

Spring 2016

Suicide prevention: The professional and moral responsibilities of the speech-language pathologist

Madelyn Anderson
moa9@zips.uakron.edu

Please take a moment to share how this work helps you [through this survey](#). Your feedback will be important as we plan further development of our repository.

Follow this and additional works at: http://ideaexchange.uakron.edu/honors_research_projects

 Part of the [Speech Pathology and Audiology Commons](#)

Recommended Citation

Anderson, Madelyn, "Suicide prevention: The professional and moral responsibilities of the speech-language pathologist" (2016). *Honors Research Projects*. 306.

http://ideaexchange.uakron.edu/honors_research_projects/306

This Honors Research Project is brought to you for free and open access by The Dr. Gary B. and Pamela S. Williams Honors College at IdeaExchange@UAkron, the institutional repository of The University of Akron in Akron, Ohio, USA. It has been accepted for inclusion in Honors Research Projects by an authorized administrator of IdeaExchange@UAkron. For more information, please contact mjon@uakron.edu, uapress@uakron.edu.

Suicide prevention: The professional and moral responsibilities of the speech-language pathologist

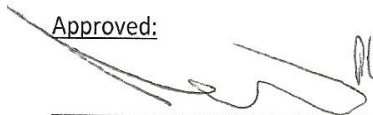
Madelyn Anderson

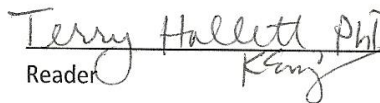
Department of Speech Language Pathology and Audiology

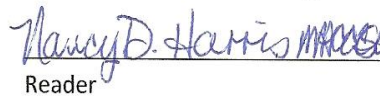
Honors Research Project

Submitted to

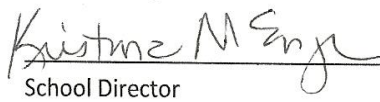
The Honors College

Approved:  Date 05/05/2016
Honors Project Sponsor

 Date 5-5-16
Reader

 Date 4/29/2016
Reader

Accepted:

 Date 5/5/2016
School Director

 Date 4/29/2016
Honors Faculty Advisor

_____ Date _____
Dean, Honors College

Note that all signatures are required (except that of one of the Honors Deans) when you turn in your final project.

See attached sample signature page.

Table of Contents

| | |
|---|----|
| Abstract | 3 |
| Acknowledgements | 4 |
| Chapter 1: Introduction | 5 |
| Chapter 2: Exploring Stuttering and Suicide | 8 |
| Chapter 3: Suicide Prevention: The Responsibilities of the SLP | 16 |
| Chapter 4: Warning Signs and Risk Factors of Suicide in At-Risk Clients | 18 |
| Chapter 5: How We Can Help At-Risk Clients | 20 |
| Chapter 6: Conclusion | 25 |
| References: | 26 |

Abstract

The purpose of this paper is to explore the possible connection between suicide and stuttering, identify warning signs and risk factors of suicide as they apply to our clients, and examine the moral implications and professional responsibilities of speech-language pathologists as they pertain to suicide prevention. From the research I conducted, I found that, as a whole, the national community of speech-language pathologists does not recognize any correlation between stuttering and suicide. However, as dictated by the American Speech-Language-Hearing Association's (ASHA) Code of Ethics, we as speech-language pathologists are obligated to make referrals outside of our profession as the need arises so as to provide the absolute best care for our clients; when and if we suspect a client is suicidal, we make the necessary referrals to mental-health professionals. As mandated reporters, we are legally obligated to report to law enforcement officials when we suspect a client is at risk for suicide. With this knowledge and these responsibilities, it is our duty to educate ourselves to the fullest extent, plan accordingly, and become aware of the warning signs and risk factors of suicide. In doing so, we can potentially save lives. This paper serves to provide the necessary information to build awareness and understanding for fellow speech-language pathologists so that we can be best prepared to help our at-risk clients as both clinicians and counselors.

Acknowledgements

First and foremost, I would like to thank Dr. Scott Palasik for his tremendous support and guidance throughout the entirety of this project. Dr. Palasik has been an inspiration and mentor to me since my return to The University of Akron in the summer of 2013. Words cannot express how truly grateful I am to him for everything that he has done for me. I owe my success to him.

I would also like to thank Dr. Terry Hallett and Mrs. Nancy Harris, the readers of this project, for their feedback and support. I deeply admire their work as educators and speech-language pathologists; I can only aspire to be half the clinician which they both are.

