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Suicide Prevention in the Genetic Counseling Context

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Utilizing a case report, this paper explores psychosocial aspects of suicidal intent in a woman seeking prenatal diagnosis. Using knowledge and practice of appropriate assessment, referral, and intervention procedures, the therapy team of genetic counselor and psychotherapist facilitated successful identification and management of this potentially suicidal client. The main counseling goals for the genetic counselor are to assess the situation adequately, decrease the immediate danger, and, with supervision and/or consultation, stabilize the seriously suicidal person until that individual can be triaged to mental health or medical professionals for treatment. The prevalence of suicide issues in genetic counseling contexts is unknown and reports mentioning suicidal ideation unusual in the genetic counseling literature. Is this reported case a rarity among genetic counseling referrals? Systematically collected information on the prevalence and resolution of suicidal issues in genetic counseling contexts would be helpful for those setting curricula for genetic counseling training programs, standards for professional certification exams, and policy and procedures manuals for clinical units.

KEY WORDS: genetic counseling; suicide.

INTRODUCTION

Suicide accounts for about 1% of all deaths in the U.S. each year, amounting to 30,000 fatalities and considerable morbidity from unsuccessful attempts (Fawcett, 1991). With this prevalence, genetic counselors may encounter a potentially suicidal patient in their careers. Utilizing a case re-

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port, this paper emphasizes how knowledge of the psychosocial aspects of suicide in the genetic counseling context can facilitate identification and management of potentially suicidal patients. Genetic counseling details of the case were previously reported in Greene-Simonson & Peters (1992).

CASE REPORT

History

The patient (V. B.) referred by the genetic counselor for psychotherapy was a 36-year-old, married, caucasian woman having psychological and somatic complications during the prenatal diagnosis process. Among those features which alerted the genetic counselor of a potential problem were an extreme level of distress about abnormal maternal serum-alpha fetoprotein (MS-AFP) results, ambivalence regarding the pregnancy, marital conflict, and various somatic symptoms. For these and other reasons she was referred for psychological evaluation and brief psychotherapy.

The referral process began with preparation of V. B. to become a psychotherapy client. The genetic counselor first discussed the goals, content, and processes of the genetic counseling and psychotherapy realms to provide the client with a clear understanding of where genetic counseling left off and psychotherapy began and where overlaps exist. V. B. was able to accept the referral in part because the process was actively facilitated by the genetic counselor. By providing information about the therapist and the counseling process and making the initial referral telephone contact with the therapist, the genetic counselor normalized the referral. In this case the therapist was familiar with psychological issues that often arise in prenatal diagnosis and was able to provide the client with a smooth transition from a focus on the prenatal diagnosis process to understanding and validating V. B.'s reactions to these procedures.

V. B. arrived late for her first therapy session due to traffic. She was dressed plainly and gave the impression of a woman easily flustered and overwhelmed. Her stated reason for seeking therapy was to be "no longer in crisis" regarding amniocentesis several days earlier.

With minimal prompting, V. B. elaborated on her worries about possible disasters regarding the amniocentesis results. These worries preoccupied her thoughts and were taking their toll on her physical health. Every bodily sensation she noticed could lead to hours of ruminations about their meaning and possible dire consequences. For example, the sensation of vaginal wetness that she attributed to amniotic fluid leakage sent her into a panic about miscarriage, all the more distressing because of her conflicted

feelings about her pregnancy. She was crying daily, could barely concentrate at work, and had to take time off because she was exhausted from sleeping only two hours per night.

Past and present relationship histories were troubled, beginning early in life. V. B. identified herself as a member of a dysfunctional family of origin. She remembered herself as a child as being withdrawn, isolated, unattractive and a failure. She attributed negative self-concepts and an adolescent suicide attempt to a conflicted relationship with her mother.

