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Ethical issues in working with suicidal clients

Theodoros Giovazolias[1]

ABSTRACT

In the clinical practice of counselling psychology and psychotherapy, therapists are likely to encounter at some point in their career clients who have tried, or will try to end their own lives. A solution to this impasse requires a number of fundamental questions to be answered concerning the morality of suicide, its relation to mental illness, etc. Indeed, such an encounter is possible to evoke a variety of moral conflicts to the therapist; this paper aims to explore the ethical issues that are raised when working with suicidal clients.

KEY WORDS: *suicidal ideation, ethics, counselling, interventions*

INTRODUCTION

Suicide is a relatively common occurrence. It is stressed that in USA there are 30, 000 certified suicides each year; many other probable suicides are not classed as such, either because the exact circumstances of the death are insufficiently clear to justify a formal declaration of suicide, or in order to protect the feelings and legal interests of the surviving family members (Beauchamp & Childress, 2001).

According to the 2000 Official Final Data, suicide in the States is ranked as high as the 11th cause of death. The statistics indicate that, on average, 1 person kills him/herself in every 18 minutes. Of great interest was the finding that each suicide intimately affects at least 6 other people. Based on the over 738,000 suicides from 1976 through 2000, the estimate is that the number of survivors of suicides in the U.S. is 4.4 million (1 of every 62 Americans in 2000); this number grew over 176,000 in 2000. (Minino, Arias, Kochanek, Murphy & Smith, 2002).

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1 BSc, MSc, PsychD, C. Psychol, Chartered Counselling Psychologist Lecturer, Department of Psychology, University of Crete, Greece

Bongar (1992) mentions that suicide is one of the major causes of death, accounting for 1% of all deaths annually. He points out that in 1990, a total of 4,485 people killed themselves in England, Wales and Scotland. That is 86 people each week, 12 people every day, or one person every two hours. This represents an increase of 6% over the figure of 1989.

The suicide rate for 1998 in the United Kingdom was 7.4 per 100,000 people, with a rate of 11.7 for males and 3.3 for females. In most countries, males commit suicide to a greater extent than females; In the United States the highest risk group for suicide is Caucasian males over the age of 35 (Gilliland & James, 1997). However, by some estimates completed suicides in the US more than tripled for persons aged 15–24 between 1950–1980, and the US suicide rate for individuals in this age group was 11.1 in 1998.

In the UK the situation regarding this age group is somewhat similar; both suicide and deliberate self-harm involve large numbers of young males, many in their late teens. In terms of numbers, three times as many young men as young women take their own lives in the United Kingdom - a total of 3,640 in 1996, up by 2% in relation to 1982. The number of women committing suicide fell by 41% during the same period (NIMHE, 2003). Some social factors which may in part underlie the recent rise in young male suicide include unfavourable trends in unemployment, divorce and substance misuse. Such factors appear to have had little influence on trends in older males and females (Charlton, Kelly & Dunnell, 1993).

In Greece, a nationwide study of suicide from 1980 through 1995 demonstrated a mean age-standardized suicide rate of 5.86/100,000 for males and 1.89/100,000 for females, an increase in suicide rates with age, and exceptionally high rates in young widowed men (Zacharakis, Madianos, Papadimitriou & Stefanis, 1998). It has been suggested that various social factors (i.e. low isolation, increased cohesion, family ties, stable national identity and cultural uniformity of the population) as well as intentional (in order to avoid the social stigma) or unintentional underreporting (inability to determine the victim's intention), may account for the low suicidal rates described in this study.

These statistical figures show explicitly that we are dealing with an issue on which particular attention needs to be placed.

In addition, there is what is known as 'attempted suicide'. The statistics show that 734,000 people in the U.S attempt to kill themselves annually (Minino et al., 2002). The prevailing view for many decades was that attempted suicide was a kind of unsuccessful suicidal act, perhaps quantitatively different, but basically displaying the same behaviour as suicide (Gibbs, 1968). Today, this term is used in referring to three different occasions: a) occasions when a person has intentionally harmed him/herself in a way that could have

led to death but was unsure whether he/she wished to die, b) occasions where an indi-vidual has aimed to create the illusion that he/she intended to die but he/she actually wanted to live, and c) occasions where an individual's brush with death was accidental (Fairbairn, 1995).

