. Of these universal dimensions, the encounter with death and loss is arguably the most pervasive and demonstrably among the least adequately addressed in professional training. It is therefore unsurprising that suicidology, as a critical subfield of death studies (Wass & Neimeyer, 1995), receives scant attention in most graduate curricula.

Westefeld et al. (2000) and Werth and Holdwick (2000) make a strong case that ignoring this literature does a disservice to counseling psychology trainees and provide a trove of valuable data that could inform such training. In my remarks I will attempt to formulate a set of 13 training goals for counseling psychologists in this area. Because my coverage of these will be necessarily synoptic, I will defer to the previous articles for discussion of topics they address in detail (e.g., risk assessment) and concentrate on goals they touch on more briefly, combining some goals where necessitated by space restrictions. A schematic presentation of all 13 goals and some suggestions regarding teaching methods appropriate to each appear in Table 1.

Personal Development

Ultimately, of course, the goal of training is to prepare counselors with the skills necessary to intervene effectively with clients and patients contemplating suicide and to assist members of the family or community struggling with the aftermath of suicidal bereavement. But a preemptive emphasis on these behavioral competencies risks marginalizing the equally important domain of counselors' personal development of the attitudes and knowledge base required for successful suicide intervention. Three training goals pertinent to such personal development are values clarification, anxiety reduction, and conceptual learning. Because the relevant knowledge base in this area is capably summarized by the previous authors, I will forgo commenting on a conceptual agenda for training and instead focus on the relevance of exploring values and attenuating personal discomfort in the training of suicide counselors.

Values clarification. Studies of attitudes toward suicide suggest sharp divisions of opinion regarding the meaning of the decision to end one's life, with some regarding it as an inalienable personal right and others considering it a sign of moral evil or personal pathology. A similar division of opinion
<table>
<thead>
<tr>
<th>Target Domain</th>
<th>Training Goal</th>
<th>Teaching Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal development</td>
<td>Values clarification</td>
<td>Self-exploration exercises, reading in ethics, group discussion</td>
</tr>
<tr>
<td></td>
<td>Anxiety reduction</td>
<td>Graded exposure, stress management training, mentoring</td>
</tr>
<tr>
<td></td>
<td>Conceptual learning</td>
<td>Lecture, reading of current theory and research, experiential exercises</td>
</tr>
<tr>
<td>Skills development</td>
<td>Prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Education and outreach</td>
<td>Modeling of presentations, mentoring, performance feedback</td>
</tr>
<tr>
<td></td>
<td>Consultation and supervision</td>
<td>Modeling of consultation, vertical teams, metasupervision</td>
</tr>
<tr>
<td>Intervention</td>
<td>Suicide risk assessment</td>
<td>Lecture on risk factors, reading, role play</td>
</tr>
<tr>
<td></td>
<td>Crisis intervention</td>
<td>Role play of active listening and directive management skills, behavioral rehearsal</td>
</tr>
<tr>
<td></td>
<td>Counseling and psychotherapy</td>
<td>Case conceptualization, supervision, case conferencing</td>
</tr>
<tr>
<td></td>
<td>Risk management</td>
<td>Protocol development, supervision of record keeping, study of mental health law</td>
</tr>
<tr>
<td></td>
<td>Competency assessment</td>
<td>Reading in law and ethics of hastened death, teaching regarding relevant medical conditions, case study of compromising diagnoses</td>
</tr>
<tr>
<td>Postvention</td>
<td>Facilitation of decision making</td>
<td>Study of family systems, supervision and mentoring in family conferencing, interdisciplinary practica</td>
</tr>
<tr>
<td></td>
<td>Death notification and</td>
<td>Specialized workshops, role play of debriefing</td>
</tr>
<tr>
<td></td>
<td>Grief therapy for survivors</td>
<td>Reading in contemporary grief theory and traumatology</td>
</tr>
</tbody>
</table>

characterizes ongoing professional debates regarding the rationality of the choice to end one’s life, whether in the context of life-threatening illness or intense emotional distress (Werth, 1999). From the standpoint of professional training, it is worth considering whether the interventionist’s own attitudes and values regarding suicide are related to his or her effectiveness in
working with potentially life-threatening clients. Preliminary evidence suggests that the answer to this question may be “yes.”