Lastly, I would like to thank my parents for their unwavering love. Your faith in me has been the foundation I have fallen back on time and time again. I could not have done this without you.

CHAPTER 1

Introduction

“Every forty seconds someone in the world dies by suicide. Every forty-one seconds someone is left to make sense of it.” On December 21st, 2012, at the age of eighteen, I attempted to end my life by suicide. Prior to my suicide attempt, in late August of 2012, I began my journey as a college student at The University of Akron. I entered the university with a declared major of Speech-Language Pathology, a foreign field of which I knew close to nothing. Like many other young, doe-eyed adolescents, blasé attitude and all, I chose this major based upon the advice of my mother and a hunch that, just maybe, I wouldn’t hate it.

In the first semester of my college career, I began to suffer from clinical depression. I lost all motivation and desire to attend classes; I neglected my obligations and duties as a student. Ultimately, the pain and suffering which I bore resulted in my decision to take my own life. Almost four years later, here I stand: alive; a survivor. Since my return to The University of Akron in the summer of 2013, I have taken the invaluable lessons this journey has taught me and used them as fuel in my determination to succeed as a student and future speech-language pathologist.

This life-altering experience has affirmed the decision I made four years ago in pursuing this career path. At the age of eighteen, I could have never foreseen the hills and valleys which I have traveled and conquered. Now, at the age of twenty-two, I know that I was led to Speech-Language Pathology for a special reason. In our field, we work with individuals who have spent their lives persevering in spite of some deficit or difficulty that impacts the very core of our existence: speech and language. The ability to effectively communicate one’s wants and needs is an essential element in life satisfaction and over-all well-being; the courage and determination of

these individuals to pursue treatment, striving to reach full communication potential, inspires me in my conviction to achieve success in all facets of my life. I know the amount of strength it takes to ask for help; I too have known the reality of an uphill battle.

For four years, I have persevered to reach a place of healing and maturing; in doing this, I have rewritten my life story. Yes, my story is that of survival, but I refuse to let this define my existence. I am not a victim; I do not choose to share this narrative in order to gain pity or to earn admiration. With trembling knees and an open heart, I speak about my personal journey in hopes that the strength and wisdom that I have obtained will allow me as a speech-language pathologist to forge true connections with other individuals as we make the journey of healing and growth together.

As a student in the Honors College here at The University of Akron, I have been charged with the responsibility of completing an Honors Research Project, the culminating enterprise of my undergraduate career. Since my return to the university in 2013, the knowledge that this project loomed ever closer on the horizon haunted me at night. I seriously grappled with the question: What was I to do? As I pondered this, I found myself consistently drawn to my intense desire to share my story and experiences. But how could I do this as a mere college student? How could I apply this to my field?

This past year, I spent many months applying to graduate school. In the process of applying to The University of Akron's Speech-Language Pathology graduate program, I wrote a letter of intent which addressed the topic of how I would succeed as a speech-language pathologist, and why. As I searched my soul for the answer to this question, I experienced an epiphany. While writing this letter, the paramount of my undergraduate career, I contemplated my successes but also my ongoing struggles. The individuals that I will work with as a health

care professional are more than just clients who are in need of speech therapy services. First and foremost, they are people: people with real thoughts, feelings, and emotions who face both hardships and adversity. These struggles impact every aspect of their lives, specifically the ability to communicate, perhaps the most important capability of them all. Although I may not understand what it is like to live with a speech or language disorder, I do know what it is like to feel alone, that no one understands, or that in some way, you are “less-than”. In my life journey, these feelings manifest themselves as depression. When I feel depressed, suicidal ideation slinks and creeps its way back into my life; such is the manner of the beast. With this self-knowledge, how could I answer the question of how I will be a successful speech-language pathologist without first acknowledging the pain and suffering that my future clients may be enduring? As I delved deeper into this train of thought, I began to wonder how I, or any speech-language pathologist, could provide therapy for any individual without also recognizing the very real possibility that our clients could be at serious risk of attempting suicide.

In our field, I am especially interested in working with people who stutter (PWS). As I continued to struggle with how I could best connect my story with my projected career, I also considered the root cause of my interest in working with those who stutter. In this pursuit, I stumbled across a genuine curiosity, a topic that had been tugging at the corners of my mind: was there a possible relationship between stuttering and suicidal ideation? In this paper, I will aim to explore the murky waters between suicide and stuttering, identify warning signs and risk factors of suicide as they apply to our clients, and examine the moral implications and professional responsibilities of speech-language pathologists as they pertain to suicide prevention.