ETHICAL ISSUES IN WORKING WITH SUICIDAL CLIENTS

Is suicide a mental illness?

The way we think about self-harm and suicide are influenced by a number of factors such as the religious and cultural context in which we have been raised. For example, for a Catholic person, killing oneself would be considered a mortal sin; on the other hand, for a traditionally-raised Japanese person, self-killing is almost required in certain circumstances.

In western culture the medical profession occupies a position of considerable importance. Physicians were, and still are, regarded as authority figures by their patients. Fairbairn (1995) stresses that the influence of medicine is largely responsible for the most common belief about suicide - that anyone who kills or attempts to kill himself is psychologically disturbed, because no-one who was psychologically stable could want to end his/her life. He points out that those people who have ended their lives or seem to want to do so are also assumed to be severely depressed in the sense of being mentally ill, rather than for example being severely unhappy. This idea is sufficiently well-established within the medical community to be considered the orthodox medical view. Indeed, even psychiatry, which is often expected to have a broader understanding of the variety of human acts, is dominated by this orthodox medical view so that most psychiatrists believe that suicidal behaviour is always, or almost always, the result of maladaptive attitudes which have their grounds to some type of mental illness.

However, although this view is generally accepted, there are other scientists who oppose it; for example, Mitchell (1971) considers that the commonly held assumption that everyone who shows a suicidal tendency is for that reason mentally ill, is not by definition true, because, as he thinks, suicidal behaviour can be more a measure of distress and despair than of mental disorder. In a similar way, Curran (1980) suggests that it is possible that people who commit suicide suffer from no true psychiatric illness, but may have been in chronic pain, lonely, seeing no hope for improvement of their predicament, and decide that on balance they might as well be dead. Szasz (1971) does not even accept the concept of mental illness and thinks that viewing suicide or attempted suicide as indicative of mental illness is erroneous. He argues that

suicide is a product of choice by an agent, not a symptom or a psychological disturbance of the individual, and that such a choice must be respected by all health professionals and other people who might want to intervene in suicide (e.g. police).

The Morality of Suicide

The discussion concerning the morality of suicide involves very contrasting ideas; on the one hand, there is a whole set of opposing arguments which is based on the view that suicide is an offence against society (Fairbairn, 1995). This can be explained in a variety of ways; it may mean that every individual has certain obligations to others which override any desire that he/she may have to end his/her life. It may also mean that people belong to something greater than themselves called Society, that their existence in some sense reinforces the existence of Society, and that only Society has the right to dispose of the lives of its members. In a similar way, there are those who advocate the deontological position (stemming mainly from the theological tradition); one major principle of this position is that God has reserved to himself direct dominion over life; He is thought to be the owner of its substance and he has given man only the serviceable dominion, the right of use, with the charge of protecting and preserving the substance, that is, life itself. Consequently, suicide is an attempt against the dominion and right of ownership of the Creator (Lester & Leenaars, 1996). However, this argument can possibly be seen as an arbitrary one, since some of those advocating this often do not worry about killing certain live organisms (i.e. animals) or go off to war believing that "God is on our side".

Another strong argument against suicide is that it would cause injury to others. Indeed, the fact that people ought to consider others as well as themselves in their actions is a fundamental principle of morality. However, who these 'others' are, the extent of their demands on the suicidal individuals and the nature of the harm that suicide might cause to them, are all issues open to debate. Along this line of thought is Ringel's (1980) view concerning the question of whether suicide can be an autonomous, rational intention. He argues that a desire for suicide is by definition an irrational desire and probably an indication of some sort of psychopathology because nobody who can reason rationally would choose to die.