Comparing would-be helpers who held accepting views toward suicide as a personal right with others who adopted an ethic of prevention, my colleagues and I found evidence that the former were less effective in choosing appropriate responses to a self-destructive client, at least as judged by highly expert suicidologists (Neimeyer, Fortner, & Melby, 1999). Still more sobering was the finding that a personal history of suicide ideation on the part of counseling psychology trainees and paraprofessionals was associated with less effective responding, and that both of these factors continued to predict response skills even after training and experience were taken into account. Taken together, these findings suggest the potential relevance of (a) screening for trainees’ own history of suicidal thoughts and behaviors and making available personal therapy where appropriate, and (b) making a focus on values clarification an integral part of predoctoral training in suicide intervention. Because of the intimate nature of the latter topic, I have found it helpful to supplement readings on the ethics of suicide prevention with relevant self-exploration exercises, a topic I will develop more fully below.

Anxiety reduction. In addition to values clarification, a focus on anxiety reduction regarding working with potentially self-destructive clients is a legitimate goal of counseling psychology training. Working with suicidal clients, counselors must grapple with anxieties about their own competence and compassion in the face of escalating client demands and intense emotional distress. Suicide counseling can be particularly difficult for counselors with elevated levels of personal death fear, because clients’ struggles with loss or death may trigger anxieties about the counselors’ own mortality. Our program of research on trainees’ reactions to client problems concerning death and suicide supports this conclusion. Kirchberg and Neimeyer (1991) found that counseling psychology students consistently rated presenting problems concerning life-threatening illness, suicide, and bereavement as more likely to trigger acute discomfort than a set of serious but non-death-related problems (e.g., rape, physical abuse, sexual abuse), a finding that was substantially corroborated by Kirchberg, Neimeyer, and James (1998). In contrast, a highly experienced group of grief counselors showed a general reversal of this pattern, ranking client problems with loss or impending death less personally distressing for them than other serious presenting problems (Terry, Bivens, & Neimeyer, 1995). The single exception to this reversal was suicide: For both novice and veteran counselors, the prospect of working with a client acknowledging suicide ideation was among the most distressing of the 15 clinical scenarios presented. Interestingly, counselors’ phobic anxieties about
death predicted their level of distress in death-relevant counseling situations, and counselors who scored high on "fatalism" and despair regarding their own deaths responded less empathically to videotaped portrayals of clients struggling with these issues (Kirchberg et al., 1998). These findings suggest the relevance of counselors' exploration of their own vulnerabilities in connection with death, dying, and suicide, perhaps stimulated by self-assessment using any of a number of well-constructed death anxiety measures (Neimeyer, 1994). Reflection on shared and unique concerns in a supportive environment, in combination with close mentoring and graded exposure to working with highly perturbed clients, could support students in developing counseling competencies with this demanding client population.

Skills Development

Outreach and consultation. Although prevention logically precedes intervention, in practical terms, training in suicide education, outreach, and consultation should follow solid development of intervention skills. As counseling students are called upon to provide suicide prevention workshops to the campus community and beyond, they will do so more effectively after they have developed an applied as well as academic mastery of the rudiments of suicide intervention. Modeling by more expert mentors, copresentation, and clear performance feedback can assist them in developing this dimension of their professional identity, which can unexpectedly "shade over" into a counseling role as distressed members of the audience approach the speaker for a private consultation after the formal presentation. Preparation for an educational role might also be broadly defined to include training in supervision of less advanced students (especially during internship), perhaps through "metasupervision" in a vertical team format by a faculty mentor. The common denominator of all of these recommendations is that the educational competencies of future counseling psychologists are themselves legitimate targets of training, which presuppose the cultivation of their skills as interventionists.

Risk assessment and crisis intervention. When training in suicidology does occur in graduate psychology programs, it is likely to concentrate on the sort of demographic, diagnostic, and dispositional risk factors capably reviewed by Westefeld et al. (2000). But although an appraisal of risk factors may justify intervention, it does little to guide it. Stated differently, knowing that a client is in a high risk category, or even that he or she is showing a level of perturbation or suicide ideation that merits serious concern, may tell the counselor when to intervene, but not necessarily how. Thus, preparation for
working with suicidal clients requires not only an attitudinal readiness but also specific skill development in prevention, intervention, and postvention.