Her past love relationship history was also reported as unsatisfying. She had two children in a first unhappy marriage and a son with her second partner whom she did not marry. After that relationship and prior to her current marriage, V. B. had an abortion about which she carried tremendous unresolved guilt and grief. V. B. viewed her current husband as incapable of dealing with emotional crises and prone to emotional withdrawal or actual physical separation if she became excessively emotional.

Social support was minimal. In the absence of a supportive adult confidante, V. B. frequently turned to her children for friendship and support.

On direct inquiry about suicidal ideation, V. B. revealed that she had considered killing herself and the fetus if amniocentesis detected anything seriously wrong. Her suicidal thoughts derived from her conviction that she should be punished for her previous abortion. Furthermore, she was very angry at her obstetrician's office for "forcing" her into prenatal diagnosis processes which might require her to consider unpleasant and threatening possibilities of dealing with abnormalities. She was also furious that "no one listened" to her when she tried to voice her wishes. This impression that no one listened persisted despite daily contact with the genetic counselor, the obstetrician and his staff.

On the positive side, V. B. had the tenacious strength and resilience of a survivor. Insight gained from previous therapy allowed her to generalize from the present crisis to recognize the pregnancy and prenatal diagnosis experiences, in part, as a repetition of past patterns of dealing with emotionally traumatic situations. Her motivation toward resolution of the current crisis was strong. Surprisingly to V. B., her husband, whom she considered a stingy man, was willing to pay for psychotherapy, thus providing tangible if not emotional support.

Diagnosis

There were several layers of diagnosis in this case. It seemed that V. B. suffered from a long term, low-grade depression (now termed dysthymia in the DSMIII-R) and relationship dysfunctions since childhood for reasons

that we did not uncover during our brief sessions. Superimposed on this were her anxiety about her own and the fetus' physical well-being, signs of a major depression and tendency to somatization of her emotional pain into physical symptoms. Her social isolation stemmed mainly from residua of past traumas and a lack of the opportunity to develop appropriate social skills.

Customarily a therapist would request records of past treatment to verify previous psychiatric history and diagnoses. Unfortunately, there was not opportunity to do so during this brief crisis intervention due to time constraints and lack of client cooperation in pursuing this action. Therefore, all diagnoses remained provisional working diagnoses to guide the direction of interventions. Permission was obtained for contact between the genetic counselor and psychotherapist to coordinate care.

V. B. was considered to be at moderate suicidal risk due to past history, current suicidal ideation, underlying anger and guilt, and strong motivation to remove herself from crisis and psychic pain. She initially perceived death as the only escape from an unbearable situation and as a means of punishing those at whom she was angry, most especially herself. On the other hand, she had made no definite suicide plans, could identify reasons to live and was taking steps for finding other solutions to her dilemma.

Therapy

V. B. was seen for two sessions during the week between her amniocentesis and obtaining results. She refused to see a psychiatrist as recommended by her obstetrician and reinforced by the psychotherapist; all parties agreed that the obstetrician would manage all medical aspects of her emotional situation with psychiatric backup as necessary.

To lessen the risk of suicide, it was important to relieve the pressures that the client was experiencing, increase support, and encourage venting of her repressed anger and grief within the safer parameters of a non-suicide contract. We agreed upon a plan in which V. B. would contact an adult support person by telephone for at least 5 minutes duration every other day, would use the local crisis hotline as necessary whenever suicidal thoughts arose and increase telephone contact with the therapist. We structured her days and evenings to re-establish regular eating and sleeping patterns.

Grief counseling figured prominently in the psychotherapy in this case. The abortion which V. B. had many years ago was never grieved appropriately because of guilt she harbored over choosing abortion. In telling her story, V. B. was able to reexperience and discharge some of the strong feelings attached to the abortion experience. Together, therapist and client

discovered similarities between the circumstances of her previous abortion and those of her current pregnancy. This discovery promoted cognitive mastery by allowing her to see her current reactions as meaningful. This, in turn, was empowering and reduced her vulnerability and panic.