The rationale here is that most suicidal individuals are actually ambivalent about the act and are likely to have fantasies of being rescued from the suicidal act and their intolerable living conditions. It may be difficult for some to accept that anyone who feels suicidal can be free from mental impairment,

such as hopelessness or depression, making mandatory intervention obligatory as the person would not be acting truly autonomously (Beauchamp & Childress 2001; Johnstone, 1999). Advocates who support intervention in suicide acts argue from a position based on the ethical principles of beneficence and non-maleficence (Beauchamp & Childress, 2001). Beneficence refers to an action done for the benefit of others, whilst non-maleficence invokes the obligation not to harm others. Beauchamp and Childress distinguish between these two principles by suggesting that in general terms whilst we are morally prohibited from causing harm to anyone, we are not necessarily required to help or benefit those with whom we have no special relationship. However, when the relationship is between therapist and client, then, according to the authors, beneficence becomes an obligation. Pelligrino and Thomasma (1988) see beneficence as being independent of, and potentially in conflict with, clients' preferences. They substantiate this claim by presenting several circumstances, especially within the health care field, in which the patient may have made irresponsible choices and they argue that the caring professional should therefore override the patient's wishes. That is also true because, according to the authors, the professional has superior training, knowledge and insight to determine the patient's best interests; the professional here is perceived as a parent and the patient as a dependent and often naove child. The term 'paternalism' is therefore often used in analogy to the action of the intentional overriding of a person's known preferences by another person, the justification being that the action will benefit or avoid harm to the person whose will is to be overridden

In contrast to this standpoint, there is a growing appreciation that there is such a thing as rational suicide (Heyd & Bloch, 1991). Accordingly, the authors stress that we have to ask whether or not it is possible for a person to make a rational choice to end his/her life, and therefore act autonomously in his/her action.

When stating positions about rational suicide, a first assumption is that it is a calculated suicide that is well planned by a person who is rational. With this thought-out plan being assumed as rational, a position of acceptance towards rational suicide has been proposed as a reasonable and ethical one especially for health care professionals when considering the autonomous wishes of those who meet certain criteria proposed by Siegel (1986) and Werth (1995). Essential to these criteria is that: "...the person has a motivation that would be understandable to a majority of uninvolved community members, the decision is deliberated and reiterated over a period of time, [and] if at all possible, the decision-making process should involve the suicidal person's significant others" (Werth 1995, p. 71)

Fairbairn (1995) points out that the question of rationality is closely bound up with the question of understanding. He believes that a minimal awareness of what death might mean and of its irreversible nature is necessary before someone could wish and intend to achieve that state and thus be capable of suicide. It seems then that for Fairbairn it is very vital to consider the extent to which the suicidal person was aware of what he/she was doing. Windt (1981) considers the following features in defining a 'rational' suicide: "a) that death was caused by the actions of the deceased, b) that the deceased wanted or wished death, c) that the deceased intended, chose, decided or willed to die, d) that the deceased knew that death would result from his/her actions or behaviour, and e) that the deceased was responsible for his/her death" (p. 41).

COUNSELLING

The possibility of confronting a situation involving suicide is ever present in counselling (Bonner, 1990), as suicidal behaviours have become an alarming societal concern (Gilliland & James, 1997). It is estimated that over 20% of counselling psychology trainees will be exposed to clinical situations involving suicide at some point during their education (McAdams & Foster, 2000). In terms of counselling practice, Rogers, Gueulette, Abbey-Hines, Carney and Werth (2001) reported that 71% of their sample of mental health counsellors had at least one client attempt suicide, while 28% had at least one client die by suicide.

