

Working with Suicide: The Impact on the Person-Centred Counsellor

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Marijke T. Moerman

School of Education

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The University of Manchester

Marijke Moerman

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Working with Suicide: The Impact on the Person-Centred Counsellor

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ABSTRACT

What are the long and short term effects of working with suicidal clients on the person-centred counsellor?

As suicide remains a major public health issue with the latest figures for the UK of 5706, an increase from 5377 in 2007 (ONS, 2010), suicide prevention strategies remain high on the public health sector agenda. With this statement in mind, and financial resources and funding at a low, an increased demand on psychological therapies can be assumed. As a result, the impact on individual practitioners will most likely intensify, personally and professionally.

This research aims to explore the extent the impact may have, personally and professionally on the person-centred counsellor. The study was structured using semi-structured interviews with a purposeful sample of ten person-centred counsellors. A constant comparative method was applied to analyse transcribed data, from which four main categories emerged: *'Experiencing the Therapeutic Encounter'*, *'Experiencing the Self within the Therapeutic Encounter'*, *'Seeking Solace – finding understanding'* and *'Counsellor's Grounding through Knowledge'*, each subsumed by several lower order categories, from which a core category *'The Counsellor's Resilience'* emerged.

The findings propose that, although the participants in this study were at times deeply affected, both personally and professionally, by their clients' stories, they were able to reclaim their strength through seeking and finding support from supervisors, peers, holistic self-care and tacit knowledge, gained through personal experience and understanding. Formal training was identified as lacking in counselling training courses. The implications of the findings and recommendations are discussed.

DECLARATION

I hereby swear that this thesis is entirely my own work and that it has not previously been submitted in fulfilment of the requirements of any other degree or professional qualification.

Marijke Moerman

September 2011

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DEDICATION

I dedicate this thesis to my parents, Martje and Kars, in admiration of their resilience, inner strength, and dignity.

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Dawn, how can I thank you for the many hours of talking me through the self-doubt and the fear, encouraging me to take another step, and rejoicing in the small victories, in staying with me in this difficult and often painful process and provide emotional sustenance.

1 INTRODUCTION

1.1 Research Rationale

The phone rang at quarter to two in the afternoon. I picked it up, a ridiculous banana shaped thing, indicative of one the fashion 'must haves' of the eighties. The voice on the other side of the line was clear and seemed so close, although nearly five thousand miles away. It was a balmy, still and quiet afternoon. The wallpaper in the kitchen was blue with tiny white flowers. I remember it so well. The voice on the other end of the line was that of my brother and I least expected what I was to hear.

He told me that my childhood best friend, then a beautiful boy, had killed himself. He had ended his life in a violent manner. I remember feeling as if I was in a vacuum of not understanding, of light-headedness, of timelessness. I felt perplexed and wept for the loss of his life and for what could have been for him, I wept for his loneliness, torment and desperation that drove him to his death. I silently cried in the car picking up the children from school, it was my turn for the school run..... Many years later yet another friend felt life to be too difficult to continue and choose to end it. After a painful struggle of nearly thirty years she walked away from us into a river. Three weeks before the final attempt she appeared to look well, she was smiling and generally her mood seemed elevated. On reflection this may have been an indication that she had resigned herself to end her life. My reaction again was one of profound shock and disbelief. What had I missed, what had I not seen or heard? But also, thinking I had failed both friends, guilt. A feeling I later understood was misplaced as I would not have been able in either case to stop their desperate act, their hopelessness, despair, and loneliness, locked in body and mind for nobody to see.

'.. despite the very best intentions of those around me... I felt only more invisible, adding to my pain and my suicidality...'

Webb (2010, p39).

Both these episodes left me spending a considerable time soul searching in an effort to find answers and formed the initial motivational basis to embark on my studies. Through trying to get an insight and understanding of the suicidal mind by reading, discussing, debating with others and exploring my own beliefs and values I attempted to get to grips with my thoughts and beliefs about the impact of self-inflicted death. Kim Etherington (2003) speaks of being speechless, voiceless, and silenced through trauma experienced in childhood, but quoting Lowen (1967) that body and spirit are rarely silenced, even by trauma. This statement made me question myself whether I

had not 'heard' or 'seen' my friends, spotted the silence of their cries. I have known and still know friends, family and clients who do not want to 'bother others with my troubles' and people are notoriously good at putting up their 'masks', covering up, in the morning facing the day. However, as a Roman proverb explains:

'No one can wear a mask for too long'

Anonymous.

These periods in my life were exacerbated later by the death of my parents who, each in their own way, I firmly believe, determined the time to step out of their life. They both had suffered a great deal during their life time and on the surface overcame deep trauma. In the end their fight was their own, graceful and without interference from others. I feel a deep respect, understanding, and compassion for them both.

In my work as a person-centred counsellor in the mental health field I am confronted on nearly a daily basis with suicidal clients, who during their initial and on-going counselling sessions, speak of serious and/or multiple suicide attempts. Through these personal and professional experiences I have felt a growing passion to explore the motives or causes of those individuals who intend to end their life, to investigate a possible explanation and/or justification of their actions, and to look into the impact these intentions would have on their environment and in particular on the supporting person-centred counsellor. During my training and being a life-affirming person, I felt my dilemma in practice would arise when it was suggested that a suicidal person should be left with their decision. The suicidal person's decision was translated for me as it being the ultimate expression of the self-actualizing tendency, the suicidal client being empowered and taking back control. Therefore, I am interested in how the values and beliefs of the person-centred counsellor impact on how they experience the client's suicidal intent or worse, a completed self-inflicted death by their client. Being a facilitator of a group who have been bereaved by suicide has given me a perspective of the intense and often decades-long emotional trauma of those left behind. These encounters often leave me with deep emotions. I have witnessed clients' distress, their hopelessness and despair but also, equally important, I see counsellors express feelings of discomfort, fear, incompetence, incapability and anxiety and empathise but also recognize their distress from my own experience. I seek my support with regular supervision, and from therapy and peers.

Hence, both my personal and professional experiences left me with not only feelings of deep understanding for the individual's choice of life but also trying to find answers for this mystifying drive for self-inflicted death. Further, to satisfy my need to understand a

way to be more supportive of the emotional state of the individual and what they are trying to tell us. Therefore, I strongly believe in the importance of the power of the word of the client. The client alone is the expert of his feelings, only he knows where the ache lies. Giving the client the chance to have their voice heard in research has been pointed out by Wosket (1999) as being of therapeutic value, given 'it is carried out sensitively and ethically' (p106). A view shared by Etherington (2001), who further argues that the voice of the client is rarely heard in research, more often it is the counsellor's voice which is heard, thereby 'giving us only half the story' (p6). I would like to add to the views of both Etherington and Wosket my own observation that in giving the client her voice we need to listen not only to the trauma of the moment but listen to the client as a whole, to acknowledge the client as a human being with a history, to be able to place the client in the context of their environment. Who is this person who wanted to end her life? What is her favourite pastime, does she have any? What is her favourite colour, who is she, or who was she before the human drama of her actions, and its traumatic outcome was played out? David Webb (2010), the author of 'Thinking about Suicide', in which he lets us in into his own experience of being suicidal and reflects back to us what it was like to be caught in the abyss of suicidality, tells us that:

*'The healing of any personal crisis of the self always begins with telling your story' and
'To listen to someone else's story without judgement and resisting the urge to offer
advice is the first and perhaps most important gift you can give to honour [the client's]
story, to honour their pain and struggle, to honour **them**'*

Webb (2010, pp 42/57).

1.2 Research Process

These reflections, experiences, and feelings fuelled my passion and academic pursuit of understanding the world of the client by intending to include work with clients into my research and therefore designed my research project accordingly.

John McLeod (2001) describes 'the development of an understanding of how the world is constructed as the primary aim of qualitative research' (p3). This understanding, I believe, would be achieved by hearing both client and practitioner.

Unfortunately during the preliminary period of the research proposal and review panel presentation I was strongly advised not to include clients as participants in my research.

I had carefully considered the ethical implications of engaging clients in research, i.e. power imbalance, possible exploitation, re-visiting trauma and its possible consequences, but also the positive aspects to clients' participation in research.

More and more researchers (Gale, 1992; Rennie, 1994; Skinner, 1998 in Etherington 2001) comment on the therapeutic value for clients to participate in research or as an enhancement to their therapeutic experience (Wosket, 1999). I rather see it as a process which may prove to be a positive experience for the ex-client who has worked through their emotional distress and desire to give something back in the way of helping 'us', society, understand the trauma and feelings they have experienced and in doing so may feel good. For example in my own experience the ex-clients who had approached me (because they had heard, through others, that I was planning to undertake research on suicide) wanted to impart knowledge in order to help counsellors support others who may be having similar experiences to their own and in so doing felt that they gave something back to the community who had supported them. This, in my view, can only contribute to the individuals' sense of self-worth and well-being. As a practitioner, I have a duty of care to the client, to give them a voice and to ensure their rights of autonomy are supported. It could be argued that only the client can tell us what it is that is helpful and/or hindering in the therapeutic process. And this, I believe, can be achieved through involving clients in a research project. To deny clients the opportunity of being heard because of my own fear, or that of others, of getting it wrong could even be considered unethical because it completely disregards and ignores the individual's experiences and the principles of validity and fidelity. Without hearing the client we can only assume, perhaps even worse judge, their feelings, intentions, perceptions, experiences. My work as a counselling practitioner revolves around listening to clients and to hear them and I know from ten years' experience how powerful this is and can be, for them. During the course of writing this chapter my supervisor introduced me to the book written by David Webb (2010). In the preface of his book Webb (*ibid*) remarks:

*'There is a fundamental flaw at the core of contemporary thinking about suicide; which is the failure to understand suicidality **as it is lived** by those who experience it' (p5).*

Today's focus of suicidality appears to lie with the prevention of suicide, getting the suicide rates down but in the process ignoring or at best paying less attention to the plight of the suicidal individual. It is imperative to acknowledge and embrace the fact that suicide is an aspect of life, and be willing to discuss it in an open and honest manner. Webb encourages passionately the suicidal individual to come forward,

to speak and be heard but also acknowledges that this is a difficult option 'in the current climate of fear, ignorance and prejudice' (p5), an option, he observes, may well end in being sectioned. The first line in McLeod's seminal work on qualitative research in counselling and psychotherapy refers to this notion of collaboration and engagement of client and practitioner in the therapeutic process and research:

'Qualitative research has much to offer counsellors and psychotherapists, in terms of generating new understandings of the complexities of the therapeutic process, and in enabling the experience of different participants in therapy, particularly clients, to be heard'.

McLeod (2001).

Therefore, to include clients' accounts of their traumatic experiences in my research study I feel would have served two purposes. It would have provided learning for practitioners through the clients' accounts of their experiences in therapy, and having been involved in the research process may have provided meaningful new insights for the client. This position was pointed out by Etherington (2001). It would further clarify the impact traumatic client experiences have on practitioners.

However, it is hoped that through the accounts of the practitioners in this study the client will be heard.

In preparation of my thesis I embarked on a piece of research investigating the person-centred counsellor's understanding and experience around the concept of suicide risk assessment, an area which has proved to be lacking in research. Interviews with counsellors revealed that the physical and psychological impact of the process of risk assessment was significant and raised questions concerning the counsellors' wellbeing, in a personal as well as a professional manner. The importance of support through supervision, from peers, line managers, even family and friends, when faced with suicidal ideation was deemed to be invaluable, suggesting the overwhelming and distressing experience attached to suicidal ideation when expressed by a client was often too much to bear, personally and professionally for the counsellor.

The impact of hearing of my friend's suicide culminated into my pursuit of obtaining an Honours Degree in Social Sciences (Psychology major), extending my academic career into a Masters in Counselling. My on-going compassion for the experiential world of the other was the motivational drive that resulted in my current research study. I am well aware that I may be trying to fulfil my need 'to be of help and support' and as long as this piece of work contributes in some way to alleviate concerns, doubts and perhaps trauma of others in their encounters with others, then my work will be done

and I will be content with that. I remain aware that I am fallible and that the truth is out there for each individual, differently experienced and interpreted. I know my truth within.

1.3 Thesis Construct

My experience, curiosity, passion and the outcome of the above pilot study on risk assessment were instrumental in defining the focus of my research. Consequently, my research concentrates on the narrative of the counsellor in relation to their therapeutic encounter with the suicidal client and aims to investigate the emotional impact on the person-centred counsellor and the shorter term and longer term consequences of listening to and working with the suicidal client on their practice and personal life. Therefore, the ensuing research question posed is:

'What are the long and short term effects of working with suicidal clients on the person-centred counsellor?'

As the concept of suicide is an extensive, mercurial and mystifying one, covering areas such as bereavement by suicide, assessing risk, suicide prevention and suicide intervention, theories on suicide/suicidal behaviour, risk factors, euthanasia and assisted suicide, I feel that in support of the study it is prudent to provide the reader with a synopsis to put the research in context. This outline is addressed in Appendix A. The Suicide Paradigm.

Chapter 2 Literature Review – The initial consideration is the first part of the Literature Review and focuses on my rationale for placing the literature review later in the thesis, which is placed after the Chapter 4 Findings.

Methodology forms the focus of Chapter 3 and places my methodological choice into the relevant methodological paradigm and concentrates in particular on the methodical hermeneutics theory of David Rennie in relation to my research. The ontological, epistemological and methodological questions will be discussed in relation to the work of Rennie and its connection with and suitability to the person-centred approach. The chapter will finish with a profile of the participants in this study, how I collected and processed the data, and how I thereafter analysed the data.

In Chapter 4 the findings of the research will be presented as a description of the main categories, illustrated with figures, and interspersed with the more poignant examples. Appendices B, C, D and E present the classification of the four Main Categories.

The literature review is the focus of Chapter 5. This review has been written to put the findings into context of relevant research and literature. I have explained the rationale for the review, the method of collecting 'data' for the review and its presentation.

Chapter 6: Discussion. In this chapter the findings are discussed in the light of the literature review, and keeping the findings in mind.

In Chapter 7 the concluding comments with recommendations for further research are assimilated.

And finally, Chapter 8: Reflexive Statement. In this short chapter I have given an account of my journey through this research project. It is a personal abridged description of my doubts and fears, but also one of hope and understanding. I felt it to be important to include in the thesis to underpin the difficult nature of the topic and the emotional journey it unleashed.

The thesis finishes with References and Appendices.

2 LITERATURE REVIEW: THE INITIAL CONSIDERATION

2.1 Introduction

As the reader of my work may have noticed from the table of contents I have presented the literature review in two parts. Although, increasingly acknowledged not to be so, traditionally, the literature review is presented before the research findings chapter, in particular when studies use a quantitative method and coming from a positivistic objectivist viewpoint. Two reasons are withholding me from following this path, the academic suggestion applied to my line of chosen methodology and my personal consideration, based on the former, and guided by my own beliefs.

2.2 The academic suggestion

The following is a short explanation of the reason for and the function of a literature review and the link to my study.

2.3 Why a literature review?

Usually, as mentioned, the literature review is carried out before conducting the research project in order to be well informed about the subject under investigation and to be able to prove the given hypothesis or null hypothesis.

The literature review is set up so that the researcher can compare their findings with the findings of other similar studies and discuss the comparisons and differences with these other studies. More importantly, they report on new insights and perhaps similar but different truths, being open to new understandings or as Mcleod (2001) professes 'the act of qualitative inquiry involves suspending and questioning the beliefs and 'pre-understandings' that one brings to the topic' (p17). 'Pre-understandings' and the individual beliefs we hold are constructed through our interaction with our environment and therefore culturally determined, influenced by previous knowledge within that cultural setting.

Sanders and Wilkins (2010) for instance identify several reasons for background reading to a research study. They point out that other research studies may give ideas on methodologies, or to use the findings in support of your own. One can learn from what other researchers gleaned from their findings, or to critically compare with. Although useful information why a literature review is a necessary part of a research

study Sanders and Wilkins omit to indicate that a review of relevant literature may also predetermine the researcher's thoughts and beliefs on the topic beforehand and as such have an influence on the outcome of a study. This is an important point as McLeod (2001) stated.

A literature review conducted before the actual analysis and findings of a study challenges this stance, as this activity can also be considered essential to good research because it tests the research ability of a research project according to Hart and he states:

- 'a narrowing of the topic through a literature review will make most research a practical consideration;
- it develops intellectual and rigorous thinking about the topic within the available time frame;
- vague searching later will be avoided by invested time and effort now'.

Hart, 1998. p13.

2.4 The function of a literature review

2.4.1 The interpretation of Creswell (2009)

A literature review will share with readers the findings of other research studies closely related to the study under investigation, and places the study within the larger literature framework of the topic. It further provides a benchmark for comparing the findings of other studies with those of the study undertaken.

Where the literature review is placed within the thesis depends on the method of research.

In qualitative research the focus of the study is exploratory meaning that not much has been written about the topic before and using the literature with the idea to learn from the participants.

In ethnography, a theoretically oriented qualitative study, the literature review is placed at the beginning of the study to give an idea in which direction the study needs to go.

Literature reviews in studies that aim to learn from the participants may be presented within the introduction to the study, in a chapter at the beginning of a thesis, or a chapter following the findings chapter in order to compare and contrast with these findings.

The latter is in contrast with the literature review in a quantitative study, but compares with former, where

the literature review is also placed at the beginning of a study for the same reason as in an ethnographical study.

However, reading and reviewing literature before actual research takes place may impede the researcher bias, i.e. pre-conceived ideas, judgments and beliefs may influence the researcher's interpretation of the data. (Frankel & Devers, 2000; McLeod, 2001). In other words we cannot 'un-know' what we know.

The contrast with the literature review in a qualitative study lies within the model in which the review is presented.

'an integrative model: summarizing of broad themes gleaned from relevant literature.

a theoretical model : focus is on related theory to the topic under investigation

a methodical model : focus of the review is on methodology'.

(Creswell, 2009).

2.4.2 Rowan and Huston (1997) – a medical version

In a review on the increasing incidence of qualitative methodology used in the reporting of research in medical literatureⁱ Rowan and Huston (1997) at the time stated that in 'the typical quantitative research article all pertinent literature is reviewed in the introduction to provide a context for the study' (p1443). They continue by affirming that qualitative research is mostly carried out 'to fill a gap in knowledge' (p1444) and observing that available literature may be limited. However, literature could be explored lightly in order not to influence the research question, in particular in 'grounded theory, case studies, and phenomenological research' (*ibid*). It may be more appropriate, they inform us, to address relevant literature later in the study to broaden the analysis and develop theory.

2.4.3 Randolph's purpose and Patton's addition

Randolph's (2009, p2) purposes for writing a literature review focus on a corroboration of existing data, to create a manuscript which can be disseminated and to identify text pertinent to the study and cites Gall, Borg and Gall (1996) for the scientific reasons in doing so, a few of which I have highlighted:

seeking new lines of inquiry

gaining methodological insights

identifying recommendations for further research

seeking support for grounded theory

Randolph (*ibid*) views a literature review as a pivotal part of the dissertation and asserts 'if the literature review is flawed, the remainder of the dissertation may also be viewed as flawed' (p1). He refers to several authors (Grante and Graue, 1999; LeCompte, Klinger, Campbell and Menck, 2003; Boot and Beile, 2005) who have commented on the often poor quality of literature reviews in dissertations and manuscripts for journals and wonders that there is little or none published information available. In his article he has given a clear and comprehensive account on writing a dissertation literature review, focussing not only on the purpose, but also addresses the taxonomy of a literature review and how to carry out a literature review and describes a method for conducting a phenomenological qualitative literature review drawing from the theory of Moustakas (1994) as a review technique.

2.4.3.1 The phenomenological method to a literature review

Randolph (2009) suggests the use of the phenomenological method to compose a qualitative literature review and follows the following steps:

Step 1: Bracketing. An explanation of which has been given at the end of this chapterⁱⁱ.

Step 2: Collecting data. Collecting data on the phenomenon under investigation by interviewing people who have experienced the phenomenon.

Step 3: Identifying meaningful statements. Highlight empirical claims about the phenomenon of interest and collect these in a spread sheet or qualitative software to make the data manageable. Thus, identifying meaning units, making memos, and collecting reductions of meaning units on index cards when, for instance, referring to Rennie's method.

Step 4: After identifying meaningful statements, give meanings to those statements, i.e. put meaningful statements into categories and then interpret and paraphrase them as groups. This activity resembles Rennie's method of descriptive reduction of meaning units into categories which will then be subsumed into main categories possibly resulting into the essence, the core of the meaning of all, *the* core category.

Step 5: Thick, rich description. This final step is to create a thick, rich description of the essence of the primary researcher's experience with the phenomenon. The goal is, as

referred to in step 4, to describe the essence of the phenomenon as seen through the eyes of the researcher who investigated the phenomenon.

Randolph, 2009. (p10/11).

Although overall an in-depth explanation by Randolph he omits an additional observation which has been put forward by Patton (2006).

2.4.3.2 Patton's view

The source of questions or ideas to be confirmed or disconfirmed, Patton (2006) writes, may be from stake holders or previous scholarly literature rather than the evaluators fieldwork'. 'An evaluation, he continues, may in part serve the purpose of confirming or disconfirming stakeholders' or scholars' hypothesis, these having been identified during early, conceptual evaluator-stakeholder design discussions or literature reviews' (*ibid*, p239). With his view Patton broadens the purpose of a literature review by heeding and including the assumptions of not only the theories of other academics and researchers' suppositions, but also the proposition and assumptions of stakeholders, who may be the funders for the project.

2.4.3.3 The link with Rennie

The present qualitative study uses Rennie's (2006) approach to Grounded Theory, methodical hermeneutics, in which the data is analysed making use of a constant comparative method. Therefore, it is imperative to stay with the methodology Rennie acknowledges which includes his view of the placement of a literature review within a research study.

Rennie (2006) explains that Grounded Theory as professed by Glaser and Strauss (1967) is 'developed in a bottom-up, inductive way, in which preconceptions about the topic of interest are put aside as much as possible, so that the resulting understanding or theory is closely tied to the data from which it derived, or *grounded*' (p61). The original Grounded Theory, Rennie (*ibid*) further suggests, asks that

'inquirers into a phenomenon should avoid reading about it prior to inquiry and analysis to minimize the imposition of prejudices' (p71).

However, Rennie (*ibid*) is well aware that each individual researcher will have predispositions which are so deeply ingrained, they may not be aware of them. These predispositions are the cultural values and beliefs we have grown up with and live and stand for. The awareness of these points of view towards the topic of the research project needs to be addressed and brought to the attention of the reader for them to

understand the researcher's understanding, a stance Rennie (*ibid*) finds 'goes to the heart of the epistemology entailed in the method' (p71). Even without having thoroughly reviewed relevant literature at the point of writing this chapter, I believe, that from my personal point of view subjectivity will be extremely difficult to put aside in analysis, although a sincere attempt can be made in the form of bracketingⁱⁱⁱ as is addressed and explained by several theorists in numerous seminal works, e.g. in Creswell (1998, 2009), Kvale and Brinkmann (2009), Charmaz (2006), Denzin & Lincoln (2005), Patton (2002), and McLeod (2001).

The academic suggestions on conducting a qualitative literature review I have touched upon briefly in this chapter not only link with the methodology of my study but also, I find, connect with my own thoughts on my study as a whole and the exploration of the experience of working with suicidal clients has on the counsellor in particular.

2.4.4 My personal consideration

John McLeod (2001) writes eloquently and clearly that:

'Qualitative inquiry generates uncertainty, ambiguity, a sense of unknowability of things, a loss of boundary between self and other. These experiences that cannot easily be contained within a set of standardised research procedures, or, to put it another way, should not be so contained. It is the willingness to enter fully into a process of inquiry, a willingness to draw upon (or risk one's integrity as a person) that gives the best qualitative research its 'edge'. (p10).

This statement voices my own ambivalence (and perhaps an exciting fear) when feeling the anticipation of entering into the unknown territory of each aspect of the research and finding my way through the initial quagmire of the different approaches of distinctive theorists. With his statement he has given me the opportunity to feel free in undertaking the different aspects of my study with a sense of individual input. A choice that I am allowed to address my research in a personal way as long as I am able to justify my choices, given that I stay within the realms of those who have attempted and succeeded similar studies in keeping with the relevant methodologies and their methods.

Being aware that Hart (1998) draws attention to trying to avoid vague searching later when time and effort is invested earlier on in the study and that a literature review carried out early on in the study will test the research ability of the project, I not only have chosen to place my literature review later into the study as 'prescribed' by my methodology, I do firmly believe it will support me in my attempt not to arrive at a

preconceived understanding of the data resulting in what I believe could be a 'blemished' outcome.

2.4.5 My concluding thought

The ultimate aim of my literature review is to produce a piece of academic work which is well reasoned and as genuine as possible. This is a thought that was inspired by Randolph (2009).

ⁱ Rowan and Huston (1997) observed that the use of qualitative research in medical journals occurred progressively more which they attributed to a recognition of the influence of unhealthy behaviour on disease. They reported that habits and behaviours more often than not match social and cultural environment. Therefore, qualitative research will provide us with a better understanding of the world the individual inhabits and why and how they do what they do in order to be able to change unhealthy habits and behaviour into healthy outlooks.

ⁱⁱ The goal in phenomenological philosophy is to arrive at the investigation of the essence of the phenomenon, termed by Husserl as 'free variation of fantasy', meaning varying a given phenomenon freely in its possible forms, and that which remains constant through the different variations will be the essence of the phenomenon. To arrive at this phenomenological reduction the researcher needs to suspend judgement of the existence or nonexistence of the content of an experience. This reduction can be seen as bracketing whereby the researcher attempts to put aside prejudgments and preconceptions about the phenomenon and not to be influenced by any pre-known scientific knowledge. (Adapted from Kvale and Brinkman, 2009, Box 2.1 Phenomenological Method, p27). Thus, bracketing in lay terms is to put aside any of your cultural values and beliefs in order to come to as true an account of the core of the experience of the other as is possible, i.e. to be nonjudgmental in its purest form.

3 METHODOLOGY

3.1 Introduction

This chapter starts with explaining my choice of methodology and in doing so giving a short overview of the methodology used in two earlier pilot studies carried out in support of my research. This overview is then followed by placing my methodological choice into the relevant methodological paradigm and focus in particular on the methodical hermeneutics theory of David Rennie in relation to my research. The ontological, epistemological, and methodological questions will be discussed in relation to the work of Rennie and its connection with and suitability to the person-centred approach. The chapter will finish with a profile of the participants in this study, how I collected the data and how the data analysis was carried out.

3.2 Methodological awakening

3.2.1 Thematic analysis versus embodied categorizing

‘As researchers, we have to devise for ourselves a research process that serves our purposes best, one that helps us more than any other to answer our research question’

Crotty, 2003. p216.

With Crotty’s thought in mind and his further musings that we can only learn from the theories presented, their strengths and weaknesses, to make an informed approach to choose a method of research which allows us to ultimately deliver a valid research project, I started my research journey with conducting two pilot studies the aim of which was twofold. I wanted to focus on topics related to my research project which would provide me with a basis from which to proceed with my research. Secondly, in order to determine which method would suit the data best I was intending to gather as well as my way of working I used Thematic Analysis (Braun & Clark, 2006; Boyatzis, 1998) in the first pilot study and in the second pilot study, the Rennie and Fergus (2006) method of embodied categorizing, or as they have also referred to with a slightly more popular and perhaps appealing term, ‘it rises from the gut’. Although thematic analysis ‘did the job’ I felt it lacked a clear epistemology, and analyzing according to procedure produced lacklustre themes. Thematic analysis is pluralistic in approach and described by Braun & Clark (2006) as a method which ‘can be applied across a range of theoretical approaches and methodologies’ (p78). They praise its flexibility, but I feel it

can become confusing and in danger of weakening a method that is not firmly based in a theoretical framework. Indeed, Braun & Clark remark that thematic analysis can be essentialist or realist, constructionist or contextualized, depending on the individual analyst and topic to be explored. However they warn the reader to be clear in which theoretical perspective they place their research and to make their method obvious. McLeod (2001) supports their warning in stressing the importance of explaining the method we have used to analyze our data. I felt slightly puzzled by this observation as an explanation of a method should be fundamental to analysis to give it substance, credibility and validity. Admittedly, now that I have progressed a little further on the research ladder I may not have appreciated the full scope of possibilities of thematic analysis at the time and only wanted to see its simplicity. Boyatzis' (1998) provides us with a definition of thematic analysis which lingers in the positivist paradigm. Thematic analysis, he explains, is a 'process which can be used with most, if not all, qualitative methods and that allows for qualitative information to be translated into quantitative data' (p4), however he recognizes 'latent' and 'manifest' themes within the data. The latent themes I would associate with the categories Rennie and Fergus (2006) speak of when applying embodied categorizing to the data. So, then why not stay with thematic analysis but turn instead to the method espoused by Rennie and Fergus (2006)?

The answer was initially quite one-dimensional: because the experience with embodied categorizing painted a livelier picture. The method allowed for creativity and asked for focused immersion in semantics, however does not lose sight of the structure of the text. The result was a more imaginative, I felt for readers accessible and understandable, but also exciting, core category. The method further appeals to my imagination, there is an innovative element to it; the discovery comes from an interaction of 'experiencing the text' and being able to 'translate' it visually through use of metaphoric language or use of images. I find that his method and explanation of the theory which it supports fits very snugly within the person-centred approach which I will address later in a separate paragraph. Rennie's method of embodied categorizing is an approach to which he refers to as methodical hermeneutics in action (Rennie and Fergus, 2006), within the Grounded Theory method (Glaser & Strauss, 1967). A method he describes as a link between methodology and epistemology.

3.2.2 Interpretative Phenomenological Analysis versus Embodied Categorizing.

Well immersed into my methodology of choice I was made aware of the suitability of Interpretative Phenomenological Analysis, IPA for short, to use as a fitting method of analysis for my study. Clearly, I did not choose this route. Nevertheless, I immersed

myself for a short period of time in the IPA method to determine whether or not I should change the whole concept of methodology I had slowly become familiar with and to give an informed account of why I wanted, but more importantly why I needed to stay with my original choice. A substantial reason, however is that I do believe a method of analysis has to be a fit with the particular analyst, how that analyst places herself in the world, how she understands, explains, interacts and experiences the world and its entities within it, a sentiment the importance of which has been recognized by for instance McLeod (2001), Polkinghorne (2005), Van Manen (1990) and Rennie and Fergus (2006). In other words how I make sense of it, and report back from it albeit in such a manner that it is understandable for my 'audience' and for them to, if not to reproduce it, come to and be accepting of a consensus of the findings.

IPA, like Rennie, busies itself with the interpretation of the experience of others and is defined more specifically by Smith, Flowers and Larkin (2009) as being 'concerned with the detailed examination of human lived experience', and in doing so 'expressing that experience in its own terms, rather than according to predefined category systems' (p32). Therefore, they apply an inductive rather than deductive system of analysis, taking the whole of the participant into account. Whereas Rennie's method of analysis is similar, I believe it differs in such that Rennie has added a further dimension in his explanation and therefore draws more from the meaning of the language used in relation to physical experiences when immersed in analysis. Rennie explains embodied categorizing in terms of the theories of Lakoff & Johnson (1999) and Gendlin (1991, 1992).

I recognize many similarities within IPA with the method of analysis professed by David Rennie, from the theoretical underpinnings to analyzing the data. Both, Rennie's Methodical Hermeneutics and IPA draw mainly from the philosophical stances of Husserl, Heidegger and Merleau-Ponty, of which a short overview of their main philosophical perspectives follows.

3.2.2.1 Husserl

To underpin their methodology, Smith et al. (2009), as well as Rennie refer to the work of Husserl, a philosophical phenomenologist and phenomenal philosopher, who lived around the turn of the 20th century. Husserl concentrated on the 'essence, eidos or idea' (Smith et al., *ibid*, p12) of things, in particular human lived experience. More importantly as Smith et al. (*ibid*) recognize, Husserl 'attempts to get at the content of conscious experience' (p14) and in doing so focus on 'the experience itself and describing it in terms of its particular and essential features' (p14). Thus, Husserl

attempts to get to the core of the personal, subjective experience of an object or subject and in doing so goes back to basics and concentrates and immerses himself into the particulars of the phenomenon under investigation of which the reflective mode is a particular important element (Smith et al., *ibid*), and an activity which is an essential part in the work of David Rennie. In hermeneutical terms, the experience of the other is interpreted. However, in the same breath Husserl mentions the importance of scientific objectivity (Bowie, 2003), which is to be considered alongside subjectivity. Both Bowie (2003) and Smith (*ibid*) give examples of the essence (eidos) of respectively the objects, tree and house. If a tree were to burn down it would not lose its meaning and we still can imagine what a tree would look like, however we would not be able to experience that tree in particular in how we would for instance perhaps marvel, smell or feel that tree. The essence of *things* is what matters to Husserl. Bowie (2003) provides us with another of Husserl's examples to explain this thought. A musical note is, to be a note at all, dependent on the notes around it to make it acoustic and fitting within acoustic ontology. When the notes become hindering to the world around it (noise pollution) it will belong to social ontology. Therefore, Husserl contends that the meaning of the essence of 'things' can be explained in practical and in emotional language, the difference, contends Bowie (2003), 'between 'being as experience' and 'being as thing', that is the evaluation of the object and the actual material object of the evaluation' (p190). A core category, as is hoped to be extracted from my study will be the Husserlian eidos of the analysis of my data, a goal both IPA and Rennie strive for in their work, and now I do.

Finally, it is important to acknowledge that Husserl uses the term 'bracketing', originally a mathematical term to indicate that we take something out of the equation to be able to concentrate on that part of the equation we need to focus on and revisit the bracketed part when needed (Smith et al., *ibid*). We need 'to bracket the taken-for-granted world in order to concentrate on our perception of that world' (p13), they explain.

3.2.2.2 Heidegger

Although acknowledging Husserl's stance, Heidegger contends that, in addition 'Dasein', the 'being', or rather being in, existing in the world and its interplay with that world, is to be taken into account. The individual always, according to Heidegger functions in relation to the world he inhabits, and Smith et al. (*ibid*) connecting to Heidegger's concept, refer to 'the phenomenological term inter-subjectivity' (p17). Heidegger looked at and drew from the work of Dilthey (1833-1911), who focused on

experience, subsequent expression and interpretation of the primary experience (Bowie, 2003), but forgetting that

'immediate inner experience is only accessible to others via the public medium of language' (p201),

whereas Heidegger argued, not only do we have 'fore-understanding' (Verstehen) (Smith et al., 2009, p25; Bowie, 2003, p200), but that language spoken by individuals is predetermined for them as that language already existed before them and therefore made communicating in and within that language meaningful. It is not the case that such a language is created by the person themselves (Bowie, 2003). This is a thought which I feel quite an affinity with as the semantic struggle I at times experience with relating my perceptions and experiences of my participants in a language and culture other than my own. No doubt some of the meaning of Heidegger's philosophy has gone lost in translation, either because the true, underlying meaning of his word was not captured or there just was not a suitable translation available. Bowie further focuses on one of Heidegger's key concepts 'what it is for things to be', which he says could be seen as 'a linguistic matter' (p202). Again, examples are used to clarify that nothing exists in a vacuum but is always part of something else, and Bowie puzzles whether we actually hold a hammer –'now I am holding a hammer'- when we hammer a nail in the wall (p208).

In explaining Heidegger's relationship with phenomenology and its connection with hermeneutics Smith et al. (*ibid*) conclude that he focuses on that which may be latent in the phenomenon under investigation but that it is also important to look at how it manifests itself on the surface, as that is undeniably interwoven with the latent part. This, therefore, is an interpretation of the thing itself or an interpretation of the interpretation of the object or subject. Thus, they point out, Heidegger's definition of phenomenology becomes hermeneutic, and in line with Rennie's perspective.

3.2.2.3 Merleau-Ponty

Language also played an important part in the philosophical ponderings of Merleau-Ponty (1908-1961):

The words and turns of phrase needed to bring my [meaningful] intention to expression recommend themselves to me...There is a 'linguagely' meaning of language which effects the mediation between my as yet unspeaking intention and words, and in such a way that my spoken words surprise me myself and teach me my thoughts'

Collinson and Plant, 2006, p248.