The enhancement of her coping skills provided alternative courses of action to suicide. Specifically, assertiveness instruction and role playing were offered with the objective of identifying and decreasing her passive coping strategies which avoided short-term conflict but led to frustration and anger eventually. Subsequently, V. B. told her obstetrician in person that she was angry with him about her prenatal diagnosis experience. She became more direct in communicating with her husband during this period. Following these actions she felt less global anxiety but still had focused worries about possible Down syndrome or amniocentesis complications. Her eating and sleeping patterns had improved sufficiently for her to return to work. She was also better able to tolerate and articulate her ambivalence about the pregnancy. V. B. agreed to continue the original plan of ongoing social support and added a new agreement about how she would cope with possible abnormal results so that she had a clear alternative to suicide identified, articulated, and rehearsed.

Several days after the second psychotherapy session V. B. called to report that the amniocentesis results were normal, that her mood was happy, and her function at home and work had returned to pre-crisis levels. She did not wish any further contact nor exploration of other issues raised during our sessions; however, we left the door open for future contacts.

DISCUSSION

Prevalence of Suicide in Genetic Counseling Context

The prevalence of suicide issues in genetic counseling contexts is unknown. Mostly it has been mentioned in conjunction with special circumstances, e.g., use of presymptomatic testing for Huntington disease (HD) (Kessler, 1987; Hayden, 1991; Bloch, 1992; Huggins, 1992; Wiggins, 1992). Persons at risk for HD are recognized to be at increased risk for suicide because of the nature of this progressive, incurable disease and the high degree of uncertainty regarding symptom onset and course of the illness.

Lack of published studies about suicide in more common counseling scenarios may be due to true rarity of the phenomenon, lack of systematic surveys, or underascertainment by counselors in clinical settings. Even in the case of V. B. reported above, the risk for suicide was not appreciated at first.

Countertransference

The invisibility of discussion of suicidal issues in the genetic counseling literature may, in part, reflect the presence of countertransference issues. This is not surprising given the multiple sources of psychological resistance in the counselor that may operate to stifle direct inquiry. These may have to do with upbringing, manners, cultural proscriptions, morals, insecurity, genuine ambivalences, and lack of professional support for raising these issues with clients. Some counselors have experienced the pain of surviving suicide in a loved one and a client's issues may reactivate grieving.

As with other unanticipated counseling occurrences, the sudden revelation of suicidal possibilities can provoke in the genetic counselor a strong wave of subjective affective responses such as shock, anxiety, fear for the client, uncertainty, and immobilization. Ideally, counseling training, preparation and rehearsal for assessing suicidality and having a fitting action plan allows the genetic counselor to contain his or her anxiety, and to act appropriately. As noted below, this should not be done in isolation but with guidance and supervision.

Assessment, General

Although the occasions of dealing clinically with suicide may be infrequent, the genetic counselor must be prepared for those eventualities when suicidal crises occur. A preventive, proactive stance may be routinely to inquire briefly of clients about suicide in the context of assessing overall levels of distress and functioning. One strategy is to develop criteria for determining an "at risk group" who will be preferentially assessed more thoroughly. For example, one might earmark certain disease entities such as Huntington disease or certain collections of demographic factors as listed in Table I. Another option would be to inquiry briefly about suicidal ideation of every patient referred for genetic counseling.

The keys to suicide assessment are development of a realistic index of suspicion, direct inquiry, and knowledge of suicide risk indications. A suicide risk assessment should include inquiry into intent, wishes, thoughts of dying, plans to put affairs in order, plans to obtain the means for suicide, and history of previous attempts in self or family members. Clients at increased risk include the troubled adolescent; depressed older adult; separated, divorced, or widowed white male; and those who are unemployed or with recent economic setbacks. Special groups may also be at high risk, e.g., gay or lesbian youth (Remafedi, 1991) and battered partners (Bergman, 1991).