CHAPTER 2

Exploring Stuttering and Suicide

As I began my work on this project, I immediately discovered that the relationship of stuttering to suicide/suicidal ideation is largely unexplored territory. The little research available overwhelmingly states that although many individuals who stutter can experience suicidal ideation, there is “no correlation between stuttering and suicide” (Fraser, 2014, para. 2). My research first took me to the homepage of the Stuttering Foundation of America, “a nonprofit organization helping those who stutter”, where I happened upon a list of F.A.Q.’s, frequently asked questions. The question that caught my attention asked: “Is stuttering caused by emotional or psychological problems?” The foundation’s response is listed as follows: “Children and adults who stutter are no more likely to have psychological or emotional problems than children and adults who do not. There is no reason to believe that emotional trauma causes stuttering.” (The Stuttering Foundation of America, 2016, para. 7). Although I certainly agree with the foundation’s assertion that emotional trauma does not necessarily cause stuttering, the response dictating that those who stutter are “no more likely to have psychological or emotional problems than children and adults who do not” left me feeling perplexed. In the midst of this troubled mindset, I continued to scour the foundation’s website for more relevant information and came across an excerpt from *Effective Counseling in Stuttering Therapy*, co-written by Joseph G. Sheehan, Ph.D. This excerpt details Dr. Sheehan’s “understanding of fear, guilt, and shame and their relationship to stuttering”, an awareness that stuttering tends to coexist with other problems. Believing that this passage would contradict the foundation’s statement that individuals who stutter are no more susceptible to psychological or emotional distress than individuals who do not, I read on.

Dr. Sheehan dictated that as stuttering coexists with other problems, so must the clinician be prepared to assist the client with said problems, as they apply to our scope of practice (Sheehan, 2003, para. 17). People who stutter are first and foremost people; “becoming a person who stutters does not exempt anyone from becoming a person with many other problems” (Sheehan, 2003, para. 17). Sheehan continued on, explaining that the fear, guilt, and shame that an individual who stutters may experience should not be assumed to be the result of the stutter, or vice versa: “A stutterer may seem depressed, and it would be easy for him—and the clinician—to assume that he is depressed because he stutters, or that he stutters because he is depressed” (Sheehan, 2003, para. 17). However tempting it may be to make this above assumption, Dr. Sheehan asserts that this relationship is speculative at best.

As someone who has been seeking out the plausibility of such a relationship, after reading Dr. Sheehan’s research, I felt foolish. I continued to comb through the Stuttering Foundation of America’s website, hoping to find some spark of truth that could affirm my stubborn, opposing beliefs. I stumbled upon a blog post by Matthew Bacchus, titled “The Thoughts of a Stutterer”, a powerful piece of writing which paints a picture of what it is like to live with a stutter. In this post, Bacchus beautifully describes the self-deprecating, undesirable nature of the thoughts that plague his personal journey as a “stutterer”: “...wondering if your life will always be like this. If so, you don’t even want to live. Suicidal thoughts of a stutterer. Wondering why live in a world where you will be laughed at, made fun of, or looked at strangely” (Bacchus, 2016, para. 3). This quote struck an immense chord with me. As I read Mr. Bacchus’ piece, I could feel his sorrow; I could live his loneliness. Research and professional opinion may state that individuals who stutter are no more susceptible to psychological or emotional distress than individuals who do not, but how can we deny the very real pain of

individuals such as Bacchus? If a person is this depressed, stutter or no stutter, so much so that he or she no longer wants to live, the situation must be properly addressed. In a literal life or death situation, which matters more: knowing that some sort of legitimate connection exists or saving someone's life?

After perusing the Stuttering Foundation of America's website, I turned to the best resource for speech-language pathologists all across the nation: The ASHA Leader. Bringing up the website, I typed into the search engine: "stuttering and suicide". Several articles appeared, one of which immediately caught my attention, titled "Back From the Brink", written by Katherine Preston. This article, originating in an ASHA convention session from 2014, details the life journeys and trials of people who stutter. In shock, I read on, as my sponsor for this Honors Research Project was chosen as one of the subjects of this piece: Dr. Scott Palasik. Preston, a "stutterer" herself, writes from the perspective of her own struggles, reporting that (according to the World Health Organization), "global suicide rates have increased by 60 percent over the past 45 years...someone in the United States takes his or her own life approximately every 14 minutes" (Preston, 2014, para. 13). From the perspective of a speech-language pathologist: "We do not know how many in those statistics are people who stutter, but we know that they are among those numbers...we know that stuttering can breed its own fatalities. And yet, we do not talk about it. Just as stuttering itself has long remained taboo, the convergence of stuttering and suicide remains largely unreported and shrouded in guilt" (Preston, 2014, para. 14).