Prevention of suicidal behaviour is a major health care target for the UK Government, which in 2002 established a National Suicide Prevention Strategy for England, a set of activities that will take place over several years, the aim being to support the achievement of the target set in the White Paper Saving Lives: Our Healthier Nation, and reinforced in the National Service Framework for Mental Health, to reduce the death rate from suicide and undetermined injury by at least a fifth by the year 2010 (NIMHE, 2003). More specifically, it aims to: a) reduce risk in key high-risk groups (e.g. young men, prisoners, high-risk occupational groups), b) promote mental well-being in the wider population (e.g. socially excluded and deprived groups, people from black and ethnic minority groups, including Asian women, people who misuse drugs and/or alcohol, victims and survivors of abuse including child sexual abuse), c) reduce the availability and lethality of suicide methods (e.g. reduce the number of suicides as a result of self-poisoning, reduce the number of suicides on the railways, reduce the number of suicides using firearms), d) improve reporting of suicidal behaviour in the media (e.g. improve population awareness of the potential benefits of help-seeking in times of crisis by pro-

moting media portrayal of suicidal people seeking help and gaining benefit) and e) to promote research on suicide and suicide prevention.

As mentioned in the beginning, the therapeutic encounter with a suicidal individual presents a variety of ethical issues for the therapist, issues which may to a great extent influence the course of action and the nature of intervention they might undertake.

Sim (1997) points out the emotional and psychological impact that suicide may have on the involved therapist, which in turn may trigger a variety of responses from his/her part: a) the therapist may feel an intense concern for the suicidal client, and undergo great distress and anguish, b) the therapist may experience a strong desire to help the individual, but may find that his/her help is not wanted or, whether desired or not, is ineffective in changing the client's predicament; this may also result in feelings of inadequacy, failure and guilt, and c) the therapist may have strong religious or moral objections to the idea of suicide and therefore find it hard to empathise with the client; in that case a sense of moral disapproval may displace empathy and understanding.

Wekstein (1979) stresses that the treatment of an individual who manifests moderate to high lethality presents a crisis situation for both the therapist and the client. He argues that every therapist must establish some guidelines in dealing with such a situation since, as he believes, inadequate evaluation or mishandling may lead to a fatal outcome. For him, the establishment of a therapeutic alliance from the beginning of therapy is imperative, since this represents a commitment from the client. He states that both the therapist and the client have to accept basic provisions of trust and agree to live up to their respective commitments. On the one hand, the client must be in a state of mind where he/she can give evidence that he/she will contact the therapist immediately if any suicidal ideation occurs. On the other hand, the therapist according to Wekstein must agree to be available to speak to the client and even to see him/her if an emergency situation arises. The same author indicates that therapists should not hesitate to make use of other available resources (e.g. the client's surrounding environment) to help themselves deal with such a situation. He suggests that when the therapist becomes aware of the suicidal intent in his/her client, he/she needs to communicate the dangers to other people who can collaborate and who are willing even to actively intervene in a suicide-preventing effort. However, he recognises that it may not be possible even for an experienced therapist to gather sufficient data in the early sessions, particularly if the client is psychotic, suffering from organic brain disease or has been misusing drugs. It should be noted here that, as Sim (1997) mentions, health professionals have to consider whom they are most concerned about very carefully. He says that it is reasonable to argue that

their priority is to further the interests of the client, and that, while the interests of the surrounding environment of the suicidal client (e.g. relatives) should also be promoted as far as possible, these must take second place.

Indeed, if we accept the argument that a person's life cannot be ended only to satisfy the wishes of others, it seems equally clear that we cannot use the wishes and desires of others to prolong the life of somebody who no longer wishes to live.

However, in thinking about how one might react in situations where one is confronted with what ap-pears to be a suicidal behaviour, two questions arise: a) when is it morally correct to intervene in an-other's attempt to end his/her life and b) when is it morally correct not to intervene in another's attempt to put an end to his/her life? Fairbairn (1995) postulates that intervention in suicidal acts is most commonly justified by referring to the autonomy of the suicidal person. For example, it is believed that intervention is justified in cases where the individual is unable to act autonomously because either he/she has not developed the capacity for autonomy, or has lost it to some extent, or something is interfering with his/her ability to exercise his/her capacity for autonomous action. According to Fairbairn it is because autonomy is commonly thought to be centrally important to being a human person, that intervention may also be thought to be justifiable in cases of suicidal actions where the actor's autonomy is threatened.