Table I. Risk Factor Ranking by Psychiatrists for Suicide in Adults[a]

Degree of hopelessness
Communicated ideation or plan
Previous attempts
Level of mood and affect
Quality of relationships
Signs and symptoms of depression
Social integration
Recent loss of relationship
Symptoms of mental status
Willingess to accept help

[a]From Truant, O'Reilly, & Donaldson, 1991.

Psychiatric conditions such as depression, anxiety, panic disorder, or psychosis with active hallucinations should always prompt the counselor to assess for suicide intent. A suicidal client may wish to escape specific physical problems such as recent injury, intolerable pain, terminal illness or severe insomnia. The client at highest risk is also more likely to be impulsive or to be using alcohol or drugs abusively. Antecedent factors such as losses, life stressors, abuse, neglect, and sexual molestation also increase risk. Persons who have been severely depressed (see Table II for diagnostic criteria) may be at higher suicide risk once the depression begins lifting because they may have more energy with which to act.

Table II. Diagnostic Criteria of Depression[a]

Depressed symptoms may be seen in adjustment disorders (brief episodes of adjustment to an indentifiable stressor), dysthymia (chronic, low grade depression), and major depressive episodes (described below).

In order to be diagnosed with a major depressive episode, an individual must demonstrate more than five of the following symptoms persisting over a 2 week period:

1. Depressed mood daily for most of the day
2. Markedly diminished interest and pleasure in activities
3. Significant weight loss or gain
4. Increased or decreased sleep
5. Psychomotor retardation or agitation
6. Fatigue or low energy daily
7. Feelings of worthlessness and guilt
8. Poor concentration, ability to think, make decisions (frequent in men)
9. Recurrent thoughts of death or suicide

[a]From DSM-III-R.

Several efforts to synthesize the above factors into a concise formula for recognizing suicidal intents have been made. One informal rule of thumb handed down from supervisor to therapist intern advises looking for the "3Hs" of helpless, hapless, and hopeless feelings which are often associated with feelings of desperation and despair. From a different viewpoint, Edwin Shneidman, UCLA suicidologist, conveniently summarizes the causes of suicide as "psychache" symptoms of hurt, anguish, soreness, aching, and psychological pain in the mind. In his efforts to measure, operationalize and mollify "psychache," he has identified a progressive suicidal process which has potential for interruption before reaching a suicidal outcome (Shneidman, 1993).

It has been long observed that more women attempt suicide but more men complete it. Psychotherapy theoreticians and clinicians using a relation-based counseling model developed at the Stone Center of Wellesley College focus on gender differences in patterns of completed suicide and suicide attempts (Kaplan, 1990). Kaplan and colleagues believe that many female suicide attempters are in a relational crisis characterized by emotional cutoff and that the suicide attempt itself represents "a reaching out to engage meaningfully with others and to repair relational disconnections, while completed suicide in women seems to reflect a conviction that there is and will be no hope for meaningful human connection" (Kaplan, 1990, p. 1). In keeping with this logic, their interventions depend on developing a high quality of mutually empathic connection in the therapeutic relationship.

Adolescents may express suicidal feelings differently than adults. It is important to recognize these distinctive warning signs in adolescents since suicide is now the second leading cause of death in this age group, having increased 191% between 1950 and 1986 (Ahmadi, 1991). For genetic counselors attending specialty clinics in which they see significant numbers of adolescents or young adults (e.g., neuromuscular, spina bifida, cystic fibrosis, craniofacial) it is important to also inquire about changes in eating and sleeping habits, peer group changes, persistent boredom or apathy, decline in school performance. More advanced behavioral indicators include violent or rebellious behavior, running away, drug and alcohol abuse, neglected personal appearance or radical personality change. Some distressed teens may complain about somatic manifestations of emotional distress including headache, stomache, or fatigue. There are anecdotal reports of suicidal teens giving away their most prized possessions. Finally, adolescents at risk for suicide may give some direct verbal warnings such as "I won't be a problem to you for much longer" and "It's no use."