But I find even more important in relation to this study Merleau-Ponty's belief in moral potential. He believed that we 'fulfil our moral potential and therefore develop and express our moral autonomy, through our choices' (Collinson and Plant, 2006, p247), and that we observe, and take in more from that what is in front of and around us than what actually reveals itself. Therefore, I would argue, to make sense of the object in front of us, there is a need to interpret what we see, hear, or experience. Merleau-Ponty, like Heidegger, focuses on both our place in and relationship to, and our interpretation of that place in and relationship to the world, but concentrated on the 'embodied nature of that relationship to the world' (Smith et al. 2009, p18). They go on to explain that we will never be able to grasp the other's experience, as this will be an experience exclusive to the other, no matter how empathic we may be and quote the following from Merleau-Ponty:

'I perceive the other as a piece of behaviour, for example, I perceive the grief or the anger of the other in his conduct, in his face, or in his hands, without any recourse to any 'inner' experience of suffering or anger.....The grief and the anger of another have never quite the same significance for him as they have for me. For him these situations are lived through, for me they are displayed' (Merleau-Ponty, 1962. 414-415 in Smith et al. 2009, p19)

This notion of the impossibility to accurately grasp or understand the lived experience of the individual directs towards the hermeneutic thought in research, that we interpret the interpretation of the other's experience, as well as with the person-centred thought that the client (or other) is the expert of their own feelings, and fits therefore well with the objectives of my research.

3.2.2.4 Schleiermacher

I feel it is prudent to also briefly mention in this group Schleiermacher, a prominent German philosopher and hermeneutist (1768-1834) who before Heidegger already had recognized as Merleau-Ponty before him, the importance of language and Bowie (2003) quotes Schleiermacher:

'there are no thoughts without discourse' (p157).

Language is needed to be able to express and communicate one's experiences and interpretation of these experiences with others and to be able to verbalize the thoughts we have. On the down side, our predetermined understanding of our language can be obstructive and hindering, in particular when interpretation of text happens cross-culturally, even within a particular culture. As mentioned before, some of the innate meaning of the word and text can be lost in translation or perhaps there is no suitable

translation available. Not producing this work in my mother-tongue I experience this thought first hand.

Summarizing, this short overview, touching on the theories of Husserl, Heidegger, Merleau-Ponty and Schleiermacher, who all embrace the importance of language as a mode of expressive oral and written communication, have informed IPA and Methodical Hermeneutics. The essence of 'things' matters to Husserl, and Heidegger and Merleau-Ponty agreeing, add the importance of the individual being in relation to his environment. Building on, adapting to and at times being critical of each other's philosophical musings, they provide a philosophical underpinning of the methodological theories for research in general, and for the theories professed by Methodical Hermeneutics and IPA in particular. Both methods are concerned with the interpretative part of trying to understand the individual's experience of the world they inhabit.

3.3 The Grounded Theory background to Rennie's methodology

3.3.1 Glaser & Strauss and The Grounded Theory

The original Grounded Theory as professed by Glaser & Strauss (1967) has through the years been influenced by different viewpoints of several theorists and not in the least Glaser and Strauss themselves, putting forward their own explanation of the theory. From Glaser's strongly positivistic stance expressed in his analytical, strongly objectivist (Glaser, 1978, 1992) theoretical model with focus on, as in the original 'opus' of 1967 (Glaser & Strauss), discovery of new theories through 'analytic procedures and comparative measures' (Charmaz, 2005, p509), whereas Strauss and Corbin (1998), focused on meaning, action and process. This Charmaz (2005, p509) notes, is consistent with 'the intellectual roots in pragmatism and symbolic interactionism' Strauss acknowledged in his earlier work. Their explanation of grounded theory therefore, Charmaz continues, 'made verification, through new technical procedures, an explicit goal, bringing grounded theory closer to positivist ideals' (p509). Therefore, Charmaz (2005) claims, the works of both Glaser, and Strauss & Corbin are embedded within a positivistic epistemology. A notion, not entirely agreed to by Denzin & Lincoln (2005) who position Strauss and Corbin in the post-positivistic arena which emphasizes validity (verification) and the use of structured analysis procedures. Interestingly, Denzin & Lincoln mention in the same breath that computer assisted tools for analysis may be used. For myself as the researcher and analyst an interesting notion because after months long struggling with Nvivo, a software program to analyse research data, I felt it did not work for me. I am a visual person and decided to work 'manually' as I needed to see my work being laid out in front of me. The relief of this little insight was and is infinite.

On the surface and referring back to the original model of Grounded Theory the method applied appears deceptively easy to reproduce as it gives clear enough guidance to follow the procedures (McLeod, 2001). With the breakaway of Strauss & Corbin (1990) from the initial explanation of the methodology of Glaser & Strauss, the former produced a manual which, says McLeod (2001, p85), was 'strong on practical issues but with little reference to underlying methodological issues', but therefore possibly more popular with the budding researcher. For myself the clearest point McLeod makes in understanding each viewpoint is in pointing out the difference in approach between them in that he places Glaser in the phenomenological field and Strauss towards hermeneutics. Glaser stresses analysis for coding as applying

patience for ideas to emerge from the data whereas Strauss applies a practical approach and follows procedures (McLeod, 2001, p85).

3.3.2 Charmaz and The Grounded Theory

Charmaz, herself a proponent of the Grounded Theory, moved away from the original positivistic Grounded Theory model of Glaser & Strauss insofar that her focus shifted from the objectivistic tendencies of their Grounded Theory model to putting more emphasis on and championing the constructivist side of it. Charmaz further advocates the tradition of The Chicago School, i.e. 'narrated life history' studies (Denzin & Lincoln, 2005, p653) in ethnographic research. A tradition which looks at the meaning and process of the individual's experience and the environment he finds himself in, a social constructivist view. However, it is not clear to me from the writings of Charmaz that she goes as far as to incorporate her embodied experience of the data to be incorporated in her analysis. A feat, touched upon by West (2001), who speaks of his dis-ease when applying Grounded Theory to analyse his data.

3.3.3 West, Grounded Theory and Heuristics

He writes eloquently about missing the 'I-Thou' moments when you have 'no interconnections' with the world around you. West's (2001) dis-ease, he explains, has its origin in following the Grounded Theory method of organizing data in categories and sub-categories, which he found to be a 'textual' rather than a 'visual representation' of the data (p128). Although with this explanation he is building a case for promoting the use of heuristic inquiry I do feel that his approach of a visual categorization, ultimately still expressed in hierarchical form, is an application of the Grounded Theory which is a clear and easy to understand and reproduce approach for the layperson. However, in addition I would say also for a person like myself who, although being person-centred and therefore according to definition being 'open to what presents itself', I still need to see structure in what I work with otherwise I will lose myself in it and am afraid of the chaos which may follow and not being able to extract myself from it. Therefore, I am assured by the method of Rennie & Fergus which not only gives me freedom of deep and meaningful interpretation, but also much needed structure. In referring to heuristic inquiry West (*ibid*) puts the emphasis on a process of reflective and deep involvement of the researcher with her participants. A quality Moustakas (1990) describes simply as 'I am personally involved' (p11), meaning that all his senses take in and experience the phenomenon in order to arrive at a deeper, insightful understanding and knowledge.

3.3.4 Moustakas and heuristic inquiry

Moustakas attributes this understanding and knowledge through immersion and indwelling, the latter not so far removed from the notion of 'embodied', I find. Both concepts are referring to lived experiencing. (indwell: infuse, and embody: symbolize). A further important heuristic method Moustakas explains is that of 'intuition' (p111). Intuition springs to life when we get a feeling about an individual which is initially difficult to verbalize but which is arrived at through the person's actions, behaviours, body language and such, and perhaps knowledge we have gained through experiences in similar situations. Moustakas refers to 'intuition being hunches' (p112), a concept referred to by Rennie (2001, 2006) as a 'gut feeling', as mentioned earlier. The heuristic approaches of West and Moustakas, with the former providing a wink towards Grounded Theory and the latter's concepts of indwelling and immersion give a sense of connection with the method of embodied categorizing professed by Rennie and Fergus. This observation leads me finally to the work of David Rennie.

3.3.5 David Rennie and Methodical Hermeneutics

The rift between Glaser and Strauss through later deviations from their original grounded theory was the catalyst for Rennie to develop his own theory of methodical hermeneutics in grounded theory.

His new 'logic of justification' (Rennie, 1998, p101), methodical hermeneutics, is explained powerfully by him through critical consideration of both the stance of Strauss & Corbin, and Glaser. He concludes that the latter's approach is closest to the objectives of the method but is in need of the support of 'a better theory of inference than the one to which he subscribes' and consequently calls for 'the need for a new direction' (p110) within grounded theory methodology.

3.3.6 Rennie's new direction – methodical hermeneutics

Rennie's (1998, 2000, 2006) proposed strand, methodical hermeneutics, within the grounded theory is a method which I feel is the closest to my objective of studying the experience of the other and to be able to relate my experiences of these experiences as closely and true as possible, as well as allowing the participants' interpretation of their experiences to surface.

3.3.7 Relativism - realism

Rennie's reasoning of using embodied categorizing whilst applying grounded theory methodology appeals to me as it appears to validate my own worldview in general and the way I understand and approach my participants and analyzing of the ensuing data in particular. His argument regarding the acknowledgment of both realism and relativism within the methodology further agrees with my stance that within reality all is relative. Rennie (2001, 2006) strives for an accommodation between the two, while also emphasizing that this line of thought is evident in their original 1967 work, as is in both Glaser and Strauss', later independent of each other's revised and developed, work. He supports this statement by further commenting that their work encourages the analyst to be 'naïve about the phenomenon, to be descriptive at the onset of the analysis and later becoming more conceptual' (Rennie, 2006, p484). On the one hand, Rennie puzzles, one is asked to 'await discovery of the social phenomenon external to the researcher, but on the other hand being asked to formulate these phenomena creatively' (p484). Simultaneously, he provides his logic regarding realism and relativism within the method, explaining that researchers are persuaded that with the correct procedures social phenomena grounded in reality can be accessed but not to forget that 'returns from the grounding will vary depending on the interests of the particular analyst' (p484). Therefore, could it be then that realism is actually embedded within relativism; the one cannot exist without the other and complement each other?

3.3.8 Embodied interpretation - categorization

Rennie's line of reasoning has brought him to develop what he refers to as methodical hermeneutics. This entails the use of embodied categorizing which Rennie feels fits the link between the methodology and its epistemology. He makes an important point by recognizing that the actual experience of categorizing has not been taken into account in the original logical account of grounded theory, as equally having been overlooked in later versions. To explain his model of methodical hermeneutics, i.e. a methodical interpretation of an interpretation, an embodied interpretation, Rennie draws from the Lakoff and Johnson's (1999) account of 'experiential cognitive structuring of experience' and Gendlin's justification of the 'felt sense in the creating of meaning, an experiential phenomenological approach' (in Rennie, 2006, p487). In an earlier argument in which he contends that the grounded theory method is hermeneutical, he attempts to offer a case for reconciling realism and relativism which he claims is intrinsic in hermeneutics. Whereas Grounded Theory has a method and philosophical hermeneutics rejects the very idea (Gadamer, 1960)^{iv}, Rennie argues that the method

he proposes, as referred to above, actually presents us with an 'improvement to apply method to hermeneutics' (p482). The very fact of Rennie's explanation that we interpret our experience of the other's experience, which may be difficult or impossible to verbalize for the other, but can be assisted by the other to give it meaning for us, however, always influenced by the interpreter's own worldview, is testament to the fact that hermeneutics and method do go together, however possibly not under the term of philosophical hermeneutics, which refers back to higher orders or Deity, and therefore neither realist nor relative. Rennie following on from the above argument refers to Ricour (1981) who, he states, advocates the latent meaning of text to be interpreted to arrive at a more in depth understanding, an embodied understanding of the text. An activity referred to by Ricour (1981) as 'depth' hermeneutic or a 'hermeneutics of suspicion' (Rennie, 2000. p484).

3.3.9 A valuable tool

Although McLeod (2001) remarks that David Rennie with his approach may have taken grounded theory beyond the boundaries of its original explanation, he does acknowledge that Rennie may have given us an invaluable qualitative tool by pushing the grounded theory researcher within the realm of ontology, embracing a more philosophical informed approach rather than the matter of fact stance Grounded Theory proposes. In short his model enhances the pragmatic, no nonsense Grounded Theory process, making it more humanistic orientated.

3.3.10 Drawing from Lakoff & Johnson

How then does Rennie construct his method? Rennie suggests joining the notion of realism and relativism in his method of methodical hermeneutics and to that effect he draws, as mentioned earlier, from the theory of Lakoff & Johnson on the one hand and Gendlin on the other hand. The Lakoff & Johnson (1999) model of experiential cognition explains our experience of the world in cognitive schemata. Rennie (2006, p485) gives us the example of people 'experiencing their bodies as containers for their organs and various substances' and how we literally position ourselves and are positioned in our world, for instance next to, in front of, behind, above, below and in what manner, i.e. joined, separated, and such. The embedded experience in relation to 'container' is aimed at the body when saying 'a feeling in the pit of the stomach', 'being spineless' or a 'gut reaction' or Rennie's examples of referring to the mind when saying for instance 'he's empty headed' (p486). Furthermore, so Rennie explains, do Lakoff & Johnson refer to the fact that 'physical entities have entailments' (p485), which have

further entailments and so on. For instance, being distraught at not being allowed to incorporate client narratives into my research, lead for me to the container image schema and its entailment of: 'I felt crushed'.

3.3.11 Lakoff & Johnson' model

Lakoff & Johnson's model appears to explain our experiences of the world around us on how as an individual we are placed in that world, omitting the sensitivities of these experiences, how it feels to be in that world, how we absorb that world, how it impacts on our emotional world. To make sense of the world around us, to understand it, we categorize into, for all easy to understand and recognizable schemata, using for instance metaphoric language. This limitation to Lakoff & Johnson's model is caught by Rennie by introducing and drawing from Gendlin's description of embodied felt sense.

3.3.12 Gendlin and embodied felt sense.

Embodied felt sense I see as a feeling which hovers between the adrenaline wave or jolt of the 'aha' moment of instant understanding of the moment and the slowly spread of a warm glow of recognition in a space and time which is perhaps not immediately identifiable. My first explanation of the experience is a clear and perhaps momentous instance, whereas the second observation of my feelings is muddier than that, it is intangible, often fleeting. Gendlin's (2003) account of the felt sense is clarified within his theory on focusing. A process which goes through six movements, i.e. *clearing a space, felt sense of the problem, finding a handle, resonating handle and felt sense, asking and receiving*. (p52-61). Gendlin's movements remind me of the earlier I-Thou moments mentioned by West (2007), as these moments also suggest a deep interconnectivity with the other as.

3.4 The Person-centred Approach and Hermeneutics

3.4.1 The beginnings – Carl Rogers

The classic or purist person-centred approach, at times referred to as 'orthodox' (Rennie, 1998) or 'literal' (Shlien, 1996) and therefore perhaps even integrative within itself considering these different levels of interpretation, was first put forward by Carl Rogers (1951) as a non-directive client-centred approach. Rogers' professing that the client-centred approach flows and is mercurial, far removed from being stilted or inflexible:

“.. professional workers in this field are working with dynamic concepts which they are constantly revising in the light of continuing clinical experience and in the light of research findings. The picture is one of fluid changes in a general approach to human relationships, rather than a situation in which some relatively rigid technique is more or less mechanically applied.”

Rogers, 1998, p6.

This makes perfect sense as working with an individual is an action of ‘human exchange’ (Leenaars, 2004), which by its very nature is distinguished by its need for fluidity. Not one individual will act and react in the same manner as the other, and will further act and react differently to another individual exploring the same issue. The counsellor working according the client-centred approach therefore moves and adapts in her practice to fulfil the needs of the particular client, following the client’s lead in pursuit of a healthy and effective therapeutic alliance.

3.4.2 Rogers’ fundamental concepts

To explain the process of his approach Rogers (1998) developed a theory of therapy; and a ‘theory of personality to understand the basic personality structure which makes therapy possible’ (p7), which he felt was overdue and necessary as the approach was often subject to criticism because it proceeds from a no coherent ‘theory of personality’ (p15). In short, his theory focuses on the client’s frame of reference: the client’s experience (‘the client is the expert of his own feelings and understandings of his world’, ‘internal locus of evaluation, her frame of reference), the client’s choice (ultimately it is the client’s decision), the latter following from the self-actualizing process. In facilitating this process of change the counsellor works according to Rogers’ well-known three core conditions, empathic understanding, congruence and unconditional positive regard (being non-judgmental). Psychological contact (being with and engaging within the counsellor/client dyad), client incongruence (a split between self-concept and awareness leading to dissonance), and counsellor congruence (availability and willingness to support the client) are the lesser referred to but equally important conditions of the person-centred approach to effectively aid the therapeutic process. These fundamental Rogerian concepts are the basic focus for the person-centred approach David Rennie explains as an experiential person-centred approach.

3.4.3 A step away - David Rennie and the person-centred approach

Defining his experiential person-centred approach as working well within the concept of the client's frame of reference but with more of an emphasis on reflexivity, Rennie (1998) is stepping subtly, but significantly and excitingly away from Rogers' traditional approach. Excitingly, as explained before and handing research a new tool by transforming Grounded Theory into a more humanistic approach. Subtly, because although reflexivity is not mentioned specifically, Rogers (1998) does refer to it once, as far as I can determine in the importance of the counsellor who 'must ask himself continually: am I actually doing what I think I am doing? Am I operationally carrying out the purposes which I verbalize?' (p25). These questions were determined through recorded and transcribed interviews with clients in which it became clear that counsellors would state 'aims' during the therapeutic sessions. The clear conclusion being that although the first question is of a subjective notion, the following question is clearly of an objective nature and therefore perhaps hinting towards the counsellor being an 'expert' using a 'tool' to implement a technique. I dare say a positivistic explanation of working with clients that is meant to be non-directive and client-centred.

3.4.4 The matter of reflexivity

Rennie (1998) introduces the concept of directiveness by the counsellor when facilitating the client's processing of their experience. This view of directiveness within being non-directive I find fits in with my experiences and findings conducting the pilot studies and the current research for my thesis. Participants reported on more than one occasion that they felt they needed to be directive in their encounter with their suicidal client to convey to the client what they felt was happening, interpret and verbalize unspoken client communications or explain options. Although they reflected perhaps it had no place within the person-centred approach, it was an imperative stance in the moment. Rennie states that although through being directive it may appear quite technical however, is not, as the counsellor attempts to draw the client to his 'cognitive activity in which they appear to be engaged with' (p2) at the time.

Rennie's specific focusing on reflexivity I find at the same time significant and exciting, and suggests he attempts therewith to get to the essence of things, Husserl's eidos. Significant because Rennie stresses counsellor reflexivity and client reflexivity are processes on a par with each other, and places high value on the counsellor as a transparent individual within the counselling dyad as long as this does not take the focus away from the client. I understand this transparency to be emotionally visible, honest and understanding to and for the client. This observation links to what Mearns

(1998) refers to as mutuality in the counselling relationship which arises out of an emotively intimate therapeutic experience for both client and counsellor and which later Mearns and Thorne (2007) touch on as a continuing experience of relational depth which add significantly to the strengthening of the client/counsellor dyad. A 'working expression' amongst the person-centred counselling community is 'being present' in the therapeutic relationship, an expression recognized and acknowledged as Rogerian by Mearns (1998, p7) but evidently only being mentioned once by Rogers himself.

3.4.5 Stepping towards hermeneutics

In earlier work on the client's experience of psychotherapy Rennie (1992) defines reflexivity 'to encompass self-awareness and agency' (p225) and refers to not only the client's process but also that of the counsellor. Within this process of reflexivity I recognize in my own practice not only a need for interpretation of the clients' experience to be able to make sense of what is happening in the counselling session, but also to be able to interpret the clients' interpretation of their experiences, therefore being wholly with the client. Rogers (1951, 1998) refers to this state as 'to be of assistance of you I will put aside myself ...and enter into your world of perception as completely as I am able'. This interpretative process I recognize to be hermeneutical since hermeneutics is defined as the interpretation of the other's interpretation of their experiences. In using my own language -influenced by my culture, environment and certainly the fact that I am tri-lingual which has influenced my daily use of linguistic expression- to interpret my data I convey to others what I have found and how I have experienced my involvement within the interpretation of the topic of my study. I therefore am well aware that, however also strive for, the 'forming' of categories will depend on my own 'common sense constructs' as well as 'the language used by informants' as McLeod (2001, p75) explains the source of categorizing. Consequently, in applying this method of categorizing I will and have engaged in an interpretive, reflexive interaction with the data.

*'The goal of arriving at an interpretation of the phenomenon (a grounded theory)
reflects a fundamentally hermeneutic approach'*

McLeod, 2001, p75.

3.5 Method

3.5.1 Data gathering

Being mindful of the responsive interviewing model of Rubin & Rubin (2005) and Creswell's (1998) suggestion for purposeful sampling, person-centred counsellors with a minimum of five years' experience were approached on an accessibility basis. They were contacted directly through my personal network in health, primary care, and private practice with a view to get a sample size of ten, a number proposed by Dukes (1984) and Riemen (1986), cited in Creswell (1998, p122) as an adequate number to collate data to describe the meaning to the collective experience of the phenomenon. McLeod (2001) recommends a sample size between eight and twenty, as fewer than eight would 'result in a case study approach' and twenty and more participants would generate superfluous data, 'i.e. unnecessarily repetitive' (p72). The onus is on gathering data from in-depth interviews with participants who have been practicing for a longer period of time and may be able to contribute more as they may be more familiar with and have all 'experienced the phenomenon' under investigation (Creswell, 1998, p55/118). Rubin & Rubin's model involves 'finding people who have had particular experiences or are members of a specific group whose rules, traditions, and values are of interest' (p37). Selecting a sample should focus not so much on the number of participants or the amount of data gathered according to Polkinghorne (2005), but rather on the richness of information this group can give the researcher:

'...that the data that were collected are sufficiently rich to bring refinement and clarity to understanding an experience'... (p140),

and further draws from statements by Merriam (2002) that we can learn the most from such samples and Patton (1990) who contends equally that 'information-rich cases are conducive to our learning about issues and are central to the purpose of research' (p169).

My rationale for this approach to choosing participants purposefully lies within the sensitive nature of the topic. Although the consensus within the counselling paradigm is that people may find it easier to open up and confide in a stranger, through an earlier pilot study involving suicide risk assessment, participants reported in their feedback that they had felt at ease because they knew and trusted me and felt therefore willing and able to disclose at a deeper level. Mearns and McLeod (1984) cited in McLeod (2001) point out that 'richness and relevance of findings may depend more on the quality of the relationship between researcher and informant than it does on the rigor of

the analysis of the data' (p82). The disadvantage of this approach is that 'findings for self-selected samples cannot be generalized' (Kvale, 1996, p233). However, in support of the former statement Kvale (2009) indicates that an interview is not only 'context sensitive' but also 'dependent on the relationship between researcher and participant and their interaction' and therefore sees the research interviewer as 'the primary source for obtaining information'. (p170).

This observation supports my own experience of interviewing the participants for my study. All participants, who agreed to take part showed a genuine willingness to be involved and felt the research was of importance for the practice of counsellors. They were happy to be part of that process, to lift some of the veil of the 'taboo factor' of suicidal ideation. This may have predetermined their views at some levels, although some participants would comment after the interview finished that they had experienced at times a new awareness and had recalled previous experiences to inform their practice, but they also dared to say they had 'enjoyed' the interview. I was humbled by the experience of these interviews as most of the participants disclosed they had personal experience of attempted suicide and were in a position of relating their experiences on a deep and 'knowing' level; and all but one had experienced suicidal attempts and/or ideation within their personal life.

Indeed, bar one, all participants remarked that when needed I should not hesitate to come back to them and would gladly impart with more information on their experience of topic, interview transcript, or both. Therefore, each participant has been given an opportunity to engage in a further informal interview after the transcript was analyzed and any further questions, remarks or insights, expressed verbally or creatively, which may have surfaced and which enhanced their original interview have been included in the final analysis. McLeod (2001) recognises this as a form of data which has not been influenced directly by the researcher.

3.5.2 Participants

Of the ten counsellors who agreed to participate, two were male and eight female, a ratio of one in four. This sample represents the general notion of 'more females than males enter the profession' and the more scientific statistics of the BACP (March, 2010) which indicate one male for every four female members^v.

Of the interviewees five were contacted face to face, four by phone and three by email. Of the latter group only one responded. All participants were sought to glean as broad a range of experience from different areas within the counselling paradigm as possible in an attempt to collect data that would be rich and representative.

Additional to the sample of participants being purposeful, approached and chosen from my network of practitioners, a further rationale for the particular focus on person-centred counsellors as participants for this study is based on the possible tension between the person-centred counsellors' core ethos of their approach and their personal values and beliefs regarding suicidal ideation in their client. The client seen from a person-centred perspective as being their own agent, with an innate potential to reach that potential (Rogers' (1951) actualizing tendency), may therefore be seen as taking back control from their (distressing) life by showing and perhaps acting on suicidal intent. Therefore, as this particular perspective may present a difficult dilemma for practitioners working within the person-centred approach, the sample of participants was chosen with purpose.

At initial contact I explained to the prospective participants what the study entailed and its purpose. When they agreed to take part a date, time and place suitable for and indicated by the participant was agreed and they were given a formal Information Sheet (Appendix F), explaining the aim of the research and an Interview Consent Form (Appendix G). The interviews, lasting between 32.20 and 70.22 minutes (average 50 mins), were audio-recorded and thereafter transcribed. Each transcript was returned to the relevant participant for perusal to indicate words, sentences or passages they wanted to omit from the transcript with the request to specify this on the Audio-tape Consent Form (Appendix H) they were given with the transcript. After receiving the consent forms any remarks were processed according to the wishes of the participants.

Given the sensitive nature of the subject matter it was important to remember that the interviews are research interviews and not therapeutic interviews. A difference, which for both, research and therapeutic interview may result in an understanding and change, that is an 'intellectual understanding' in the former and a 'personal change' in the latter. (Kvale, 1996, p26).

Of the ten participants six were in paid employment and four were given their time as a volunteer (2) while in paid employment or retired (2). Of the six participants in paid employment, one was employed full-time, the remaining five part-time. See following Table 1 for the participants' profile.

Table 1. Participants' Profile

Partici pants	Gender	Age	Years of exper ience	Level of training	Practice setting	Ethnici ty	Religion
Anna	F	50	10	Diploma	College private practice	Scottish	None
Lea	F	52	8	Diploma	Voluntary sector	English	Christian
Janine	F	60	5	Diploma	Voluntary sector	Scottish	Christian
Vanda	F	48	6	Diploma	Voluntary sector	Scottish	Ecumenic al
Robert	M	74	30	Diploma Supervision Training	Private practice EAP	English	Previous Church of England
Mary	F	63	12	Diploma Supervision	Academic setting voluntary sector	Scottish	Spirituality
Julia	F	54	6	Diploma	Voluntary sector	Scottish	None
Ali	F	51	12	Diploma Supervision Training	Public Health sector	English	Evangelic al Christian
Patrick	M	48	28	Diploma Supervision Training	Academic setting private practice	English	Roman Catholic
Eva	F	45	8	Diploma Supervision	Mental health sector	Scottish	Roman Catholic

Participants' average age: 54.5 yrs; average years of experience: 12.5 yrs.

Note: Diploma: Qualified person-centred counsellor

Supervision: Qualified person-centred supervisor

Training: Qualified trainer

Of the ten participants three have had a serious suicide attempt; three have experienced suicide attempts within the family. I am well aware of the human drama that accompanies this statement and I would like to urge the reader to keep that into consideration at all times, no matter the viewpoint they may have.

3.5.3 Ethical Considerations

My research has been registered with the University Ethics Committee.

Ethical consideration in this study is focused on the protection of the participants' anonymity, as well as their emotional wellbeing and will be carried through into any potential published work as a result from this work. Further, ethical consideration is given to the data gathered for this study. (See Appendices F, G and H).

Appendix F, the participant research information sheet explained the interview process, the measures taken to ensure confidentiality, their right to withdraw at any time from the project, and the pathway to secure professional support in case this became necessary. Given the nature of what people would share but to stay vigilant to the role of the researcher, the latter was important to bear in mind at all times as a duty of care to the participant. Appendices G and H would give the participant the opportunity to raise further questions concerning the interviews and the ensuing process, as well as their right to withdraw any of the data text from the interview transcripts they deem unsuitable.

As an accredited member of the BACP I abide by their ethical framework for good practice in counselling and psychotherapy (BACP, 2002) and the ethical guidelines for researching counselling and psychotherapy (Bond, 2004).

3.5.4 Data analysis

Instead of having a team of researchers available, as well as an extended time frame, I was initially the sole analyst working within a time frame dictated by set deadlines. Although I found later additional input from participants a helpful aspect I was not able to fully reproduce Rennie's approach of engaging a team of fellow researchers to discuss and emerge in the data. It therefore was necessary to adapt the method to my available resources, but keeping as close to his method as possible.

3.5.5 Interview analysis

The interviews were analysed using Rennie and Fergus's (2001, 2006) model of embodied categorizing, a perspective which allows for an empathic relationship between researcher and text, the argument being that categorizing from the bottom up rather than top down to let the analyst's physical sense take the lead will be better, and thus endeavouring to depict a truer account of my interpretation of participants' interpretation of their experiences. This manner of analysing is based on Grounded Theory as developed by Strauss and Corbin (1998). A method that calls for immersion

in the data to sort, code, categorize and compare transcripts within and with each other. They suggest opening up the text to expose thoughts ideas and meanings within the text, which meant staying close to the initial text leaving little or no scope for subjective interpretation. Each line, segment or meaning unit of text, at times as long as a paragraph, were carefully considered, identified and coded descriptively and thereafter interpretatively. Throughout this process I kept memos on emerging ideas, possible connections, thoughts and further ponderings, an activity which was not necessarily limited to the times I was immersed in data analysis specifically, endeavouring to keep an open mind and focus on what the material offered to avoid subjectivity.

3.5.6 Analysis process

Before I started the analytic process of each transcript, it was read and listened to again in order to immerse and ground myself in the data text. Each transcript was analysed individually keeping in mind of what I know, and experienced the human being behind the participant to be. I see each individual as unique with their own distinctive set of circumstances, experiences, views of their world and their place in it and I therefore not only was interested in the final representation of all ten participants' interpretation of their experiences of the topic but I felt it essential to allow each participant their own voice and convey their meaning and understanding of the phenomenon individually.

The process of analysis provided its own set of distress for myself. Well into the analysis I experienced a four day 'meltdown' during which I was convinced I had it all wrong and needed to start again. Not wanting to use post it notes for fear of losing oversight, as I had experienced during previous assignments, I had devised a workable template on how to extract meaning units, identify categories from these meaning units and collate categories which I felt belonged together. This entailed use of the computer, even though I had decided before I did not want to use the Nvivo data analysis software. From the meaning units I would identify a category, store it on the window opened next to the meaning units document, and add appropriate further meaning units, or set up a new category, if need be. It was an equally laborious project as the 'post it' notes approach, however it felt more secure, as it was all stored in the computer and I could back up my data regularly. The moment arrived that I became lost in this process, and after a few sleepless nights, feelings of unbridled panic, re-reading the relevant articles on analysis, and starting again, this time using the conventional method of 'a round table with A4 pieces of paper and many post it notes'.

After having assigned well over a hundred meaning units I realized that from 'my method' the same categories emerged. 'Analytic rebirth' and deep satisfaction ensued.

When six to eight meaning units would form a group with a similar meaning I would define a preliminary category to them. At times however, having a good overview of the entire body of data through having been immersed in the data through reading and listening again to the transcripts a higher order category would 'pop' into my head. Their unexpected emergence was at times a scary and unsettling realization, as they came too early and I had to put them aside or check against the data whether they would fit and still fit when following 'my set path'. My intuitive responses to data text are quite strong and discussing this with my supervisor, Gendlin's (1978) 'felt sense' was referred to and that the notion of 'felt sense' is a theory but that there is not an instruction booklet that says how to do it. West during a personal discussion refers to the 'je ne sais quoi' of interpretive data analysis. West (2010) refers to this emergence of tacit knowledge, in his explanation of the Johari window applied to qualitative therapy research interviews. Tacit knowledge, West (*ibid*) states, appears at the least expected moments, for me that moment would be just before I drift off to sleep and am convinced I will remember my thought in the morning.

In short all transcripts were checked against each other for meaning units which might fit into newly found sub categories, subsumed into categories and related categories were integrated into a main categories resulted ultimately into a core category.

After each transcript was analysed and meaning units were established and provisional emerging categories were identified I presented these findings at the informal interview with the participant to discuss, reflect on and verify their credibility and appropriateness. Participants were further given the opportunity to read parts of the findings for further verification of their understanding of the findings. The feedback of their remarks is presented in Appendix K. McLeod (2001) refers to this action as a credibility check (p186) and points out that although this can be difficult and can create problems when participants disagree with what is presented on the other hand it will add value to the research.

3.5.7 The matter of the interview questions

It needs to be pointed out that I did not analyse the data keeping entirely to the questions (Appendix J1) I had formulated beforehand, and later revised (Appendix J2), in mind. The questions were meant to act as a 'soft' guideline to help participants re-focus as in my experience they are notoriously good at drifting off focus. I therefore aimed to get some structure in the interview so that the interview hour was not spent on

material I had not anticipated to hear. Although a contradiction in terms I did not want the analysis data to be structured in such that I would focus on analysing with a focus on the questions posed but put all the meaning units from each participant in consecutive order as and when the interviews took place and extract the meaning units from the transcribed interview and determine categories. I did not want a structure within this process as I was concerned I would miss the nuances throughout the text.

3.5.8 Validation: What do the theorists say?

In qualitative research, explains Patton (2002), 'the researcher is the instrument' (p14) validating the methods he uses. The credibility of the research therefore centres on the researcher's competence and thoroughness in conducting the research, taking into consideration the tribulations in their own life. This paragraph on validity is therefore meant to explain the credibility and trustworthiness of this study.

Stiles (1993), Elliott, Fisher, and Rennie (1999) and Morrow (2005) all recognize and comment on the importance of validity, credibility, and trustworthiness in qualitative research providing us with guidelines to follow. Elliott et al. (1999) suggest that their publishability guidelines should not be used in a rigid manner but are rather meant as an evolving set of guidelines for those involved in conducting, reviewing and examining research in general. The evolving guidelines Elliott et al. (*ibid*, p220) propose are worth noting and are assimilated in table 2 as follows:

Table 2: Evolving Guidelines

For Publication of Qualitative and Quantitative Research Studies in Psychology and related Fields

Guidelines shared by Qualitative and Quantitative Approaches	Guidelines especially pertinent to Qualitative Research
Explicit scientific context and purpose	Owning one's perspective
Appropriate methods	Situating the sample
Respect for participants	Grounding in examples
Specification of methods	Providing credibility checks
Appropriate discussion	Coherence
Clarity of presentation	Accomplishing general vs. specific research tasks
Contribution to knowledge	Resonating with readers

Morrow (2005), in enhancing the guidelines of Elliott et al. (*ibid*), provides further guidelines with the focus on Subjectivity and Reflectivity in Qualitative Research, Adequacy of Data, and Adequacy of Interpretation. I have given a short overview of Morrow's (*ibid*) contribution to the interpretation of validity in research.

3.5.9 Subjectivity and reflectivity in Qualitative Research

3.5.9.1 Adequacy of Data

Morrow (2005) proposes a sample size of 12 as ample, and not to fall victim to the feeling of having to please for instance review panels, journal review boards and relevant committees. More important is to be mindful of the correct interview procedures, such as, 'quality, length, and depth of interview data; and variety of evidence' (p255). Samples are purposeful (Rubin & Rubin, 2005; Creswell 1998) in qualitative research in order to glean rich data from a group of participants who are familiar and/or experiences with the topic under investigation.

Morrow (2005) further suggests using fewer rather than more questions. Well thought out questions may draw more in depth answers rather than for the participant to have to answer many questions and therefore not giving more profound answers.

3.5.9.2 Adequacy on Interpretation

Adequacy of interpretation is directly connected to and follows the adequacy of the data. Adequate interpretation and presentation is critical in the process of data analysis to arrive at a valid outcome. The researcher, Morrow (2005) states, continuously interacts during the analysing process with the data, checking, rereading transcripts and repeated listening to tapes.