Nevertheless, it should be mentioned here that the criteria in defining what constitutes a 'threatened autonomy' are quite debatable, since they may be influenced by one's personal values and moral systems.

Szasz (1971) adopts an even more liberal position on this matter; in an effort to explain the profound antisuicidal attitude of the vast majority of health professionals, he argues that the therapists seem to perceive suicide as a threat, not just to the suicidal person's well-being but also to their own value sys-tem. He sees the interaction between therapist and client as a struggle for power and stresses that the suicide preventing therapist claims that he/she only wants to help his/her client, while he/she actually wants to gain control over the client's life in order to save him/herself from having to confront his/her doubts about the value of his/her own life. It would seem that this view, although radical in its conception, may also explain the personal frustration that therapists often experience, when they are confronted with a successful suicidal act of their clients.

This thought is commonly accepted within Existential Theory, where the approach of death is in general seen as a developmental and existential issue that must be faced (Yalom, 1980). In that sense, a person who is considering suicide and a professional who allows for the discussion of suicide as a ration-

al option, are together focusing on this issue and, as a result, facing their death anxiety. On the other hand, the professional who forces his or her value about the sanctity of life on another person is perhaps forcing the individual to live, or at least not discuss his or her concerns openly, because of the professional's inability to deal with his/her own death anxiety. However, other theoretical schools would take a different view on the matter; for example, Cognitive-Behavioural Theory holds that suicidal ideation is a result of rigid, extreme, dysfunctional and counterproductive assumptions that need to be tackled and modified. Suicide then is perceived as a response to thinking that one's situation is intolerable, and that nothing can be done to change it (Fennell, 1998). It is clear that the therapeutic approach within this model would be characterized by a directive intervention which would involve the fundamental change of distorted cognitions and the consideration of alternative solutions in the form of constructive problem-solving.

Along these lines, another important question raised at this point is when confidentiality should be breached? Siegel (1976) feels very strongly that confidentiality should not be breached under any conditions. He believes that therapists cannot make judgements on when it is proper to violate an individual's revelations or confessions. Moreover, he does not consider the role of the suicidal client's family to be important in preventing him/her from his/her lethal behaviour. It seems though that this view undervalues the utilisation of significant others and the fact that very often their attitude towards the attempter may determine his/her future suicidal behaviour.

However, the current Codes of Ethics of different boards take a different view on this matter; for example, principle 4.3 of British Psychological Society (BPS) now reads:

"...therapists should, in exceptional circumstances, where there is sufficient evidence to raise serious concern about the safety or interests of recipients of services, or about others who may be threatened by the recipient's behaviour, take such steps as are judged necessary to inform appropriate third parties without prior consent..." (BPS, 1998, p. 3).

Many professionals are discussing the controversial instances of suicide under the category of rational suicide. Allowing any suicide seems contradictory to good practice, when mental health professionals are accustomed to intervening when a person acts in a way that poses a danger to self. Beauchamp and Childress (2001) charge that where suicide is concerned, failure to intervene (and thus breach confidentiality) seems to "symbolically communicate to the potential suicide a lack of communal concern, and works to diminish our sense of communal responsibility" (p.286). Werth and Cobia (1995) in a study concerning psychotherapists' attitudes toward suicide found that eighty-one

per cent of the respondents (n=146) believed in the concept of rational suicide, and, when asked to define rational suicide, many of these respondents included making the decision in concert with friends and family so that the suicide does not lead to guilt feelings in significant others. In addition, suicidal ideation prompted by a painful terminal illness was viewed as significantly more acceptable and thus requiring significantly less intervention than suicidal ideation prompted by chronic physical pain, chronic endogenous depression, or bankruptcy.