Preston reports research conducted by psychologist Thomas Joiner, author of "Why People Die By Suicide" and "Myths About Suicide," who believes that "people kill themselves when they have both the desire to die and the ability to die" (Preston, 2014, para. 17). In this

belief, Joiner claims that the “pathway to suicide” stems from the interconnection of three conditions: “thwarted belongingness...perceived burdensomeness...and fearlessness” (Preston, 2014, 17).

The first condition, also known as “isolation”, marks the first milestone on the “pathway to suicide”: individuals feel alone, excluded, and disconnected. From the perspective of a person who stutters, Preston writes of her own isolation from the outside world as she wrestled with the presence of said stutter. She goes on to share pieces of Dr. Palasik’s story and of his inner battle as a young man feeling “imprisoned and silenced” by his stutter. Dr. Palasik shares his tale, painting the picture of a teenage boy, deeply struggling with the stutter that seemed to control his life. In his senior year of high school, Palasik chose to stop speaking, believing that the perceived judgment of others would disappear; instead, intense loneliness set in as his “rage toward his stutter turned toward himself” (Preston, 2014, para. 22). Dr. Palasik shares: “It snowballed into this idea that if I was alone anyway, then what did it matter if I was dead or alive?” This thought process led him to the dark road of suicidal ideation: “That’s what is so scary about people who are suicidal: These thoughts do not scare you. It feels right, it feels natural” (Preston, 2014, para. 23).

The second condition, “perceived burdensomeness” is described by Joiner as the feeling of being a liability, that an individual is letting his or her family down simply by existing (Preston, 2014, para. 24). Preston writes of the individuals such as herself who “could no longer square off against that monster called stuttering”: “Many of the people who talked to me about feeling suicidal remembered their lowest moments being those times when they felt hopeless about their future, when they couldn’t get work, when they felt like their stutter was trapping

them into a smaller and smaller life, when they felt helpless to change their situation” (Preston, 2014, para. 26).

The third and final condition on the pathway to suicide, “fearlessness”, also known as “the ability to die”, develops over time. As an individual who followed this same pathway, I know how it feels to slowly grow accustomed to the reality that you are going to die by your own hands. This insidious process numbs you from the inside out; there is no feeling. Preston writes: “For some, the strength that comes from the daily battle of speaking can be transformed into something deadly” (Preston, 2014, para. 29).

Preston’s piece weaves the connection between communication and emotion; “the ability to be heard by others, to listen to what the world has to offer each day, to share readily and easily one’s memories, experiences, opinions and dreams—all contribute to a sense of social completeness and belonging, to feelings of contentment” (Preston, 2014, para. 2). This relationship manifests itself in the connection between emotions and communication disorders, or in this case, in the connection between suicidal ideation and stuttering. Preston admits: “While there are no data to indicate a higher rate of suicide among people who stutter, we know anecdotally that thoughts of suicide do occur among people with communication disorders, including stuttering” (Preston, 2014, para. 5).

After reading this incredibly moving article, I felt as though I had finally found a likeminded individual whose journey I could both relate to and understand. Stories like Preston’s and Dr. Palasik’s further fuel my passion for the work we do in our profession. Although I feel a strong, personal connection to Preston’s piece, I know that no matter how impressive and moving it may be, the article is strictly anecdotal, devoid of sufficient evidence proving the existence of a relationship between stuttering and suicide, which Preston even admits herself.

Returning to The ASHA Leader, I discovered a response to Preston's piece, titled "Troubled by Stuttering Article", printed in the August issue of 2014. This response from Jane Fraser, a representative from The Stuttering Foundation of America, goes right for the throat, once again reminding the public that there is "no correlation between stuttering and suicide" (Fraser, 2014, para. 2). The foundation follows with this remark: "Simply stated, there is no evidence that those who stutter are more likely to commit suicide than anyone else in the general population" (Fraser, 2014, para. 3).