Failure to provide this multifaceted training can result in professionals who are unprepared for the challenges they will confront with overtly or covertly suicidal clients. For example, Neimeyer and Pfeiffer (1994) attempted to identify the most common errors committed by a large sample of counselor trainees and medical students by examining the incorrect responses of each group to the Suicide Intervention Response Inventory (Neimeyer & Bonnelle, 1997; Neimeyer & MacInnes, 1981). In general, the medical students were substantially more likely to respond in a defensive, distanced, advice-giving, and authoritarian fashion, as well as to dismiss client complaints with simplistic reassurance and to inadequately assess suicidal intent. In contrast, errors made by counselor trainees tended to take the form of excessive passivity or failing to sufficiently structure an emergent crisis that called for directive management. This suggests that training in suicide intervention for counseling psychologists should provide ample opportunity for trainees to assess risk of self-harm and rehearse the development of action plans in realistic role-plays involving escalating levels of lethality. The assignment of vivid first-person portrayals of suicidal crises such as William Styron’s *Darkness Visible* as a basis for the construction of simulated patient roles can enhance the realism of such enactments. Such readings can also cultivate a deeper empathy for self-destructive individuals for the students assigned to play these parts (Woodward, 1998).

As Westefeld et al. (2000) have noted, training in these core suicide assessment and crisis intervention skills can be evaluated using the Suicide Intervention Response Inventory (SIRI), a brief self-administered questionnaire whose validity and reliability have been demonstrated in several psychometric studies (Neimeyer & Bonnelle, 1997; Neimeyer & MacInnes, 1981). In addition to documentation of training gains, the SIRI can provide a convenient mechanism for performance feedback in the context of crisis intervention classes or training modules or a stimulant to class discussion of the distinction between helpful and unhelpful responses to different client situations. Faculty using the SIRI to assess the competencies of relatively advanced counseling psychology trainees should select the revised version of the instrument, whose response format has been modified to remove the ceiling effect found in the original version designed for paraprofessionals (Neimeyer & Bonnelle, 1997).

*Counseling and psychotherapy.* One of the dangers of current training practices in suicidology is fragmentation: Risk assessment and crisis management are too often presented as “stand alone” skills, disconnected from the broader conceptual frameworks that guide counseling and psychotherapy.
Practically speaking, the largely atheoretical bent of research and clinical work in suicidology can leave the trainee at a disadvantage in integrating suicide evaluation and intervention into a comprehensive treatment plan for the self-destructive client. Thus, case conceptualization exercises (both written and in case conference format) with real or hypothetical suicidal clients might be a useful adjunct to systematic coaching in crisis management. Ideally, such conceptualization would help students bridge their own preferred counseling theory and its associated empirical base with the demands of their specific cases.

One promising candidate for a bridging theory of this type is a hybrid cognitive-constructivist model, which integrates a substantial empirical literature on the structure of suicidal cognition in a clinically useful fashion (Hughes & Neimeyer, 1990). For example, in one of the rare prospective studies in the field, hopelessness, self-negativity, subjective confusion, and poor problem-solving performance predicted subsequent suicide risk in a group of hospitalized psychiatric patients (Hughes & Neimeyer, 1993). Moreover, those patients at the highest risk of self-injury showed a unique breakdown in cognitive organization and the emergence of all-or-nothing thinking, suggesting a qualitative “phase shift” in conceptual structure as lethality jumped to new levels. This observation is compatible with the conjectures of Westefeld et al. (2000) based on a chaos theory model of suicidal cognition and suggests that the style and target of therapy might also need to shift with increasing risk to match the client’s state of mind. One concrete aid in assessing the cognitive dimensions of escalating lethality is the well-validated Firestone Assessment of Self-Destructive Thoughts (FAST), a scale that reflects the respondent’s endorsement of self-statements that range from self-deprecation, through giving up, to dramatic suicide injunctions (Firestone & Firestone, 1998). Although the integrative capacity of cognitive therapies is likely to make them attractive to students, the contributions of other contemporary theories of counseling and therapy might well be extended to address the unique demands of working with suicidal clients.