With regard to my research Patton (2002) provides in particular the following thought for ascertaining validity within hermeneutic research. He reminds the reader that in hermeneutics the interpretation of data must remain only and always an interpretation. The meaning of a text, then, is negotiated among a community of interpreters, and to the extent that some agreement is reached without meaning at a particular time and place, that meaning can only be based on consensual community validation. Kvale (1996) refers to this interaction as a 'conversational circle' (p46), where our 'understanding of the human world depends on conversation and our understanding of conversation is based on our understanding of the human world'. In hermeneutical terms he refers to this as the 'hermeneutical circle' (p47) in which the understanding of data occurs through the meaning of the smaller parts of data text in relation to the text as a whole. Understanding of the smaller parts may influence meaning of the whole of the data set, which in turn will have an influence on the meaning of the separate parts, and so it continues.

3.6 Summary

The choice of methodology is explained by discussing Rennie's Methodical Hermeneutics in relation to Interpretative Phenomenological Analysis, Thematic Analysis and Grounded Theory. The influence of the philosophies of Husserl, Heidegger, Merleau-Ponty and Schleiermacher on these methodologies are addressed. In the paragraph 'method' the process of data gathering and issues of validity are attended to.

^{iv} Gadamer contends that method does not explain truth and argues that hermeneutics pursues the understanding of truth. Truth is not defined by scientific method or technique, but goes beyond the limits of methodological reasoning. The truth of spoken or written language may be revealed when we discover the conditions for understanding its meaning. (Gadamer, Truth and Method. From: <http://www.angelfire.com/md2/timewarp/gadamer.html>).

^v The BACP Membership Department issued the following latest figures as per 7 June 2010: Female Membership: 27,736 (83%); Male Membership: 5,598 (17%). Of the total figure for male and female 25% are accredited. The high number of non-accredited members is attributed to trainee membership.

4 FINDINGS

4.1 Introduction

Analysis of the data using the constant comparative method as explained by Rennie (1994; 1998; 2000; 2006), yielded 956 meaning units. The analysis procedure is discussed in Chapter 3 Methodology, from pt.3.5.4. data analysis, pp46-49. Four main categories emerged from these meaning units:

'Experiencing the Therapeutic Encounter'. 'Experiencing the Self within the Therapeutic Encounter'. 'Seeking Solace – finding understanding' and 'Grounding in Knowledge',

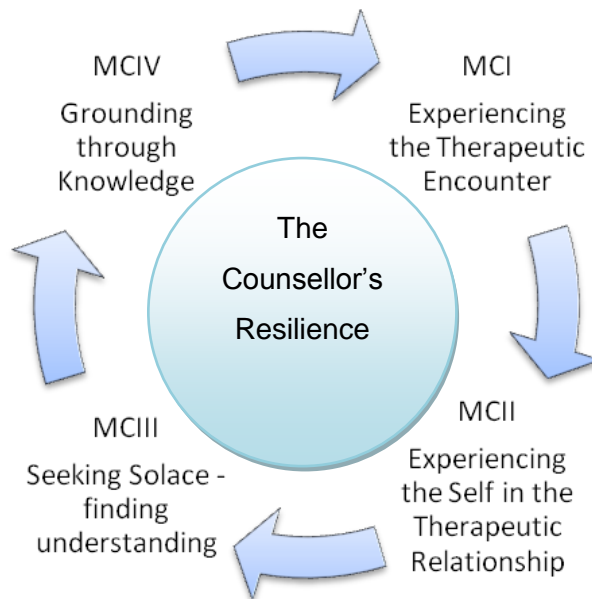
each subsumed by several lower order categories, and further sub categories as presented below. Through my interpretation of these main categories a core category emerged, the meaning of which embodies the overall experiences of the participants in their relating to working with their suicidal clients:

'The Counsellor's Resilience'

There appeared to be a clear circular movement in the four different stages of participants' experience of working with suicide, which started and ended with their experience of the therapeutic encounter, as figure A shows.

Figure A. The Counsellor's Resilience

The visual presentation of the Core Category 'The Counsellor's Resilience' enveloped by the four different stages of participants' experience of working with suicide.



The Core Category 'The Counsellor's Resilience' emerged from the collective of the four main categories through my interpretation of the participants' process through the four identified stages of experiences in the cycle of their work with the suicidal client.

The acknowledgement of their strengths and weaknesses, their seeking support through knowledge and engagement with others when 'the going gets tough', to find grounding for the next session and 'be with' the client again, had an unspoken feeling of resilience to it. I felt it appropriate to lift this understanding from the data and quantify it in a core meaning, depicting the participants' flexibility, spirit, stamina, and strength.

In their initial encounter with the suicidal client the participants' first thought was for their client, exploring the level of intent, acknowledging and meeting the client empathically in their distressed state. After the session with the client was finished is where the participants felt the impact of their deep engagement with the client surface. They would start looking around for support, initially from peers, line managers perhaps, phone their supervisor, and on coming home express their 'difficulties of the day' with a family member or friend. Inner resources were tapped into. Internal reference was made to their existing knowledge gained through their own personal experiences with suicidal thoughts and feelings, from which they drew the strength that hope was always an option, and they would offer it in their efforts to understand their client's emotional pain. By accessing, in the immediate aftermath of their therapeutic

encounter with the suicidal client, the former, and extending their knowledge longer term through additional training and reading material, participants found on-going strength and compassion to support their suicidal client.

As is evident from the main categories, the processes involved in these different stages are emotionally laden for the participants. Although they would 'regroup' their emotional involvement, they had to 'revisit' feelings of doubt in their professional skills, anger at their client's situation, or perhaps even behaviour, their own fear of what might happen, of feeling powerless. This cycle of emotional turbulence the participants found themselves in, was a continuous movement which was supported and controlled by the resources mentioned before and the participants' inner drive for holistic self-care.

Each main category, and their categories, is presented in a table indicating the codes that formed the category. Appendices B, C, D and E represent the classification of the main categories. The main categories are described, illustrated, and interspersed with the more poignant examples from the data. If applicable, interconnection between categories is indicated by the codes that refer back to the codes in the relevant table. For the 'visual reader' I have incorporated a figure depicting the related Main Category, her categories and sub categories, to aid the understanding of the written text.

It needs to be noted that in some of the categories, where it may be expected that all participants would be represented, not all are. For instance in Main Category III, Seeking Solace – finding understanding, the first category 'The supervisory backbone' eight of the ten participants are represented. This does not mean that the remaining two did not turn to supervisors or line managers, but rather that the topic was not brought up by the remaining two participants during the interview. This notion is to be applied to all categories.

Further, both the terms 'participant' and 'counsellor' have been used intermittently throughout the text where I thought either the one or the other would fit more appropriately in the text and add to its readability. The quotes have been presented, either embedded in the text, or as stand-alone for the same reason.

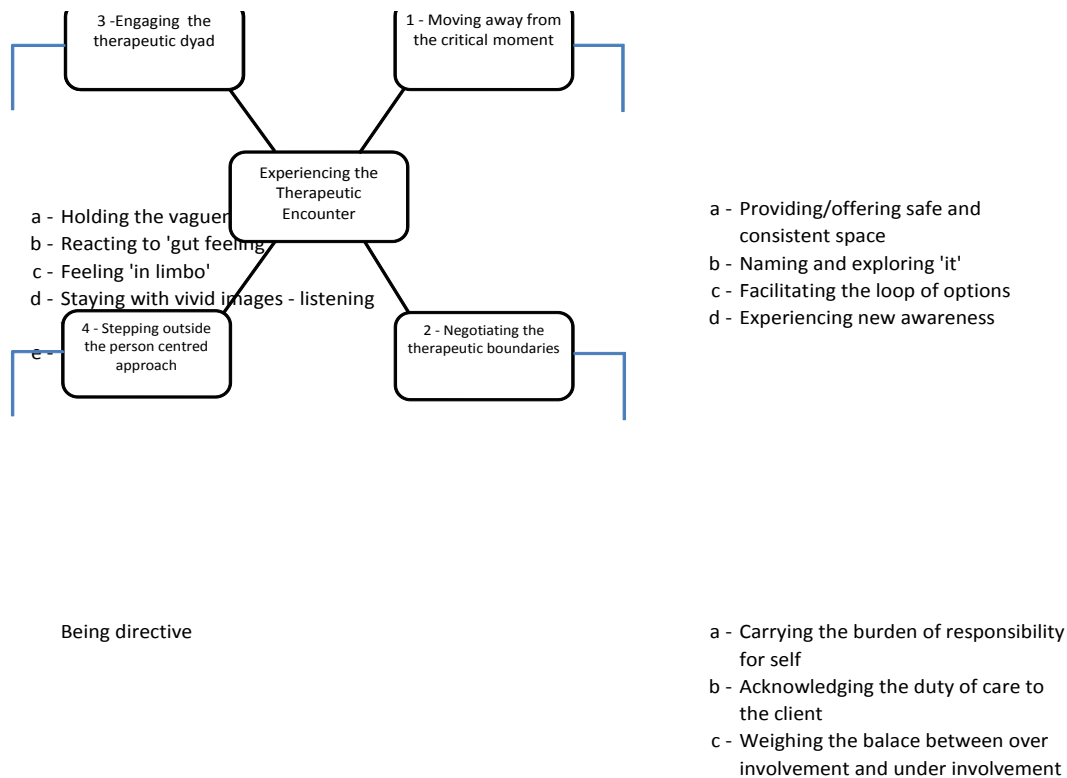
Finally, 'client' in this chapter has consistently been referred to by the third person feminine possessive adjective or pronoun for no other reason than consistency and simplicity.

4.2 Main Category I Experiencing the Therapeutic Encounter

'Experiencing the therapeutic encounter' is the first movement, the first occurrence in, what I have referred to as, the cycle of therapeutic movement for counsellors when relating their overall experience of working with suicidal clients. Within this initial encounter a myriad of silent activities were taking place in quick succession, at times concurrently, such as presented in the first two categories, 'a moving away from the critical moment' at the same time 'negotiating the therapeutic boundaries'. By the 'critical moment' is meant that moment the client presents herself in a state of deep distress and not being able to fully engage in a rational manner with her counsellor. Categories three and four, 'engaging in the therapeutic dyad' and 'stepping outside the person-centred approach' refer to the counsellors' overall engagement within the therapeutic encounter during that first realization of being confronted with a suicidal client. The participants' experience of interacting and connecting with their suicidal client will be addressed in Main Category II.

Main category I is subsumed by four categories as shown in figure 1 below. Each category will be clarified using examples of the data text specific to the particular category.

Figure 1: Experiencing the Therapeutic Encounter.



4.2.1 Category 1: Moving away from the critical moment

4.2.1.1 Providing/offeringsafe and consistent space

By providing and offering a safe, reliable, and harmonious place participants felt they were moving away from the critical moment at which the client introduced their suicidal intent. Their own experience gave them an insight into the clients' experience of their feelings: *'.....it was never as bad as I thought it was at the time...but it felt so bad...'* (Anna.18), and accepted that clients might feel like that because when *'...I hear people describing their lives and everything that brought them to that place...'* (Lea.29), *'....something has become intolerable.....'* (Janine.81).

They were able to diffuse the initial critical and crucial moment by keeping calm: *'...I....didn't react in a sort of panic way...'* (Anna.53). 'Being at ease' with themselves and able to understand the clients' contradictory emotions of sadness but also joy at feeling a release from their experiences, participants felt the clients became more 'comfortable' within themselves and starting to engage with their counsellor:

'.....although I am very conscious of feeling anxiety but I feel it possibly at a higher point.... I can be really open with her...' (Ali.27);

'...to me there will always be a sadness.....if it gets to a point that life is so bad....' (Lea.70).

Participants accepted clients' choices and their position, and felt at ease in that place: *'... I will stick with it...I will not leave....' (Vanda.87).* They further tried to adjust themselves to each facet of clients' overall demeanour, while observing changes in their clients. Personal characteristics, they concluded, play a decisive role in clients' choices.

By allowing people to be expressive in their feelings and in doing so participants facilitated the clients to make their own choices:

'.. I try to attune myself to any little detail at all that may lead....that they would want to do something...'(Vanda.4);

'.....freedom of choice is big on my agenda...' (Lea.66).

In conveying the feeling of hope to make sense of the blackness, the bleakness, and the emptiness: *'giving hope...building on the hope....' (Mary.28),* the participant felt the client would be able to recognize a possible different future as 'no one knows what the future holds', whereas another participant's hope was that in giving the client enough room they would *'.....develop their own answer....'(Vanda.38).*

Being open to the client's distress: *'..... I wanted to ...eh.....reach out to him.....I wanted to connect with him...to actually say I am here and I can hear you and it is OK whatever you want to say' (Mary.4)* and willing to try and understand 'the why' of the client's wish to end her life, participants were able to hear the sadness of the intolerable outlook of the client's view of the future. This stance of acceptance, and silently conveying to the client that they felt that *'.....it is not a sin.....' (Janine.32),* felt that it was made to be 'speakable': *'... I said.....you know.....it.....it's really quite a normal thing to have suicidal feelings.....' (Vanda.62).*

One participant felt that reflecting back what the client had been saying would give clarity and would be helpful for both to get a clearer understanding of what the client had meant: *'.....quite often when I am say...when I reflect back.. usually not suicide.....the client will come back and says....I am not thinking of doing myself in...I am not thinking of suicide...'(Ali.11).*

Talking about suicide and facilitating the client in '*...finding another ways of coping could feel like being in control for them....*' (Mary.38). This might show the client that actually there is another way bar suicide of taking control and, give her an empowering tool by providing a more grounded way of thinking which may ultimately lead to the client beginning to cope with her situation. The feeling they could be 'really open' with the client because of the relationship already in place had grown out of and was based on a mutual feeling of trust, transparency and honesty:

'...she [the client] knew I would be affected by this....and I could talk to her and say....you really understand this is not something that I can just let you go home with....knowing this...'(Ali.39).

4.2.1.2 Naming and exploring 'it

Participants felt that in asking '*... have you contemplated suicide...?*' (Janine.50) and exploring the meaning of suicide '*....we spoke around the issues that made [] come to that decision....why they wanted to do that....where there other options.....*' (Anna.8) they would alleviate the tension and were holding off a potential suicide. Although in this case the participant conveyed the client had felt there was no reason not to go through with it, and through negotiating an agreement: '*.....a contract if you want to call it.....*' (Anna.8), she felt they had delayed the client's decision, engaging the client in a dialogue to look at different options.

By trying to avoid circumventing the issue and showing 'openness' and clarity: '*...have you been harming yourself....*' (Ali.34/69), it was hoped that the client would feel comfortable enough to be able to mirror the counsellor's honesty and directness and that '*... they would make a more informed choice...*' (Vanda.39).

'..... I am trying to be very direct about it...I wouldn't avoid it...sort of address what is there and hopefully the client would feel comfortable enough...to be able to open up and speak to me...and become more comfortable about.... it if I am more open about it and direct.....and you know it is not a thing you can't talk about....' (Anna.53).

The openness was also helpful for the counsellor herself as one participant recalled. Talking about plans was quite helpful as it made them cautious and wary to the fact that '*...there is still that moment of thinking...*' (Ali.99) Questioning the motives and trying to find the reasons for the suicidal thoughts and feelings meant that for the client to express these was very important: '*....if you feel that bad to be suicidal then it has to be said....and talked about...*'(Lea.24), because '*...is it not true that most survivors say they wish they hadn't tried.....*' (Lea.71).

Some participants mentioned that they rarely introduced the word 'suicide', only when they had a sense of real despair they would *'...not shy away from it..... and be kind of naming it...'* (Patrick.10). They would rather avoid using the term 'suicide' in favour of asking questions about events leading up to a client's vague expressions of indicating suicidal thoughts and feelings:

'...you know...I would explore...to try and ascertain what was the meaning of this event... for them....' (Robert.86);

'...help that person to understand those feelings...' Lea.24.

In particular in an introductory talk with the client where confidentiality issues are discussed it was felt better not to mention suicide at that point but instead *'...talk about self-harm, harm to others...'* (Ali.6). however, if there was a suggestion that a client was indicating suicide was a possibility, then: *'....I would be very cautious...but I would use the term.....and become increasingly specific when I feel there is a strong possibility....'* (Ali.9/13).

By *'kind of naming it'*, Patrick further referred to carefully exploring clients' intent by using clients' own language and to go with that : *'.....usually the person has their own language....they may say something as obvious as I don't want to exist anymore...'*(Patrick.13), or they would be verbalizing what they were observing, the client's demeanour, a statement which might suggest the way they felt: *'.....are you feeling really bad....are things really bad for you....are they so bad that you are considering suicide.....'*(Anna.10). However, this participant felt it was important to know when to say and not be frightened to say *'...are you suicidal..?'* (Anna.78).

4.2.1.3 Facilitating the loop of options

By enabling the client to open up through exploring their issues, and for instance checking *'.....whether or not they got a plan...'* (Ali.118), and assisting them in their understanding of their feelings by giving them space to let their thought processes go the distance, participants hoped for clients to perhaps make a different choice or at least consider the consequences. In negotiating a contract, as discussed under the previous category, participants facilitated the clients' process to work through a loop of options and to find *'... a way back in...'* (Mary.21).

'...I asked him have you ... ehm thought about suicide and he said yes ...many times but he also said I know it wouldn't be difficult... and then he said but I know the consequences and I don't want [] to find me... so..' (Robert.51);

'..we spoke around the issues that made them come to that decision..' (Anna.8).

The strong need to provide options for the client, also with regard to safeguarding self, was expressed by one particular participant as follows: *'.....you're... you're just so desperate to hang on to anything at all that's going to provide a loop... so that there is another option there.. and to think that you've not contributed in anyway by not doing something....'* (Janine.48).

Breaking down and looking at broader support systems that the client may not see or perhaps *'...chooses not to see.....'* (Vanda.75) would provide accessibility to other resources to support the client. In being able to be with them and meeting the person in their distress, without being in denial or putting up their own shield, Vanda felt she was empowering the client to work through the anguished stages of *'.....do I want to or do I not and what the consequences are.....'* (Vanda.36).

4.2.1.4 Experiencing new awareness

There was a deep felt acknowledgement coming from an insight through personal experience. Vanda expressed it as 'having a knowing', having a deep felt understanding of what that felt like. It was the experience of a non-swimmer and nearly suffocating, of the struggle involved to catch your breath, and of the freeing and jubilant feeling to come up for air. In remembering how this 'return from the depths' felt for herself the participant felt a calmness descending during her encounter with the client because she felt herself the hope and strength she had experienced *'when I came back up again.'...and in a kind of spooky kind of way...I enjoyed my journey..'* (Vanda.83).

'A real piece of enlightenment' was experienced by Ali when she felt she could not take responsibility for the client because *'....I had no relationship....'* This feeling occurred as a strong indicator for her: *'.....I felt alarm bells going off in my head.....'* (Ali.71). It was the first time she had thought *'.....I don't need to go into this anymore...'* (Ali.73) and to involve others was valid. This experience was described by Ali as 'fascinating', as it pointed at the link between a trusting therapeutic relationship with a client and the confidence this would give the counsellor to act accordingly. This episode of enlightenment encouraged the participant in trusting her own feelings and insights as well as becoming more aware of not *'flipping into a medical model'* when someone shows suicidal intent but rather work alongside the person. She felt she would now *'.....pull in the help that I need when I feel it is appropriate to do so...'* (Ali.85).

Whereas one participant related thoughtfully, but nearly surprised: *'...it doesn't shock me...I am actually comfortable.....is the word.....'* (Anna.8), another participant spoke of

the challenging demands of the therapeutic encounter when they had experienced that 'a sense of control' was not there. Patrick had been confronted with a situation through a third party and because he felt he had not been directly involved, there was no direct relationship, no connection, he had felt *'....amazed at the anxiety it created.....and it was about a lack of sense of control...'* (Patrick.44). The latter suggesting the need for clear and workable boundaries in order to feel safe.

4.2.2 Category 2: Negotiating the therapeutic boundaries

4.2.2.1 Carrying the burden of responsibility for self

Even though responsibility is, at times, shared with other professionals as will be discussed in Main Category III, Seeking Solace, participants reported on their awareness of care and safety for themselves, and the weight it carried for them. Feeling vulnerable with respect to clients' potential actions would not only put the counsellor in a difficult position, but would also make her become guarded and cautious.

One participant in particular felt that responsibility and strength of the relationship appeared to be dependent on each other. Sometimes the responsibility of the welfare of a client could be shared with other professionals, but as the client was handed back to them, the responsibility seemed to weigh more heavily: *'....both GP and the psychiatric team.... have said that they are happy with her progress ...they altered her medication a bit under the understanding that she continues to see me....assuming we got clearly a good a good therapeutic relationship.....'* (Ali.61). Even though this was felt to be flattering, it emphasized the level of responsibility.

Knowing the impact a lack of relationship has on self with respect to the level of responsibility she felt for her client, Ali realized that the difference in her reaction to her client was caused by the non-existent relationship with her client that she experienced at that moment and not because she could not handle the situation. *'....I didn't think it was my responsibility.... ...there is no way that.....I knew that in terms of the session but I couldn't handle this.....that I thought that I had developed a relationship or as a counsellor I felt that I was engaging therapeutically with her...and that made a big difference on how I felt about it.....'* (Ali.81).

Appreciating the need for firm boundaries to keep oneself safe and avoid taking risks came at times from the realization that: *'.....I was answering the phone or replying to*

texts all over the place....at weekends....at evenings....it should have been much more rigid.....so that's probably the one thing I have changed....so far.....' (Anna.34).

The necessity of adhering strictly to the therapeutic boundaries was further highlighted by another participant who recognized the possibility of stepping into and becoming submerged into their clients feelings to the extent that they felt they were almost *'...taking on these feelings...of hopelessness and helplessness and.....almost colluding.....(Mary.13)*, struggling with being able to keep a therapeutic distance.

The notion of keeping oneself safe, contained, and competent was strong enough for some to keep themselves appropriately distanced from the crisis:

'....I learnt not to get caught up in what I call the drama of it.....and keep strict time boundaries.....' (Patrick.23).

At the same time, however Patrick acknowledged that the boundaries of confidentiality might have to be stretched to keep a client safe, but only if *'[I]thought it was appropriate to speak to a GP, psychiatrist or family member....that would be put in place.....' (Patrick.66).*

4.2.2.2 Acknowledging the duty of care to the client

The duty of care to self and the participants' knowledge of the duty of care to the client are lying embedded in a burden of responsibility. Depending on the stage of the relationship and the knowledge of the client's 'behaviour' the counsellor can be pre-occupied with thoughts of the welfare of the client and feel a need to check out what is happening. The uncertainty, anxiety, and heaviness this concern raises for the counsellor is expressed best in the following excerpt:

'.....I haven't heard from []....so....I check it...I wait till tomorrow, and tomorrow....still haven't heard....so a wee check again...and I think Ok right....that's unusual...two days.....maybe three days.. very unusual.....and I think I need to check it out and the reason I need to check it out is.....to see what has happened...because if they have taken their life.....and I haven't come across that yet....if they have taken their life.....I think.....I think I would take a big responsibility for it...I know I shouldn't but I think I would take a big responsibility for it.....' (Anna.19).

Being absorbed by the thoughts of what might happen the counsellor felt in this instance that it was appropriate to take action '*.....because normally the girl I am talking about usually texts me every second day or so...that's the contract...and she hadn't...*' (Anna.13). Afterwards, Anna stated, she had felt relief she had reacted, not only as a reprieve for herself but also to let the client experience that she cared for her well-being.

Ali stressed that by letting the client know that the counsellor really cared, some hope might be rekindled. She remembered vividly how after the graphic description of a near fatal suicide attempt by a client: '*.... I felt I had to make sure that I let her know thatthat I really understood.....that I also cared very much.....that she didn't just leave and go home and do it again.... .. and be more successful.....*' (Ali.43). This particular participant felt strongly that in giving appropriate and effective support to a suicidal client, involvement of the wider medical profession was imperative as a back-up for herself, '*.. she needed to be assessed by the psychiatric team...I needed that clout...*' (Ali.44).

In other instances, however, if feeling it to be appropriate and needed, participants would, by mutual agreement, discuss with clients their choices '*....I would say there are other choices for them...*' (Anna.16). The client would be given the opportunity to phone her GP and in doing so the counsellor would be helping that client in her process of becoming involved in taking responsibility for her actions. However, this might again leave the counsellor to wonder about boundaries: '*.....so it feels I am a little bit more directive at times...*' (Ali.65).

One participant was very clear in how she saw her role of responsibility towards her client by stating she did not feel responsible for people but felt responsible for her part in the therapeutic process: '*....it's the client who does the work and myself who is facilitating that process...*' (Lea.50). She commented on the restrictiveness of the time limit of the therapeutic sessions, of this dipping in and out of a client's life and their story: '*...I can't go home with that person on a Tuesday night.....*' (Lea.49), which, she felt, contributed to the levels of responsibility counsellors need to hold towards their clients.

Trying to find a healthy balance by keeping boundaries appeared to be the key to finding equilibrium between over and under involvement:

'.....I had.....a concern in myself that I would.....could be over involved.... but I also was aware of....could II did not want to be under involved.....' (Mary.10).

4.2.2.3 Weighing the balance between over-involvement and under-involvement

Finding the balance between feeling over-involved and being 'perhaps' under-involved was expressed by participants on different levels: *'.... I am not the kind of person who lies awake at night worrying about my clients.....absolutely not.....it is about that level of responsibility...we are in a relationship, we struck up a kind of a deal...and I will play my part (Lea.58).* As Lea felt that it was not healthy to be worried about her clients, the probability of becoming under-involved is present. In keeping a certain emotional distance she felt she kept herself within the boundaries relating to the therapeutic relationship. It was not because of an inability of being empathic, but rather because of keeping the responsibility within the confines of the therapeutic relationship.

Others appreciated that they had perhaps become too overly involved, although they did not necessarily explicitly say so: *'..... well my boundaries are rubbish I mean..... sometimes they are rubbish.....I don't mean rubbishI'd say usually my boundaries are elastic..... (Anna.34).* This was a situation which had evolved from the client's suicidal state of mind at the time and their wish to be in contact via text as the latter, provided a fast and immediate exchange. It has to be noted that the client in question was a young teenager, a client group who it can safely be assumed, depend heavily on their usual manner of communication, in this instance texting.

One participant's anxiety for the client's well-being resulted in feeling a need to reach out beyond the official boundaries of counselling by phoning the client and speaking through an intermediary to them. This situation had created conflicting feelings and thoughts for the participant which, although addressed in supervision, were still quite vivid in her memory judging from the hesitation with which she relayed the memory:

'.... O my goodness...ehm....here is me I am a counsellor and I am speaking to someone.....with him.....and actually said very little and....ehm..... I asked if he was OK...and also sent an email to this client.....' (Mary.11).

Julia, in order to avoid feelings of over-involvement, felt supported by her supervisor, who suggested to put on '*... your [counselling] coat when you come in and take it off when you leave..*' (Julia.8). The constant thinking of that least tolerable of things, suicide, took all of the participant's emotional energy to deal with whether the client might actually take an attempt too far or not: '*.....took up a lot of time.....not time as in hourly time time in my headspace...*' (Anna.29).

Once again, this shows that, despite recognized boundaries, it was not always easy for the participant to let go of her thoughts and feelings surrounding her work with the suicidal client and how time consuming the involvement could become, but gaining an awareness of boundaries as to '*.....ehm, well it's looking to get not as deeply involved or very aware of how deeply I am getting involved.....*' (Anna.32).

4.2.3 Category 3: Engaging in the therapeutic dyad

4.2.3.1 Holding the vagueness

Being unsure of their own interpretation of what was happening within the therapeutic encounter participants were trying to make sense of their own thoughts, searching for reasons, looking for answers that were not forthcoming:

'.. I think I can imagine...don't think it's just superficial...' (Lea.30);

'....I think it was at least a couple of times...' (Vanda.21).

This vagueness of the not knowing further invaded their ability to stay with the process at the time as it had a tendency at times to get in the way of being professional and objective. '*.. I have to be able to divide those two categories....I have to be professional, objective.....but I wouldn't be human if sometimes if I did not let my emotions impinge.....sometimes on that....*' (Lea.81).

While trying to find reasons, participants would equally reflect on the overwhelming complexity of the issue and question clients' motives '*....when you think about it...it's people talking about suicide....there's something in their life.....*' (Janine.81) and in trying to understand the why they created a feeling of dissonance for themselves as they started guessing what might be going on: '*.....possibly that's the way the client may perceive.....maybe there is the possibility...but that's not going to happen....*' (Janine.85).

Others were aware of having to stay with the vagueness of inferred references to possible death, but they felt it to be manageable.

'...but at the moment I feel I have managed to manage these situations as well as I could do....' (Ali.123).

4.2.3.2 Reacting to 'gut feeling'

When assessing how far clients have gone into the direction of wanting to kill themselves, and the signs are rather vague and not obvious to pinpoint, participants would at times react to their 'gut feeling': *'...I don't know.....I wonder....it just comes to me.....'* (Ali.110). Reflecting on their reactions during suicidal ideation disclosure, Ali further conveyed that, because no one had ever told her to make appointments with other professionals and had not received the benefit of appropriate training or information, she would use her common sense: *'...I just felt the GP needed to know...'*(Ali.119).

One participant reported to react as follows when she sensed that a client had suicidal thoughts: *'...mmm...it's then one of the first things I'll ask....'* (Anna.8). That instinctive feeling that something was not the way it should be while being with the client was expressed by another participant simply as *'.....you know.....I have a... knowing....'* (Vanda.85), referring to a feeling of knowledge borne from either her own earlier experiences, or from an intuitive feeling: *'....it was a conversation that made me feel that suicide, ending your life was awas a possibility.....'* (Vanda.40).

4.2.3.3 Feeling 'in limbo'

(being caught between the knowing and the not knowing)

Feeling caught between the 'knowing' and the 'not knowing' stems from the participants' doubts as to their ability to determine whether the way they carry out their client practice in relation to suicidal ideation is correct and effective or not:

'....no one has ever actually told me that. But I told my supervisor what I had done and they never said ...O that possibly sounds sensible or something.....no one told me....but that's is what I do .. in my work....' (Ali.120).

Another participant referred to the invisibility of the clients' feelings and thoughts and the effect it had on them, the darkness surrounding the suicidal ideation. This not knowing what was happening was expressed as a physical feeling: *'.....the heavy weight at the pit of my stomach...I recognize it as a black ball...'* (Julia.16). Being able to hold on to the reassurances of others even a considerable time after a completed suicide attempt *'.....they said she had triedat least a couple of times...'*(Vanda.21) did not take the doubt away and kept the participant wondering whether she had reacted appropriately at the time.

When she was confronted with a coherent and lucid client who the participant felt was telling the literal truth in indicating she was intending to kill herself, she had acted accordingly, by involving others. However *'....she did not kill herself as far as I know because I would have heard about it...leaving me with 'lots of unanswered questions.....' (Robert.62)*. The participant felt emotionally manipulated by having had to assume the worst and after having acted on instinct, she was left with not knowing the outcome or getting any explanation.

This uncertainty of having to live with the 'not knowing' and having to hold the 'not knowing' was felt to be *'.....part of the job...'(Mary.34)*. However, this vagueness of being kept in limbo would cause anxiety and concern as is evident from the following hesitant and faltering remark: *'...I don't know...you know.....if they have or haven't... ..but I don't know whether they have or notit is a bit of an anxiousness...concern.... ..actually.....because I was.....I hadn't heard anything....I did not hear...anything.....' (Anna.12)*, causing the participant to ruminate about what might or might not have happened, but not getting or finding any decisive answers. This feeling of doubt was further voiced by Julia, who reflected: *'...mmm.....if there are cases where I have got it wrong and I haven't known....but I have a sense there could be others where it made a big difference.....the way I followed them in counselling....'(Julia.39)*.

4.2.3.4 Staying with vivid images - listening to clients' narrative

In recalling their experiences most participants were relating some of their clients' narratives. At times these narratives were graphic in detail: *'....she told me that everything was in place.....she had a rope.....putting it around her neck...how that felt...'(Ali.37)*.

Clients might give an immediate indication about how they would end their life: *'....she was going out at the end of the session and stood at the door and said....I am going to go out and I am going to jump of the bridge into [] ...and kill myself.....' (Robert.55)*, or that they were considering to take their own life: *'....she had two attempts recently...and wakens up every morning...and eh.....just wants to....thinks of suicide every morning when she waking up....and how.....' (Anna.28)*.

Receiving a phone call from a suicidal person outlining their intent had left Julia with a vivid image of what was happening or might happen after the call was finished: *'.... that person ...was.....had already started and that the act would end up finalized after we cut off the phone.....that was my belief....'(Julia.4)*. Another participant, commenting on a client who had been a witness to a suicide and told the circumstances in detail,

stated: *'....the horrific nature of what she brought....yeah.....that enters my mind....that's still there...'(Janine.64).*

The often profoundly distressing nature of these narratives is best expressed by Patrick's recall of one of his client's anguish:

'.....he was threatening to kill himself.....eh.....and they wanted me to fix him...and when he came in he said....he said he was going to douse himself in petrol...and set himself on fire to punish and he would go back to [] and do this...and it felt incredible....'(Patrick.16).

Not only did participants listen to the client verbalizing their experiences in, at times, clearly extremely graphic detail but the vivid images they conjured up stayed with them for extended periods, occasionally never to be forgotten. This had an obvious effect on each of these participants, which has been addressed in Main Category II. Experiencing the Self within the Therapeutic Encounter.

4.2.3.5 'Being human'

Being able to be *'....as real as possible with clients....'* (Vanda.49) in showing compassion, transparency and honesty, but also 'angst', was felt to provide hope for the client. Simultaneously, however, it posed the question of how much you would give away of yourself in your quest of allowing yourself to be human. This 'consent to self' felt like freeing oneself so as to be able to be more relaxed with the client. Engaging in this dyad of humanity, but not having all the answers: *'... she said you don't know....and I said no....I don't know that...for sure.....but the chances are quite high....that that is what it will be (improvement of circumstances)...and it looks like it is going that way.....'* (Anna.77) provided another option for hope for the future.

Meeting the person on that level of humanity was as one participant expressed it *'....meeting someone in that place...it's a very very powerful experience for the person....to feel me there.....'* (Anna.21), with the hope it would give the client the belief of the possibility of change.

The encounter with the client was experienced as an engagement with someone, another human being and it was all about the emotional aspects of the relationship, about not being distanced from the other, or seeing the client as an object to be observed.

'.....it is all about nurturing and openness within that....' (Lea.18);

'.. not about seeing the client as an object....' (Robert.106).

The importance of the depth of the relationship was referred to by Janine as follows: *'.....the relationship with us is that kept her coming...'* (Janine.8). This participant indicated the importance of the therapeutic encounter, in all its intricacies, verbally and non-verbally. It is by being able that *'....to be able to give small parts of me....'* (Vanda.50) the client was shown empathy, honesty, and humanity with a hoped for possibility of finding their own informed choices towards an improved future.

4.2.4 Category 4. Stepping outside the person-centred approach: 'being directive'

Although the meaning units within this category were relatively low and the number of respondents was only three I felt it was important to highlight the particular fact that a few participants specifically touched on the reality of recognizing that they at times felt they needed to be explicitly 'directive' under certain circumstances. This need arose from their ethical frame of reference as the participant felt it would not potentially be right to leave the client the state they were in:

'... in the back of my head all I wanted to do was make somebody else aware in this..... in the agency.....that there was a something... that was potentially not right which would allow ...me to beso that when I was going I felt safe enough to leave her' (Janine.43).

When concerned the counsellor would not hesitate to involve others: *'... at one point I was a little bit more worried because they had not had an appointment with the GP in a few weeks...I got her to ring the GP during the session so it feels I am a little bit more directive at times...'* (Ali.65), supporting the previous participant who felt that in particular circumstances *'....something needed to be done....'* (Janine.42).