At first, while reading this response, I felt offended. I sat in utter disbelief, appalled that someone, anyone, would have the gall to disagree with my personal beliefs. Like a toddler throwing a tantrum, fingers in my ears, humming a tune to overpower the reprimanding of my parents, I shook my head. In the midst of this reaction, I came to an abrupt revelation. My rejection of the negating evidence provided by The Stuttering Foundation of America and by the national community of speech-language pathologists as a whole, was not based in a genuine pursuit of the truth but rather in a selfish desire to be right. I stubbornly fought the scientific research because I did not want to admit that my nagging beliefs were unfounded. At this point, I came to a conclusion: it no longer mattered whether I was right or wrong. I, as a future speech-language pathologist, must educate myself with the most current literature available so as to provide the best possible therapy for my clients. Ultimately, the welfare and success of said clients are my number one priorities, not stroking my wounded ego.

Attempting to navigate the murky waters which surround suicide and stuttering has proven to be a difficult task, much more difficult than I had first realized. However, as I released my need to be in the right, I accepted the challenge to learn with an open mind. At this point in time, with the research conducted and results gathered, there is no proven correlation between

suicide and stuttering. Mulling this over, I pondered its implications. So, there's no reported correlation. Does that discount the pain and suffering of these individuals in their battle against the monster that is stuttering? Absolutely not. I may not be able to prove that such a connection exists but I can take all of this newfound information, add it to my repertoire as a burgeoning speech-language pathologist, and move forward.

Following this epiphany, I returned to the "Troubled by Stuttering" article. Fraser and the Stuttering Foundation of America attempt to poke holes in the entirety of Preston's piece, stating that "the implication of a link between stuttering and suicide represents a troubling departure from ASHA's emphasis on 'evidence-based practice'" (Fraser, 2014, para.6). As much as I identify with and respect Preston's piece, this comment is not unfounded. We as speech-language pathologists are charged with the legal, ethical, and moral responsibility of presenting our clients with the best current evidence, incorporating our own clinical expertise and the values of the client, so as to administer the best, most effective therapy. Although Preston's piece speaks straight to the heart, it could never hold up as legitimate evidence or research.

At the end of this response, The ASHA Leader takes the opportunity to make a rebuttal: "Back from the Brink" explicitly states in the introduction, "There are no data to indicate a higher rate of suicide among people who stutter." The intent and focus of the article were to raise awareness and sensitivity to the possibility that speech-language and hearing clients may be among the 1 million people who commit suicide worldwide every year" (The ASHA Leader, 2014, para. 9). This statement was like the flick of a light switch. Suddenly, I knew that The Leader's response was my mission all along. I alone cannot prove that suicide and stuttering are connected in any way, shape, or form. Rather, I can take this opportunity to promote awareness and understanding in our field. We as speech-language pathologists must be mindful of possible

suicidal ideation in our clients with any communication disorder, not just in people who stutter, and what we can do to help within the scope of our practice. This is our duty, not just as healthcare professionals, but as compassionate human beings. How can we, from our standpoint as speech-language pathologists, prevent suicide?

CHAPTER 3

Suicide Prevention: The Responsibilities of the SLP

In this next step of my research process, I began to scour The ASHA Leader for more resources which would support their original statement of wanting to raise “awareness and sensitivity” to the cause of suicide prevention within the field of Speech-Language Pathology. In this pursuit, I came across an article titled, “Clients Who Threaten Suicide—and Our Responsibilities” written by Judith Maginnis Kuster, MS, CCC-SLP, published in November of 2012. Interestingly enough, Kuster’s area of expertise is stuttering. In this piece, Kuster shares a personal experience from October of 2011 when hosting an online conference on stuttering. During said conference, a participant posted: “I just had it today, wanted to end my life because of my stuttering. didn’t want to be embarrassed anymore about my speech problem. I am 23 years old & I am a person who stutters. Stuttering has changed my life drastically...I feel hopeless (Kuster, 2012, para. 7). Kuster was able to connect said participant with potentially life-saving help. Following this experience, at a Stuttering Conference, Kuster posed this question to a panel of professionals: “Do any of your training programs have a required course where suicide ideation, threats or attempts in clients is discussed?” (Kuster, 2012, 8). Of the twenty-five professionals present, only one responded affirmatively. Reading this, I let out a gasp. How could a group representative of the best and brightest in our field not have access to such resources?

