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Suicide and Boundaries: The Therapy of Karen C.

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ABSTRACT

The following article deals with the issue of self-disclosure by a mental health therapist during the therapy with Karen C. She was 46 years old at the time of her referral and had been married to her husband for 22 years, with three sons 15, 17 and 19 years of age. Karen was referred to the therapist for suicidal ideation resulting from grief over the death of her 19 year-old son in a motor vehicle accident. At the time, Karen had a firm plan for suicide and it was clear from the outset that the possibility of suicide was real. Encounters with a number of healthcare professionals had done little to move Karen forward, and she had significant trust issues resulting from these previous experiences. Within the resulting therapy there arose an occasion where a significant boundary crossing occurred: the therapist disclosed aspects of her own private life that related to suicide. This disclosure was not consistent with normal therapeutic practice and yet was a pivotal moment for the client. Brenda Whiteman was the therapist involved in this case and recites the case in the first person.

Key Words: boundary crossing; suicide.

The Case

Karen was 46 years old. She had been married to her husband for 22 years and had three sons: 15, 17, and 19 years of age.

In late October 2006, Karen's eldest son, William, died in a single-car motor vehicle accident. On the advice of her husband and family, Karen did not identify her son's body nor did she view his body at the funeral, a decision she would later deeply regret because it made the resolution of her grief and despondency vastly more complicated.

Karen withdrew into herself, refusing to partake of any aspect of life, save for those that were absolutely necessary, such as preparing meals for her family. She would then retire to her bedroom, refuse to talk or interact and would imagine and plan for the day that she would be reunited with her son. She spent no time with family or friends and could not be convinced to share in family gatherings on holidays or special occasions. The distance between Karen and her husband slowly became an ocean of silence.

Karen had received counselling for one and a half years through her Employee Assistance Program (EAP) with a social worker in private practice. Little, if any progress was made. Her grief was profound. When Karen's EAP coverage ran out, the social worker agreed to work with Karen on a private basis. However, due to Karen's inability to move through her grief and her persistent suicidal ideation, she was advised that she was not following the 'normal steps' for resolution of grief. Her therapy was terminated by the social worker. Karen perceived that therapist's decision as evidence that she could not be redeemed. Karen felt rejected, alone and wanted to die.

In June 2008, having grave concerns for Karen's life, her family physician gave her a prescription for an anti-depressant, which she did not want to take. The doctor informed her that if she did not take the medication, he would no longer be her family doctor. Karen started the medication in June but stopped taking it three months later. At that point, in August of 2008, her physician made a referral to me on an urgent basis for therapy. I phoned Karen

to set up an appointment. After a short telephone conversation, Karen reluctantly agreed to see me for one appointment.

It was immediately apparent to me that Karen was at high risk for suicide and that the probability of her returning for further sessions was unlikely. There were few solid guideposts upon which to rely. (Joiner 2005) Her lack of trust in and respect for professionals was a major roadblock to reaching her and developing a relationship of trust. My fear that her threats of suicide were real meant that time was of the essence if I were going to be able to help her resolve her grief and prevent her suicide. We needed time to create a reciprocity of understanding and compassion that could permeate her shield of fear and distrust that kept her vulnerable to her own emotional trauma and mental confusion. She was refusing medication, hospitalization, further therapy and even family support. I believed that reaching her with empathy, compassion and complete respect was the only possible path to saving her life at that point. I had to trust my own judgement.

I advised her that if she would agree to come back and see me the following week, that I would allow her to commence therapy without the aid of any medication, as this was her choice. I also agreed that I would not insist on her hospitalization due to her suicide risk as long as she committed each week to return the following week before she made any decision about her life. She must always have 'one last session' with me. It worked. It was a start.

In March 2010, Karen's 18 months of therapy with me contained many cliff-hanging moments but her choice to die now became 'next week's choice'.

Karen had an appointment with me late in the afternoon on a Friday. I had been concerned since, following several months of progress in therapy, she had recently regressed and had once again been talking about suicide. This was a session that I could not reschedule.