**Competency assessment and facilitation and decision making.** A final training goal concerning intervention would address the multifaceted skills required to assess competencies in terminal patients requesting aid-in-dying or withdrawal of artificial life support or hydration. Although some of these skills overlap with generic or suicide-specific counseling competencies (e.g., empathic attunement, competence in assessing mental status), others are no doubt unique to this domain of practice, as Werth and Holdwick (2000) discuss. To take but a single example, the counseling psychologist consulting on a terminal patient who is considering hastening her death might need to evaluate hopelessness differently than in a case of conventional suicide.
intervention. Rather than representing a "cognitive distortion," pessimism about the prospects of an acceptable quality of life (defined in the patient's terms) could represent a realistic appraisal of the future. Assessing this adequately would of course require the cultivation of a specialized knowledge base in oncology and other relevant medical specialties that will necessarily go beyond the core curriculum of counseling psychology. But as counseling psychologists increasingly seek employment in behavioral medicine contexts, specialized internship opportunities will need to develop to support such career paths.

A brief comment about the format of such training is also in order. Although some academic coverage of hastened death should probably be part of all graduate programs in counseling psychology (perhaps in conjunction with discussion of ethical issues in suicide prevention), the more substantial elective training that is required for specialization in this area should include experiential elements. Meta-analyses of death education suggest that training that offers opportunities for personal exploration and simulated engagement with death and loss situations is more effective in assuaging student anxieties (Durlak & Riesenberg, 1991), a finding that has relevance for this emotionally demanding field of practice. One model for such experiential training has been offered by Werth (in press), who uses court reports, background articles, and media coverage of the Youk-Kevorkian trial to prepare students to reenact it as a means of exploring end-of-life decision-making issues. Developing the roles of mental health and forensic experts, and testifying physicians and family members, students develop keener insight into the ethical quandaries and legal safeguards that need to accompany aid-in-dying discussions. Extensions of this basic concept might well involve counseling psychology trainees in enacting simulated discussions with patients, families, and other members of the medical staff as a way to practice the mediating role they would likely be called upon to play in this unique practice setting.

Death notification and grief therapy. A final domain of training goals concerns postvention, a broad term covering all supportive services provided to survivors in the wake of suicide or elective death. As counseling psychologists work increasingly with the immediate aftermath of traumatic death (e.g., in hospital settings), they will encounter unique demands that differ from those that attend outpatient practice. One of these is notifying family members of the death of loved ones, a task shared by physicians, police officers, social workers, and the clergy. A recent survey of psychologists attending death notification workshops indicated that they had performed an average of 18 such notifications, although several had performed far more (Stewart, Lord, & Mercer, in press). Few, however, had received any training
in this stressful function. Overall, respondents reported that death by suicide was one of the most emotionally demanding circumstances for them as notifiers, and they identified survivors' tendencies to act out physically or to respond with intense anxiety or panic upon hearing the news as magnifying the stress associated with this difficult but important function. This suggests that postvention training be augmented to include the immediate support provided to survivors of suicide that commences with notification of their loved one's death.

Beyond the immediate context of death notification are the additional professional activities of trauma debriefing and potential grief therapy for survivors. Counselor trainees performing crisis debriefing (e.g., in school or work settings in which a student or coworker has committed suicide) can benefit from systematic role plays of acute interventions and new treatment resources now available in this field. Furthermore, counseling psychologists working with persons bereaved by suicide would benefit from instruction in contemporary theories of grieving as an active process that can be facilitated by reflective engagement (Neimeyer, 1998). Likewise, they can profit from acquaintance with specialized measures of postsuicide grief reactions that can help them target particular responses such as stigmatization, shame, guilt, and anger, which are relatively common in this form of traumatic loss (Bailley, Dunham, & Kral, in press).

CONCLUSION

Although counseling psychology is generally in the forefront of training in the mental health field, it shares the relatively scant attention to issues of suicide assessment, prevention, intervention, and postvention that characterizes other related professions. Such issues will take on new relevance and urgency as counseling practice evolves to address the complexities of end-of-life decision making. Fortunately, contemporary research and scholarship are beginning to redress this inattention, and the major contributions contained in this issue of The Counseling Psychologist take a long step toward offering its readers the benefits of an accumulating knowledge base. In my remarks, I have tried to extend the implications of this burgeoning literature for training in the profession, suggesting a range of emphases, strategies, and resources that educators might draw upon selectively to augment their training efforts. I hope that these suggestions and the series of articles of which they are a part will make a helpful contribution to the more comprehensive training of counseling psychologists as they address the life-and-death needs of the clients who seek their assistance.
REFERENCES