Kuster continues: “Of course, counseling people who are suicidal is not within the scope of practice for an SLP or audiologist. Yet professionals should know the basics of what to do in many emergency situations. While someone is dialing 911 to summon help, everyone should know what to do if someone is choking, bleeding severely, having a seizure, having an apparent

heart attack or stroke, or not breathing. Basic first-aid courses are required in many work settings” (Kuster, 2012, para. 9). As Kuster states, as speech-language pathologists, we cannot provide counsel to our clients who may be suicidal; it is legally outside the scope of our practice. However, in a situation where an individual is expressing that he or she is going to hurt his or herself, what are we allowed to do? In many work settings, not just specific to SLP’s, individuals are trained to learn CPR and other basic life-saving gestures to be used in emergency situations. Why then are we being left untrained and uneducated on how to provide “life-saving gestures” in emergency situations where our clients express that they are going to kill themselves? How can we help from our perspective as both clinician and confidante?

In the remainder of Kuster’s piece, she provides a variety of links for readers, including crisis hotlines, online support, and prevention resources. Browsing through these, I couldn’t help but wonder why our field is lacking in awareness and understanding when there is such a wealth of resources right at our fingertips. Amongst these resources, I clicked on the link to “Preventing Suicide: A Toolkit for High Schools”, a PDF provided by the U.S. Department of Health and Human Services, funded by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), which aims to “help high schools, school districts, and their partners design and implement strategies to prevent suicide” (Preventing Suicide, 2012, p.9). This free, 229-page PDF contains an immense amount of preventative information, including the general warning signs and risk factors of suicide. Wanting to identify how these manifest themselves in our clients with communication disorders, I read on.

CHAPTER 4

Warning Signs and Risk Factors of Suicide in At-Risk Clients

According to this toolkit, “warning signs are indications that someone may be in danger of suicide, either immediately or in the near future” (Preventing Suicide, 2012, p.41). If an individual is expressing the desire to hurt or kill his or herself, actively seeking out means to end his or life, or demonstrating a preoccupation with death or dying, seek immediate help by calling 9-1-1 or the National Suicide Prevention Hotline at 1-800-273-TALK (8255) (Preventing Suicide, 2012, p.41). Additional warning signs warranting the referral or contact of a mental health professional include “hopelessness...rage...recklessness...withdrawal from friends, family, or society...[or] no reason for living” (Preventing Suicide, 2012, p.41). Reading these warning signs was difficult for me. At a point in time, I exhibited all of these warning signs as I prepared to end my life. The process of reviewing these, as painful as it may be, was a reminder as to what I should be aware of and cognizant of as I work with clients. The time I spend with a client, one-on-one, could perhaps be the only time in a client’s life where someone, anyone, is truly listening to what he or she has to say and to what he or she might be terrified to say aloud.

According to the toolkit, “risk factors for suicide refer to personal or environmental characteristics that are associated with suicide” (Preventing Suicide, 2012, p.33). Certain “behavioral health issues/disorders” may leave an individual more susceptible to suicidal ideation, such as “depressive disorders...anxiety disorders...personality disorders” (Preventing Suicide, 2012, p.33). “Personal characteristics” such as “hopelessness...low self-esteem...loneliness...perception of being a burden (e.g., to family and friends)” also play an immense role in the vulnerability of an individual to suicide/suicidal ideation (Preventing Suicide, 2012, p.33). With the individuals that we treat, I would be shocked if they didn’t exhibit

any of these risk factors. Living in a world where the ability to effectively communicate is of utmost importance, I can only imagine how an inability would affect my self-worth and perception of my environment. Avoiding the snares of suicidal ideation would feel next to impossible.

CHAPTER 5

How We Can Help At-Risk Clients

With these warning signs and risk factors in mind, I returned to The ASHA Leader. I quickly stumbled across an article titled “Be Prepared to Help At-Risk Clients” written by Joseph Donaher, PhD, CCC-SLP and Lisa A. Scott, PhD, CCC-SLP, published in the May issue of 2014. As I scrolled down, the opening paragraph of this piece jumped out at me: “Imagine the isolation of not being able to communicate with others. Imagine the alienation of not feeling accepted, the frustration and hopelessness of feeling beyond help. Imagine the deep depression and angst that could drive a person to consider suicide. These feelings are reality for many of our clients struggling with communication disorders, especially those with coexisting mental health issues” (Donaher & Scott, 2014, para. 1). After just reading through the various warning signs and risk factors of suicide, this article appeared to be a direct response, only focusing on individuals with communication disorders. According to Donaher and Scott, the “mental health conditions we most often see in clients are anxiety (for example, generalized anxiety disorder, social anxiety disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder) and mood disorders (for example, dysthymia, depression, bipolar disorder)” (Donaher & Scott, 2014, para. 3). These mental health conditions compounded with emotional responses to feeling alone, excluded, and disconnected can result in a perfect storm where clients fall into the traps of suicidal ideation. As clinicians, we must “carefully heed the client’s attendance and variations in performance or interest levels not tied to a communication disorder” so that we can make “better and earlier referrals”; we may be the soldiers on the forefront who see the battle coming before anyone else (Donaher & Scott, 2014, para. 5). “If a client’s desperation does escalate”, what can we as speech-language pathologists do? What is within our power?