Critical Incident – The Boundary Crossing

Ten minutes before her Friday afternoon session was to begin, I received a phone call advising me that my ex-husband had died the day before. We had been divorced for about four years at that point. The caller told me that he had died by suicide.

Amidst the shock, sadness and disbelief, I had a decision to make: Karen was out in the waiting room and her session was to begin shortly. Although I was distraught, shedding some tears and struggling to maintain my composure, I was concerned about rescheduling her appointment. My intuition told me that sending her away without seeing me or without an explanation could be risky. She was fragile. I knew she needed to see me that day and I was not willing to abandon her in that moment with a weekend looming over her and her suicidal thoughts having recently returned. I feared not seeing her that afternoon might trigger a disastrous turning point for Karen.

Then I realized that this sad, strange turn of events in my own life might be somehow therapeutic for Karen. The coincidental nature of this event might resonate with Karen, given her own desire to end her life. I felt that it would be clinically relevant, appropriate and even therapeutic to share this circumstance that had just happened in my own life regardless of the fact that I would be crossing a personal boundary. As I struggled to garner my composure, I made the decision to bring Karen in for her session and to share this information with her and to spend a little time discussing it.

Karen always stated that her family and children would be better off without her due to her inability to care for them any longer. I hoped that my session with her would open up a new perspective. My intuition led me to share with her my sadness and shock over this death, allowing her a window into the world of one who had just learned that an important person in her life had died by suicide. I spoke about my fears for my ex-husband's son, then only 17 years old, who now had to deal with this tragedy in his life.

Karen was honoured that I had shared this with her, expressing her sadness and condolences. Then she began to speak about suicide from his perspective, explaining why he thought it was his only choice. She offered her understanding because of how she had been feeling for so long and she attempted with great skill and insight to tell me what he was thinking and why and how he must have been feeling in the days and weeks before he took his life. Then, she slowly began to realize that his decision was one that from this point forward would be a burden for all those who loved him. She began to make the case for suicide being a mistake, a misguided action, a decision that arises from grief and sadness and depression but which is ultimately a terrible choice. When she left my office that day, I knew she had turned the corner. I felt at peace with my decision.

Karen and I met for six more months. After two years of weekly and then bi-weekly sessions, Karen was no longer in therapy. She is now working on her own book about her journey and hopes one day to publish it and help other parents in similar tragic circumstances. She has separated from her husband and is living with her two boys while they finish their post-secondary education. She is now pursuing another university degree, looking towards a career in a helping profession.

She speaks of her son, William, freely and with joy and strength in her voice. It is important to her that she continue to speak of him as a loving mother would: proud, protective and adoring. She has forgiven him for the accident. She has forgiven herself for what happened to her when she lost her precious son.

Analysis

Karen presented with extremely poor affect, low mood, inability to make eye contact, physical tremors, obvious signs of a severely traumatized state that masqueraded as depression and an inability to process both her emotions and her cognitions. She was having trouble processing auditory information and would frequently ask me to repeat what I said to her, unable to comprehend simple comments or questions. She displayed a disinterest in everything.

Karen had become lost to herself in the quicksand of grief: she had become increasingly introverted, reclusive and detached, fantasizing that she would soon take the steps to end her life and be joined with her son once again. (Cutcliffe and Stevenson 2007; Joiner 2010)

In order for her to move through the grief and become unstuck from her traumatized state, it was necessary to have her move into her feelings with greater focus and attention in order to process those feelings in her body. Early in her therapy, I recommended that she take an extended leave from work in order to narrow her focus onto her grief, a counterintuitive idea. She would only get past her grief by embracing it and processing the horror of what it meant to lose her son. Attempts to distract herself from her pain only worked to aid and abet the emotional fracture that kept her stuck. Karen immediately took a leave from her job that ultimately lasted for over a year during her therapy.

I resolved to take the journey with her, feeling her pain, empathizing with her sadness, understanding a mother's sense of loss and grief. On more than one occasion, Karen crumbled into a ball of sobbing grief, falling from the sofa in my office onto her knees. I would pick her up and hold her, offering her compassion and warmth while she released searing cries of sadness and horrible, heart-wrenching grief. Karen needed so much more than clinical expertise to heal; she needed a human being with whom she could connect. She needed a radical approach.