The sixth participant in this group *'....would ask specifically....'* and be *'.....actually quite directive....'* (Mary.6) when she felt that a client had a plan. Mary further, after a long pause, contemplated the potential negative reactions to reflecting back to the client and what the consequences of that might be: *'.....I think if I was only reflecting back to them what they were saying.....that I could actually be reinforcing feelings of hopelessness and helplessness...and sowhat I always want to do is.....let's talk suicide...let's actually speak about this...let's..... talk to me about it, say how you are feeling.....'*(Mary.7).

In opening up a dialogue with the client by suggesting: *'....let's explore it....let's look at it...let's see it', what's going on'*(26), Mary was engaging the client directly, involving her and was actually directly referring to the suicidal intent.

4.3 Main Category II

Experiencing the Self within the Therapeutic Encounter

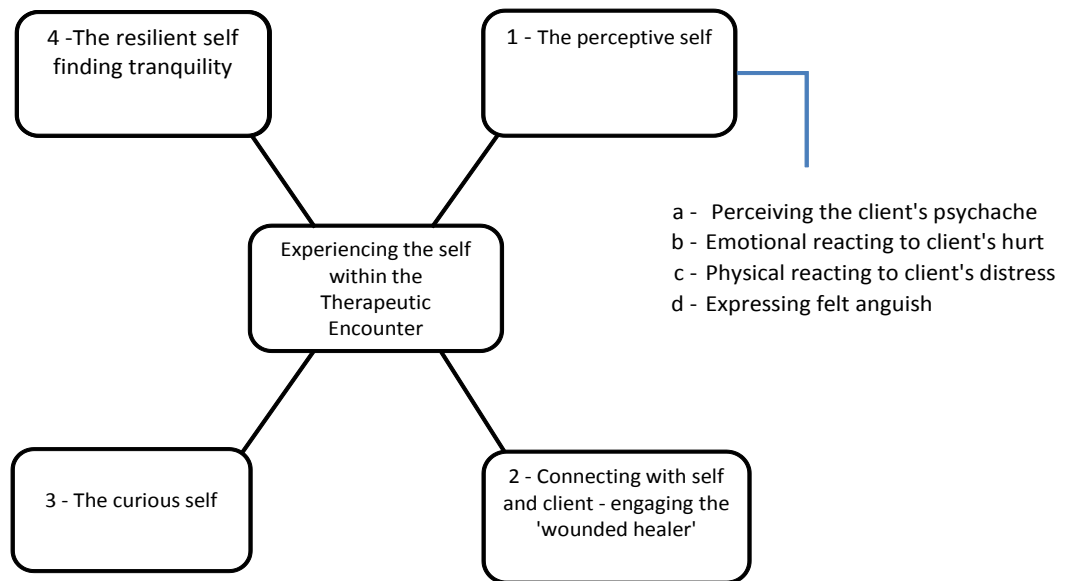
The second occurrence within the therapeutic encounter with the suicidal client, and closely following the experience of the encounter, focuses on the person-centred counsellor's experience of the self. Within this category four sub categories were identified: 'The perceptive self'; 'Connecting with the self and client – engaging the 'wounded healer'; 'The curious self' and 'The resilient self – finding tranquillity'.

The first category, 'The perceptive self', is subsumed by four sub categories which respectively focus on the perception of the client's psych-ache, the counsellor's emotional reacting to the hurt, the counsellor's physical reaction to the client's emotional distress, and the fourth sub category, the counsellor expressing her hurt. Sub categories 1a, 1b and 1d are further subsumed by smaller groupings, with the view to arrive at a, for the reader, clearer overview of the different dynamics gleaned from within this category.

Within the encounter with the suicidal client the participant sensed, observed, absorbed, and reacted to the distress they found the client to be in. In their attempt to be with, stay with, understand, acknowledge and hold the client they experienced overwhelmingly emotional reactions, such as guilt, feeling disorientated and deskilled, closely followed by physical manifestations, for instance exhaustion, feeling breathless and shaken up. Within this container of emotional turmoil the counsellor connected with the client engaging their own experience in having a deep, powerful and confident understanding of their suicidal client at all times being aware of their own personal and professional limitations. Category 2, 'Connecting with self and client – engaging the 'wounded healer'', centres around the aforementioned issues.

Category 3, 'The curious self', concentrates on the fascination of some participants with and their being intrigued by the concept suicide. Finally, as illustrated in category 4, the resilient self – finding tranquillity' counsellors would recoup and become stronger; they kept their fear at bay through dipping into and drawing from their previous personal and professional experiences. Recognizing a duty of care to self they would engage in relaxing and creative activities, for instance listening to music, massages, and writing poetry.

Figure 2: Experiencing the Self within the Therapeutic Encounter



4.3.1 Category 1: The perceptive self

4.3.1.1 Perceiving the client's psyche-ache

In the initial stages of being with their distressed client all participants appeared to follow a pattern of having a sense or getting a sense of the level of potential suicidal intent, closely followed by what they reported as their observation of their clients' inner turmoil expressed by demeanour, -down-cast eyes, posture, withdrawn. These activities resulted in absorbing and reacting to what they just had heard and witnessed. This initial stage of sensing, observing, absorbing, processing, and reacting moved in quick succession of each other and perhaps not always in the order as has been portrayed here. The wave of the client's psychological hurt could have a fluidity about it, but could equally present itself as a stunted movement, depending on where the client was in her process, and the counsellor adapted and 'flowed' with it to accommodate the client's process. Therefore, where for a few participants the stage of 'observing' may have preceded the stage of 'sensing', the phase of 'absorbing and reacting' I perceived to be following the first two stages. Because of the mercurial nature of the above activities and their tendency to flow into each other, over each

other, or even concurrently, I felt it appropriate to describe this movement as an integration of all the experienced components, just so that the reader is presented with a coherent whole rather than a stilted collection of illustrative text. Therefore the coding (e.g. Anna.82;1a1/3) and presentation in this category deviates slightly from the presentation in the other categories.

A.1-3: sensing, observing, absorbing, and reacting:

In a client's life struggle the participant, sensing what the client projected stated: *'....it's something within you.....that you feel what's going on...how they look ...what they say...what they don't say..everything about them.....'* (Anna.82;1a1), and in feeling their all-consuming pain and melancholy, related:

'...it's.....quite dire.....her predicament...dire....pffff.....great sadness...great sadness that a human being great sadness at..... what a tragic life...(Anna.31;1a1/3).

Observing the turmoil of the client and sensing her confusion and hurt, another participant pointing to their chest said: *'..there was something about the truth of what she was saying...there was something about here....[pointing at chest]....a feeling....'* (Robert.70;1a1/2). Mary observed and acknowledged the client being *'....stuck in a very lonely place.....'* (Mary.8;1a2), further appreciating the indignity the client felt: *'.....there was so much shame around...'* (Mary.11;1a1).

In making their assessment of the situation participants would react by questioning: *'...what was the meaning of the event for them and for counselling....'* (Robert.87;1a3), but they would also find that after a client left the room they experienced:

'....feel myself changing and thinking I would not feel a guilt there....because I think I did everything I could...in a difficult situation...ehm...and for that person I am aware that I have a feeling that that person that if they were going to do it nothing would have made a difference...' (Julia.38;1a3).

Listening to and staying with the accounts of the clients who relate, at times, their suicidal intent or attempt in very graphic detail: *'... how she felt and the noose...going tighter ...that made me wary....'* (Ali.100;1a3) conveyed a sense of the fear the client may have been in *'.....it was frightening for her...and frightening for me...'* (Ali.98;1a1/3).

Patrick spoke about the for him astonishing experience of one client's story: *'...and when he came in he said he was going to douse himself in petrol...and set himself on fire to punish []...it felt incredible...'* (Patrick.16;1a2/3).

The invisibility of pain Lea articulated as *'....it is painful for them trying to express how they feel...it feels sore and it feels harsh...'*(Lea.35;1a1). Her observation of the clients' struggle to express themselves in their grief emphasized that the clients' feeling of being trapped in their distress had resulted in an inability to verbalize their anguish:

'...because the building blocks of language are diminishing before them....' (Lea.33;1a2), and

'.....I can't really put it into words, he said....but looking at him I could see it was a bad place to be in....'(Lea.51.1a2),

The apparent strength of clients was repeatedly observed by Anna, who marvelled at the clients' resilience to pull themselves together immediately after they left the counselling session, walking away acting as if everything was fine: *'...I continually observe this now.. she had no way out..but she has the strength to go on and function even although she says every morning she thinks about suicide.....but it never fails to amaze me..'*(Anna.70;1a2).

4.3.1.2 Emotional reacting to client's hurt

The counsellors' instant reactions to what they saw, heard and took in during their sessions with their suicidal client was articulated by the participants through a range of different anxiety provoking feelings, that is from feeling trapped, manipulated, disconnected from self to feeling sadness, anger, sorrow and feeling deskilled, stunned, concerned, reportedly resulting in lack of concentration and insomnia. Within this group of emotionally laden responses however, a few positive effects were identified, such as a feeling of composure, stillness and a belief in hope. The latter were considered to be a powerful catalyst for the former, sustaining the counsellor in being able to stay with their client, even though the ratio of anxiety provoking feelings to positive effects was roughly 2 to 1. Following the philosophy of presentation in category 1a, the text has not been broken into the different smaller segments as posed in the tables, but presented as a harmonious and consistent whole for the reader.

b1-2: helpful experiencing and anxiety provoking responses:

Being stressed and tired and coming into the session no matter how distressing it would be had *'...a calming effect and would reduce my stress levels...'*(Patrick.92), which points at the relatively beneficial nature in certain instances of the therapeutic nature of their profession for some counsellors. Other participants would voice equally strong statements in staying and holding the client to the best of their abilities:

'....I feel I can empathize with people who are suicidal and I don't think...O God....what's going to happen now...'(Lea.23);

‘....as long as I can say it is the best I can honestly work with that client in that hour.....’ (Patrick.46);

‘.....no matter what it is.....I don’t think....I can’t cope with this or...I am not going to be able to get through with this..I feel I am emotionally with the person.....’(Lea.56).

Anxiety and frustration within the therapeutic relationship would not always occur because of the experienced distress of suicidal clients, but at times was a direct result of the counsellor trying to find support for suicidal clients struggling with suicidal thoughts and finding that the system fails them: *‘...what frustrates me isthat the system regularly fails to meet their needs....’(Patrick.27)* and *‘... because we treat it like an illness...’(Patrick.114)*, making him lament increasingly quietly, followed by a moment of thoughtful contemplation: *‘...I feel anxious now.....I don’t trust my associations to be mature enough to represent me....and to represent a mature view of what is required of clients who are suicidal.....’(Patrick.37).*

The notion of ‘not knowing’ clients’ intentions and following actions left most participants feeling deskilled at times, resulting into fears of failing to provide adequate and effective support:

‘....I don’t know what people do....’(Janine.77);

‘..... more or less I feel as though I would be swallowed up in their story and I felt inadequate...’(Janine.91);

‘..... part of the job is living with it.....it is actually not knowing....being able to hold ‘not knowing’....’(Mary.34);

‘....so I don’t know...it seems to work to a certain extent[contracting with client]...so far...’(Anna.9).

At times participants would feel starting to be disconnected from their practice after suicidal ideation had been presented *‘..it would have an effect on subsequent client...because my attention was split...very hard to stay focussed on someone with more mundane issues....’(Robert.95)*, or indeed from self: *‘.....a lack of concentration because [things] are always playing around in your mind.....’(Lea.81).* Such situations might lead to withdrawal from practising as Anna reported happened after an intensely difficult, all-consuming period with a chronically suicidal client: *‘....it must have been the summer...eh....where I had no contact with anything or anybody so it was a total disconnect....’(Anna.63).*

The potentially all-consuming nature of their work gave participants cause for contemplation as Janine reflected *‘..I more or less I feel as though I would be*

swallowed up in their in their story and not being able to sit with them.....'(Janine.91). Lea considered the possibility of becoming increasingly emotionally involved rather than professionally engaged, harbouring a latent fear of being 'sucked in':

'....I think sometimes you need to take time to sometimes stand back from the situation and to digest what is going on and to reflect on what is going on and observe on what's going on because it can be the case where I have become...emotionally involved where I have to.....be professionally involved...where I have to be objective....'(Lea.79).

At times the participant would feel 'held to ransom' emotionally : *'...she knew I was upset.....she knew I would be affected by this....'(Ali.39)*, they would feel drained, weary and being very conscious of their rising anxiety levels, but feeling an *'.... intense relational working at that point.....'(Ali.31)*. For others it meant a time of high anxiety through being held by the thought of not knowing what would happen if: *'.....the thing for me is....what if it is at a time when I have decided I am not answering my phone...(Anna.50).*

'.....what if.....we may never know....what if.....'(Julia.36).

The tragic, ultimate choice of some clients was mostly expressed by the participants in feelings of sadness : *'...I would be deeply saddened....probably shed some tears'(Anna.65)*, or *'.....sorrow.....what a waste.....'(Robert.10)*. However, there could also be an element of 'anger' present, depending on the circumstances surrounding the suicide. *'...it was kind of anger against him...because of where he did it and how he did it....it seemed a particularly awful way of doing it.....'(Robert.14)*. For Mary, also working with the bereaved by suicide, anger was channelled into a positive outcome: *'.....well, all I can say there is an energy....it's an energy to say....there is another way.....'(Mary.24).*

Even though participants would be going through these quite often harrowing experiences and feeling disorientated, they would take a step back by taking some time out and bring themselves back comforted through their faith; *'..just what I do....it helps me to be really still inside.....'(Eva.42).*

4.3.1.3 Physical reacting to client's distress

Although the emotional and physical reaction to the client's anguished state would quite often be simultaneous, such as reporting that the heart beat would go faster, or a

feeling of being on edge or indeed having 'butterflies in their stomach' through anxiety or shock, the physical manifestations of emotion would more often occur after the client had left, such as breathlessness, exhaustion and feeling shaken up.

Lea could imagine the 'stripped person': *'...so when I see that stripped bare person...that I keep mentioning...somehow it is impacting on me in a physical way...it can express itself then in anxiety...my heart is beating faster....'* (Lea.45).

Other participants likened the experience of sadness to a weight they were burdened with, the memory of it made one participant feel her heart thump:

'.....it's a heavy feeling...it's a sadness....' (Vanda.13);

'.....heavy weight of the black ball at the pit of my stomach....' (Julia.15);

'.....feeling breathless.....a few steps behind from where I am meant to be...I feel a bit shaky.....I actually feel physically shaken up.....' (Eva.33).

Anna reflected on a recent session during which a client had discussed their suicidal intent. Towards the end of the interview she pondered: *'..that was mild trauma what I felt..I was disorientated and in shock and a bit shaky...so I suppose I was mildly traumatized....'* (Anna.91). Another participant experienced the feeling of turmoil in his body and pointing at his chest declared *'.....there is something about here....a feeling.....pain.....'* (Robert.70).

These events would for most participants lead to feeling exhausted, not always because of the emotional experience attached to engaging with the suicidal client, but sometimes because of sheer relief that they had been reprieved of the sole responsibility for the client:

'.....also felt very tired, but a different sort of tiredness...because of the relief....I didn't think it was my responsibility.....' (Ali.80).

In acknowledging the strenuous demands, emotionally and physically of being with clients in general and clients in deep, unspeakable pain in particular, a participant with many years of experience declared: *'...I think it is quite physical demanding work...'* (Patrick.63) but would not give this work up for anything.

4.3.1.4 Expressing felt anguish

In expressing the anguish felt through the pain conveyed by their clients all participants, emphasizing the difficult nature of the topic, would quite frequently use non-verbal signs of emotion when a particularly challenging moment occurred.

Although category 1d has been presented in the table as four separate entities, that is non-verbally, verbally, using metaphoric language and imagining, it is clear that the correlation between these four categories is high, as a non-verbal emotion is mostly the immediate reaction to or result of an emotive thought or feeling, an example of which is an illustration used in the previous category illustration: *'...there was something about here....[pointing at chest]....a feeling....'(Robert.70)*. Verbal expressions relate to stronger than usual references to participants' experiences of their clients' anguished manner.

Using metaphoric language is a powerful tool to verbally express and underpin the importance of what it is that is meant, that is when the user has difficulties to verbalize the intensity of her feelings or beliefs adequately. Through imagining participants would be verbally painting a picture in their mind's eye to make sense of what the experience meant for them, again, often accompanied by non-verbal signs. Non-verbal signs can be still, such as smiling, slumping, looking pensive, or animated, such as gesturing, laughing, voice animated, and changing position. Examples from each of the participants will follow and possible links between non-verbal signs, verbal expressions, metaphoric language use, and imagining are identified.

Recalling a past episode involving a completed suicide and where there had been no indication whatsoever of the intentions involved, *'.....I left her at 1 o'clock that day and she had taken her life at quarter to three.....and it was quite clear ..I couldn't have done anything.....'*, Vanda, still showing the perplexity (non-verbal) in her face, continued that although it had been quite a long time ago it has *'....just been there on my tummy (verbal; non-verbal/pointing) ..it's a heavy feeling.....(metaphoric)'*(Vanda.13).

Obviously being left reeling (expressed in his tone of voice which became slow and pensive, non-verbal) after a spontaneous act of suicide by a young client Robert after a long pause, stated: *'.....no warning at all.....absolutely nothing....it seemed a spontaneous act on his part....of rage.....'*(Robert.29), stating much later in a recap of his revisited experiences *'.....yes....counselling is difficult.....(staring)....'* (verbal/non-verbal) (Robert.95), becoming pensive once more.

To put increased emphasis on a particular event which occurred when clients explained in graphic detail how they had started a serious suicide attempt, the participant recalled in a quiet, but strong voice (non-verbal) *'...it was a day that went over the mark..... (metaphoric use of language)'*(Ali.52). Just a week following this episode and drawing from that experience Ali was faced with a different client indicating suicidal intent. In an animated voice (change in voice, non-verbal) she parted

with : *'....I just felt alarm bells going off in my head....' (metaphoric use of language)'(Ali.71).*

In describing the sadness of a client's life Anna felt:

'.....I feel I've been hit by a bus.....temporarily...stunned like a rabbit in the headlights....when it is particularly tragic....and that...(sigh, sigh)...captures how I am feeling.....(metaphoric, non-verbal).....'(Anna.32), slumping backwards (non-verbal) in her chair. As did Lea who slouched and sat back (non-verbal) into her seat while reflecting that *'...you engage in the therapeutic process...to enable the person to shift and move to a different place.....yeah....'(Lea.72),* her voice lowering in pitch and growing slower expressing a heaviness, as if she had to carry out physical exertion (verbal/non-verbal).

The picture of a client who cannot cope and never will, and might take her life through fear was for Patrick a harrowing experience which he expressed as follows:*'...their only escape is to take their life....now that picture stirs up so much distress in me.....' (imagining) (Patrick.107),* speaking slowly and quietly (non-verbal).

Thinking back of suicidal clients past, Lea had quite graphic images in her mind and used imagery, metaphors and non-verbal signs to emphasize the intrusive nature of her words: *'....I always imagine this bare, this stripping....and I can always see the bones and the flesh.....(imagining)'(Lea.39)* and spoke of the emotional impact it has on her: *'...but for me when I see them strip their person...for me it's ...real something going on in the pit of my stomach....sometimes I can find myself swallowing back.....(swallows)....my emotions are all up.....'(imagining, metaphoric, non-verbal) (Lea.40).*

While exploring the client's suicidal intent Anna found it difficult to encompass their motives:*'.....I think I find it hard to understand why someone wouldn't want to live...you know...why someone...wouldn't want to live...what makes it so bad for them....(hand fluttering, trailing voice)..'(non-verbal)(Anna.46).* By fluttering her hand it felt she indicated the incomprehensibility of the suicidal thought, further expressed through her trailing voice, as if lost in thought to process her own feelings on the matter.

With a clearer focus on self another participant engaged in her usual relaxation of driving after a particularly taxing session:*'....I drove down the motorway...(smiling).....and the roundabout.....(laughing)...and I felt...as I was driving*

up and down...I would have said....I was aware of my body softenI could [feel that] physically...(non-verbal, verbal, metaphoric)' (Julia.10).

Recalling a situation four years ago and reflecting on her practice as a newly qualified counsellor at the time, she recalled how she found herself with a suicidal client in the counselling room and realised how 'ill-equipped' she really was to work with suicide: *'...I would describe myself as having pussyfooted around the whole topic.....'(Janine.2).* Well into the interview and referring to her description of feeling 'ill-equipped' and she remembered how scared she had felt at the time of becoming too involved. She defined that feeling as *'...being swallowed up....'(metaphoric) (Janine.95).*

One participant sums it up short and sweet:

'.....it's quite scary to be a counsellor indeed....' (verbal)(Mary.29).

4.3.2 Category 2: Connecting with self and client – *engaging the 'wounded healer'*

In connecting with the client but also with their inner emotional selves during their being with the distressed client, most participants touched on using their own experience, which gave them the confidence to be as real as possible and let their humanity 'speak'. In being aware of and voicing their own vulnerabilities, i.e. feelings of wanting or needing to keep a distance, perhaps even being detached, they would try to steer away from the 'psych-ache'. The 'psych-ache' they experienced was reported to most often flow over into physical pain as has been discussed in Category 1. While acknowledging their limitations they showed genuineness, transparency, and open-mindedness and in doing so were able to empower their client. Some of these experiences of participants are portrayed by a few examples in the following description.

In reflecting on their own involvement in the therapeutic relationship, one participant elaborated on and questioned her perceived failure, or skills, to connect with the suicidal client: *'.....it's really interesting you know..this is something that's happened for me from..the very first time I saw anybody....that...and I don't know whether it is something that is in-built...I talked about it in supervision...I don't know whether it is...an insensitivity...I don't know whether it's an inability to really connect...I question this many times.....actually when that hour is over I feel OK and it's..'(Lea.45).*

Despite this perceived inability to connect with her client the same participant had earlier mentioned that she felt no anxieties around the issue of suicide. She indicated

that she felt she could empathise with and understood the client: *'....although I have never felt suicidal..I think I can understand why people do.....'(Lea.21).*

The awareness of their potential and possible fallibility, and therefore humanity in their encounter with the raw distress and grief that accompanies suicidal ideation, was succinctly expressed by Robert: *'.....well.....you know....counsellors can get it wrong.....for whatever reason.....'(Robert.117).* A sentiment shared by another participant when reflecting on their relationship with a client who had chosen not to attend the sessions any longer, making her consider: *'..... well..... I didn't do very well there.....and it would be me thinking what can I learn from that.. .. you know there was something there for me to chew on and think about....'(Janine.69),* additionally contemplating what the options were for her to improve practice.

For most participants their own traumatic experiences were felt to be invaluablely helpful and gave them an insight in their practice and deep understanding of, and feeling for the client in their distress. As Mary pensively stated: *'....something happened..... totally out with my experience...coming to terms with and in that process thinking you know.....I can't do anything here....helpless, hopelessand.....actually....being in personal counselling myself....and appreciating the difference that it makes to be with someone who can hear..who can hold my story...and be in the feelings...and...thinking.....I'm not mad....ehm.....(long pause).....ehm...'(Mary.27).*

For Vanda her experience with personal trauma and still being able to connect with that feeling, showed itself she felt, through her ease and confidence in being with a suicidal client: *'....I am very open minded and I mean...I've had a lot of life experiences and ehm....working on my own mental health...you could say I've taken quite a calm approach now....'(Vanda.32).*

Having been in that position herself and acknowledging the client being entrenched in an intolerable situation, the participant understood:

'.....I did try to end my life years ago....so there is a lot of empathy forehm...the people that feel like this..... '(Vanda.49).

Their own experiences made participants try to be as real as possible and find a balance which was helpful, supportive, and also more mindful of the suicidal person. : *'.....I am really conscious.....much more.....that people who are suicidal aren't there just because they decided to be.....'(Ali.21) and '....I'm going to be more aware...part of that will be from listening to clients..... '(Julia.32).*

A few participants touched on the thought of the risk of complacency creeping into their practice. Believing suicide to be a 'normal human emotion' they had normalized the thoughts and feelings that accompany the condition and in being with the suicidal client at times the thought would surface: *'....I am becoming too comfortable with this....then I worry ...and is that right...'*(Eva.45). On staying with the client in their process and finding a connection with them, even though it might be seen by some as becoming comfortable or complacent, Patrick held a different view. He remarked on the empowering nature of psychological contact and pointedly referred to what the outcome of such a connection might be: *'..... I actually see it as it could make the difference between somebody literally taking their lives or not.....'*(Patrick.29).

4.3.2.1 Category 3: The curious self

The curious self was not only questioning the immediate motives of the client, but felt a strong inner need to know about the deep emotion behind the wish for death. The invisibility and difficulty to grasp understanding felt quite incomprehensible for the participants. The direct consequences in this work for the participants involved their own self and practice, in such a way that, at times, they surprised themselves by experiencing new awareness relating to their practice or how they felt about suicide in general.

A few of the participants in trying to understand someone who genuinely feels they want to end their own life felt a sense of curiosity which they thought was quite astonishing and, embarrassingly, felt perhaps alluring: *'.....this is an extreme end of emotionyou know it's a place that perhaps not a lot of people actually get to in their life time.....so there is something about that that is kind of intriguing for me... it's voyeuristic in some way.....like...I need to know more about this....I want to know more..'*(Lea.28).

Not only would they question and wonder about their own skills *'....should I have done something here.....what could I have done anyway....'*(Robert.98), the clients' motive or intention would equally be speculated about : *'.....it was left.... ehm..... because it didn't have an ending over the so many counselling sessions it wasn't agreed and it wasn't something that came from..... the client just choose to stop coming..... so that's still is there in a way wondering what has happened.....'*(Janine.67).

Ali was quite intrigued by her own reactions leading to a new awareness and consequent strength and confidence when she actively realized that they did not have to take responsibility for the client when she was not in a relationship as yet : *'....it was a real piece of enlightenment because I had worked with suicidal clients many*

times...and this is the first time that I thought...I don't need to go into this anymore....I need somebody else....I find that fascinating.....'(Ali.74).

Working with and experiencing a possible change in the client, resulted in Julia wanting to learn more about suicide and to delve a little deeper into the phenomenon: *'...it has actually made me far more interested.....to know about it....'(Julia.30).*

Although still believing strongly in her own right to commit suicide Julia felt that through listening to clients who had been bereaved by suicide, the act of suicide could be a selfish act, judging from the effect it had on other people and therefore:

'....it is taking me more down ...thinking more about it outside of me...yeah.....than just on me...'(Julia.35).

4.3.2.2 Category 4: The resilient self – finding tranquillity

In their attempt afterwards to process the initial shock of listening and hearing the suicidal ideas of the client, and access to a supervisor was not immediately available, participants would find other ways to recover and choose to do what benefitted them, perhaps through 'self-talk': *'......this bit came in 'you be fine' and I think there was this knowledge of I can carry.....whatever here....'(Julia.13),* or through different, perhaps more mundane activities.

Driving in particular was for some participants a time during which they were able to gather their thoughts and find their peace and strength: *'... but if I'm driving in the car when I finished upit clears my head.....'(Janine.66).*

Janine drew strength from remembering the more positive moments she had shared with her client: *'.....I'm feeling the laughter which we did share and feeling the.....the relationship.....of what went on just in so far as that wasn't about suicide so.....'(Janine.53);* for others renewed energy was received from their faith: *.....I would be sitting in some quiet prayer...ehmactually that can be more powerful for me ...it's very comforting.....(Eva.37).*

Being able to speak to family after a particularly difficult day was of great relief: *'....and I could tell my husband how I felt...you know....'(Ali.50).*

Turning to other significant people in their life *'.....if nothing else is available, your partner or your friends...'(Patrick.47),* would be equally helpful and although friends, Patrick stated, often did not have an inkling, at times, their 'sick' humour, albeit misplaced *'..almost helped...'(Patrick.50).*

To regain their grounding after the isolating experience of being with a suicidal client and perhaps not or only partly being understood by those around in their personal life,

participants engaged in physical activities such as going to the gym, walking, gardening, or *'.....just being outside.....all of those things are essential....'*(Patrick.42). Staying away from situations one did not have any control over, either in personal or professional life and taking time out would benefit self and client: *'.....I actively avoid stress now...'*(Patrick.94), or *'.....time balance stressors that affect me outside work....'*(Ali.127).

Others showed their creative side and externalized their inner thoughts about their experience in poetry: *'...I wrote a poem...not a very good poem but expressing some of these very mixed emotions...I think it did help.....'* (Robert.33). Looking at art was felt to be giving a spiritual experience: *'.....it's a natural high for me.....because of its beauty.... [Van Gogh's Chair]....'* (Lea.80).

Other creative pursuits focussed on going to watch a movie in the dark, listening to talking books and music which was all deemed to be great transporters to detach themselves from the difficulties they had encountered with their clients. It gave them the tools to stay grounded, confident, less fearful and in it they found peace and gained harmony within themselves. Belief in the future, that change is a possibility was for one participant what she needed, to carry on with her work: *'... there is something about...yeah....about the human survival instinct....it's there andit keeps me going.....yes.....it keeps me going....uhuh...'*(Mary.52). The same feeling of strong determination was expressed clearly by Anna who would, when a case had been particularly tragic, *'...catch myself up and kind of try to bring myself round.....to keep going with what is going to happen next.....'*(Anna.32).

4.4 Main Category III

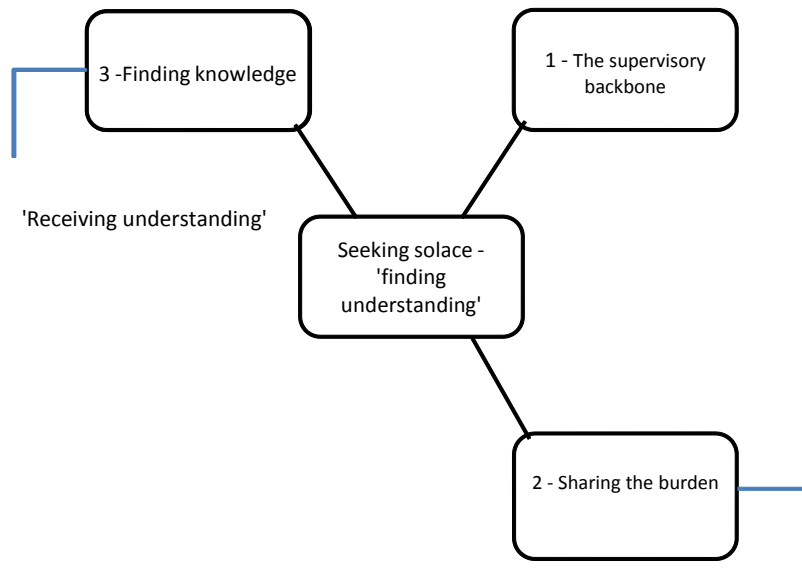
Seeking Solace – ‘finding understanding’

‘Seeking solace’ appears to be the third activity for the participant in the cycle of therapeutic movement when working with suicidal clients. After engaging in and establishing the therapeutic relationship, closely followed by the realization the effect of the therapeutic encounter has on the self, the participant appeared to rally and focus on finding comfort, support and relief by involving others, or through seeking alternative means of support.

Although support and guidance received through supervision and the gaining of understanding through interaction with others was the focus for the counsellor in the aftermath of their therapeutic experience with the suicidal client, a focus on sharing their burden through contact with their peers and other professionals, and at times family and friends, was deemed equally as important by some. Turning to spiritual means of support, such as prayer, quiet contemplation, writing poetry was felt to be extremely helpful in restoring their work/life balance to a healthy level in which they were able to resume being available for and effective in their client work.

This main category is divided into three categories as shown in figure 3 below. As before, each category will be clarified using examples of the data text specific to this particular category.

Figure 3: Seeking Solace



a - Through human exchange
b - Spiritually

4.4.1 Category 1: The supervisory 'backbone'

There was no doubt that being held and able to discuss '*....that sort of impact...you know.....*'(Lea.106) with their supervisor to get reassurance '*..when emotions were all up..*';(Lea.40) was mentioned by most participants as very important and would be their first thought and port of call: '*.... it was a bit of a crisis for me and I did speak to my supervisor on the phone.....*'(Janine.37).

In supervision participants would have the opportunity to explore the subtleness of the moment in which the client introduced their suicidal ideas and address questions relating to for instance on how to best pose the question. Being very conscious of working in an effective manner was discussed at length and would give them a platform to explore the sense of it all. Because of their personal understanding and knowledge of suicidal ideation, and some of the participants having suffered a serious suicide attempt themselves, it was important to get it right one of the participants stated.

‘..... like if you were making something you’d knock the raw edges off it and.... you knowthat’s what I discuss with my supervisor about ehm..... these type of things you know..... could I have asked maybe in a different way.....or more open.....it has to be sometimes...ehm...you know....hold on here is this what you are telling me...’(Vanda.47).

As uncertainty and knowing that boundaries can become blurred because of the emotional nature and feelings of responsibility, a heightened need for supervisory involvement was indicated. Fear of over-involvement gave the counsellor urgency into contacting their supervisor to keep themselves within the boundaries and work ethically. *‘....I certainly.....took him to supervision.....very quickly.....because I had a concern in myself that I wouldcould be over-involved....’ (Mary.9).*

Sharing this responsibility and feeling secure in their supervisor’s trust, even when the participant felt their boundaries were inadequate, the supervisor, keeping in mind an ethical framework would give them a reality check. Having their supervisor’s trust in what they were doing at the time helped them to feel confident to be able to do what they felt was necessary at that given moment in order to keep their client safe, even if that meant the boundaries had to be stretched.

‘.... my flaky boundaries.... well that was pointed out quite a lot..... ehm... I’m very aware of it and under certain circumstances I’m sure some of the things....ehm....I think BACP got mentioned a few times....but my supervisor trusted me enough to know that I would be safe.. I mean safe with the clients so that gave me.....ehm.....confidence in what I was doing.....’(Anna.67);

‘.....I don’t know what would have happened if my supervisor had...definitely not....can’t do this...don’t do that...or whatever....I don’t know what would have...happened....’(Anna.71).

Anna felt that the particular client group she was working with, young people in their late teens, were specifically vulnerable and felt that the ‘usual’ boundaries for this group might be detrimental to the working relationship.

When participants felt that when reaching out beyond the ‘official’ boundaries of counselling it was especially important to keep a check of their ethical framework, which they would follow up and explore in supervision: *‘....I needed...to...reach out....and so...I...contacted this client...by phone...and spoke to my supervisor about him..... to seek reassurance.....’(Mary.11).*

Supervision was referred to by one participant as a guiding exercise: *‘.....remember you put your [counselling] cloak on when you come in and take it off when you leave.....’*(Julia.6), where concerns could be flagged up. It helped to challenge and not only see something in a slightly different way, but also to validate their practice and feel supported in what they were thinking and doing: *‘.....I know I can go there and be really heard and listened to....’*(Mary.46).

Regular supervision, *‘....definitely, have extra supervision...be in regular contact....’* (Patrick.41) was considered essential and useful, it was a safe place, where they found *‘.....someone to offload to....., someone I can trust.....’*(Anna.36). Supervision was very much thought about in terms of the relationship with the supervisor at a mutual level and how they would work together: *‘...it’s meeting with....ehm....with a person...yeah....first and foremost really....a human exchange indeed’*(Mary.48), which not only helped them feeling safe within the therapeutic relationship, but also safe personally.

The supervisor needed to be able to stay with difficult and challenging processes *‘.....who are really open to explore these issues themselvesand see it as a spiritual, psychological and political process...not just one thing....’* (Patrick.74) thus providing new insights for the participants, who would receive a good understanding of what would or would not affect them and in doing so *‘...increases my awareness of fitness to do the job...’* (Anna.129).

In being able to stay with such demanding processes, the supervisor provided a safe place for the supervisee to explore and from where also comfort and validation of the taxing nature of the participants’ work was acknowledged: *‘.....and she is saying so there is quite a lot that is going on.....in there or in that work...and you see a lot of really distressed clientsso it’s like a reality check...my support systems give me a reality check..’* (Anna.81).

In general participants found supervision informative which facilitated their internal supervisor. Seeking guidance, comfort and reassurance during and after a traumatic encounter with a client, quick access to a supervisor was supportive and very much appreciated. It was deemed invaluable at that moment as it reinforced that: *‘..... my reactions are ok and my trust in my reactions are okand just sometimes that I’m not.....I’m not over reactingand seeing the supervisor’s reaction to some things that maybe I am becoming ...you know...complacent in thinking they are OK...’* (Anna.90).