According to Donaher and Scott: “The vast majority of people with communication disorders are not at risk for suicide, and determining suicidal risk does not fall within the scope of practice for SLPs or audiologists. It is the mental health professional’s responsibility to do a systemic, thorough suicide evaluation...” (Donaher & Scott, 2014, para. 7). According to ASHA’s official Code of Ethics, from Principle IIa.: “Individuals who hold the Certificate of Clinical Competence shall engage in only those aspects of the professions that are within the scope of their professional practice and competence, considering their certification status, education, training, and experience”. Donaher and Scott are completely correct; evaluating or assessing clients for mental health issues or risk of suicide is not our responsibility. Our responsibility as speech-language pathologists is to treat and assist our clients in reaching their full communication potential. However, as pointed out by Donaher and Scott, we are considered “mandated reporters...As such, [we] are legally obligated to report to law enforcement officials or an abuse/neglect hotline when [we] suspect a client is at risk for suicide (Donaher & Scott, 2014, para. 10). In addition to this legal responsibility, ASHA dictates in its Code of Ethics, Principle Ib.: “Individuals shall use every resource, including referral and/or interprofessional collaboration when appropriate to ensure that quality service is provided”. Keeping this in mind, we as speech-language pathologists may not be able to assess or evaluate our clients for mental health issues or risk of suicide, but we are able and expected to report and refer when these issues arise. Just as our Code of Ethics instructs, it is our charge to use every available resource and outlet to provide the absolute best care to our clients. By reporting any legitimate suspicions and using the avenues of referral, we ensure that quality service will be administered. In doing this, we just might save a life.

As speech- language pathologists, even if the majority of our clients do not experience suicidal ideation, we should have a plan in place for those that might. To prepare for a potential crisis situation, Donaher and Scott suggest composing an “emergency plan” (Donaher & Scott, 2014, para. 11). Prior to the creation of said plan, educate oneself on the “policies and guidelines of your school or institution and your county’s crisis response protocols regarding suicide and mental illness”; in doing so, one is both knowledgeable and aware of the necessary steps that must be followed when reporting such a situation. Secondly, “clearly identify who you will contact at the time of crisis and have those numbers handy...this list should include someone who is easily accessible to assist immediately...that person may be asked to stay with the person at risk or to contact others for help” (Donaher & Scott, 2014, para. 13). In our pledge to provide referrals for our clients, we must be well-equipped and prepared to “connect [our] client[s] quickly with a mental health professional or counselor...if none of these options is available, be ready to call 911 for speedy help getting [our] client[s] to an appropriate service provider” (Donaher & Scott, 2014, para. 14). An emergency plan such as this must be appropriate, effective, and timely; lives’ may depend on it.

As speech-language pathologists, we wear many hats. We are so much more than “just therapists”. We are clinicians, we are advocates, we are counselors: “Counseling people with communication impairments is part of our job description...it is a necessary part of our clinical responsibilities” (Bradshaw & Gregory, 2014, para. 2). In my research process, searching for more pertinent information, I happened upon an article written by Janet Bradshaw, ABD, CCC-SLP and Kyomi Gregory, MA, CCC-SLP titled “The Other Side of CCCs: Communication, Counseling and Clinicians”, published in May of 2014. In this piece, Bradshaw and Gregory provide guidance for readers on how best to “tend to the emotional side of...clients”; the two

describe and supply a variety of counseling techniques for both speech-language pathologists and audiologists to utilize throughout the entire rehabilitation process: “diagnosis, treatment, and discharge” (Bradshaw & Gregory, 2014, para. 1).

After just reading Donaher and Scott’s article on how to best help our at-risk clients, I began to put two-and-two together. The process of constructing an emergency response plan for individuals in crisis situations is an excellent example of a preventative measure. But, how can we ensure that every moment we spend with our clients is a preventative measure? Quoted in Bradshaw and Gregory’s piece, Audrey Holland, author of “Counseling in Communication Disorders: A Wellness Perspective”, states that one of the most important components of “establish[ing]...rapport with client[s]” is “promot[ing] a safe place for communication” (Holland, 2007). When we demonstrate to our clients that we are safe, trusted individuals, we become more than therapists: we become confidantes.