I believe it was my willingness to offer her human kindness, compassion, empathy, mutual respect, unconditional positive regard, warmth, time, attention, concern, and a willingness to listen to her that allowed her to begin the long climb out of the hole of grief into which she had fallen. Although supported by clinical expertise, ultimately it was an awareness of the common humanity that Karen and I shared that provided for me a sobering foundation for the 'model' of therapy that I offered to Karen. I had to go with her, literally and figuratively, into the darkness in order to lead her out.

It is important to say that this boundary crossing was one that I felt was necessary and therapeutic, but also safe to undertake. I felt this way for two reasons: Karen's stage in therapy at that time, and I knew this client very well after working with her for almost two years. This decision was founded on a solid relationship of trust at that point. It was a decision that I felt comfortable with, given what was by then a profound connection.

Discussion

The literature on boundary violations focuses mainly on sexual abuse, financial exploitation and conflict of interest.(WPA 1996; Gabbard and Crisp-Han 2010; Franke and Riecher-Rössler 2011) Disclosure is not commonly discussed and it is difficult to find any article which examines disclosure by the therapist to a suicidal client. Thus, it is important to take this opportunity to examine the role of disclosure as a potential boundary violation or as a potential aid within the context of suicide.(CPSO 2004)

As already admitted, the disclosure cited is clearly a boundary crossing, as personal disclosure does not form a normal part of mental health therapeutic practice. Given this understanding, the first moral question must be:

Was the boundary crossing also a boundary violation?

Let us first distinguish between 'crossing' and 'violation'. The following quotation serves the purpose of distinguishing 'crossing' from 'violation':

> *Boundary crossings represent departures from usual therapeutic practice that do not harm the patient or the therapeutic work (the principle of nonmaleficence). Boundary violations, in contrast, depart from usual practice but have the effect of harming the patient, often (but not always) in the form of exploitation of the patient. (P.19 Gutheil and Brodsky 2008)*

It follows from this definition that if the act of disclosure caused harm, then the action was clearly a boundary *violation*. If the outcome were neutral or positive, then there would be little reason to suspect the action to be a boundary violation.(Gutheil and Gabbard 1998) In our case, the answer seems quite simple: since the actions resulted in a very positive outcome, there was no violation.

The question, however, is not only whether there is a positive outcome, but also whether the therapist is culpable. The therapist may be culpable, independently of whether or not there has been harm (Gutheil 2010).

A thorough examination of culpability includes reviewing both the therapist's *intentions* and *actions*, as there might have been malicious intent or negligence. Thus, we can judge the therapist on the intervention of disclosure, that is, the therapist's intentions and methods. The question is whether the therapist acted within the spirit of the therapeutic relationship.

A review of the therapist's intent in the preceding case reveals little to worry about. The intent of the therapist was clear: to help the client within the therapeutic relationship. Both therapist and client attest to this. In addition, it seems clear that the therapist had nothing to gain personally by disclosure.

In reviewing the process of disclosure and the content of the disclosure, there is again no indication of therapeutic inappropriateness. The therapist was very experienced in mental health issues, the therapeutic alliance had existed for a good length of time, and the therapist and client knew each other well and trusted each other. There was good reason to believe that there was a significant level of trust between the client and the therapist. The therapist related an authentic story which resonated with the client.

This analysis demonstrates that one has good reason to believe that a therapist can accurately assess the difference between a boundary crossing and a violation if the following conditions are met: the therapist is particularly compassionate in a situation, and the therapist is dedicated to, and cares for, the client (Lakeman 2010).

> *"When clients reported disclosure as helpful, their reasons were similar to therapists' rationales for disclosing. This supports both theory and empirical studies of therapists' beliefs about the effects of disclosures. The greatest effect was on the alliance. The clients in this study valued their therapists'*

disclosures because they contributed towards:

- *a real relationship,*
- *a sense of connection, intimacy, closeness or warmth;*
- *trust, safety, or a decrease in alienation;*
- *a sense of being deeply understood, welcomed or cared about;*
- *an opportunity to identify with the therapist;*
- *a sense that the therapist would take responsibility for mistakes" (Hanson 2005).*

If both the intentions and disclosure of the therapist are above reproach, and there is no harm done to the client, then one can say there was no violation. In addition, if the outcome was positive, then this might serve as a paradigm for a therapeutic option which could be utilized by other therapists in similar situations (Gutheil and Brodsky 2008).