Perhaps identification of a suicide prevention specialist at one's own institution (try Psychiatry, Child Psychiatry, Social Services, or Medical Psy-

chology Departments) or in the community may be useful *before* a crisis occurs. Purposes might be to obtain training in suicide assessment and intervention and developing working liaisons which can be accessed in times of crisis. Informing this mental health professional of the scope of genetic counseling services may prove mutually beneficial.

Suicide Assessment, Focused

When faced with a potentially suicidal client, the primary goal is to establish whether or not there is genuine intent to do harm to self or others. The counselor could initiate the inquiry in a matter-of-fact manner with a series of questions:

"Have you been thinking about harming yourself?
Have you felt suicidal in the past?
Did you ever act on those feelings? What happened?"

If the answer to all of these is no, there is probably no need to go into more detail.

If the answer to the above question about suicide is yes or if there are any lingering doubts about intent, it is best to go on directly to specific questions related to further assessment of suicidal thoughts, feelings, and actions, such as:

"How long have you been feeling suicidal?
Do you have a plan now for how you would end your life?
What would you do?
Have you made a will, given away your favorite belongings, or been putting your life affairs in order?
Have you bee tempted to drink or take drugs? How much have you been drinking lately? How much today?
Have you been saving up prescription medications from your physician? How many do you have stockpiled now?
Do you have access to other means such as a gun, etc? Where are they now?"

Direct inquiry about psychological and social resources, hope for improvement, and motivation to live are also important. Some relevant questions might include the following:

"Who is your main support?
With that person's permission, would you be willing to call that person to keep you company until we can get more help?

Are you willing to give that person or someone else the gun or pills or car keys?
Do you see any other way out of this present problem besides suicide?
How long can you promise me that you won't harm yourself?
What do you have going for you right now?
What do you have to live for: loved ones? children? job? unrealized goals? . . ."

Intervention

Once the counselor determines that a significant risk exists, he or she assumes the responsibility to take action. The general guiding principles are: Client safety supersedes all other concerns. The level of intervention should be proportional to the degree of risk. The environment should be the least restrictive that is also judged to be safe (see Table III).

The main therapeutic goals appropriate for a genetic counselor regarding suicidality are to assess the situation adequately, to decrease the immediate danger, and, with supervision and/or consultation, to stabilize the seriously suicidal person adequately until the client can be referred appropriately to mental health professionals for treatment. Genetic counselors are not generally psychotherapists and, therefore, are not expected to provide primary treatment for someone who is suicidal. However, genetic counselors do generally possess the qualities that are most important to

Table III. Interventions for Suicide Preventions

General recommendations:
1. Assess adequately; inquire directly about suicidality.
2. Decrease immediate danger of harm.
3. Stabilize mood.
4. Get help.
5. Document.

Specific recommendations:
1. Do not leave person alone, even in bathroom.
2. Remove means of suicide.
3. Increase frequency of personal and telephone contact.
4. Encourage safe venting of feelings, especially anger and hopelessness.
5. Increase social support, with permission.
6. Obtain patient cooperation in a non-suicide contract.
7. Refer for psychiatric evaluation, psychotherapy, and/or medication.
8. Medicate for depression, agitation, anxiety, pain, or psychotic features.
9. Hospitalize, if necessary, voluntarily or involuntarily for surveillance, restraint, and therapy.
10. Follow-up post-crisis.

assist a client feeling isolated enough to commit suicide: The abilities to listen, care, and transmit empathy, concern, and emotional commitment. Genetic counselors are accustomed to dealing with people in crisis due to medical emergencies.

Many suicidal feelings are situational and subside with time, catharsis, support, and psychiatric intervention. However, suicidal ideation should be taken seriously since many eventual suicides were preceded by a fair number of warning signs. Treatments are varied and may involve hospitalization, psychotropic medications, or outpatient counseling.