Also quoted in the same article, George H. Shames, author of “Counseling the Communicatively Disabled and Their Families: A Manual for Clinicians”, claims that becoming a “good listener and skilled interviewer allows clinicians to coordinate with clients’ emotions and to promote a strong clinical rapport” (Shames, 2006). In this endeavor, we grant clients the opportunity to share their true emotions and feelings; they recognize that we will listen, without judgment, and provide support. When we cultivate an atmosphere of acceptance and understanding, we as speech- language pathologists leave necessary space for us to ask difficult questions of our clients, when we see fit. We set the stage for this through the development of a strong working relationship. Donaher and Scott remind readers that in order “to determine whether a person is in danger of acting on suicidal tendencies, [we must] be ready to ask”

(Donaher & Scott, 2014, para. 15). A question as simple as: “Are you thinking about hurting yourself?” could open the floodgates.

Bradshaw and Gregory state: “Counseling is a listening process...as clinicians, we must recognize our own emotions, as well as those of the clients...when we listen to our clients, we validate their feelings...clients, who feel acknowledged, can feel empowered in all struggles” (Bradshaw & Gregory, 2014, para. 10). When we empower our clients, we empower ourselves; it is both our moral and ethical responsibility. In this empowerment, let us work to increase awareness and understanding of our clients’ emotional needs. Regardless of whether a client may or may not be experiencing suicidal ideation, we can educate ourselves; it is better to err on the side of caution. There is no harm in being prepared. Yes, we cannot counsel those who are suicidal. However, we can act as the stepping stone to life-saving help, but only if we take the time and energy to become so. “By asking...questions, knowing risk factors and having an emergency action plan, SLPs and audiologists can play a significant role in suicide prevention” (Donaher & Scott, 2014, para. 19).

CHAPTER 6

Conclusion

Throughout this long, arduous research process, I have turned over a number of leaves and discovered various resources in my pursuit of learning what it means to be a speech-language pathologist who works to prevent suicide. I have identified warning signs and risk factors of suicide as they pertain to clients; I have pinpointed both the moral implications and professional responsibilities of speech-language pathologists as both clinicians, counselors, and advocates. Returning to the article “Back From the Brink”, author Katherine Preston quotes a man referred to as Tim, a person who stutters who once attempted suicide: “It is only the beginning of the journey...I have so much more to do, and so much more to say” (Preston, 2014, para. 36). In our field, as a future speech-language pathologist, I will devote my life to provide hope and light to clients who may be suffering, lost without the will to survive. Together, we will continue the journey. Together, we will do all that they want to do. Together, I will guide them so that they can say all that they have to say and so much more simply because: life is worth the living.

References

- Bradshaw, J., Gregory, K. (2014). The other side of CCCs: Communication, counseling, and clinicians. *The ASHA Leader*, 19, np.
- Donaher, J., Scott, L. (2014). Be prepared to help at-risk clients. *The ASHA Leader*, 19, 52-58.
- Fraser, J. (2014, August). Troubled by stuttering article [Letter to the editor]. *The ASHA Leader*, 19, 5.
- Holland, A. (2007). *Counseling in Communication Disorders: A wellness perspective*. San Diego, CA: Plural Publishing.
- Kuster, J. (2012). Clients who threaten suicide- and our responsibilities. *The ASHA Leader*, 17, np.
- M Bacchus. (2016, Feb 1). The thoughts of a stutterer [Web log comment]. Retrieved from <http://www.stutteringhelp.org/thoughtsofastutterer>
- Preston, K. (2014). Back from the brink. *The ASHA Leader*, 19, 44-50.
- Shames, George H. (2006). *Counseling the communicatively disabled and their families: A manual for clinicians*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Sheehan, J. (2003). Principles of counseling people who stutter. In *Effective counseling in stuttering therapy*. Retrieved from <http://stutteringhelp.org/content/principles-counseling-people-who-stutter>
- Substance Abuse and Mental Health Services Administration. *Preventing Suicide: A Toolkit for High Schools*. HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2012.
- The Stuttering Foundation of America. (2016, April). *F.A.Q.: Stuttering facts and information*. Retrieved from <http://www.stutteringhelp.org/faq>