Recommendations

If the boundary crossing in question was not a violation and the outcome was very positive, we are faced with the following question:

Can what we learn here be translated into common practice?

After all, this situation is not dissimilar to that of the surgeon. Just as a surgeon tries a new technique, so a therapist may push the envelope of therapy by utilizing boundary crossings with suicidal clients. The boundary crossing may be viewed by the therapist as a novel intervention. The intention is clearly to provide better therapy. Should we then recommend personal disclosure as a standard therapeutic measure?(Roberts 2005; Henretty and Levitt 2010)

There are, unfortunately, some significant barriers to recommending that all therapists engage in boundary crossings to enhance their therapeutic effectiveness with suicidal clients. The barriers include the therapist, the evidence and the nature of suicide.

Specifically:

1. Dealing with suicidal clients may be rare and risky for the therapist.
2. We know very little about suicide.
3. Suicidal clients are very demanding for the therapist.

The most significant barrier for the therapist is the lack of experience concerning suicide. In large part, this is due to the relative rarity of suicide itself. Unlike depression or anxiety, the truly suicidal client is rarely seen by the therapist and therefore most therapists have little or no practical experience with completed suicide. It would be inappropriate, therefore, to *require* boundary crossing as a standard practice.

The relative rarity of suicide, combined with the scarcity of clinical trials results in very little evidence to support a well-grounded and detailed approach to using disclosure as therapy for the suicidal client. Suicidal studies are inherently risky, and there is good reason to believe it will be some time yet before we fully understand the treatment of the suicidal client. This lack of evidence is a significant barrier to advancing therapy through the use of boundary crossings. Every intervention should be based on both clinical and experimental evidence, which in turn provides a model for care.

The third item is a little more perplexing. Aside from these preceding practical matters, there is also the nature of suicide itself. Effective suicide intervention must take the therapist into the frame of mind where the suicidal client lives. The therapist must embrace the pain of the client. This is difficult and demanding. The therapist must move the suicidal client from a very dark place to a place which is both safe and fulfilling (Rudd, Joiner et al. 2001). This may take special efforts beyond those required in usual mental health therapies.

It is this 'special effort' which concerns us the most when dealing with suicide. In mainstream mental health situations, the therapist provides the client with opportunities to change. The therapist uses a number of techniques to allow the person to see different opportunities, to make choices, and ultimately to act in a positive manner to change the condition. This approach is based on the notion that only the client has the ability to change. What is particularly perplexing with suicide is that the client feels powerless to change. The suicidal person feels they have been thrust headlong into an abyss (the maelstrom), disconnected from everyone.

The seriously suicidal person often rejects every opportunity that is provided by the therapist. If there is no opportunity, there is no permanent solution. In a true sense, the client does not want to be helped. With no possibility of being helped, and no feeling of inherent value, the client feels unworthy of help, often rejecting help from the therapist and everyone else. It is important to understand this dark deep place in which the suicidal person dwells; otherwise, it is not clear how far the therapist must go to connect with this person and how much work is required by the therapist to help the person out of the hole. (Rudd, Joiner et al. 2001; Cutcliffe and Stevenson 2007; Joiner 2010)

When a person has lost all hope, significant boundaries are created (Fiske 2008; Kaplan and Schwartz 2008). This description characterizes suicide perfectly: being alone, in isolation from humanity. That state is difficult to penetrate; for the therapist, it is difficult and frightening to enter. There may be effective therapy which includes boundary crossings, in which the therapist begins to share and form serious bonds with the client.(Bergmans, Langley et al. 2009) Indeed, we might even speculate that effective suicidal therapy requires boundary crossings as in some addictions therapy (Gutheil and Brodsky 2008). This may, however, be asking too much for any particular therapist to undertake.

How much is too much? How much is enough when a life is at stake?

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