Conversely, two participants touched briefly on the effects of hindering supervisory relationships and, although not referred to in neither table 3 nor figure 3, I felt it to be worth mentioning pithily. One of the participants remarked on not feeling supported by her supervisor and the effect this had on her. Another participant felt let down by his supervisor, who had insisted on a particular action in connection with the suicidal client, against the supervisee's own judgment of the situation. This resulted in the supervisee losing trust in his own ability and ultimately it led to the breakdown of the supervisory relationship: *'.....supervisor panicked and so I panicked and stopped trusting my experience.....the client stopped working with me...it's a real learning lesson for me...'(Patrick.72), highlighting the importance of: '....it's very much about the relationship that I have with a supervisor (smiles).....'(Mary.47).*

4.4.2 Category 2: Sharing the burden

4.4.2.1 Through human exchange:

It is important for counsellors to be able to share their responsibilities and concerns. As one participant, put it: *'...in the back of my head all I wanted to do was make somebody else aware in this.....in the agency that there was a something that was potentially not right which would allowme togo so that when I was going I felt safe enough to leave her.....'(Janine.43).* This sharing of responsibilities and understanding from others, even on a non-professional level (family, friends), together with having the opportunity of being able to discuss and perhaps debrief how what happened in the counselling room had impacted on them was very helpful for participants and they felt held in their own distress,*'I was having a difficult and involved time..... and [that] was helpful...like holding me.. '(Eva.41).*

With supervision not always readily available after a particularly harrowing encounter and feeling fragile at that particular moment, participants would find someone they could trust, to free themselves of the immediate impact of trauma: *'.....if I am....really bad and shaken.....and I can't move on I need to find someone to offload some of that.....my colleague if she was available....eh...obviously someone that I can trust....just to kind of unload a bit of that to move on and.....'(Anna.36).*

4.4.2.2 Spiritually

Failing direct access to colleagues, *'.....looking most definitely for support from your peer group...'(Ali.46),* or for instance a line manager, who would hold a duty of

care not only to their counsellor/employee but also the client, some participants would find reassurance in '*...some quiet prayer....*'(Eva.37). Prayer was a powerful activity in which some participants would find comfort for themselves but was also fallen back on to take care of the client '*....I prayed for her basically because....you know....I wanted her to be safe....*'(Ali.56).

Participants would actively be seeking and finding plenty of support, not only by turning to colleagues but equally by disclosing their feelings of the moment to family or friends. This disclosing of feelings and getting support from elsewhere rather than supervision was a sharing of the burden of emotional heaviness without disclosing the content of the therapeutic encounter with the suicidal client: '*.....and I could tell my husband how I felt...It had been a bad day...had a suicidal client....had to take them to 'emergency....'...it all gives a level of difficulty of my day without giving any detail...*'(Ali.51).

Sometimes participants found understanding and strength in engaging in therapy for personal and professional development:

'.....actually....being in personal counselling myself....and appreciating the difference that it makes to be with someone who can hear..who can hold my story...and be in the feelings...(Mary.28).

Not only through connecting with others, including personal therapy, would the participant find themselves and build their emotional resistance up again but equally, they saw physical activities as a means in which they could lose themselves for the moment and find strength, confidence and reassurance to move on: '*....massage, exercise.....there is always something somewhere where I can take.....mmmm...yeah...gardening....*' (Patrick.42).

'....and put lots of things in place to get plenty of support and not waiting until it's a crisis anymore....' (Patrick.95).

Whereas some participants found great comfort in inward prayer and referring to their prayer life (using rosary beads) and being able to connect with that physically at times of deep distress: '*..... I've been bringing something in that has meaning to me...and holding it...it's rosary beads....bringing me a comfort....*'(Eva.39), others would find solace in writing poetry. One particular participant recalled an instance where although receiving support from colleagues, supervision was not really 'in

vogue' (Robert) at the time. He could not recall receiving any help after a client had killed themselves. Therefore, to express his distress following the turmoil and drama he experienced when losing the client through suicide this particular participant expressed his distress in an emotional poem. Others would find solace in for instance reading, listening to music, or '*.....watching a movie in the dark..... by myself.....*' (Lea.89)

As an additional form of acknowledgement and support, humour was perceived an important aspect and although remarks by friends would at times be off the mark and evidence of their being removed from the situation they said: '*.....you should just have themselves top themselves.....*' (Patrick.50), it was seen as an intention to diffuse a perhaps for the friends difficult moment. It was taken as such by the participant who further commented that their humour was almost helpful. At the same time the participant was very well aware that there was little or no understanding there, leaving him to comment: '*.....in that humour you haven't got a clue.....*' (Patrick.51). However, at that moment the participant found it a welcome distraction from the seriousness of the moment.

4.4.3 Category 3: Finding knowledge – receiving understanding

Being part of a team would give some participants the opportunity to feel supported and 'professionally in a very good situation' as they had access to immediate support and were able to discuss their concerns within close proximity of their workplace, which was very helpful. At times when there were issues that clients felt desperate about they could be addressed '*in a more practical way by someone else in the team*' (Mary.17). It was important to know that, when it was difficult to move on and they felt shaken by what they had heard, they needed, without delay, to be able to '*.....find someone to offload some of that.....obviously someone I can trust...*' (Eva.36), someone who would understand. Understanding would not only come from practical support colleagues provided, or through the supervisory relationship, but also through seeking and finding knowledge and understanding of the situation through indwelling, inward praying and by being '*guided to say the right thing...*' (Eva.38).

The sharing with many like-minded people, '*.... they get it instantly....*' (Patrick.56) and drawing from endless similar opportunities presented through workshops, conferences, supervision groups, which not only functioned as outlets to process their experiences, offered knowledge and constructive feedback for their practice and self, providing further fortitude for the participants.

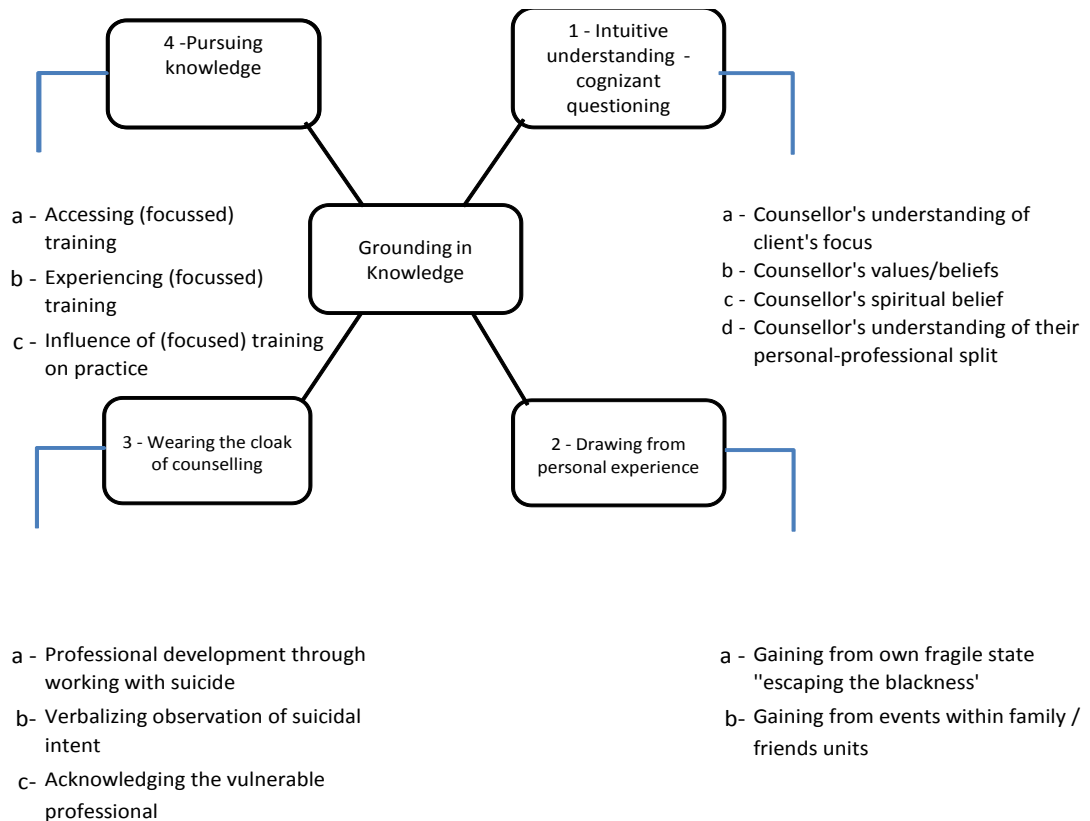
Although already quite confident in what they were doing in obtaining further understanding, participants would *'....pull in the help that I need when I feel that it is appropriate to do so.....'(Ali.85)* and ask for or share information with specialist others, for instance with GP's, occupational health consultants and psychiatric teams in order for the responsibility *'.... not to lie completely on my shouldersI had told...shared information with the right people....and that helped me a lot....'(Ali.59)*.

The above category may at times appear difficult to be separated from the previous categories within Main Category III. I felt it might be clearer if some aspects of the participants' finding comfort, support, relief and strength would be presented separately, for instance finding solace in a supervisory relationship may provide a different dynamic for the counsellor than seeking and finding the same with a peer group, other professionals or indeed through spiritual fulfilment. Within the supervisory relationship the counsellor should be able to tap into and lay bare their weaknesses, their doubts, whereas in the peer group scenario the counsellor may feel inhibited.

4.5 Main Category IV Grounding in Knowledge

The last development within the cycle of therapeutic movement which, it appeared, the participant counsellors in this study experienced, was their seeking grounding in the knowledge they already possessed. This was expressed by them as an intuitive understanding which ran parallel to cognizant questioning in that they also appreciated and understood their clients' processes, drawing from their own values, beliefs, their professional perspectives and an understanding and acknowledgment of their personal-professional split. This split refers to difficulties counsellors may have with the question how to separate the personal, emotional involvement from the professional, qualified and skilled participation expected from them. In supporting the client and trying to get an understanding of the client's emotional state, they would recall and draw from their own experiences, personally and through family and friends. Professionally, they get their understanding through working with suicidal clients, through their knowledge of how to recognize and their skills of how to verbalize suicidal intent. Being able to recognize and acknowledge suicidal intent, together with counsellors' understanding of their own vulnerability within this professional stance, are important aspects of working with this client group, as these are prerequisites for being able to keep themselves safe. Therefore, participants would pursue to broaden their knowledge base and access focused training. However they further commented how useful, but also disappointing and lacking in delivery it could be and what influence it had on their practice.

Figure 4: Grounding in knowledge



4.5.1 Category 1: Intuitive understanding – cognizant questioning

4.5.1.1 Counsellor's understanding of client's focus:

In trying to find meaning in clients' expressions, participants would talk potential intended actions through with them to assess how concrete their thoughts might be and acknowledge their present state:

'....when they talk about it I don't want to be here anymore....I will talk about if they have a plan...' (Ali.91).

Participants recognized that people make choices that you would not want them to make, but also that they may only have that one choice. Counsellors understood that at that moment death may be where the client is bound because there is nothing else: *'...it is more appealing....' (Mary.41).*

Although it was found to be a very difficult subject, out of respect for that person's belief and because they acknowledged their difficulties, the participants thought it important to look at the bigger picture for the client and not to take her right of choice away *'....if this is the right thing to do for them ...(Patrick.30) as it would '...make things go away for them in their eyes...' (Joan.46).*

Even though the killing of oneself might be the only option left for the client, there was also the belief, that inherent in the client was the strong sense of survival and that this was an aspect the participant felt they could build on, in particular when clients kept coming to counselling because: *'...that tells me something.....' (Mary.20).*

Julia thought that perhaps *'....people who would be feeling suicidal would probably not want to end their life.....' (Julia.25).* However, in being aware of the difference in mind set of suicidal people, the counsellor recognized that ending their life might be an escape from an unbearable situation, acute or long term, and would try *'.....to help and make that choice clearer for them....' (Vanda.2).*

4.5.1.2 Counsellor's values/beliefs:

Inevitably, throughout the interviews participants' own values and beliefs were brought into the ponderings when relating their experiences. One participant, harboured a deep seated anger concerning an individual event, where the suicide had a particularly devastating impact on those left behind, which had left him feeling that *'....actually ...I think it's morally wrong.....' (Robert.22).* It was experienced as a near 'black and white stance' and made him aware for a need to temper and watch that feeling as it could easily *'...colour things with clients...it could be hindering...or helpful....(Robert.122).*

Even when being respectful of the client's choice, some participants had a sense of urgency to protect life as they personally felt suicide was not an option: *'.....it goes against my whole being to allow that to be an option...' (Janine.47); '....it would be such a terrible waste....' (Lea.86)*

On the other hand one participant was very strong in her believe that it was the clients' right to choose whether to live or die, a perspective borne from her personal stance on ending life:

'...my own view is so compact, genuine...so definitely...100% my feeling.....' (Julia.24).

'....yeah although it is the person's final choice..I still think it is worth saving...don't think I can allow....or would do as much as I could to stop them....' (Anna.39), she sighed deeply.

Although participants felt caught between their own value and belief system and the client's acknowledged right to choice, they trusted the client's innate drive to survival, which provided them with the strength to build on and draw from in order to make sense of what was going on for the client. They felt there was a big difference between what the client was feeling and what they were thinking.

4.5.1.3 Counsellor's spiritual belief:

Religious belief would for some dictate that '*....we should not really be the person to decide to end our own life....*' (Lea.60). To others, religious upbringing could have had a bearing on their work with suicidal clients: '*...there is this thing in my background that says it's a sin.....it's a mortal sin.....*' (Patrick.32).

Although their religious stance saw 'life as a gift' and 'death is not an end' those participants with a religious background felt that faith did not have to get in the way and still believed in the right to choice for their clients.

'...I don't think that it is not morally right...' (Lea.62);

'....I don't have any sort of indoctrination....' (Eva.19);

'..it (religious denomination).....does not mean to take that right awayat that particular moment...' (Janine.76).

Coming from life-affirming perspectives some participants were strong in their personal conviction that suicide was '*..morally wrong..*' (Robert.120) and a selfish act of '*....an easy way out....*' (Julia.33). It needs to be clarified that both participants' viewpoints had occurred through intensive work with those bereaved by suicide and becoming aware of the devastating effects of a suicide on those left behind.

4.5.1.4 Counsellor's awareness and understanding of their personal-professional split

There was a general sense of questioning amongst a few of the participants on how to be able to separate personal beliefs and feelings from professional viewpoints, as it could possibly create an atmosphere of dissonance for themselves and in their professional duties: '*...I don't know whether I can separate entirely personal and professional...because to me it's just an integration of who I am...'* (Mary.15).

The tension between participants' upbringing, whether religious or not, and what was expected of them in their professional role, was an ethical issue that invariably would end in supervision. '*...that would not fit in...'* (Patrick.33), the participant said, referring to his personal beliefs on the right to die against his professional ethical framework.

Awareness of having strong personal pro-life viewpoints resulted in an understanding of the potential impact this perspective might have on their practice. As one participant put it: '*...it could be hindering then...or it could be helpful....I need to moderate it.....*' (Robert.124).

Another participant, with an equally strong outlook concerning the client's right to choice, pondered the dilemma between her standpoint and that of the organisation she worked for: '*.....that [her standpoint] is probably considered a contradiction with the*

ethics in the organisation....' (Julia.18), resulting in a different set of ethical considerations from the counsellor.

Whereas it was felt that mostly personal experience would influence professional practice, one participant, recalling an event from her personal life involving suicidal ideation, realized that her actions to support the person *'....were informed by my experiences as a counsellor....'* (Ali.19).

4.5.2 Category 2. Drawing from personal experience

4.5.2.1 Gaining from own fragile state – escaping the blackness

During the interview some participants would lapse into memories of their own previous distress which had resulted in suicidal feelings and attempts at their own life. In retrospect they recognized there were other choices but at the time *'it felt so bad for me....so I can understand why people think it is better to take their own life...or they don't have the ability ...they can't see there are other choices....'* (Anna.18). Looking back they realized that it was never as bad as they thought at the time and they concluded that that was probably why they were able to stay with and hold the client and support her appropriately in an understanding that came from deep within. Being comfortable in working with someone who is suicidal came for Anna from an earlier personal experience of escaping an intolerable situation for which, it had felt, there was no other choice and that eventually she *'..had taken back a bit of power.....'* (Anna.17).

Having experienced personal trauma was felt to be helpful in recognizing the blackness, hopelessness and, at times, the pointlessness of life a suicidal client may be caught up in. The participant knew from personal experience that this desperate state could change and this offered hope in that: *'...personal trauma...ehm....has helped...in making sense of it....'* (Mary.29/30). It enabled the counsellor to identify that moment with the client in their experiencing, but also to hold the possibility of options and hope, when clients question what else is out there, when they reject and turn their back on life and

'...walk through that door..escaping from everything....' (Mary.43).

'..I always had hope life would change...' (Vanda.57);

'.....you know....there are other options...you see...it is opening other doors...'
(Mary.43).

Vanda recalled the time when she developed a way of hiding her feelings treating them 'almost as a secret' and she used the expression, 'time bomb' to describe being on the

edge of darkness set to explode. Drawing attention to the fact that the mood in an on-going state of emotional turmoil can quickly change into an impulsive act the participant recalled the sudden change *'...that day the hope had left and I had decided that...'* (Vanda.59). This experience was now deemed quite helpful in the counselling room as she would use terms such as *'...you feel not quite sure when it's going to explode..'* (Vanda.60).

'....you know.....they're not against you...ehm....they're very much with you....' (Vanda.71). This participant's own realization at time of deep distress that other people were not condemning but actually very accepting of that distress, further enhanced them in their practice to gain a broader picture of the suicidal client's experience. The participant felt that through her experience she was in a better position to facilitate the client to voice their distress and she hoped for them to be able to admit to 'the feeling', in order to attempt to escape the blackness.

4.5.2.2 Gaining from events within family/friends units

4.5.2.2.1 grown in understanding:

The experience of suicide within a family or close friend setting often involved extreme levels of feelings for participants, ranging from uncontrollable grief to deep detachment and denial as a consequence, and even if it happened a considerable time ago, memories were still reverberating. For Janine, when recalling these events, the 'learning' gained from these experiences made her in her present work feel *'....relaxed enough to be with....relaxed enough with it....'* (Janine.99), and enabled her to open doors to different choices for the clients. Another participant felt she was able to work in an understanding and confident manner: *'...having gone through personal trauma....ehm...has helped....spotting the signs..'* (Mary.28).

Early personal experiences would influence the way one worked with clients and participants felt that:

'..it was not a place that I am frightened to go....it's not alien to me.....' (Patrick.15);

'.....really feel competent, comfortable now to not panic...' (Patrick.24);

'..really think about my relationship with people now...' (Lea.16).

Her personal experiences left one participant with a heightened sense of self-belief, a new feeling, which allowed her to be with clients at a deeper level: '..gosh.....now I don't feel it has such an impact....I feel perfectly confident sitting with them..... thinking about it.....'(Julia.22).

4.5.2.2.2 acknowledging and understanding traumatic effects:

Having gone through suicidal intent, attempts and completed suicides from loved ones made a few participants comment on the traumatic effects these had on others and themselves. Difficult dependency behaviours were pointed out pensively: *'...they became ...not demanding....but there was a lot of contact afterwards....it was quite difficult'* (Robert.51), and for him a shocking and perplexing experience: *'....I had no idea....'* (Robert.49).

This event highlighted the importance of taking suicidal thoughts and feelings very seriously at any time, because as a professional, participants contemplated, you could be getting it wrong when people are either vague in their indication or when a counsellor thinks it might not be that serious. Being able to perhaps feeling slightly detached from the meaning of suicide : *'...I..learnt very quickly not to get caught up in what I call the drama of it....'*(Patrick.23) came from early experiences of losing close family members to self-inflicted death.

Negative and at times mocking reactions from family members to a suicide in the community left one participant perplexed, in particular as family members had had an encounter with the suicidant in the moments before he killed himself: *'...he said...I'm fine....lovely day, then walked across the railway line and stood in front of the 11o'clock...'* (Vanda.67). The ensuing mocking reactions and laughter from family members who had graphic jokes on the incident were explained away as misunderstanding and denial of trauma, and thought to be caused by *'the fear surrounding that and the serious consequences of it...'* (Vanda.71).

4.5.3 Category 3. Wearing the cloak of counselling

4.5.3.1 Professional development through working with suicide

Working with suicidal clients for a period of time made some participants more confident and comfortable in their style of working and affirming of their approach, feeling they gained in their ability to work at a deeper level and in their ability to be with clients in that moment: *'...I guess to me it feels even more like being person-centred....'* (Julia.21).

The more they were hearing about 'it' and being exposed to 'it', through contact with peer groups and work colleagues in different settings and/or disciplines, the more understanding and knowledge they felt was gained *'....by talking about it....with others...'*, (Lea.3).

A third participant, exclusively working with young adults, noticed that her experience of using contracts with younger suicidal clients *'...certainly seemed to work....'* (Anna.21),

and she attributed that thought to the young person's limited life experience in comparison to older persons, who might not go for contracts.

4.5.3.2 Verbalizing observation of suicidal intent

A few participants reflected on whether they would actually feed back to the client when they felt they were observing suicidal intent through her demeanour and what was said. Whereas one participant would, on the one hand, not use the word 'suicide' specifically, he would on the other hand not be hesitant to use it when he became aware of the need for it:

'.....I rarely use the word suicide though.....suicide attempt.... however, I wouldn't shy away from it.... when I had a sense of real despair.....I would be naming it....'
(Patrick.10).

In reflecting back the client's anguish the counsellor would try and *'.....find their language....yes...'* (Patrick.13), recognizing that the person usually will have her own way of expressing her distress, and not necessarily use the word 'suicide' either.

When paraphrasing the client's statement of *'...you could do yourself in...and can you tell me a little bit more about it...'* (Ali.70), the participant felt she opened the door for the client cautiously, avoiding any misinterpretation of the client's meaning by inviting her to speak to get a clear understanding.

Others would be more directive, and in order to assess what the risk was, discuss the meaning and explore the mediacy of the client : *'...I go straight to the pointare they suicidal....'* (Anna.21), but in doing so, again, they would open the door for the client to speak. Feeling comfortable and adopting a gentle client led approach but *'...not being frightened or knowing when to say....are you suicidal....'*(Anna.78), and was *'...something I do regularly....'* (Anna.11).

4.5.3.3 Acknowledging the vulnerable professional

4.5.3.3.1 Recognizing and holding boundaries:

Becoming submerged in and taking on the feelings of the client, one participant became aware of her own weakness in keeping the boundaries tight as she was 'becoming deeply involved'. She mentioned how she had recognized how 'flaky' her boundaries had become in order to be supportive of what had turned out to be quite a demanding client for whose life she feared: *'... my boundaries became flaky.... I was answering the phone all over the place.....at weekends at evenings..... and it should have been much more rigid.....'* (Anna.34).

When over involvement was threatening to become an issue, concerns regarding confidentiality might come into play, as was the case with one participant who, having no direct access to a supervisor, felt it would be very difficult to involve others. The statement of Patrick bears witness to this dilemma of whether to involve other professionals or not: *'..it had felt so tempting to go out for the medical approach and involve GP's and psychiatrists.....he just needed to be heard.....'* (Patrick.61).

Conversely, it was felt that under involvement was equally a possibility: *'.....I was left thinking...if there was somethingI could do....that it could be.....hopefully useful...or...or...some sort of connection.....some sort of engagement...'*(Mary.14). For some however, as a duty of care to themselves and their client and keeping in mind that no premature actions would be taken, involving others would override everything: *'.....I can only project what I would do and I think if someone really was in that place ...I think I would be saying....that I am really really sorry... but out of duty of care for them ..I am going to give their GP a call....'*(Eva.61).

4.5.3.3.2 Acknowledging and holding the process:

In acknowledging and holding the client's process participants would be drawing from what they believed in, what they were feeling, what they felt comfortable with and trust themselves and their own instincts. Even though they were not always sure they anticipated: *'.....there is hope.....she does want to change....I hope she's got the time to....'* (Eva.71).

The limited time often assigned, a one hour session per week, was experienced as a fleeting touching of connections: *'...dipping in and out of a connection.....people come and go....'* (Lea.15). To hold this process for themselves participants would allow themselves space to facilitate the development of what was happening in the counselling room at its own pace. On hearing from a client 'I do myself in' one participant gave herself the time to *'....first giving her the information bit on confidentiality.....I thought.....I just do this.....'* (Ali.70), before reflecting back to the client what she had first heard, holding the client in a calm environment, created by a composed counsellor. Yet, holding the client process evoked for another participant anxieties around their own strong views on suicide which, she thought would be detrimental to the therapeutic process and she felt as if *'..the process became more monitoring and policing.....'* (Julia.44).

4.5.3.3.3 Impact on the professional:

The effects on the participant of processing traumatic information in their working environment ranged from feeling wary, at times being uncertain of what was happening and questioning themselves, to having lingering memories of past clients and reproaching themselves for not always thinking coherently or logically.

Recalling past events participants indicated that they remembered not so much of what actually the client had brought to the session but rather the feeling of inadequacy they had felt at the time *'...I didn't feel frightened..... but I felt very difficult.....very ill-equipped in that particular episode....and almost as if I didn't want to create the waves.....(Janine.13)*, thinking the client might leave if they would bring it *'into the limelight'* (Janine.15).

A participant who had worked with a group who had been bereaved by suicide remembered every person in that group: *'....I could say I can picture every single person...'* (Julia.45). These experiences had influenced and changed her feelings and thoughts on suicide drastically, leaving her to question her own thoughts on suicide.

The issue of suicide would remain around, for some *'...you know it [working with suicidal clients] was 24/7....it never stopped....'* (Patrick.10) and *'....the traumatic became quite normal...'* (Patrick.2), suggesting a kind of desensitization. Participants would reflect on and try to find answers *'....was she doing it because she was fed up looking after...or...'* (Janine.87), and contemplate the impulsivity of the act and the unsolved questions it left: *'...he said I'm fine ..lovely day.... walked across the railway line and stood in front of the 11 o'clock train had made up his mind or had he?.....(Vanda.68)*. These vivid memories left participants with an unsettling notion of 'not knowing'.

Being alongside the client, participants became well aware of their own fallibility. One participant recalled how he had *'....felt terribly bad professionally and unclear whether I took the right action....'* (Robert.67), and another participant remembered how the client's baring her soul became emotionally *'.....quite horrific and difficult to distinguish between.....me and them.....'* (Lea.41).

Most participants raised the issue of the duty of care to their clients by accepting a certain level of responsibility: *'....I explain to them that I will take responsibility if I need to...'* (Ali.92).

Another participant felt, not taking sole responsibility for the client, that *'....it is the client who is doing the work, I facilitate that process....so I don't feel responsible for people...'* (Lea.51).

4.5.4 Category 4. Pursuing knowledge

4.5.4.1 Accessing (focused) training

In speaking about their continuing pursuit of seeking, finding and taking part in relevant and appropriate training, participants conveyed they would seek this through local authority workshops, reading, in house training, seminars/workshops on national and international level, even if they did not always find satisfaction and/or enlightenment. Some felt that their grounding in working with this client group lay within their training in the person-centred approach, their work with suicidal clients, but not necessarily through specific training courses.

'.....I would say actually my initial training was what I am actually grounded in.....where I am professionally....ehm...you know like ASIST (applied suicide skills intervention training)it seems all very basic level training...for me.....' (Anna.73).

Participants felt that their initial Diploma training programme, even though for some suicide had not been addressed at great length at the time, had developed their understanding on how to be with suicidal ideation rather than that it had attributed to gaining an insight in the topic itself:

'maybe the usual....very superficial.. workshop on death and dying.....' (Patrick.101);

'....that was very much left out in the training...very much missed out...' (Julia.53);

'... the training I've had wasn't much....' (Robert.38);

'...I am aware of where I am with it...and I am comfortable with it...and when I need to make the judgment call of getting help or not...and that all came from my basic diploma training...really knowing me...knowing who I am.....absolutely..' (Eva.77).

For some participants focused training was informative in that it had taught them how to ask, that it is ok to ask, and not to feel *'....kind of a bit of tongue-tied, feels a bit better.....'* (Vanda.42).

Although other participants felt that the specific training had been lacking or giving nothing new it had, however, further strengthened their existing knowledge: *'.....surprisingly I came away from that training day thinking...actually I did not learn anything new...just reinforced what I already knew....'* (Ali.105). One participant

thought it to be going into depth and as it *'.....focused purely on suicide.... it was able to bring it into the limelight...'* (Janine.33).

4.5.4.2 Experiencing (focussed) training

4.5.4.2.1 'lifting the veil':

Training with specific focus on the issues surrounding suicide was felt to give participants not only confidence but also emphasized their levels of responsibility. It highlighted the significance of the relationship and made participants think about the meaning of the relationship they had with people. It gave them an awareness of the gravity of the topic. Training should not be underestimated some participants felt, as they were facilitated by it in their thought processes and it helped them to break down different issues within suicidal ideation: *'.....it being discussed and actually broken down into what people do...are they just contemplating or...?'* (Janine.26). *Bringing it '..out of the dark corner....'* (Janine.23) demystified the issue and the participant was able then to acknowledge its existence and work from a basis of informed knowledge.

Training in specifically the person-centred approach was also acknowledged as a 'focused' training in that it: *'developed me professionally....to be in a position where I trust my judgement.....'* (Anna.74). It had given one participant the strength that she would actually be able to talk about it: *'...it felt like you dared to discuss it...'* (Ali.103). Their person-centred training had given them peace of mind in that they felt confident they would be able to look after themselves properly: *'.....really knowing me.....knowing who I am...'* (Anna.77), and having a positive bearing on how to 'be' with the person: *'....I want to hear their story now...and understand why they have these feelings...'* (Vanda.33).

The immersion in exploring and training in the non-directive approach left one participant fully satisfied that it was the most powerful of approaches. It allowed him to be alongside the person in her journey and accompany her without taking her control away, leaving the client her right to choose: *'.....it could be the ultimate act of the self-actualizing process....'* (Patrick.83).

4.5.4.2.2 'a missing link':

Although positive experiences regarding their training were strong and centred mainly around their gained confidence in 'being' with the client, participants also highlighted some negative aspects. Some did not remember receiving specific client suicide focused training, or it being covered and pondered: *'I don't believe they did.....that was very much left out in the training.....surely, there must have been....'* (Julia.56),

whereas others thought it had not been high on the agenda: *'..we touched on it...had a day on suicide....'* (Anna.75), or *'.....ehm...I think I did....'*(Mary.35).

These negatives concentrated in particular on the lack of adequate comprehensive training, giving them at times feelings of uncertainty, and perhaps of getting it wrong, missing something in their assessment of the situation. *'....I did not have anything deep or systematic...ehm..it did not give much help about what you were supposed to do....'* (Robert.89).

Whereas some participants had felt their basic person-centred training had given them the stronghold to work with suicidal clients and had experienced it as *'....pretty profound....but still not enough...'* (Patrick.99), others felt out rightly that *'...just touching on suicide...and talking to some extent about it...'* (Anna.73) had left them feeling ineffective and unsure.

At times focus on suicide during training would come by default when other students chose it as a topic for presentation: *'.....had they not gone into it we wouldn't have had anything on it....we didn't get any training on assessing people for suicidal ideation....'* (Ali.109).

4.5.4.3 Influence of (focussed) training on practice

4.5.4.3.1 learning to wear the professional cloak of counselling:

Relatively few participants commented on the effect specific training had on their practice. They felt it had made them more aware of the difference between theory and practice and it had enabled them to differentiate between the different narratives of clients. Training, they concluded, would make them 'safe' in their practice, make them feel more knowledgeable and competent, and able to work with the suicidal client, as they had gained insight into their life. Training would provide them with the opportunity to focus on their own and each other's reactions when 'clients' brought the issue of suicidal thoughts and to form a picture of what suicidal ideation meant: *'...it provided ways of managing thoughts and feelings...'* (Mary.35). Listening to what was said: *'...do they have suicidal feelings....or do they have a plan....'* (Vanda.25) and being aware of any kind of idiosyncrasy, distinguishing and taking note of the level of severity was, although seemingly obvious, considered very important and something that the participant felt better equipped to do after having participated in the training.

The right to choice was discussed at the course Anna attended and the theory was that the person may have only that choice left. However the participant in her practice did not experience this to be so *'..it does not always work out like that when you are counselling....it is very hard to say this is the last choice a person has....so let them do*

it....I don't think I could.....so far I haven't been able to.....' (Anna.38). It highlights the fact that theory and practice do not always go hand in hand, in particular when working with vulnerable human beings.

4.5.4.3.2 impact of (focused) training on self in practice:

One half of the participant group remarked on the influence training specific to the topic of suicide had on how they viewed themselves within their practice, applying their learning to how 'to be' with the person and to feel at ease and comfortable within the self: *'...before I would gasp.....now... I want to hear and understand...'* (Vanda.33).

Having learned how to find the support to feel safe, have trust in self and feel confident within the therapeutic relationship, together with now being able to show that to a client, in, for instance, levels of disclosure, but also questioning their own motives, would lead to further growth in their practice. Issues around disclosure raised doubts on what to divulge to clients about their own experiences: *'....I am not quite sure about that [disclosure] yet...I suppose my training said not a lot.....and I want to be human to my clients...'* (Vanda.90).

Being able to talk about suicide felt cathartic: *'.....it almost felt like a breath of fresh air ...to be able to ask somebody and bring it on the table.....'*(Janine.28). It was thought that clients would probably not volunteer to impart information concerning their ideas about what they intended to do with their lives. The training had prepared them *'...to allow me to be more myself...'* (Patrick.102) and not as a result *'...lose confidence in my experience of that person....'* (Patrick.88).

Participants wondered how they could have recognized signs of suicidal intent before they had received training, concluding *'....I couldn't have...'* (Vanda.10), and felt now better equipped through their gained knowledge, having become more composed, calmer and accepting in their encounter with the client: *'...I am comfortable with it.....'* (Anna.77).

5 LITERATURE REVIEW

5.1 Introduction

It is clear that literature on the subject of suicide is wide-ranging. It covers personal accounts and professional explanations, theories, debates and information, in particular in the areas of suicide prevention and intervention, and issues surrounding assisted suicide and euthanasia are given regular media attention. Within this vast literary availability I have found that research, dedicated specifically to the impact of working with traumatic material on practitioners, such as suicidal ideation, concentrates in general on the medical model, but is effectively non-existent when the focus is on the counsellor who practices from a person-centred perspective.

Although research literature on my topic is scarce I was able to identify relevant research studies from different disciplines with similar grounds in common, for instance psychiatry, psychology, and education.

Initially, I restricted myself to search for studies with a specific focus on the impact of suicidal ideation on practitioners going back a decade. I felt this was an appropriate cut-off date to review the most current literature on the topic and for it to be still manageable for myself. However, during my search I soon found earlier relevant and influential work by known authors on the phenomenon of suicide, with a focus on the suicidal individual, notably Shneidman, Leenaars and Firestone.

To stay authentic and respectful to the reviewed studies from different disciplines, and theoretical explanations from, for example psychology and psychiatry, which adopt a medical model, I used their terminology as is reflected in this literature review. For instance, practitioner, counsellor, therapist, and clinician are used intermittently where the subject matter would define their use. Additionally, the medical model uses 'patient' and 'treatment', whereas the counselling practitioner uses 'client' and 'therapy'. At the same time highlighting the fundamental difference between the medical model and counselling: the former already creating a power imbalance purely by its use of language, whereas the counselling practitioner and in particular the person-centred counsellor aims to work on a basis of mutuality in which the client is an autonomous being.

In reviewing the literature I used the following resources: PsychInfo, ASSIA, dedicated journals, on-line resources and other relevant material, such as media information if and when appropriate.

As my findings show four specific areas involving the experience of the therapeutic encounter in relation to client, and self, the search for support and finding a focus in knowledge, I reviewed the available literature relating to these four areas. I endeavoured to determine how the findings of studies extracted from these disciplines potentially supported or opposed the findings of my study, which will be addressed in the discussion chapter.