Stabilization can often be achieved by urging the person to express distressing feelings in your presence, to assist the client in finding specific reasons for hope and meaning, to increase the number and quality of social contacts immediately, and to provide a safe environment until the client can cope better with whatever crisis provoked the episode. Many suicide experts suggest that the counselor obtain a verbal and preferably written contract that the client will not harm himself or herself for a specified time period, at the end of which the situation can be reevaluated and a new contract negotiated if necessary.

The revelation of suicidal thoughts without interruption, judgement, criticism, or rejection may be a great relief to a person who has been feeling suicidal and may have been carrying this burdensome feeling alone. In some cases, the client will open up and spontaneously start talking and perhaps crying, sobbing or yelling. Sometimes this catharsis may itself be sufficient to defuse the psychic bomb of suicide risk. In other cases, it may become apparent that the client was only speaking in a metaphorical manner to express deep psychic pain and without any intent to act, and once this is heard, both client and counselor can move beyond consideration of suicide.

If the counselor believes that suicide in imminent, immediate hospitalization should be considered. One possibility might be to arrange for an escort to a walk-in psychiatric emergency room. Another is to call the Psychiatric Emergency Team (PET) member on call in your community. Another is to call 911.

Suicide hotlines can also be invaluable in assisting both the suicidal patient directly by providing a psychosocial safety net via the telephone connection and indirectly through referrals and recommendations. The individual may call as often as necessary without worrying about imposing repeatedly on a friend. The hotline can also provide referrals for care and support. If the genetic counselor is unsure how to proceed in a certain situation, the hotline may provide suggestions and support for the counselor as well.

Ethical–Legal Issues

Several ethical and legal issues may arise in management of a genetic counseling client who is potentially suicidal. There are few laws pertaining to suicide; however, regulatory agencies and professional organizations have standards for behavior or codes of ethics addressing the issues (Schutz, 1990; California Evidence Code, Section 1024; California Business and Professional Code, Chapter 13, Division 2, Section 4982, Subsection d). Standards of practice are also shaped by civil law suits pertaining to harm (torts) done to individuals.

Malpractice is defined as "an act or omission that falls below the standard of reasonable care and skill and that results in or aggravates an injury to the patient" (Schutz, 1990, p. 2). There are two malpractice liability issues likely to arise in the management of the suicidal patient:

1. The therapist failed to take action when he or she had knowledge of suicidal intent and could have avoided foreseeable harm. This hinges on the dual responsibilities of making an adequate assessment, and on making reasonable attempts to manage the dangers inherent in the suicidal situation. Both suicidal risk and interventions exist on continua which should be matched proportionately so that increasing risk is matched by increasingly directive activity by the counselor.
2. The counselor's act directly contributed to the suicide (Schutz, 1990). This will not be addressed further in this paper.

Within the genetic counseling code of ethics are principles and guidelines that may influence the counselor's actions (NSGC Code of Ethics, 1992; Benkendorf, 1992). This code is founded on the concept of responsibility in relationships with self, clients, colleagues, and society. In section I, counselors' responsibility to themselves calls for information-seeking, continued education, keeping current with standards of practice, recognizing limits of one's own professional role, and implicitly knowing when to refer. In section II, counselors' responsibilities to clients extend to respecting clients' values, enabling clients in autonomous decision-making, and maintaining confidentiality. Genetic counselors recognize that some technologies provided in the context of genetic counseling may have profound effects on clients and strive to help them deal with these sequelae. In section III, genetic counselors strive to foster respect and cooperation among professions and within the profession. This may range from sharing information in case reports to challenging current standards of care. In section IV, genetic counselors recognize responsibilities to society and adhere to laws and regulations of society.