These results seem to validate the idea that there can be a continuum of "intensity of suicide interven-tion". The basic premise of this position is that the conditions that cause suicidal ideation to arise should be taken into account when a therapist is deciding on the amount of intervention that is necessary and appropriate. The results of the above survey suggest that a continuum can be drawn, with a person facing a terminal illness occupying the end delineated by high acceptance and little preventive action and someone who has declared bankruptcy at the end delineated by low acceptance and a great deal of preventive action. Physical and psychological pain can be placed along the continuum. Fairbairn (1995) seems to agree with this notion when he states that: "an instance in which it is difficult to justify intervention in a suicidal act by reference to the harm that will be experienced by oneself or others as a result of the death, would be where that harm is likely to be small relative to the suffering the person will undergo if he/she is prevented from killing oneself" (p. 199). He uses the example of dreadful pain caused by suffering terminal cancer. Werth (1995) considers the case of people suffering from AIDS. He notes that for a person with AIDS, death is an issue that needs to be confronted. He believes that allowing a person (especially in symptomatic HIV disease) to decide whether to continue living may provide the ultimate form of empowerment – a condition that is thought to be vital to persons with AIDS.

In a similar vein, several questions arise at this point; how does the competent therapist assess the severity of suicidal ideation? How does he/she accurately assess the risk of impending physical or psychological damage to other parties, given that successful suicide may lead to the infliction of damage or death to others, either by intent or by accident? At this point we need to highlight the issue of a therapist's competency to treat a suicidal client. One of the critical tasks of the psychologist who is called to treat the suicidal client is to have to evaluate a priori the strengths and limitations of his or her own training, education, and experience (i.e., technical knowledge and emotional tolerance level) in the treatment of specific client populations in certain clinical settings.

According to Shea (1999) and Rogers (2001), suicide-risk assessment

should specifically focus on the collection of data related to suicide-risk factors including suicidal ideation and level of planning. This data collection or assessment phase is ideally carried out via a combination of a clinical interview, information from formal assessment measures, and by gathering relevant collateral information from third-party sources (Rogers, 2001). There are several important characteristics to consider when assessing suicidality. For example, Shneidman (1987) suggests that the assessment phase should focus on relevant situational factors (e.g. an inability to endure frustrated psychological needs), cognitive factors (e.g. thoughts about the cessation of suffering), affective factors (e.g. helplessness in the here-and-now, hopelessness about the future), and relational factors (e.g. communication of the intention to relieve oneself of life burdens). When clients display suicide-related characteristics in these areas, it is important for counselling psychologists not to discount the potential to commit a suicidal act.

Research studies have identified certain immediate signals that are important for counselling psy-chologists to assess in a potentially suicidal client (Battle, Battle, & Tolley, 1993; Hazell & Lewin, 1993). As the number of these signals increases, so does the likelihood that a particular client may be suicidal. These signals include: a history of previous suicide attempts, having a specific plan to harm oneself physically, recently cutting off communication with friends and/or family, giving away prized possessions or putting personal affairs in order, and a preoccupation with death.

CONCLUSION

This paper has attempted to address some of the ethical issues in working with suicidal clients. In concluding, it is important to note that the issue of suicide illustrates vividly the ethical difficulties that may arise, even for the most experienced practitioner. Dealing with a suicidal client may be an emotionally stressful experience, one in which therapists have to reconsider their value systems, one in which they often find themselves being caught up in two minds about the course of action they should undertake. Indeed, in any situation in which one person encounters another person who wants to end his/her life, it is very difficult to make accurate predictions about the likely after effects both of the suicide attempt - if it is allowed to proceed - and of interventions in it.

Currently, the prevailing directive when confronted with a suicidal person is to change his/her mind through any means possible to ensure that he/she cannot follow through with his/her plans. However, as Werth (1995) has stressed, provided certain criteria are met, it should be acceptable for professionals to be open to exploring suicide as a viable alternative. The intensity of suicide in-

tervention would be more appropriate if it were variable and dependent on the suicidal ideator's life circumstances. Professionals would then be obliged to learn how to distinguish between those who meet the criteria for rationality from those who don't. One interesting result of this need for increased suicide knowledge and interviewing skills may be a decrease of the fears that make working with suicidal individuals such an anxiety-provoking endeavour.

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