5.2 Working with traumatic material/suicidal ideation

In investigating the dialogue of suicide in the counselling process Reeves (2004) identified a need to explore 'the influence of counsellors' personal beliefs about suicide in their work with suicidal clients, factors that prevent counsellors from exploring suicide with clients, and how or whether continuing professional development opportunities might support counsellors develop confidence in working with suicide' (p69). His study, using discourse analysis to process data gleaned from existing research material, focused on the language used by suicidal clients to express their intent. However, Reeves recognized that not many counsellors in his study would use the word 'suicide' directly. There may be different reasons for this. Counsellors may fear litigation (Reeves and Nelson, 2006), they may feel morally opposed to the idea of suicide (Reeves and Mintz, 2001), hindered by early personal experiences (Niemeyer, Fortner and Melby, 2001), lacking appropriate training (Reeves, 2010) and therefore feel deskilled, fearful, apprehensive and even angry (Fox and Cooper, 1998; Trimble, Jackson and Harvey, 2000 in Reeves, Bowl, Wheeler and Guthrie, 2004, Reeves and Mintz, 2001). Training, say Jobes & Maltzberger (1995), will give the clinician confidence in their practice and ultimately the patient the chance to explore alternatives from their deep despair and experience a human connection in their emotional isolation.

5.2.1 Anger and fear, negative reactions to clients' suicidal intent

Thoughts of lacking skills and feelings of fear and resentment can all have a harmful effect on an effective and healthy therapeutic relationship, resulting in a possible negative, perhaps fatal result (see par. 5.2.3.). Anger for instance, Dahlenberg (2004) writes, can be detrimental to the therapeutic relationship. It is an emotion with the ability to negatively influence practitioners' responses to clients (counter-transference).

This emotion needs to be channelled in a positive manner for the practitioner to become effective in the therapeutic relationship. Dahlenberg (*ibid*) found that clients showed increased approval of therapists who were 'emotionally disclosing after an angry episode and who took partial responsibility for disagreements in therapy' (p438), therefore showing their humanity in the face of deep distress. Dahlenberg (*ibid*) remarks that countertransference (see par. 5.6.4.2.) issues are addressed more openly with a trend for therapists to disclose their feelings to their patients to help the therapeutic process, rather than 'suppress, overcome or ignore' these feelings (p439).

Fear appears the overriding factor in working with the suicidal client (Reeves & Nelson, 2006). Fear of getting it wrong and failing the client, fear of litigation, fear of death itself, fear of the unpredictable nature of the concept suicide, fear of the unknown, perhaps fear of the impact of their own perceived feelings in the aftermath of a suicide all add to the stress the counsellor experiences when with a suicidal client.

5.2.2 The link from anger to Carl Rogers

When sharing with their clients the feelings that arise during the therapeutic relationship, the person-centred counsellor is said to be congruent, but needs to disclose these feelings carefully and in a sensitive and appropriate manner, keeping in mind the counselling session is about the client and not the self (Merry, 2002). When these feelings pertain to difficult emotions, such as anger, Merry writes, it is advisable to discuss this with a supervisor, and quotes Carl Rogers (1959) on congruence:.

'....when self-experiences are accurately symbolized (in awareness), and are included in the self-concept in this accurately symbolized form, then the state is one of congruence of self and experience....terms which are synonymous....[are] integrated, whole, genuine.....' (p206).

Rogers (1980) in later work simplifies his explanation of congruence to:

'....there is a close matching, or congruence, between what is being experienced at the gut level, what is present in awareness, and what is expressed to the client....'
(p116).

Rogers further declares:

'...a sensitive ability to hear, a deep satisfaction in being heard; an ability to be more real, which in turn brings forth more realness from others; and consequently a greater

freedom to give and receive love - these, in my experience, are the elements that make interpersonal communication enriching and enhancing..’ (p26).

These statements by Rogers (1951) underpin his Proposition V ‘Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived meaning that ‘unless experience is adequately symbolized, unless suitably accurate differentiations are being made, the individual mistakes regressive behaviour for self-enhancing behaviour’ (p491). This refers back to Dahlenberg’s statement that disclosing their feelings (being transparent) will help the therapist in establishing a healthy therapeutic relationship, with forward movement to a potential self-actualizing position of the client, and to which Rogers refers as ‘growth-promoting’ (p26). Kapoor (2006), an NHS counselling psychologist wrote, in her personal reflections after the suicide of a patient, that when given the opportunity to speak about her traumatic experience, and be heard, she was able to move on from a state of withdrawal from others and self:

‘...I felt marked by the experience....my confidence shattered...I felt scared and alone..’ and ‘....the most useful thing was ... she allowed me to choose when I spoke about this experience and when I did not....’.

Anopama Kapoor (p10)

5.2.3 ‘Potholing’ and exploring suicidal intent

Reeves (2010) likens the exploration of suicidal intent with ‘potholing’ (p136). He compares the inner structures of the caves with the client’s inner make up, the different crevices and holding places with the client’s ‘memories, histories, fears and joys’ (p136). As counsellors we explore the cave with the client. However, what happens if counsellors may become too fearful of the darkness of the cave and are resistant of entering and exploring the more threatening crevices when both client and counsellors peered inside, because the client’s fear of entering has overpowered us. Apart from possibly having an in-depth fear of death itself, there is also the possibility that the client’s fear may have caught the counsellor on a day that she feels ‘low’, less resistant to life’s vicissitudes and is engulfed by the client’s fear. From a psychodynamic viewpoint countertransference is taking place, and again, when not addressed has a negative effect on the therapeutic relationship, the counsellor is not being congruent if not addressed, if the counsellor retreats. Such a negative reaction may ‘not only be problematic but also suicidogenic’ (Leenaars, 2004, quoted in Reeves, 2011, p101). It is therefore reasonable to assume that applying the core conditions of the person-centred approach would have a potential positive effect of working with suicidal intent.

Shea (2002) underpins this thought by stating: 'the clinician's ability to convey a non-judgmental understanding of the client's right to view suicide as a rational solution may introduce the rapport that is needed to help the client choose another solution' (p5).

5.3 The importance of the therapeutic relationship

In an information sheet, issued by the BACP, that gives guidelines on working with the suicidal client Reeves and Seber (2005) indicate that 'the relationship with the client' is one of the areas for the therapist to consider as extremely challenging when encountering a suicidal client.

5.3.1 The Aeschi Working Group and the importance of the therapeutic alliance

The Aeschi Working Group, Michel, Leenaars, Jobes, Maltzberger, Orbach, Valach, Young and Bostwick, form a movement for the improvement of working therapeutically with suicidal persons. Their focus is the therapeutic alliance between patient and therapist in their belief that to establish, first and foremost, a human connection with the suicidal person is of utmost importance in the prevention of her suicide. The following has incorporated the statements of some of this influential group of theorists on suicidology.

5.3.1.1 The role of the therapeutic alliance

The role of the therapeutic alliance and its importance has been explored by several theorists and assimilated in a text by Michel and Jobes (2011). Michel (2011), in quoting a few definitions on therapeutic alliance states for instance that the crucial characteristic of the therapeutic alliance is:

'the collaborative aspect of therapeutic alliance as an interactive, recursive, and creative process, which requires an intimate interpersonal and interactively focused process' (p14).

Michel further refers to Michael Balint (1973, p2) who wrote:

'Therapy happens not in the patient nor in the doctor but between the two of them'.

Horvath, Gaston, and Luborsky (1993) recognized three, more general aspects of a therapeutic alliance, Michel remarks in the same breath, which centre around:

The patient's perception that the interventions offered are both relevant and potent;

Congruence between the patient and the therapist's expectations of the short- and medium-term goals of therapy;

The patient's ability to forge a personal bond with the therapist and the therapist's ability to present as a caring, sensitive, and sympathetic, helping figure.

This means that the patient/client can expect transparency, honesty, and empathy from her therapist and both may therefore be able to build a healthy and working relationship in therapy.

5.3.1.2 Therapeutic attachment and the therapeutic relationship

In a study investigating therapist's psychological adaptation to client suicidal behaviour, Horne (1995) found that the level of attachment between therapist and client correlates positively with acute emotional distress experienced by the therapist, with the possibility of long-term reactions to client suicidal behaviour. Although the study does not reveal whether low levels of attachment, i.e. the therapeutic relationship has not yet been established or is proven to be tenuous, or there is a strong attachment bond between therapist and client because the therapeutic relationship is established and healthy, both levels would be equally valid to presume that a therapist's acute emotional distress at his client's completed suicide is justifiable. His findings point not only to the importance of the therapeutic relationship but also the impact it can and has on the therapist, and how the therapist can become caught in a counter transferential state, if not addressed appropriately.

Orbach (2001, 2011) supports this view and referring back to transparency, honesty and empathy as building blocks for a sound and effective therapeutic relationship, he explains that his therapeutic approach of showing 'therapeutic empathy with the suicidal wish' (Orbach, 2011, p123) means he acknowledges the client's despair in arriving at an abyss, and that suicide may be the only option left. Earlier he referred to this as a 'principle of extreme empathy on the verge of total identification' (Orbach, 2001, p141). Orbach tries to see the client's situation from every possible angle, i.e. his circumstances, his innermost feelings, and strives for a discovery of something of interest in the client in order to get a deep understanding of why the client feels he has reached the end of his resistance to distress. This, Orbach (2011) claims is the 'general approach which dictates a special attachment between client and therapist' (p123), guided by compassion. It provides the opening of a door to hope of a reduction in the level of suicidal intent.

'The therapist's capacity for empathy –that is, the ability to understand and to feel intuitively the perspective and experience of another- is a critical component of validation and of the therapeutic alliance'.

Schechter and Goldblatt, 2011 (p98).

This observation reminds us of Orbach's (2001) approach to attempt to see the patient's situation from his perspective. Schechter and Goldblatt (2011) emphasize that the initial therapeutic encounter with the patient starts with a genuine interest and acknowledgement (validation) of the patient's 'subjective experience' (p94). However, the patient's experience, more often than not, being dark and oppressive and causing him excessive fear, hostility, rage and isolation may cause the therapist to withdraw from the patient, affecting the therapeutic relationship detrimentally and aggravating the patient's emotional pain.

5.3.1.3 The therapeutic encounter and loss of professional perspective

In their study on counsellors' experiences of working with and how they respond to suicidal clients, Reeves and Mintz (2001) identified 'a significant theme' in that 'the counsellor demonstrated an apparent loss of professional perspective once their client expressed suicidal thought or intent' (p174). The result was that counsellors felt deskilled, questioning their competence and their ability to practice safely. Referring to above mentioned account regarding countertransference and congruence, it appears that the participants in the above study had not yet contemplated the implications of their reactions to suicidal intent and the effect this may have had on the suicidal client. However, Reeves and Mintz (*ibid*) do acknowledge this and remark in their concluding discussion that 'it is also important to hold the valuable learning that is available from listening carefully to the subjective world of the practitioner and in doing so the doors that might be opened for our own professional and personal exploration' (p175), a statement in line with the philosophical ethos of The Aeschi Group as outlined above.

5.3.1.4 The importance of the initial therapeutic encounter

Jobes and Ballard (2011) have explored and explained suicide as an interpersonal act. They state that as soon as the concept of suicide is introduced within the therapeutic relationship, no matter whether this happens at the onset of the relationship or further into the therapeutic relationship, the goal posts change. Both client and counsellor will feel the emotional, and although not referred to by Jobes and Ballard (*ibid*), also the physical impact of the introduction of suicidal ideation. If not heard and acknowledged by the counsellor the suicidal person will feel lonely and alienated from his

environment. Jobes (1995) refers to the poor relational skills of suicidal persons who have a problem maintaining relationships that sustain them and that may support them to overcome their period of emotional distress. Joiner (2005) proposes that 'two psychological conditions are necessary to the will to live, effectiveness and connectedness. If one is intact, so is the will to live'. (p134). A proposition, that relates clearly to the theory of the Aeschi Working Group, who put such emphasis on the therapeutic relationship of client/patient and counsellor/therapist. If the connection can be made between both there is hope to prevent a potential suicide. As Leenaars (2004) contends 'crisis intervention starts in the first encounter. It requires a development of an active non-judgmental rapport or therapeutic alliance. Rapport is the ability to relate mutually in a human encounter' (p200).

5.3.1.5 A thought underpinning the importance of a therapeutic bond

To emphasize the importance of the therapeutic alliance across all areas of therapy, I will finish this part of the review with a reference to an observation by Tehrani and Vaughan (2009). In a study examining the nature and benefits of the therapeutic alliance between herself and a client suffering extreme trauma from bullying in the workplace, Tehrani remarked:

'This study provided an opportunity to engage in a journey of discovery, in which both parties played a vital part. Perhaps the most important thing to be established in this therapeutic relationship was the demonstration of what could be achieved when two people work together in an atmosphere of honesty, trust and openness to make some sense of what is occurring by pulling together wisdom from whatever source appeared to be relevant' (p16).

5.4 Therapists' emotional and physical reactions to working with trauma material.

Christianson and Everall (2009), investigating school counsellors' experiences of client suicide used in-depth interviews, which after transcribing and using thematic analysis to analyse the data, identified four themes: Taming the Control Beast, Wearing the Mask; Interpreting the Dance; and Staying in the Game. These metaphoric representations of the counsellors' experiences capture their processes through the suicide of a client and its aftermath in an imaginative manner. From feeling powerless, to pretending at work that all is well, in the meantime processing personal experiences relating to the client suicide, to putting in place personal support systems, the themes give a more 'human' account of the experience of the counsellor. The conclusion

invariably directs to the importance of available resources, training and support through supervision, peer groups, self-care if, in this instance school counsellors, are to be better equipped, personally and professionally, to work with the suicidal student.

In comparison, Kleespies, Smith and Becker (1990) investigated psychology interns' incidence, experience and perceived impact of suicidal ideation. Although it was established that the participant suffered from stress levels after a patient suicide, it was not indicated what and how they articulated their feelings, but were reported to seek support from supervisors.

Reeves has carried out several studies to identify issues and dilemmas counsellors face when presented with a suicidal client and remarks on the depth of their feelings of hopelessness and powerlessness:

'Counsellors reported experiencing a range of distressing feelings when working with suicidal clients, including anxiety, fear, panic, impotence and doubts about their ability to practice, as well as doubting their own professional competence and their ability to work safely and appropriately'.

Reeves and Mintz, 2001 (p173).

Training, the participants in this study reported, had not equipped them adequately to work with this client group, and the added fear of litigation heightened their anxiety when working with this client group.

In a later study Reeves et al. (2004) investigated the dialogue of suicide in the counselling room, transcribing videotapes and using discourse analysis to analyse the data. The researchers found that counsellors rarely refer to the word 'suicide' directly and the reasons they gave for this observation and assimilated from previous research, and briefly referred to in par. 5.2. were possibly:

The nature of a counsellor's own view of suicide and whether or not they are able to 'tolerate' the idea of suicide morally appears to influence the nature of counsellor intervention (Neimeyer et al, 2001; Reeves and Mintz, 2001).

Mental health practitioners often fear that asking a person about suicide might put the thought into the client's mind and therefore change the nature of risk or the intensity of it (University of Manchester, 2002).

Counsellors do not always have opportunities to acquire and develop a 'risk awareness' in their core training (Reeves et al. 2004).

Counsellors do not always conceptualise the management of a boundary of confidentiality as making judgements about suicide risk (Reeves and Mintz, 2001).

Counsellors do not always ask about suicide because they feel fearful, incompetent, anxious, impotent or angry in response to the expression of suicidal ideas by their clients (Fox and Cooper, 1998; Trimble et al., 2000; Leenaars, 2004).

Reeves et al. 2004 (p69).

These points suggest that personal and professional factors may influence a counsellor's ability to effectively respond to a suicidal client. Feelings of incompetence are described by Kapoor (2006) as 'a wave of panic' (p11) which projected the therapist into thoughts of doubts and what they could have done in a different manner.

5.4.1 Concluding observation

Most of the studies discussed, in addition to their main focus of improving suicide awareness and prevention training, exploring (post) intervention and coping strategies for (trainee) practitioners, and investigating the different reactions to experienced trauma, such as countertransference and compassion fatigue, give some credit to the emotional fall-out experienced by the practitioner in this line of work. Focusing in training on for instance seminal work by Shneidman (1985; 1993; 1996, 2001) and Firestone (1997), who give in-depth theories on the workings of the suicidal mind may give the practitioner a more informed baseline to work from. Not many studies pay exclusive attention to the plight of the practitioner, and consequently particular research is scarce and I have had to 'borrow' relevant research from quantitative, and/or mixed method studies. In itself these studies are an extremely valid point of reference, however I wonder about the depth of an account of emotion when a participant is presented with a questionnaire to fill out, rather than being engaged in a one-to-one interview which can produce richer data.

Whereas the explanatory language in quantitative and mixed methods research seems more clinical and academic, directed at a professional audience, a qualitative study may present their findings in perhaps a more creative, more meaningful and, for the practitioner who may work at 'ground zero', usable language to communicate with.

5.5 The importance of training and its influence on practice

Rudd, Joiner, Jobes and King (1999) comment that 'suicide or suicidal behaviour cannot reliably be predicted' (p440). They note that available literature does not provide

us with appropriate guidelines for treating suicidal patients, mainly because of ethical issues involved in conducting research involving this group of individuals. However, they have also identified that a growing number of researchers are attempting to find out what will work under certain circumstances.

With this reflection of Rudd et al. (1999) in mind it can be assumed that however much training we aspire to as practitioners, it will most probably never be enough to counter the forces of unpredictability in suicidal intent. Nonetheless, attempting to try and understand the phenomenon suicide, from suicidal individuals' motivation to kill themselves, to understanding others' reactions to the suicidal actions, formal training will be one way. Formal training for those who work in the caring professions, or those who are the gatekeepers in society, for instance in education, will provide invaluable benefits for them in their efforts to support people who are potentially at risk from suicidal ideation. This training will not only have to focus on how to assess risk, but also, and perhaps more importantly, on how to establish a robust therapeutic alliance with the suicidal person.

5.5.1 The therapeutic alliance and training

Konrad Michel (2011) notes that the 'ability to establish a therapeutic alliance' develops through training and subsequent experience (p17). He refers to studies by Strupp & Binder (1984), and Hersoug, Hoglend, Monsen & Havik (2001), which indicated that observing a structured approach, such as the tenets of the psychodynamic paradigm provide, was the probable cause of a negative outcome in establishing a positive therapeutic alliance. Indeed, the study by Hersoug et al. (2001) found that patients would prefer to be supported by therapists who had little training and experience, rather than being seen by therapists with a psychodynamic background. This finding was attributed to, and what I perceive to be quite a generalization, the fact that a psychodynamic therapist would be less likely to seek support and patient background information; possibly, as pointed out in paragraph 5.6.4.2., as a result of unresolved countertransference issues. However, equally Michel (2011) refers to studies by Crits-Christoph, Siqueland, Chittams, Barber, Beck, Frank and Woody (1998), and Krupnick, Sotsky, Elkin Watkins and Pilkonis (1996), who, to the contrary, identified that well-experienced therapists practicing from a psychodynamic point of view were able to successfully establish an effective therapeutic alliance. They assumed therefore that some structure can only be productive. Conversely, the thought may also be that their way of being with a patient/client is one of the more deciding factors for practitioners to be positively effective in building and maintaining a therapeutic relationship, rather than

having received formal training and I refer to the study by Battista (2008) of trainee clinical and counselling psychologists, discussed further in this segment (par.5.5.3).

The focus of the above studies concentrates primarily on the medical modalities, whereas in education, where the teaching staff has an invaluable gate-keeping function, the training opportunities seemed to be sparse or lacking.

5.5.2 Suicide awareness and training in education

In this paragraph I have highlighted five studies that focus on the difficulties that teachers experience in their work environment through lack of appropriate resources.

In a study exploring high school teachers' experiences with suicidal students, Freedenthal and Breslin (2010) looked into suicide prevention training for teachers. They found that evidence of research in this area is very sparse. More than half the teachers in their study (58.8%; n=120) reported having had a student disclose suicidal ideation to them. The median hours of specific suicide prevention training this cohort of teachers had received during their career was two. They further refer to a study carried out by King, Price, Telljohann and Wahl (2001) who investigated 226 high school teachers, half of whom had ever encountered a student disclosing suicidal ideation and less than half felt able to recognize suicidal thoughts and feelings in students. How many teachers had received suicide prevention training could not be determined.

Another study by Westefeld, Kettmann, Lovmo and Hey (2007) found that a considerable number of the teaching staff was uninformed regarding high school suicide. Their study identified the need for suicide prevention training for teachers. Being uninformed on the prevalence of high school suicide, leads to believe that not only the students may be put in peril, but equally so the teachers who have not been appropriately educated in the possibility and frequency with which student suicide occurs.

Davidson (1999), who carried out an earlier study, involving a short one hour suicide prevention training, on the responsiveness of teachers of children and young adults to suicide prevention training, determined that after the training they received the teachers were increasingly proactive in dealing with disclosed suicidal ideation.

The latter study underpins the findings of a more recent study by Tompkins, Witt and Abraibesh (2009) who established that dedicated suicide prevention training programs in schools would have a possible reasonable effect on for instance school personnel's self-worth, attitudes towards suicide prevention strategies and general knowledge.

Christianson (2007), in a study exploring the experiences of qualified school counsellors, comments on the positive implications of having received appropriate and nationally standardized training. School counsellors would draw strength from focused training and hopefully be adequately equipped, in addition to access of additional resources. These resources are identified as support systems consisting of peer groups, professional assistance, as well as personal ways of looking after the self, and considered a necessary requisite to be able to withstand the emotional intensities of working with suicidal ideation.

The above studies suggest that although it is an established thought that training facilitates practice it appears still wanting for teaching staff. However, The Suicide Prevention Resource Center located both in the United States and the United Kingdom, offer extensive information on suicide awareness and prevention, and a dedicated webpage provides training information targeting teachers. It gives guidance to teachers regarding recognizing and responding to warning signs in their students.

5.5.3 Suicide prevention and intervention training for psychology students

Investigating a different discipline from education, Battista (2008) conducted a study in suicide risk assessment and intervention training focusing on the impact this might have on clinical and counselling psychology therapists in training. He found that specific training related to suicide was lacking in core clinical psychology training. The disappointing level of offered training in this area resulted in the trainee therapists feeling deskilled when assessing potentially suicidal clients, adding considerably to their stress levels. However, when having received adequate training and believing to feel more competent and skilled, Battista (*ibid*) did not find a correlation between the amount of training and the trainee therapists' feeling confident and skilled enough to work with suicidal clients. Their stress levels remained high. Battista (*ibid*) concluded that no matter the amount of training offered and received, working with the suicidal client was essentially fearful and stressful. The depth and intensity of working effectively with suicidal clients is encapsulated in the study by Cooper (2005), who explored the counsellor's experience of 'relational depth' (p87). He quantified this expression as a profound feeling of being with the client which was experienced as intense feelings of empathy, transparency, acceptance, and he concluded that:

'the experiencing of relational depth is one of the best predictors of therapeutic outcomes' (p93).

5.5.3.1 Accessible training resources

It is perhaps prudent to mention at this point LivingWorks (<http://www.livingworks.net/>) which offers accessible suicide awareness and prevention training, such as ASIST (Applied Suicide Intervention Skills Training), safeTALK, suicideTALK and suicideCare, programs directed at the public in general (suicide- and safeTALK), caregivers (ASIST) and professionals (suicideCare), a resource often provided free.

The University of Oxford Centre for Suicide Research, linking suicide prevention organisations worldwide in pursuit of the advancement of suicide prevention strategies, and The Centre for Suicide Prevention at The University of Manchester, working in conjunction with other research groups to update policies and service planning, are leading research organisations that not only focus on the advancement of policies, but also signpost those in crisis and provide resources when seeking knowledge in suicide prevention.

Mental health professionals who had received training in suicide risk assessment were found by Herron, Ticehurst, Appleby, Perry and Cordingley (2001) to have a more positive approach towards suicidal clients and they called for negative mind-sets to be addressed in formal suicide risk training. A more recent study by Oordt, Jobes, Fonseca and Schmidt (2009) confirms the findings of Herron et al. (2001) as they identified in practitioners an overall positive improvement in managing suicidal clients, as well as changing suicide care practices, and policies, after having received relevant suicidology training. It would support them by having access to not only others with possible shared feelings and experiences, but also to training material and further guidance on the topic. Having access to the 'right policy and guidance material document –whether it is at institutional or individual level- can be the safety net' (p17) for the counsellor. As referred to before, Reeves and Mintz (2001) also hold dear the learning to be gained from listening intently to the client and what is and is not said by her.

5.5.3.2 Moving towards training in risk assessment

It appears that formal suicide training focuses in particular on the suicide prevention and intervention strategies and technicalities of assessment procedures, such as for instance discussed in Duffy and Ryan (2004).

5.5.3.2.1 Clinical risk assessment and human connection

As referred to earlier, the importance of the therapeutic alliance within suicide prevention strategies has been brought into the academic interest through the philosophy of the AESHI Group, who calls for a strong emphasis on 'being with' the client in the therapeutic relationship. This combination of strategy and in-depth human connection with the client is an intervention measure Shea (2002) refers to when he explains the implementation of the CASE approach (Chronological Assessment of Suicide Events). The CASE approach is a tool for clinicians to determine when manipulation by the patient is present –in order to gain access to professional support- or whether the client presents with serious and lethal suicidal ideation. In recognition of the positive effect of a healthy therapeutic relationship Shea (*ibid*) remarks that 'the ability to develop an early alliance, while simultaneously attempting to tone down the immediate crisis via concrete problem-solving and solution-focused intervention' (p200), often has a positive effect on further consultation with the suicidal client.

5.5.3.2.2 Risk assessment training in counselling

In a study exploring risk assessment training on counselling courses Reeves, Wheeler and Bowl (2004), remark that in particular in the UK there is 'little evidence' (p236) of training in suicide risk assessment which is included in counsellors training courses, although globally the importance of this is acknowledged quoting studies by Appleby et al. (2000), Herron et al., (2001), Neimeyer et al., (2000), Trimble et al., (2000), Werth (2002) and Westefeld et al., (2000). As mentioned in par. 5.2.1, fear can be an overriding factor in working with the suicidal client and that training would provide a platform for counsellors to address and 'explore their shared fears about suicide' (Reeves & Nelson 2006, p17) and to work competently with suicidal ideation (Neimeyer, Fortner and Melby, 2001).

5.5.3.2.3 Risk assessment training for clinicians

From the medical discipline, studies by Jobes (1995); Oordt, M.S., Jobes, D.A., Rudd, M., Fonseca, V.P., Russ, C., Stea, J., Talcott, G.W. et al. (2005); Oordt, M. S., Jobes, D. A., Fonseca, V. P. and Schmidt, S. M. Oordt et al. (2009) focus on the evaluation of professional training in clinical suicidology (Jobes, 2011). In summing up the former three studies Jobes (*ibid*) remarks, that 'training across mental health disciplines is possible' (p390), however is often insufficient say Trimble et al. (2000). Jobes (*ibid*) further states that significant levels of change in confidence, knowledge and attitudes were noted after completed training, but he expressed doubt over the sustainability of recommended new practices for clinicians, as clinicians may prefer to stay with

practices they know and are comfortable with when faced with difficult situations, and refers to the familiar quote of: 'teaching old dogs new tricks' (Jobes, *ibid*).

Westefeld et al. (2000) found in an earlier study that although, in particular trainee counselling psychologists were exposed to clients presenting with suicidal ideation, specific training covering the area of suicidology, was rare. In other studies, for instance by King et al. (2001), and later Westefeld (2007), the importance of and need for suicide risk awareness and prevention training which focuses on trainee teachers have been pointed out. Oordt et al. (2009), approaching the topic from a medical perspective report that clinical care would improve through offering specialized formal training in practitioners attitudes and their behaviours towards the suicidal client, no doubt, ultimately 'a life-saving endeavour' (p31) in the future they assert.

5.5.4 Concluding remark

The above explanation further suggests that the lack of specific suicidology training cuts across different disciplines; and that the debate on the subject continues, without a firm training outline which is geared towards and suitable for the specific disciplines.

5.6 'Caught in the client's psych-ache': Vicarious Traumatization.

'.....there is a cost to caring.....'.

Figley, 1995 (p.1).

There is significant literature exploring practitioner burn-out, over-involvement, identification, affective reactions, and vicarious traumatization. As I have referred to in my research proposal (Moerman, 2009) exploration of vicarious traumatization often focuses on those working with sexual abuse issues and post war traumas, and studies focus on either the traumatized clients without for instance identifying the nature of the trauma or naming trauma as a collective name for amongst others violent crime, war, genocide, rape (Buchanan, Anderson, Uhleman and Horwitz, 2006; Pearlman and Mac Ian, 1995), or practitioners working with sexual abuse issues (Chouliara, Hutchison and Karatzias, 2009; Bride, 2007), and other disciplines such as for instance the law (Vrklevski and Franklin, 2008), Mental Health (Buchanan et al. 2006; Schauben and Frazier, 1995, Alexander, Klein, Gray, Dewar and Eagles, 2000)), education (Christianson and Everall, 2009; Freedenthal and Breslin, 2010), and social work (Bride, 2007).

5.6.1 The research story so far

Most of these studies deal with identifying the impact suicidal ideation has, and how people should look after themselves, rather than addressing the impact on their practice and equally, if not more importantly the impact on their person and private life, how they have experienced being exposed to trauma and how they deal and have dealt with it.

Reeves, Bowl, Wheeler and Guthrie (2004) question the level of impact that 'personal history, level of training and experience of working with suicidal clients, and death acceptance' (p69) would have on the counsellor and in quoting Niemeyer et al (2001) point to 'the ability of the counsellor to respond to suicidal clients' (p69).

Although I identified research which focuses on practitioners' and therapists'-in-training experience of working with traumatic material, (Kleespies, Smith and Becker, 1990; Reeves and Mintz, 2001) as previously discussed, research into the area of the affects and effects of suicidal ideation on counsellors is limited, and research involving person-centred counsellors' experience of working with traumatic material virtually nil.

5.6.2 'Qualitative questions' answered by quantitative methods

It is surprising that in exploring the level of distress, which is difficult to quantify, if not impossible, some of these studies use quantitative methods to analyse the data. Having said that, Schauben et al. (1995) and Alexander, D.A., Klein, S., Gray, N.M., Dewar, I.G. and Eagles, J.M. (2000) utilise mixed methods, which not only focused on the workload of practitioners working with sexual abuse survivors but further explored the levels of their distress and their consequent support strategies using a qualitative approach. Alexander et al. (2000), conducting their predominantly quantitative study amongst eligible consultant psychiatrists in Scotland, used a qualitative method to analyse data from questionnaires, which posed the question to consultant psychiatrists to identify their most distressing suicide, which was answered by half of the participant consultant psychiatrists. The impact on their personal lives was reported by 33% of the participants, quoting irritability, sleeplessness, low confidence. However, the focus was predominantly on suicide prevention strategies and the need for training was highlighted, training which not only addressed suicide risk but more interestingly and enlightened, the certainty of suicides. Comparing this study with a study from an educational discipline, study by Freedenthal and Breslin (2010) on high school teachers' experiences with suicidal students using a 'pen-and-paper survey' (p85), reported on direct and indirect contact with the suicidal student, i.e. whether students

had directly mentioned personal suicidal thoughts and feelings or those of others to the teacher. Freedenthal & Breslin (*ibid*) commented on the failure to explore the emotional implications of contact with suicidal students.

Others use empirical methodologies, Pearlman et al., (1995); Hendin, Pollinger Haas, Maltzberger, Koestner, and Szanto (2006) respectively choosing a quantitative method of data collecting and analysing, and, Chouliara et al. (2009) who reviewed relevant literature and, on the basis of their findings, called for further investigation into the effects on counsellors/practitioners working with this kind of trauma.

Dexter-Mazza and Freeman (2003), in an investigative survey of trainee psychologists' assessment of the adequacy of their training with respect to suicide awareness, give an informative overview of the existing similar studies (Kleespies et al. 1993; Neimeyer, 2000; Trimble et al. 2000, Dewar, Eagles, Klein, Gray and Alexander 2000), which provide analogous findings to their own. Dexter-Mazza et al (*ibid*), in support of these studies, found the results of their study 'troubling' (p216), as only one half of participants indicated that they had received formal training suggesting that many a patient/client may not receive appropriate treatment. They quote Neimeyer (2000) who argued:

'when such training is offered, it is typically limited to risk factors and a cursory discussion of 'no-harm' contracts, coupled with the ethical necessity to report and prevent self-injury. Needless to say, this leaves trainees substantially unprepared for managing the complexity of actual suicidal crises'

(p551).

5.6.3 The missing 'experience link'

Winter, Bradshaw, Bunn and Wellsted (2009), in their meta-analysis, offer a systematic review of quantitative and qualitative studies focusing on the prevention of suicide. In their review they consider both the effectiveness and process of counselling people presenting with suicidal ideation.

Noteworthy is the fact that of the approximately two hundred studies examined by Winter et al. (2009), only three studies focused on training skills in counselling and psychotherapy (Amish, 1991; McLeavey, Daly, Ludgate & Murray, 1994 and Wheatley, 2000), and five studies specifically investigated counsellors' or therapists' experiences, reactions to and perceptions of working with suicidal clients (Gurrister & Kane, 1978; Araminta, 2000, Reeves & Mintz, 2001; Rubinstein, 2003; Reeves et al., 2004). There appears to be a plethora of studies which explore the effectiveness of

psychotherapeutic approaches and strategies, such as cognitive-behavioural interventions, dialectical behaviour therapy, and psychodynamic therapy, and the effects these intervention and/or treatment programs would have on the client. However, there is a significant lack of information on the experiences of the practitioners and the effects working with suicidal ideation has on them. The role of the therapeutic alliance, created through the profound engagement of client and therapist is pivotal in the therapeutic relationship as identified by Michel & Jobes (2011), however the topic is sadly minimally addressed if not nearly forgotten, judging by the scarcity of available literature.

5.6.4 Compassion fatigue, countertransference, vicarious traumatisation.

Like Reeves (2010), Reeves et al. (2004) and Reeves and Mintz (2001), Rudd and Brown (2010) draw attention to the challenges of working with suicidal patients which may lead to personal reactions. They state reactions such as ‘fear, aversion, malice, ‘empathic dread’, which may lead to an avoidant or fear-based treatment that is not in the patient’s best interest, and may lead to a violation of ethical principles ultimately putting the client at risk’. (Everall & Paulson, 2004, p32). Rudd et al. (2010) suggest as part of twenty-two points practice recommendation for clinicians working with suicidal patients, to:

‘Monitor and respond to countertransference reactions to the suicidal patient (particularly those that are chronically suicidal) and routinely seek professional consultation, supervision, and support for difficult cases’ (p443).

A point that is easily transferable across different disciplines.

Personal reactions to difficult narratives of clients and patients, for instance fear, malice, and aversion such as pointed out by Reeves (2010), Reeves et al. (2004), Reeves and Mintz (2001) and Rudd and Brown. (2010) may lead initially to feelings of emotional and physical tiredness, being less attentive, becoming careless within therapy, not listening attentively, not interacting as usual with family and friends, sleepless nights, in other words compassion fatigue, popularly known as ‘burn out’.

‘The unspoken message is if you are burned out its already too late’.

Fahy, 2007 (p201).

5.6.4.1 Compassion fatigue or burnout as secondary trauma

Burn out or compassion fatigue (as identified by Figley, 1995 cited in Fahy, 2007) encourages dialogue between practitioners and supervisors about the risks involved in working emphatically with difficult clients, patients, and situations. (Fahy, *ibid*). Compassion fatigue or secondary traumatic stress is a slow moving, invisible and intangible entity which, when it engulfs, overpowers the individual. Fahy (*ibid*) clarifies the difference between secondary trauma and compassion fatigue, with the former seen as a condition and the latter a process, because she states, the symptoms for trauma stress 'parallel PTSD (post-traumatic stress disorder), while compassion fatigue may encompass philosophical and policy work stressors that devalue workers as a whole'. (p202). Empathic engagement can have a detrimental effect on counsellors' effectiveness working with clients who present with traumatic experiences which may have further recriminations on the counsellor's place of work, as Sexton (1999) suggests. Everall & Paulson (2004) in recognizing the emotional costs involved in 'the ethic of caring' (p32) ascertained that training with a focus on the risks involved in working with trauma leading to secondary trauma and burnout has only just been introduced for trainee counsellors, a notion earlier acknowledged by Pearlman and Maclan (1995).