Specifically related to suicide, the obligation to report or otherwise intervene in a potentially fatal situation may conflict with the duty of confidentiality. All professional codes mention aspects of care for others as well as to protect confidentiality (NSGC Code of Ethics, 1992; Schultz, 1990). The codes do not generally prioritize these duties in ways that resolve all conflict. The NSGC code sets out guidelines which the counselors strive to uphold. Recognizing that it may not always be possible to adhere equally to each of these, the counselor, guided by the spirit of the ethical code, applies the overall principles of caring responsibility to pragmatic decisions (Benkendorf, 1994, personal communication). Every effort should be made to respect the privacy of the potentially suicidal client while also reducing danger. One means of achieving both would be to have the client participate as fully as possible in whatever decisions are made about management of the suicidal risk. This approach would be consistent with Section II of the NSGC Code of Ethics. Practically speaking, it is better to have the client's permission to involve others in her or his care. Other professional groups including social workers, marriage and family therapists, psychiatrists, and psychologists have explicit clauses within their professional codes of ethics (Schutz, 1990, pp. 108, 111, 113, 130, 152) recognizing limitations on the duty to hold client information private and confidential when there is a threat of suicide. The following passage from the code of the American Association for Marriage and Family Therapy (AAMFT) is typical of expectations: "Information is not communicated to others without consent of the client unless there is clear and immediate danger to an individual or to society, and then only to the appropriate family members, professional workers, or public authorities" (Schutz, 1990, p. 113). In settings where such limitations exist, this should be made clear to clients before the counseling process even begins, as part of the informed consent process, or establishing a "therapeutic contract" at the outset.

SUMMARY

The above case report illustrates a successful blending of genetic counseling and psychotherapy in helping a client distraught about prenatal diagnosis avoid acting on suicidal ideations. Several guiding principles may be helpful to keep in mind when assessing, treating, and referring potentially suicidal clients:

1. Suicide prevention depends on a willingness and ability on the part of the counselor to read suicidal hints correctly, to inquire

forthrightly, and intervene actively on behalf of clients who may temporarily need your help.

2. Do not leave a suicidal person alone if you think there is immediate danger.
3. Encourage the client to talk, and then listen empathetically. *Do not* try to cheer up the client. Cheerful platitudes convey that you don't understand what they are experiencing.
4. On the other hand, even persons with a strong wish to kill themselves may be ambivalent. Suicide counseling involves a balance between hearing the pain and helping the client recognize, honor, and align with the wish to live.
5. It is common for there to be some warning hints of suicidal activity. Take every complaint as a serious attempt to communicate emotional distress.
6. Tangible and intangible supports are important.
7. Seek professional consultation from a crisis hotline, colleague, psychiatrist, or psychotherapist who can advise you of your responsibility and limits of confidentiality in your state when suicide risk is present.
8. Obtaining the client's permission to inform the referring physician and/or other professional supports can be a first step in building a therapeutic alliance among all concerned parties.
9. The painful aspects of life underlying the distress may not resolve with the passing of a suicidal crisis. Therefore, there need to be broader therapeutic goals such as ameliorating isolation, relieving physical and mental pain, and learning strategies for daily living and for coping with crises.
10. Document the entire interaction, including specific preventive actions taken, in the medical record. If such exceptions or limitations to confidentiality exist within the practice setting, it may be important to make these known to clients even before the genetic counseling process begins.

CONCLUSION

Is the above case a rarity among genetic counseling referrals? Is knowledge of suicide assessment and intervention extraneous to the everyday practice of most genetic counselors? These questions cannot be answered at this time because of the lack of systematically collected information on the prevalence of suicide issues in genetic counseling contexts. This information would be helpful for those setting curricula for ge-

netic training programs, standards for broad examinations for genetic counselors, and policy and procedure manuals for clinical units.

With the rapid pace of genetic technological developments, the expansion of genetic testing into primary care medicine, and with awareness of the profound effects that genetic information and testing can have on individuals and families, situations involving clients at risk for suicide may become more common. If genetic counselors encounter suicidal ideation in a significant, albeit modest, percentage of patients, it would be important to develop practice guidelines for identification, evaluation, intervention, and referral in the practice of genetic counseling.

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