Compassion fatigue as defined by Farber (1979, 1983) and Freudenberger, (1975) in Fahy (2007):

'..Exhaustion of a practitioner's mental and physical resources attributed to his or her prolonged and unsuccessful striving toward unrealistic expectations (internally or externally derived)..' (p201).

5.6.4.2 Countertransference

In his critical review of literature on the reactions of therapists to working with trauma Sexton (*ibid*) focused on three concepts that are similar, i.e. countertransference, compassion fatigue, and vicarious traumatising. Countertransference, he explains, happens in all therapeutic relationships, is attributed to work with a particular client, and when not addressed will have adverse effects on the therapeutic relationship, and can lead to devastating and a potentially fatal outcome.

Countertransference as explained by Maltzberger (2011):

'..when empathic capacity is blocked, there will be a tendency to distance oneself from the subjective experiences of patients in trouble...' (in Michel and Jobes, 2011, p44).

5.6.4.3 Vicarious traumatisation

Vicarious traumatisation, on the contrary, is the effect of long term working with traumatic material involving more than one client. Sexton (*ibid*) quotes Figley (1995) in defining compassion fatigue (secondary traumatic stress) as ‘the natural consequent behaviours and emotions resulting from knowing about a traumatising event experienced by a significant other and the stress resulting from helping or wanting to help a traumatised or suffering person’ (p395). In other words feelings of helplessness and powerlessness temporarily overpower the ‘helper’ emotionally (crying, shaking) and physically (tired, exhausted). Investigating protective factors which soften the risk of practitioners being vicariously traumatised when they work with trauma Harrison and Westwood (2009) found that they possessed a plethora of strategies to avoid such a condition. Supervision, training, personal, and professional development, organisational support, mindful awareness, spirituality, optimism and holistic self-care (extensively explained on pp207-213) are the areas Harrison and Westwood (*ibid*) identify. However the participant sample in their study was purposefully selected. It consisted of experienced clinicians (at Masters or Doctoral level), many years (10+) of experience, and noticeably ‘self-identified as having managed well in this work’ (p206). It therefore gives an interesting, in-depth and informative description of approaches to look after their own emotional and physical well-being.

Vicarious traumatisation as defined by McCann and Pearlman (1990):

‘Vicarious traumatisation: a long term alteration i.e. therapists’ own cognitive schema, or beliefs, expectations and assumptions about self and others’ (p.132).

5.7 A positive thought and hope

Although limited in presentation, given the above portrayal of negative impacts on practitioners when they engage in working with trauma, Chouliara, Hutchison and Karatzias (2009) refer to the positive aspects of working with this client group. They quote and cite studies on personal growth gained through working with trauma material (Benatar, 2000), as well as ‘unexpected benefits’, such as ‘increased spiritual and existential well-being’ (Brady et al. 1999 in Chouliara et al., 2009, p55).

The person-centred counsellor in particular, by the very nature of her approach, non-judgmental, congruent, emphatic, and respectful, striving for deep psychological contact to understand the whole of their client strives to instill hope in the client and hopes that the actualizing tendency inherent in individuals (Rogers, 1951) will result in

psychological re-adjustment, resulting in a positive outcome. Rudd and Brown (2011) contend that to give, find, and have hope is almost certainly seen as the 'vehicle of change' within the therapeutic relationship, and in emphasizing the approach of the Aeschi group state:

'The therapeutic relationship is the vehicle of change for suicidal patients'

(p178).

5.8 Conclusion

The above identified literature and the apparent lack of specific relevant literature strongly suggests that my focus area is under-researched and consequently, that knowledge about the person-centred counsellor's experience of engaging with the suicidal client and its subsequent impact on their personal and professional life is little or not known.

Although my interest and research in this topic started well before the more recent development of changing social policies with regard to proposed cut-backs in funding across the board but notably to the public health sector and education, a recent article (December 5, 2010) in Scotland on Sunday highlighted for me again the necessity of paying attention to the 'plight' of the counsellor. The article 'Student suicide fears as mental health cuts loom' by Fiona Macleod emphasizes that mental health services in universities are already 'fire-fighting' and more pressure is to come for the counselling services when students find their financial situation becomes increasingly difficult, through less work opportunities versus having to work more hours to be able to pay their fees. Expected higher numbers of referrals set against diminished resources will put additional strain on counsellors available, in particular those working with emotionally high impact suicidal clients. My own experience as a manager of a counselling service in the mental health sector in Scotland, which as a charity depends heavily on funding from the local health board, confirms that pressure is mounting for the counsellor.

Thus, less funding and an increase of client referrals, which it is perceived has been brought on by the HEAT^{vi} targets, set by the Scottish Executive, will put added pressure on those working with vulnerable clients and suicidal clients in particular.

^{vi} HEAT targets for 2011/12

Throughout the year, people from across NHSScotland have worked with their stakeholders to develop the HEAT targets for 2011/12. The targets for 2011/12 focus NHSScotland on working with its partners to deliver services that will support the Scottish Government's quality ambitions and wider national outcomes.

For 2011/12 there are 17 targets which set out the 'performance contract' between Scottish Government and NHS Boards. The key HEAT themes this year are:

Health Improvement – themes

- Taking action to address Scotland's major public health challenges with an increased emphasis on disadvantaged groups and ensuring children get the best start in life. Working to embed health improvement services as part of the 'health offer'.

Efficiency - themes

- Supporting NHSScotland to maintain financial balance and to maximise efficiency savings to reinvest in frontline services, through eradicating waste and modernising healthcare services to improve the quality of care. Continuing to lead the public sector on its action to tackle climate change through carbon emissions & energy consumption targets.

Access - themes

- Introducing for the first time new maximum waiting time access targets for alcohol misuse and psychological therapies, which will help tackle some of Scotland's biggest economic and social problems. Delivery of the 18 weeks Referral to Treatment target improving quality of care through removing the uncertainty and worry for patients caused by unnecessary waits for diagnoses and treatment.

Treatment - themes

- Improving patient safety through further reductions in healthcare associated infections (including MRSA and C.diff). Improving access to stroke unit care and reducing the risk of disability as well as death.

6 DISCUSSION

'It is our duty to see that the suicidal person's right emanates from his or her unbearable pain and that only the ability to understand and to address this pain grants us the basis for intervention'

Orbach, 2001, (p141).

6.1 Introduction

As, from the beginning, this thesis has been written with the practitioner in mind I will start with a word for them, followed by a short explanation of the core category 'The Counsellor's Resilience'. Next in this chapter the research question in light of the findings will be considered, I will discuss the findings in relation to the available and relevant literature I have identified, and finally reflect on the limitations of this research.

6.2 A word to the practitioner

This thesis has been written with you in mind. From first-hand experience I am very well aware of the difficulties you are faced with when working with the suicidal client. The soul searching involved, about the 'rights' and 'wrongs' of wanting to end your own life, that may occupy your thoughts. The doubts you may have about 'doing it right', saying the right thing at the right time, not underestimating the client's potential intent when she is vague in her indication of suicidal thoughts and feelings. The ensuing hours spend in supervision, with line managers, peers and perhaps even with a family member, speaking about the 'not knowing', the intangible, the uncertainties, perhaps the fears you may have, not finding the words to express what you feel, and exploring your deepest frailties with them. But you live in hope, in hope that perhaps the next time it will be easier, better for the client. Your inner resilience and your external support system provide the strengths to be there and meet your client at the next appointed session. Your client lives in hope, in hope for finding an answer to the innermost demons that plague her so, in hope for being heard, in hope for being seen. Your undertaking as a counsellor is laden. I acknowledge that fact. Unfortunately, as is evident from the literature review research into the experience of the counsellor working with the suicidal client is sparse and with regard to the experiences of the person-centred counsellor, it is unknown.

Ultimately the relationship you have established with your client, may give her the confidence to part with her deepest feelings and struggles, and enable her to provide that hope for her.....

6.3 The Counsellor's Resilience

6.3.1 The definition of resilience:

'Resile: recoil, rebound, resume shape & size after stretching or compression; have or show elasticity or buoyancy or recuperative power'.

From: The Concise Oxford Dictionary of Current English, 5th Edition, 1964.

'Strength, toughness, adaptability, hardiness: the resilience of human beings'.

From: Collins Thesaurus of the English Language – Complete and Unabridged 2nd, Edition 2002.

6.3.2 The core category revisited

As discussed in Chapter 4, Findings, the core category 'The Counsellor's Resilience' emerged as a hidden, but powerful theme from the four main categories through my interpretation of the participants' process through the four identified stages of experiences in their work with the suicidal client. Further into this chapter (Paragraph 6.4. p134) the interrelatedness of the four main categories which merged into the core category, and its perpetual circular movement of experiences, is resumed.

The acknowledgments of references to the definitions of resilience are signposted in red.

6.3.2.1 Examples of resilience in Main Category I. Experiencing the Therapeutic Encounter.

In each of the main categories a moment can be identified in which the participants' resilience can be recognized. In Mcat 1 Vanda describes how she feels at ease and grounded with her clients' choices and the position she finds them in. She stays with her clients in their distress and acknowledges her own weaknesses by potentially 'putting up a shield', and ponders: *'...do I want to or do I not and what the consequences are....'* (p61), concluding with conviction: *'....I will stick with it...I will not leave....'* (p58) (*elasticity, hardiness*). Ali, remembering difficult situations in which her clients may have inferred suicidal intent was able *'to manage these situations as well as she could...'* (p66) (*adaptability*).

6.3.2.2 Examples of resilience in Main Category II. Experiencing the Self within the Therapeutic Encounter.

In Main Category II, category 4 refers to the resilient self. Strength would be found in spirituality, either through quiet contemplation in prayer, or from enjoyment in nature, and belief and hope in the future. This would bring the participant renewed energy and faith in the meaning of life, and *recuperative power*.

Eva would *'be sitting in some quiet prayer, actually that can be very powerful for me....it's very comforting...I catch myself up....to keep going with what is going to happen next.'* (p83).

Robert wrote poetry to express his experiences *'...not a very good poem...but I think it did help....'* (p84).

Mary's belief in the human survival instinct gave her hope and *'.. it keeps me going. Yes...it keeps me going....'* (p84).

6.3.2.3 Examples of resilience in Main Category III. Seeking Solace – 'finding understanding'.

Supervision, either with their clinical supervisor, through informal peer groups, or with other professionals in their workplace, provided participants with the abilities to develop their self-awareness in that they knew when they needed to take 'time out', and how to look after themselves. But also that they could trust the thought that they felt being held, supported and valued by them, and that they were acknowledged in how their work with this client group affected them.

Anna: *'.....[supervision] ...increases my awareness of fitness to do the job....'* (p88).

Patrick: *'.....and put lots of things in place to get plenty of support and not waiting until it's a crisis anymore.....'* (p90).

With the last example Patrick referred to his engagement with supervision groups and encounter groups which he actively sought and in which he was able to bring his issues and develop his own 'internal supervisor' to keep a check on his own emotional and professional wellbeing, and *'rebound and resume shape'* emotionally after harrowing sessions with his clients.

6.3.2.4 An example of resilience in Main Category IV: Grounding in Knowledge.

In this category it was obvious that most participants did not only find grounding in conventional knowledge alone to persevere and continue working with their suicidal clients. The usual ideas of gaining knowledge such as through literature or training, but also through believing in and building on their own values and beliefs, and their

personal experience was for most participants the comfort zone they needed as their innate support when their work became difficult and confirmation they were doing 'the right thing'. It would leave them with a heightened sense of self-belief, and self-awareness: *'....I feel perfectly confident setting with them [the suicidal client].....thinking about it.....'* (p98) (*strength, buoyancy*), Julia said, smiling reassuringly with a new 'bounce' in her voice. Eva was equally confident that her training had given her tools to look after herself effectively because a focus on 'self-awareness' had been an important part of her person-centred training course she said and it had led to her *'...really knowing me...knowing who I am...'* (p103) (*strength*). This provided her with the ability to sustain her work with the suicidal client.

6.3.2.5 Commentary to the core category.

The above examples are testimony to the participants' ability to 'rebound' and 'recuperate'. It shows how they are able to adapt to the situation and reflect their flexibility, spirit, stamina and their strengths, through self-help, i.e. 'self-talk' and 'self-monitoring' find personal and professional grounding. Christianson and Everall (2009) recognized this ability or strength in their study on school counsellors' experiences of client suicide and remarked that they found that their participants had felt no other option than to stay in the school system and work with suicidal students. Some of the participants 'even embraced the opportunity to work with that highly-demanding population as they believed their personal loss helped them grow professionally' (p162). Although other studies (e.g. Tompkins et al. 2010, Freedenthal and Breslin, 2010, Alexander et al. 2000, Trimble et al. 2000, Schauben and Frazier, 1995), may report the impact several aspects of working with suicidal clients has on practitioners' professional and personal life, and it can be reasonably assumed that they continue working with this client group; specific mention of resilient attitudes is sporadically made. As far as I have been able to determine, only Christianson and Everall (2009), Harrison and Westwood (2009), and Smith (2009) have identified this characteristic of human resilience in their research studies. Harrison and Westwood report on the positive and life-affirming disposition of the participants in their study. The philosophy of these participants enabled them to see 'the gift side of loss, which is to say that devastating experiences can also be generative, and that these are not mutually exclusive', this meant Harrison and Westwood continue, that their participants recognized that 'pain and positive transformation coexist' (p210). The participants further stated that they felt their personal and professional life had been enriched by their working experiences with trauma material. Smith comments that working with trauma lets people get in touch with the dark side of human nature, which facilitates

practitioners 'to acknowledge the pain, the resilience, and courage of normal people who have endured impossible events. Listening to their narratives and trying to connect takes you to the core of what it is to be human' (p155). These findings are suggesting that practitioners' personal positive outlook on life and the ability to convey this professionally in their interaction with their traumatised or deeply distressed client, without denying the client the acknowledgment of this trauma or distress (Orbach, 2001), has not only a positive effect on the therapist, but also hopefully on the client.

6.4 Considering the research question

The research question posed was:

'What are the long and short term effects of working with suicidal clients on the person-centred counsellor?'

Although a relatively and seemingly easy and straightforward question to put forward, the answer was not as clear-cut and presented itself in four different areas which interacted, correlated, and interrelated with each other. The reality of which was recognized by Harrison and Westwood (2009). They reported that the themes they identified in their study identifying protective measures to prevent vicarious traumatisation of mental health therapists that themes 'emerged within and across clinicians' narratives of practices' (p208). The 'themes' or 'main categories' in this study were equally derived from the narratives of experiences of the participants and the one would fuel the other, and the other was unsustainable without the former.

As the long term effect of working with the suicidal client evolves from and in turn has an effect on the short term effects of the same, once again showing its interrelatedness, I will for clarity's sake, discuss each main category separately. Although the Main Categories have been followed in this discussion chapter, I have not necessarily followed the subsuming categories for each of Main Categories, as discussion would cut across categories and sub categories.

6.5 Discussing Main Category I: Experiencing the Therapeutic Encounter

6.5.1 Moving away from the critical moment

Reeves (2010) has dedicated his work to counselling the suicidal client. He assimilated 'the essential aspects of working with suicidal risks in counselling' (pp166-168) and gives perhaps the most exhaustive overview to date. The thirteen points he refers to all deal with the moment the counsellor is confronted with the risk of a client's suicidal intent. The participants' experiences of the initial therapeutic encounter with the suicidal

client are reminiscent of the plethora of feelings, insights, and actions in the moment, as Reeves (*ibid*) describes. By acknowledging and being open to the client's distress, and diffusing the initial critical moment by staying calm, by conveying a feeling of hope to make sense of the blackness, being able to 'name' suicide, explore and facilitate the client in their understanding of their distress, participants felt they offered a safe and congruent environment in which it was hoped the suicidal client would be able to express and explore their state of deep distress. As will become apparent from further explanation of the Main Categories, these helpful characteristics of the participants occurred through their experience and understanding, and on-going drive for not only gaining further knowledge, but also an awareness of self-care. Reeves (*ibid*) states the importance of knowledge of policies of organisations counsellors may work for, being aware of their ethical framework and how it may be helpful and hindering their actions, for example with regard to the boundaries of confidentiality, and knowing where to access further resources to facilitate their practice. Awareness of these points gave the participants the confidence to provide a safe enough and congruent environment for the suicidal client.

In being able to name 'it', was also a helpful aspect for the participants as they themselves were made aware that there might be '*still that moment of thinking*', as Ali stated. Orbach (2001) asserts that each suicidal person will experience an inner struggle between a wish to die and to live, even then, he says, 'the decision is not final' (p140). Therefore being able to focus on that moment and listen to the suicidal client's language and verbalize her demeanour, a statement which might verbalize how the client felt, and hear her story, will be imperative to allow the client to voice her pain in her own words (Orbach, *ibid*). Some participants reported being in favour of asking questions about the events that led up to the client's suicidal intent. This stance may well be the difference between life and death for the client, as Orbach (*ibid*) states, if we are not willing to hear the client's story, but only verbalize her argument, i.e. reflect her line of reasoning, she may feel her argument is valid and the consequences may be fatal.

Orbach's (*ibid*) point is supported by Reeves, Bowl, Wheeler and Guthrie (2004) who concluded that being reflective rather than explorative may well exacerbate the feelings of despair in the suicidal person 'rather than restore hope' (p70). However, one participant's experience was that in reflecting back what the client had said was thought to be helpful for both client and counsellor as it would provide clarity for both.

6.5.1.1 The loop of options – the facilitation of hope and its meaning

Although contracting is not necessarily seen as a person-centred approach to the risk assessment process (Mearns, 1997; Worrall, 1997; Merry, 2002), this study showed at times participants would negotiate an agreement (see also Mcat IV, p101) and felt by doing so had delayed the client's decision and opened up the dialogue for options and change.

Even though it might be perceived as 'being directive', the participants felt they had facilitated the client's process and by offering a loop of options finding 'a way back in' for them. Reeves and Mintz (2004) found that the counsellors in their study did not engage in any formal contracting with their suicidal clients. Indeed, they would leave the clients to set their own boundaries, which may result in fatal outcomes (Hendin, Pollinger Haas, Maltsberger, Koestner, and Szanto, 2006). In an unpublished study, carried out in preparation of this thesis, I investigated the person-centred counsellors' experiences of assessing risk in the suicidal client. Within the process of assessing risk four main categories were identified (see Appendix M). One of the main categories 'Ambiguity of Contracting' explains the inhibiting and facilitating aspects of contracting.

Inhibiting because the client might feel they are pressurized into making a choice, but conversely if they felt comfortable with the contract it might give them a voice, restore autonomy and therefore might be facilitating.

Inhibiting because it might prevent clients from opening up, although ultimately it might protect them, however it was recognized it would protect the organisation, and the counsellor. It was felt that client autonomy was put in jeopardy and contracting could take away from the genuineness of the therapeutic relationship.

For the participants in this study, an agreement or 'contract' gave them an option, to not only provide a pathway to change for the client, but also safeguard them ethically.

Contracts according to Bond (2000) are important in particular when informed consent is the issue, and he quotes:

- the procedures or methods to be used, and
- any risks and benefits, and
- being informed of relevant alternatives (Bond 2000, p88).

Embedded within the loop of options lies the possibility and expectation of hope. Offering hope will restore the feeling of hopelessness in the suicidal client. Brown, Wenzel and Rudd (2011) refer to 'the hope kit' (p283) used in cognitive behavioural

therapy and which consists of items which have a specific and special meaning for the suicidal person, for instance a photograph, a postcard, anything of value for that particular person. The 'hope kit' for the person-centred counsellor lies within the formed therapeutic alliance, the core conditions applied and the whole of the self-offered. Weinberg, Ronningstam, Goldblatt, and Maltzberger (2011) point out 'alliance-facilitating factors' (p296) that focus on a fear of death, the wish to live and get better, but also highlight the importance of attachment towards the practitioner which may engender hope. In discussion with practitioners they have commented on the importance of attachment and when it was not present, when the client appeared detached they felt the client did not connect in psychological contact. Not to be confused with, as one participant pointed out, the risk of becoming emotionally attached as a counsellor. Whereas the client will glean hope from the counsellor's acknowledgement, respect, listening to, empathy and honesty, the counsellor may become overwhelmed and risk becoming over involved.

6.5.1.2 Balancing the therapeutic relationship

Within the therapeutic relationship boundaries, duty of care, responsibility and hope were touched upon most. The therapeutic relationship in itself was thought to be important, and crucial with respect to feelings of responsibility towards the client. The strength of the relationship and the level of responsibility were experienced by one participant as dependent on one another. The therapeutic alliance has been described by Michel (2011) as a 'major, although largely unspecific, therapeutic element that keeps the suicidal person alive in the short term as well as in the long term' (p24). This is an important point to make as in the case of Ali who felt the therapeutic alliance had not been established when the client disclosed strong suicidal intent and felt she needed at that point involve other professionals as she thought it was not her responsibility at that moment. Michel (*ibid*) further contends that a strong therapeutic alliance forms the basis for effective therapy. He considers the establishing of a therapeutic alliance an art form at the core of which lie the core conditions of empathy, honesty, respect, but also being able to listen attachment, and give hope. When however the time is not there to establish that connection on a deeper level, the counsellor has a responsibility, a duty of care to client and self to keep both safe.

Boundaries of confidentiality were at times stretched by some participants by involving others, professionals or family members, but only if appropriate and it warranted the client's safety, or to keep themselves distanced from the crisis by setting strict time boundaries. Trust and confidentiality are undeniably linked. The Ethical Framework states that 'being trustworthy is regarded as fundamental to understanding and

resolving ethical issues' and 'restrict any disclosure of confidential information about client to furthering the purposes for which it was originally disclosed'. (BACP 2011, p5). However, the BACP Ethical Framework also points to the practitioner's obligation to be mindful of the circumstances in which disclosure is considered, as is reasonably possible and to be appropriately accountable for decisions made' (p5). To keep oneself safe, contained and competent within the therapeutic encounter could become difficult when the participant felt overwhelmed by the hopelessness and helplessness of the client, as one participant recalled and who had felt she was 'almost colluding' in the client's feelings of deep distress. It was deceptively easy another participant stated to become emotionally attached.

Bond (2000) states that when a counsellor has 'reasonable grounds for believing that the client is a serious risk of committing suicide' (p103), breaking confidentiality may be considered in the best interest of both client and counsellor. And as in the case of Ali, who felt the therapeutic relationship was not established, and she felt she could not deal with the client at that particular moment, it was in the best interest of both herself and the client to involve others. As did one participant who in caring for the client's wellbeing made the decision to reach out beyond the official boundaries and spoke to the client through an intermediary to determine the client was safe.

An awareness of keeping a healthy balance by keeping boundaries appeared to be a key for finding the equilibrium between over and under involvement, a situation which may result from issues of counter transference as is further discussed in MCAT IV. The emotional issues arising from counter transference, has 'a potential of disrupting the [therapeutic] alliance' (Dalenberg 2004, p441). These disruptions impact on the self of the practitioner and are further highlighted in MCAT II.

6.5.1.2.1 The complexity of suicide

The complexity of suicidal ideation and the vagueness and mystery with which participants have to work is made clear by participants reflecting on the impact suicidal ideation had on keeping the professional and personal separated:

'I have to be able to divide those two categoriesI have to be professional, objective....but I wouldn't be human if sometimes if I did not let my emotions impinge...sometimes on that...'. Lea.

Shneidman (2001) wrote: 'There is no simple answer to the enigma of suicide..' (p5). His statement supports the intricacy of the participants' experience of their 'being' with

the suicidal client in that encounter where suicide is referred to, and trying to understand it. Participants reported to respond to an instinctive feeling that something was not the way it should be and, although, as mentioned before (Par. 6.5.1.1. p136) practitioners may be inhibited by their own traumatic history, they would draw from their personal experiences to answer their 'gut feeling'. Vanda stated that the ensuing 'conversation' with her client made her feel that '*ending life was a possibility*' for the client. Therewith opening the channels of communication and establish psychological contact with the suicidal client.

An intrinsic part of the therapeutic encounter revolved around the ability of listening to and being able to handle the often graphic detail of the suicidal clients' narratives.

Narratives as such are testimony to the need for counsellors to be aware of the duty of care they have to self and underpin the suggestions of Harrison and Westwood (2009) that self-awareness and self-care training strategies is essential, as discussed in MCIV, par.6.8.5.

The doubts participants felt whether they had acted appropriately within the therapeutic encounter but had been left guessing whether their intervention had been effective, had a direct effect on the self and further practice and has been referred to in MCII.

6.6 Reflecting on Main Category II: Experiencing the Self within the Therapeutic Relationship

Suicidal thoughts and feelings, from mild to overwhelming are not rare and are presented significantly in the practices of the participants in this research project. Significantly, perhaps not in the number of instances these thoughts and feelings are presented and represented here, but significant rather in the level of impact. The impact of working with a suicidal client often has a considerable and intense bearing on the counsellor, personally and professionally.

Whereas in earlier studies the emphasis regarding impact of working with suicide was placed on work practice, more recently studies have recognized the effects working with the suicidal client group have on the practitioner. For instance, Chemtob, Bauer, Hamada, Pelowski and Muraoka (1989) and Trimble, Jackson and Harvey (2000) who studied the impact of patient suicide on psychologists and psychiatrists reported mainly on the effects this had on the clinicians' professional life rather than their emotional well-being. With 'professional life' was meant 'the therapists' work settings, allocation of professional time, and kinds of disorders among patients treated' (p297). Conversely, studies by for instance Alexander, Klein, Gray, Dewar and Eagles (2000), Harrison and

Westwood (2009), Christianson and Everall (2009), Smith (2009), but in particular by Reeves (2010) culminating in his work 'Counselling Suicidal Clients', have all acknowledged the impact working with suicidal clients has on the practitioner.

6.6.1 Following and reacting to the client's hurt.

Sensing and observing the client's emotional pain, the fear, guilt and shame they may feel, was experienced by the participants with a sense of incredulity. Utter astonishment at what the client may resort to in trying to find a way out of their pain: *'..He said he was going to douse himself in petrol....and set himself on fire to punish..it felt incredible...'* Patrick recalled. In contrast Anna was amazed to repeatedly observe the clients' resilience in pulling themselves together after particularly distressing sessions: *'...she has no way out...but has the strength to go on and function even although she says every morning she thinks about suicide.....but it never fails to amaze me....'* These are two examples of the extreme emotional involvements counsellors are exposed to during their encounter with the suicidal client.

The emotional effects of sadness, anger, sorrow resulted often in a lack of concentration and insomnia, however at times the participants also reported to feel a level of composure, stillness, and a belief of hope. The latter feelings of hope and calmness point towards the therapeutic nature of the profession for the counsellor.

The fear of failing to be effective in their practice came from a situation of 'not knowing' what the clients' intentions may be, and which resulted in a state of feeling deskilled professionally, with a level of high anxiety personally. Emphasising the experiences of the participants in Harrison and Westwood's (2009) study, who accepted 'their inability to articulate or apprehend this mysterious, transcendent unknown' (p210), another participant, Mary, felt that it was just *'part of the job being able to hold the not knowing'*. Once again, an example of the difference in experiencing of the participant and, how being with the suicidal person affects each participant in a similar yet different way. Working at heightened levels of weariness and being very conscious of rising anxiety levels was related to as working at a deep relational intensity. Cooper (2005) who investigated therapists' experience of relational depth found that participants had reported increased awareness of the person-centred core conditions (i.e. empathy, acceptance and congruence) with being conscious of the client being congruent and acknowledging this to the therapist. The description of relational depth by the participants in his study sound like a synchronized therapeutic dance, both partners (client and therapist) being wholly in tune with each other. For the participants in this study the meaning of 'relational depth' varied in such that they felt the deep emotional

connection of understanding, a 'knowing' the suicidal client. The 'therapeutic dance' was not synchronized yet, it was tentative, exploratory, participant and client knowing, but not yet acknowledging. Ali contemplated: '*..She knew I was upset....she knew I would be affected by this.....*'.

Anger and fear, overriding emotions recognized in most relevant studies (for instance Reeves and Mintz, 2001; Reeves, Bowl, Wheeler and Guthrie, 2004; Dalenberg, 2004; Kapoor, 2006; Christianson and Everall, 2009) and identified by Rudd, Joiner, Jobes and King (1999) as 'non-therapeutic reactions', which they state, may lead to an 'avoidant or fear-based form of treatment that is not in the patient's best interest' (p443). Participants recognized withdrawal from their practice after an all-consuming period of working with a chronically suicidal client as the demands on the participant had been taxing to such an extent that she became physically 'avoidant' of the client. Another participant reported feeling emotionally 'avoidant', disconnected, as he would experience after recurring incidents of presented suicidal ideation. A reaction which may possibly have blocked his 'empathic capacity' towards his clients (Maltsberger (2011, in Michel and Jobes, 2011, p44).

In support of the above I further refer to Appendix N for some thoughts on issues of over-involvement, empathy and the 'as if' condition of empathy which I addressed in an exploratory earlier unpublished assignment in preparation for this study (Moerman, 2007).

Dalenberg (2004), as Harrison and Westwood (2009), comment on the countertransference issues, within the therapeutic relationship such as a negative processing of clients' fear and anger, and easily, these emotions expressed by their clients have had an effect on the participants in this study. However, most participants recognized the origin of their fear and anger, as well as the physical reactions they experienced, and were able to tend to these as is evident in MCAT's III and IV.

Physical reactions, such as breathlessness, heart thumping, disorientation, tiredness and shaken acknowledged the strenuous demands of being with the suicidal client. The participant in expressing their physical feeling would use an expression referring to their body as a container for their own anguish: '*..the heavy weight of the black ball at the pit of my stomach..*' Julia remembered. These physical manifestations may also be signs of countertransference which present themselves as parallel processes to that what the client is experiencing. An observation and thought I have not been able to sustain with any research evidence. However, trauma-related countertransference, if not acknowledged may result in the therapist practicing inadequately and therefore in

danger of being in breach of their ethical framework, ultimately putting their clients at risk (Everall and Paulson, 2004). Participants in this study recognized the signs of emotional and physical exhaustion and were able to control their stress levels through seeking and finding appropriate supports and supervision (Horne, 1995).

6.6.2 Expressing felt anguish

All participants in trying to make sense of and verbalize their experiences in working with their suicidal clients would make use of non-verbal signs of emotion, use of vivid language, and metaphoric language. Non-verbal signs of emotions could be 'a look of perplexity' on the participant's face when recalling a particular situation, or becoming pensive, sitting back in their chair, making involuntary, fluttering movement with their hands. The language participants used became vivid by using these physical expressions and using language which would intensify the meaning of their experiences. For instance 'being hit by a bus', 'stunned like a rabbit in the headlights' or 'feeling swallowed up'. I have not been able to identify research literature that discusses this specific manner of expressing traumatic experiences, which could be classified as informal coping strategies to diffuse traumatic feelings and thoughts. Reeves and Mintz (2001) refer to informal coping strategies however rather as 'ways of distancing themselves emotionally from the session' (p174). A strategy reported by participants in this study as well, who would start to feel disconnected from their practice after suicidal ideation had been presented, but also effect their 'being with' the client. The metaphor is a powerful tool to communicate strong expressions of feelings, thoughts, beliefs, and values. Both client and counsellor can explore the different meanings of their experiences in the same setting by using metaphoric language in an attempt to explain these experiences (Linehan, 2008).

Rennie (1994), albeit in a study investigating the rhetoric of the client in therapy, points out the importance of narrative in the experience of storytelling. He argues that language is an important tool for a client to relive their experiences. For a client to feel heard and understood, in particular when specific issues are being dealt with, a sensitive use of language is important in an effective therapeutic relationship. In a further study by Watson and Rennie (1994) on a client's experience of significant moments during therapy, they found that clients use specific clear and vivid language to enable them to make sense of their reaction with the positive effect of eliciting change. This observation by Rennie (*ibid*), and Watson and Rennie (*ibid*), I feel, is just as valid to apply to the narrative of the counsellor's experience of their 'story' when

recalling their intense experiences with the suicidal client, an observation that points to the bond between client and counsellor.

6.6.3 Engaging the ‘wounded healer’: connecting with self and client

The participants spoke of reflecting on their previous personal experiences concerning suicidal ideation which they felt gave them the confidence and ease to be as real as possible, and be compassionate and understanding of their suicidal client. They were helpful, supportive, and also more mindful of the suicidal person in the therapeutic encounter because of their personal experiences, participants reported.

Neimeyer, Fortner, and Melby (2001) believed that a personal history of suicidal ideation, as well as personal beliefs on a person’s right to suicide negatively influenced a counsellor’s ability to work effectively with the suicidal client group. This statement appears to contradict the experiences of the participants in the current study, of whom a few had a serious suicide attempt in the past, and all bar one participant had experienced previous serious suicidal intent/attempts. Using past experiences has been highlighted by Michel (2011) as a positive phenomenon in therapy sessions. Therapist and client understand ‘each other’s actions and words through relevant past experiences, personal beliefs and direct knowledge’ (p22) and are thus able in a mutual understanding to arrive a new insights (Michel, 2011). From the participants accounts it appeared to have given them an advantage rather than a hindering approach in their practice as they were able to recognize their own distress and weaknesses in the face of the client’s hurt, and their own shortcomings within their ‘being with’ that client.

The value of being able to connect with the client, hearing and acknowledging them and in doing so steering away from a possible lethal outcome (Orbach, 2001), would have an empowering effect on the suicidal client Patrick felt: *‘..it could make the difference between somebody literally taking their lives or not...’*. Patrick’s thought is reminiscent of the importance of the therapeutic alliance The Aeshi Group assigns to it (See Chapter 5, par.5.5.3.2.1. p121). Although participants did not relate whether they overtly disclosed their personal experiences to clients it is clear from the findings that they used these experiences in a positive manner, helpful for the suicidal clients. It can safely be assumed that the participants were able through their overall demeanour, i.e. body language, verbal expression, as is evident from the findings, to be transparent in such a manner as to be effective in their practice and secure a ‘safe’ outcome of a difficult session. Dalenberg (2004) emphasises the negative impact on outcome and client satisfaction when therapists present themselves as ‘blank screens’ (p438). The

participants in this study presented themselves as far from being 'blank screens'. Some participants felt a genuine curiosity to find out what motivated a suicidal client to act on their feelings and thoughts, but also they embraced new awarenesses regarding self and their practice, which felt to be seeking a way out of a personal isolation within the professional sphere and therefore conducive for professional and personal wellbeing. New awareness, as much as their connection with creative and spiritual interactions and connections (see paragraph 6.3.2.2. p132, and 6.7.2. p147) are helpful to sustain and enable practitioners to continue their practice (Harrison and Westwood, 2009).

6.7 Considering Main Category III: Seeking Solace – 'finding understanding'.

6.7.1 Supervision: Support and guidance

Invariably participants commented on the importance of and need for supervision and spoke of supervision to be essential, useful, a safe place to explore, to gain guidance, comfort, trust, and reassurance, and for the supervisor to be able to stay with challenging processes. Reeves (2010) gives a broad overview of what he considers 'the essential aspects of working with suicide risks in counselling', and 'the thought of it' he concludes, 'is staggering' (p168). He explains issues around confidentiality, duty of care to the client, ethical issues arising from subscribing to the ethical framework of the counsellor's governing body in relation to the policies and procedures of the organisation the counsellor may work for, be familiar with available resources, be self-aware with respect to their own views on suicide, be aware of the different levels of the meaning of suicidal ideation for different individuals, and the difficulties people may have in expressing suicidal thoughts and feelings and the skills counsellors need to explore the clients' distress. Finally, counsellors need to know where, how and what can support them in sustaining their professional life, but also their personal life, ethically and effectively. Considering the multitude of different thoughts, feelings, impressions, actions, and duties the counsellor needs to juggle at a crucial moment in the therapeutic encounter it can be safely assumed that the counsellor may struggle, personally and professionally, at times. Thereto Reeves (ibid) explains, counsellors need to apply self-care strategies and engage in regular clinical supervision. Participants indicated that in supervision they were given the opportunity to explore the subtleness of the moment when clients introduced their suicidal ideas, a point supported by Reeves and Mintz (2001) who identified the importance of supervision for counsellors to regain their notion of competence, personally and professionally, and 'to manage a sense of self-doubt and impotence' (p174).

To be held, to be able to discuss, get reassurance and explore their own fallibilities in supervision was mentioned by most participants in this study as being very important. Working with the suicidal client evokes the strong possibility of a heightened sense of incompetence in the counsellor of questioning whether they 'get it right' or have said 'the wrong thing'. These thoughts combined with their anxieties about the blurring of their boundaries through the emotional nature of this work, participants felt needed to be addressed in additional supervision sessions. Although the participants in this study who had a history of suicidal intent/attempt did not appear to be negatively influenced by this in relation to their work with suicidal clients, if anything rather the opposite. However, Pearlman and Mac Ian (1995), as did Neimeyer, Fortner and Melby (2001) identified the opposite to be true. The trauma therapists with a personal trauma history in their study showed more negative effects from working with trauma than those who had not experienced trauma. Therefore, being able to explore in a non-judgmental manner in supervision and to reflect on their decisions had a 'normative and formative function' on how the participants worked with their clients and how/whether suicide risk had been identified and responded to (Reeves, 2010, p152, citing Hawkins and Shohet, 2007). *'Someone to offload to, someone I can trust' was essential and useful* Anna parted with. As mentioned before in par.6.3.2.3, p132, it increased her awareness of fitness to do her job, one of the important aspects of working with the suicidal client as Reeves explained. Eva's contemplation underpins the argument of Pearlman and Saakvitne (1995a, cited by Sexton, 1999) who reason that supervision should be 'relational and interactive', rather than 'authoritarian and expert-based' (p400).

6.7.1.1 Supervision: a reality check.

Participants in this study addressed the issue of the boundaries of confidentiality and where their responsibilities lay, and their fear of becoming over-involved, and perhaps under-involved. Therapists are not responsible for making changes in clients' lives Harrison and Westwood (2009) concluded, keeping the boundaries of involvement strict for therapists. However exploring *'Could I maybe have asked in a different way....more open', was one thought, or 'I had a concern in myself that I wouldcould be over-involved'* another consideration, was legitimate to investigate in supervision to seek reassurance and gain confidence. Reeves (ibid), as indicated above, refers to the normative and formative function of supervision for counsellors to explore their reasons for approach or decisions, and he further cites Hawkins and Shohet (2007) by adding the restorative function of supervision, whereby the counsellor is given the opportunity, the space to 'heal', personally and professionally by being able to address the

emotional issues which arise in her work with clients. Professionally, the formative function of supervision will not only restore their self-belief in their practice skills and knowledge, but also influences the emergence of learning in three specific areas identified by Hawkins and Shohet (2000), and which they state 'are brought into relationship with one another:

- The client situation and context
- The supervisee's experience and understanding
- The supervisor's experience and understanding'

(p179).

Some of the participants had personal experience of suicidal intent and attempts and they in particular felt they needed 'to get it right'. Sexton (1999) comments, that counsellors who have experienced trauma themselves may need more supervision to work through lingering issues. An honest and open supervisory relationship is imperative, he contends. Participants felt their supervisor facilitated their internal supervisor, insofar that when the boundaries needed to be stretched depending on the situation, they were able to do so as they felt they had the support and trust of their supervisor. *'My supervisor trusted me enough to know that I would be safe....safe with the clients....that gave me confidence in what I was doing'* Anna said, recalling an instance whereby she felt her boundaries were 'flaky', but the circumstances involving a young student called for a more relaxed approach. In reaching out beyond the 'official' boundaries of counselling it was imperative to keep a 'reality' check on their way of working, keeping over-reactions and complacency in check, and supervision would provide that reassurance, participants felt. Sexton (1999) remarking on trauma therapists' self-care and professional accountability points to the importance of regular supervision as 'the work is too demanding to do without supervision, and should be understood as an ethical responsibility' (p400).

6.7.1.2 Supervision: effects of lack of support

Reassurance and guidance from a supervisor helps to challenge viewpoints and consider different perspectives, as it will validate and support the counsellor's practice and gives personal sustenance. Referring back to the afore-mentioned 'areas of unique experience' as proposed by Hawkins and Shohet (2000, p179) and their reference to a 'formative, normative and restorative function of supervision' (p51), a model proposed by Proctor (1988a), it appears that not only the supervisee will benefit from a trusting and balanced supervisory relationship, but equally so the supervisor. Further, Weak

(2002) identified three conditions for an effective supervisory relationship, 'equality, safety and challenge' (p33), embedded within four different styles of supervision seeking that focused on affirmation, practice, satisfaction and knowledge. West (2007) recognizes that, at times the supervisory relationship will fail to provide this support, as experienced by a few participants, and the effects for counsellor and client can be devastating. The counsellor may lose faith in her working practice, becomes unsure about decisions to be made and ultimately working with clients becomes unsafe. One of the participants, following the suggestion of the supervisor and against his own judgment of the situation, conveyed how he lost trust in his own ability to judge a situation with a suicidal client and how it had led to the breakdown of the therapeutic relationship with the suicidal client. This incident indicated the importance of a supervisory relationship on a mutual/equal level, where not only the supervisee needs to find the trust from the supervisor but equally the supervisor needs to trust the supervisee in making choices and decisions which in turn have been informed by the relationship established between supervisor and supervisee, equal supervisory relationship as proposed by Hawkins and Shohet (ibid), and Weaks (ibid). As Mary remarked, *'it is very much about the relationship I have with a supervisor'*. Paget and Wosket (1994) highlight the importance of the supervisory relationship. Poor supervisory relationships will inhibit the counsellor/supervisee and may lead to, as mentioned before, unacceptable outcomes, whereas a healthy relationship between supervisor and supervisee encourages the latter to disclosure and 'move the process of supervision forward and encourage open exploration' (p69).

6.7.2 Finding confidence and understanding

Not only did the participants find solace and strength in supervision or as one participant referred to, in encounter groups or group supervision, but holistic self-care was considered to be an important aspect of working with clients, and in particular when working with a suicidal client group.

Holistic self-care for most participants evolved around personal therapy, finding support from family and friends, through physical activity, such as exercise and gardening, reading, quiet contemplation, or expressing their distress in writing poetry, and through finding humour. Sexton (1999), who reviewed literature on the reactions of therapists to traumatic material presented by clients, refers to several authors on vicarious traumatisation (McCann and Pearlman, 1990; Munroe, Shay, Fisher, Makary, Rapperport and Zimmering, 1995; Pearlman and Saakvitne, 1995) who mention the benefits of humour for the spiritual balance of the therapist who works with trauma, and

although it may be difficult when faced with trauma it is an ‘essential aspect of being an effective trauma therapists’ (p400), he writes.

Harrison and Westwood (2009) comment that ‘self-care provides balance, and at times closure’ (p211). Self-care restores the therapists’ equilibrium and therefore they will be able to engage fully again in the therapeutic relationship, and also on a personal level. Being able to split the personal from the professional, as identified and explained in Chapter 4, Main Category IV, 1d, is also seen by Harrison and Westwood (*ibid*) as a form of self-care. A split, considered by one participant as particularly difficult; the participant felt that personal beliefs and feelings were at times difficult to separate as, for this participant it was an integration of who she was.

6.8 Discussing Main Category IV: Grounding in Knowledge

6.8.1 Knowledge through intuitive understanding

Being able to recognize and acknowledge suicidal intent but also being aware of one’s own vulnerability within their professional life participants recognized as a prerequisite to keep them safe in their practice. Knowledge participants would find in their understanding of the clients frame of thinking and take also the bigger picture into consideration. Death may be ‘*more appealing*’, and may be ‘*the right thing for them*’, a thought which has been recognized as valid by Orbach (2001) who suggested that ‘the narrative of loss’ (p143) would be the best approach to acknowledge the client’s state of distress. Orbach contends that the common denominator in each suicide is the discourse of loss, i.e. loss of a loved one, loss of status, financial loss, loss of a future, loss of limb. Therefore, he suggested, engaging in ‘extreme empathy’ (p141), might soften the barrier of loneliness for the suicidal client. Of course this does not mean the practitioner should imply to agree with suicidal intent, but acknowledge the suicidal client in their suicidal distress. Kinder (2006), in support of this ‘understanding of the bigger picture’ equally felt that it was essential to ‘stay within the client’s suicidal thoughts/hopelessness rather than rushing into reframing the cognitive ambivalence’ (p18). Knowing that inherent in each individual there is the innate drive to self-actualization, was what participants felt they could build on. However, self-actualization is depended on the state of the self, which Michel (2011) contends, is not a ‘stable mental structure’ (p186) but a continuously changing account of rationally thinking processes which are being recreated endlessly. If this be true, Michel states, ‘the self is a fragile phenomenon’ (p186). Considering therefore the stance of the participants, who know and believe in their client’s potential to inner strength for survival and

weighing off their client's wish to die against their inner drive for survival, but in their acknowledgment of their client's 'frame of suicidal intent', resist the temptation of rescuing their client. Omer and Elitzur (2001) in comparison call for an 'anti-suicide text' (p131). This means that at all times the practitioner should try to avert the potential suicide. And although they recognize that most mental health professionals would not agree with this straightforward stance, which feels directive and implies not hearing or listening to the client's narrative, they do propose that in extreme cases physical force may be used. Omer and Elitzur (*ibid*) assume that as long as the suicidal client is still alive there is hope, and they will try to persuade her by using their proposed anti-suicide text. Thus the question arises whether the client has effectively been heard. In this study the participants' clients kept coming to counselling, which Mary felt '*....tells me something....* ' ; but she also acknowledged that suicide might be more appealing for her client, and so acknowledging the client's thought processes.

6.8.2 Awareness of organisational policies and procedures

On a different note, being aware of and familiar with organisational policies and procedures (Kinder, 2005, Harrison and Westwood 2009, Reeves, 2010), if and when working in such an environment is crucial for the practitioner in general as they have to be aware of potential conflicts between themselves and other members of staff, which may then have a negative effect on their work with clients. One of the participants, working in a voluntary organisation specifically referred to this predicament when speaking about her strong outlook on the client's right of choice, which she felt was probably considered a contradiction with the ethics in the organisation. McLeod (2003) identifies several areas where conflicts within an organisational setting may arise, but interestingly has not touched on the counsellor's personal set of values and beliefs which may be in conflict with those policies and procedures of the organisation they engage with.

Areas of potential conflict:

- Being pressured to produce results by the agency rather than the client.
- Maintaining confidentiality boundaries.
- Justifying the cost of the service.
- Dealing with isolation.
- Educating colleagues about the purpose and value of counselling.

- Justifying the cost of supervision.
- Avoiding being overwhelmed by the numbers of clients, or becoming the 'conscience' of the organisation.
- Avoiding the threat to reputation caused by 'failure cases'.
- Coping with the envy of colleagues who are not able to take an hour for each client interview.
- Creating an appropriate office space and reception system.

McLeod, 2003, p419.

Being in perceived organisational ethical conflict, may have the potential of emotional disturbance for the counsellor, having a detrimental effect on the client. It is therefore important for the practitioner in general to familiarize themselves with these as to avoid hindering situations. Conversely, organisations should have established policies which encompass the general well-being of their practitioners, they should be aware, Harrison and Westwood (2009) argue, of the 'impact of traumatic work on clinicians and institute policy to hold caseloads to reasonable levels' (p208).

6.8.3 Understanding through personal experience

Although Neimeyer et al. (2001) found that counsellors' personal experiences of suicidal feelings and thoughts negatively influenced their work with suicidal clients, participants in this study reported they had gained skills from their own experience. It was often helpful, participants commented, to understand the level of the client's felt sense of hopelessness and their being caught up in the view that life was pointless. They were able, through their own experience of personal trauma, *to 'make sense of it'* as Mary remembered. It enabled participants to identify with her client in their experiencing in the moment, but at the same time hold the possibility of hope. The importance of providing 'hope' has been pointed out as a pivotal factor when working with suicidal clients. Hope has been described as passing on that life is meaningful (Harrison and Westwood, 2009), or even by offering 'a solution' (Orbach, 2001). The latter explains that in being able 'to touch the heart of the pain embodies the promise for better coping with a problem' (p143) suicidal clients attempt to have answered. Intense empathic engagement with the client's suicidal narrative, to be able to identify with their trauma and hear and acknowledge what they convey, but at the same time gently confronting the suicidal client by offering an alternative may change the direction of suicidal thought in the client (Orbach, 2001). This stance supports participants

accounts, who reported similar approaches to providing relief from their clients' state of dissonance, Shneidman's (1996) perturbation. From experience they knew to follow their clients' narrative of suicidal feelings and thoughts, rather than falling prey to trying to 'rescue' their client.

6.8.3.1 Importance of empathic connecting

I have not been able to identify any reference to the importance of practitioners' personal experiences on their practice, whereas it appears an important factor to be able to connect with the suicidal person in deep empathic engagement. Cooper (2005), and Mearns and Cooper (2005) refer to working at deep empathic engagement, meeting a client at 'a level of relational depth' (p87). Cooper recognizes that the area of working at relational depth is under researched at the time of his study and gives ample examples which are testimony to the feelings of in-depth connectedness of the participants. However, it has not touched on the fact that personal experience, a 'knowing' about the feeling of deep distress would enrich that moment of deep connectedness with a client, which would take working at relational depth a step further. Cooper (*ibid*) concludes that high levels of empathy, acceptance and honesty/genuineness is reported by, primarily person-centred, participants during relational depth experiences which not had a positive effect on the clients as they respond and are perceived as being 'very real' (p94), occasionally participants reported on feeling there was a moment of change, they felt slightly. This resonates with the experience of one participant, Julia, who experienced a heightened sense of self-belief, a new feeling that allowed her to be with clients at a deeper level. However, her 'new feeling' did not arrive through being with a client on an empathically deeper level, but the sudden insight that her own experiences were going to be helpful in working with the client at that level.

6.8.4 Learning gained through professional experiences

Professionally, the counsellor regards herself able to facilitate the client's process, preferably with a view to a positive outcome of the therapy. However, when this is not the case, and the client attempts, or worse, completes suicide, the counsellor's belief in their professional ability will be shaken to the core and they will put their level of competence in question (Chemtob, Bauer, Hamada, Pelowski and Muraoka, 1989; Alexander et al. 2000). Chemtob et al. (1989) referred to suicide as 'an occupational hazard' (p294), because, they contend, suicide is certainly not an uncommon phenomenon and its traumatic nature will therefore have a profound impact on the therapist, personally and professionally. The participants in this study were aware of

the impact suicidal intent and/or attempt had on them, and realized what they would do, and could not do. That is becoming and being aware of their own professional fallibility when confronted with the suicidal client as one participant recalled '*did I take the right action?*' or another participant for whom the client's suicidal disclosure felt '*very difficult*' and which made her realize how ill-equipped she was at the time to work with this client group. Christianson and Everall (2009) comment that there is little research into the personal impact counsellors experience in their practice. As I have mentioned before (par. 6.4., p134), the 'main categories' in this study sustain each other, referring to their interrelatedness in which it was difficult to present them as distinguished separate entities. This has been acknowledged by Berman, Jobes and Silverman (2006, cited in Christianson and Everall, 2006, p164) who state that professional and personal issues relating to client suicide become 'fuzzy' and that they are not mutually exclusive (Anderson, 2005; Berman et al, 2006, cited in Christianson and Everall, 2006, p164). Participant Anna in this study spoke of the difficulties in holding boundaries while counselling a young student and becoming involved in excessive contact with the client that extended into her weekends, and which became all consuming. The professional and personal intertwined here, physically and emotionally and difficult to separate and take a step back without proper support, supervisory and theoretical. Maintaining clear boundaries was one requisite Harrison and Westwood (2009) wrote to prevent being emotionally overwhelmed by working with difficult client groups. Participant Mary questioned whether she was able to separate entirely the personal from the professional because it was she said '*an integration of who I am*'. Perhaps it needs to be remembered that practitioners are human beings first and counsellors/therapists second. For practitioners to be able to support suicidal clients on an informed basis it is clear that to counter the impact this work has appropriate formal training should be available.

6.8.5 The need for training

Training will enable counsellors to recognize, acknowledge, and understand the effects traumatic experiences may have on them. This, Reeves and Nelson (2006) point out can be achieved by offering training courses which gives counsellors access to relevant resource material as well as guidance from professionals. Lacking formal training may leave the counsellor with feelings of personal and professional inadequacy, shame, guilt, and aversion. One participant indicated how the aftermath of a completed suicide had left him shocked and perplexed and he had 'no idea', no indication, suicidal thoughts were present, let alone a suicide was imminent.

Considering his recall of the incident which dated back twenty plus years, was still vivid, and with available training lacking the participant relied on peer support and supervision. Reeves, Wheeler and Bowl (2004) identified that 'training in assessment skills was located in clinical supervision' (p243). Risk assessment training (Reeves, 2005) to be able to recognize the suicidal indicators in clients, but also learn to recognize signs of their own vulnerability within this professional dimension, is a prerequisite for keeping themselves safe. The participants in the study by Harrison and Westwood (2009) drew attention to the specific need of 'training in self-awareness and self-care strategies' (p208).

6.8.5.1 The lack of formal training: 'there is nothing new'

To keep themselves safe, participants would pursue to broaden their knowledge base and access focused training. However they further commented how useful, but also disappointing and lacking in delivery it could be and what influence it had on their practice. *'It was superficial', 'it was very much left out of our training', 'it all seemed very basic training to me'* were but a few of the comments participants parted with. Although the necessity of formal training in the particular area of suicide is recognized and recommended in most studies focussed on working with suicidal clients in different disciplines (Pearlman and Mac Ian, 1995; Trimble, Jackson and Harvey, 2000; Everall and Paulson, 2004; Battista, 2008; Freedenthal and Breslin, 2010), it appears from the literature that to date formal training is still in its infancy. Although efforts are made with basic training packages offered by for instance LivingWorks (2004), and the resources available on the internet for education. However, participants also commented on the positive aspects of their counselling training.

6.8.5.2 Basic counselling training: 'lifting the veil'

The non-directiveness of the person-centred approach, showing empathy and being congruent, allowed them to be alongside the client and their believe in the client's ability to live to their potential, gave them the confidence they felt to work with suicidal clients and be able to hear, but also to gently challenge and confront their clients. Other participants commented on how they would be able to look after themselves because they knew who they were, an awareness of self they had gained during their person-centred training. A way of being captured by Orbach (2001) as:

'Obviously, the best way to the heart of any person in distress is by building the relationship on the basis of empathy and the extension of a human hand beyond the barrier of loneliness in an attempt to reach out to the hurting person' (p140).

6.9 Limitations of the study

The topic of suicide is in many areas of our lives still a taboo subject which has been, is, and will be proven to be difficult to speak about. So too, it proved to be for the participants in this study. Whereas some spoke confidently, quietly and open about at times their most intimate and at times heart-breaking experience, others were hesitant, and it showed that they did not find it easy, as a sentence would be left unfinished, or they would just say 'this is very difficult'. When this would happen I would offer to finish immediately, but invariably participants wanted to continue. I am aware that this may well have interrupted the flow of thought which then veered into a different, perhaps less enriched account of the participant's experience.

I am very well aware that sometimes the emotional aspects of the topic influenced my ability to 'stay' deeply immersed in the data, and in addition being the lone researcher, I therefore may well have missed to spot opportunities in the data that a group of researchers would have been able to identify. However, it has been my personal concern to do the participants justice in my representation of their innermost experiences they parted with during the interview.

This research being practice-based and carried out with participants not only known to myself but also practicing from a basis of similar values, beliefs and shared assumptions means one works from a tacit understanding. This understanding may therefore influence the participant not verbalizing possible important data. In doing so perhaps otherwise relevant information is omitted from the data.

However, there is potential rich data that emerges from trust, which the participants in my study felt they had through mutual understanding, but perhaps working with different approaches or disciplines may have yielded different data, and ultimately may have come up with a different finding or outcome. A researcher coming from a different approach, for instance psychodynamic, or a different discipline such as psychiatry, may approach a similar study from a different perspective and probably yield somewhat different data than the present study.

It further needs to be remembered that this research study is the outcome of a snapshot of a small group of practitioners on a particular day of interviewing with me. How we all are on that day will have influenced the data.

The client sample, although adequate, was relatively small, with eight females and two males, ranging in age from 45-74 years of age, and therefore not representative. Although all participants were person-centred, it needs to be taken into account in how

far their counselling approach has been infiltrated by different counselling approaches during their years of practicing.

As deadlines were to be kept, and most importantly daily life with its ups and downs continued while analysing data, it may well have influenced my level of immersion in the data.

In analysing data from transcribed audio-taped interviews, the narrative flow of language has become diluted as I heard it. In written text the intonation, the pitch, the intensity, the rhythm of the participants' speech is lost in translation, therefore possibly giving a different or perhaps slightly altered meaning to the experience of the participant, and therefore, relying on my interpretation of that experience on paper which may well have lost its depth of meaning, depending on my own state of mind and involvement at the particular time of analysis.

Although prompts, focused questions, were used to positively influence the richness of the data, not always did I adhere to the questions I was interested in having answered. When the participant indicated through their demeanour that it appeared difficult to stay with a particular thought and veered off I did not pursue, and followed the participant where they went. Ultimately, however, this offered a different set of rich data and therefore not necessarily warrants 'a limitation'.

Finally, English not being my mother tongue and being influenced by two additional languages, it is possible that I have missed or interpreted differently some of the linguistic nuances of the participants, again perhaps influencing a certain level of depth in the interpretation of the data.

6.10 Summary

As pointed out in the introduction this discussion has been written with the practitioner in mind, and started with words of encouragement to them followed by an explanation of the core category 'The Counsellor's Resilience', and the fluid movement of the counsellor's engagement within the therapeutic encounter as is represented in figure A, p54. Further discussion of the research question *-What are the long and short term effects of working with suicidal clients on the person-centred counsellor?-* followed, and the findings which have been presented keeping the format of the presentation of the findings chapter in mind to facilitate the reader.

'The prevention of suicide is everybody's business'.

Shneidman (1985, p238).

7 CONCLUSION AND RECOMMENDATIONS

In this chapter I will provide the reader with some concluding thoughts on this research project by summarizing its progress, offer recommendations for further research and, with a word to the reader, bring this chapter to an end.

To share with the reader some of the impact this study has had on me, positive and negative, a reflective statement, encapsulated in a short chapter, will finalize and complete my thesis.

7.1 Conclusion

My research aimed to explore the extent of the professional and personal impact suicidal intent and/or attempt has on the person-centred counsellor. As I mentioned at the onset of this research study, suicide remains a major public health issue within the UK. Death by suicide increased in 2008 to 5706, a rise of 329 deaths by suicide in 2007 (ONS, 2010). The latest available figures however show a slightly downward trend with a fall of 31 deaths by suicide in 2009 (ONS, 2011).

Therefore, suicide prevention strategies remain high on the public health sector agenda, and as I have noted before, this will most likely intensify the impact on practitioner, personally and professional.

I carried out this research by interviewing ten experienced person-centred counsellors using a responsive interviewing model (Rubin & Rubin, 2005) and following Creswell's (1998) suggestion of purposeful sampling. Embodied categorizing (Rennie and Fergus, 2001, 2006), a constant comparative analysis method, yielded four main categories which subsumed the core category 'The Counsellor's Resilience'.

The first main category 'Experiencing the Therapeutic Relationship' identified the participants' engagement with the suicidal client. The intricate 'dance' of their cognitive and emotional abilities is made apparent by the different categories within the main category. The ability to negotiate the critical moment, within this moment to negotiate the therapeutic boundaries and being able 'to abandon' their professional approach if necessary by stepping outside of their person-centred way of working, and engaging the whole of the self within the counsellor-client therapeutic dyad is discussed.

In the second main category 'Experiencing the Self within the Therapeutic Relationship, the self in relation to the experiencing of the suicidal client is considered, in particular with regard to reactions within the self, the connection of the self with the client in their

distress, the self who is curious and inquisitive, and the self who is resilient, who recovers and gets back to the task at hand.

Seeking Solace – ‘finding understanding’ is the third main category. It describes the support and coping strategies participants seek and find, such as clinical supervision, support through personal indwelling (spirituality), through human interaction and creative pursuits. Finally, finding understanding of the entirety of, and grounding in the encounter by means of the former creative and interactive activities.

The focus of the final category, main category four, Grounding in Knowledge, lies with the counsellors’ use of their intuitive knowledge, gained through personal experience, as well as their pursuit of further knowledge.

As discussed in paragraph 4.1, p54 the four main categories represented a circular movement which started and ended with their experience of the therapeutic encounter. From these categories an understanding of the participants’ resilience emanated which was evident by the expressions they used during their recall of experiences. The core category ‘The Counsellor’s Resilience’ ensued.

During the process of my research I have not identified any major visible or tangible breakthrough in lessening the statistics on suicide rates, nor has an infallible script emerged to prevent suicide. Despite increasing numbers of studies, reports and other relevant literature, as is evident from my literature review, discussion and the explanation ‘Research in Context’, Appendix A, p185, it appears to me that we are searching and researching, however not yet arriving at a satisfactory supposition. We are provided with reviews on studies concerning suicide, for instance by Winter, Bradshaw, Bunn and Wellsted (2009), training recommendations regarding suicide prevention skills, as in study carried out by Battista (2008), the investigation and explanation of suicidal behaviour and its origin as explained in the works of Firestone (1997) and Shneidman (1985, 1993, 1996, 2001), and to date occasional studies which are carried out investigating the effects working with the suicidal client has on the practitioner, such as the studies by Chemtob, Bauer, Hamada, Pelowski and Muraoka (1989), Alexander, Klein, Gray, Dewar and Eagles (2000), Reeves and Mintz (2001), Christianson and Everall (2009), Harrison and Westwood (2009), and Freedenthal and Breslin (2010). The studies by Chemtob et al. (1989), Alexander et al. (2000) and Freedenthal et al. (2010) were quantitative, mixed methods and quantitative studies respectively with n=100+. The qualitative studies by Reeves and Mintz (2001), Christianson and Everall (2009), and Harrison and Westwood (2009) all used a distinctively lower number of participants, ranging from four to seven.

With this observation in mind and the experiences related by the participants in this study, in particular the perceived lack of formal suicide skills prevention training which was expressed as superficial and basic, and considering the level of responsibility involved working with the suicidal client group the following recommendations are suggested.

7.2 Recommendations

7.2.1 Training recommendations

As most counsellors will encounter a suicidal client at one point in their practice, it stands to reason to assume that formal suicide prevention skills training is incorporated into their initial counsellor training curriculum. This does not always appear to be the case as is evident from this study.

Therefore, initial counselling training should cover risk assessment procedures and what this would mean in relation to organisational policies and procedures, and in terms of the organisations ethical framework and the counsellor's ascribed ethical framework with regard to that of the organisation counsellors may work for.

Further issues to be incorporated in counselling training programmes, such as the importance of the therapeutic alliance when working with a suicidal client in particular, the topic of responsibility, latently present however often mentioned fleetingly, and training regarding professional distancing, that is wearing an armour coat within their empathic being with the suicidal client, would be beneficial for the counsellor in their professional practice.

Being made aware of the high potential incidence of vicarious traumatisation and being able to recognize the early signs thereof in self, as well as having knowledge of the ensuing holistic coping strategies available would further benefit the counsellor in carrying out their practice in a wholesome manner.

7.2.2 Research recommendations

The studies of Pearlman and Mac Ian (1995), and Neimeyer, Fortner and Melby (2001) found that having personal experience of traumatic events and suicide would have negative effects on their practice. The former reported that practitioners experienced higher levels of negative effects from working with this client group, and the latter that their personal history of suicidal ideation showed negative effects on their counselling skills. In contrast, the participants in this study reported that their earlier personal experiences of suicidal ideation made them more aware of the difficulties clients were

facing and they would feel comfortable with the emotions surrounding the issue. However, the relatively low number of participants in my study compared to the 188 participants (trauma therapists) in the study of Pearlman and Mac Ian (*ibid*) and 131 volunteer psychology and counselling psychology students, as well as a group of hotline volunteers from a Suicide and Crisis Intervention Service in the study of Neimeyer et al. (*ibid*), leads me to suggest that a more extensive research of my current research, involving a greater number of participants may provide a truer picture. Furthermore, these studies, including my own study, base their findings on the experiences of the counsellor-client approach. It would be helpful to find whether the client would have the same experience and interpretation of the interaction between herself and the counsellor to determine what is actually helpful and what is hindering in the therapeutic encounter.

Research on personality types to determine whether some individuals would be more effective than others working with this client group, or even cross-cultural studies, to see if counsellors in countries where suicide is 'forbidden' would be better or worse in their practice, may add valuable information to our knowledge base, which ultimately may benefit the client.

7.3 And finally, a word to you the reader

How can you capture the true extent of the hopelessness and helplessness of the suicidal client? Although often intangible in its wordless expression, at times their despairing emotional pain is physical. Shneidman (1985) recognizes hopelessness and helplessness as 'the common emotion in suicide' (p131). It is an emotion filled with feelings of psychological weakness turning into despairing thoughts that nothing but self destruction can stop. 'The desperate individual provokes his fate' states Lowen (1967, p97), explaining that in desperation people may go too far in their suicidal attempts. Each time a desperate act is carried out the suicidal person will find herself further removed from life, until the distance becomes too great and only finality can and has been reached. I have mentioned in the discussion chapter (paragraph 6.1.2) that the undertaking of the counsellor is laden but that they have hope, hope that next time the suicidal client will feel better, but also to have the knowledge that the client will live in hope, hope that support is offered. This may however also put a burden of responsibility onto the counsellor, professionally and personally.

Working with suicidal clients should be like any other topic in counselling, but the nature of suicide, as pointed out, is so far reaching with respect to the impact of the

thoughts and feelings of the intent of the suicidal client. The way we treat suicidal clients is as we would act towards any client, with respect, no matter their intent. The difficulty arises, because we have to constantly monitor the client, a change in behaviour, in demeanour, verbal expressions, in keeping vigilant to any of these changes that may occur. This presents an enormous responsibility for the counsellor, professionally and personally.

We have to be knowledgeable about not only the issues surrounding the suicidal client, such as the ethos of care to them, the ethos of care to self, the policies and procedures of organisations we may work for, but also be aware of the consequences when a suicidal attempt has been completed. The raw and complicated grief of those bereaved by suicide focuses on the emotions of guilt and shame, and long-lasting ruminating thoughts about the 'why' and the 'what if'. Having worked extensively myself with those who have been bereaved by suicide I have experienced the unspeakable grief that leaves people voiceless. The knowledge of the potential extensive implications of suicidal ideation leaves its mark of responsibility again on the counsellor, professionally and personally.

I was asked what my general thought was that evolved from this study. I journeyed through my work, and I can only say: counselling is difficult, it is very difficult.

8 REFLECTIVE STATEMENT

This short statement bears witness to some of my more poignant experiences while working on my research project. Although at times deeply personal I felt compelled to share them with you, the reader, just as the participants had found the courage to share, at times, their most private feelings and experiences.

8.1 An 'explosive' start

I arrived at a profoundly disappointing stage when it became clear at the university review panel that I had 'to drop' part of my intended research as it proved to be 'dynamite'. The dynamite part of my research centered on the experiences of therapy for the suicidal client. The panel strongly advised me not to continue with that part of the proposal. Their reaction to it was quite robust. It scared me and although I passed the panel, it felt the most important part had been ripped out. Driving back home I felt deflated. First I did not understand why I should feel so low, as I had 'passed the panel'. It dawned on me 2 hours driving up North, back home, that I had lost something. I had lost the core of my motivational spirit that had driven me to embark on the Doctorate. Since doing my Masters, for which I investigated the experiences of clients with alcohol related problems receiving person-centred counselling, and during which a friend had taken her own life, I wanted to focus on the particular client group with suicidal ideation. The death of my friend had left a scar, and it had not been the first time I lost a friend under similar circumstances. I could not quite understand why what had happened to her, happened. I needed to know more, what had her thoughts been, how could I have helped, why was it not noticed, how deep had her pain been, why? How could we, should we have intervened? It became a pressing need, but also curiosity for me to investigate the answer. That need still has not evaporated, the curiosity slightly satisfied now that I have had to delve into the seminal and not so seminal works on suicidology and suicide. One thing is clear to me, 'the why' is still 'a why', some theorists come close, but there is still always at the end a tiny question mark, as I believe that we will never be able to exactly predict the fatal actions of the suicidal person, in particular if they may not know themselves exactly why they feel and act so. We can guess and we can theorize to try and get some understanding and support the person, but I feel in the end we need to let go and accept the course of events.....

8.2 A pivotal moment

In my second year of the doctorate a close friend disclosed to me that she was suicidal. Not 'feeling suicidal', but 'suicidal'. It felt very immediate to me and it came like an unexpected bullet that hit right into my heart. I was shocked, panicked and was very angry. Not exactly the reaction we read about a counsellor should have. I knew my reaction had not been the desired one and my excuse was that I was 'emotionally involved' because it was a very good friend. In my work I see, on a daily basis, clients who present with suicidal ideation, and am always present. I am not scared to be with the suicidal person. Therefore, my reaction to my friend's disclosure, kept to myself, was shocking for me. Needless to say the emotions were explored at length in supervision and personal therapy. It highlighted for me, in practice, the marked difference between the 'therapeutic' involvement, our 'being with' our loved ones and our clients.

8.3 Methodological angst

Methodology was a difficult issue. For a long time I felt I had chosen the wrong methodology for my data. I read Rennie's article on conceptualizing (1988) again and the last paragraph opened the door slightly for me, and which told me that technically I was allowed to structure my choice of words in any way I wanted and it would be appropriate for my chosen research approach. That was a relief. Discussing the matter with my academic supervisor, he also suggested I should 'draw up my own set of rules', which I felt would be a bit pretentious. However, he meant I should figure out my own rules after carefully reading Rennie's. That opened the door a little bit further and brought clarity to my at that moment confused methodological mind. I had been afraid to analyze wrong, and to do an injustice to my participants. I had not anticipated how scary this work could be. A method needs to 'click' for me, I need to be sure of it and support it. Interpretive analysis, I find, is subtle and difficult to convey. I do not think there is a new truth to be discovered.

8.4 Hermeneutic chaos or getting lost in research

Analysing the data provided a difficulty for me that I had not anticipated. It took several weeks to a few months of struggling with Nvivo, only then to realize that the 'roughness' with which I tried to understand its workings, was within me. I did not have the visual connection with my data I would have when I was doing it 'by hand', I was afraid I would get lost somewhere in the depths of computer software. I remembered

saying to my supervisor that I was a 'visual person, but that I still tried to keep the whole lot contained in my computer'. I felt in chaos. I have a problem with 'getting lost', losing my way, feeling lost, and it is a recurring nightmare, a fear which clearly flowed over into my data analysis. I immersed myself frequently in thoughts on how I should approach the amount of data best and willed myself to keep as much to the outline of data analysis as proposed in my methodology. I found that to be nearly impossible because of the amount of data I was working with. But I discovered, that working on a limited amount of data I could concentrate on effectively without losing myself in it, I 'divided' the data up in reasonable, for me workable chunks. It might not have been the correct way, but it was manageable for me.....A decision I came to finally after four extremely intense days of soul searching, sleepless nights, being very upset and feeling sick.

8.5 Being overwhelmed and scared

The process of writing my thesis was, I felt, wrought with parallel processes. I was very concerned at times that the subject matter would engulf me and purposefully I would work on my project regularly in order to make progress but not at long periods of time. I felt that I needed time out often as at times my thoughts became 'cluttered' with 'strange' ideas. For instance how easy it was to find ways of ending life through listening to so many different impressions, experiences and thoughts participants had conveyed that went through my mind. It was scary and warranted to involve my personal supervisor and therapist to discuss these matters regularly. Not long ago a client said to me: 'an angel sits on one shoulder and the devil on the other', incongruently smiling while she said it, being in such emotional turmoil and suicidal. I could imagine the internal dialogues she would have with her other self, and thinking that the angel and the devil were the voices that argued with her. Again, a pivotal moment for me because, although my own experience with the research cannot be compared with the torment of a client, I could imagine how devastatingly tiring it must have been for her and I physically felt the flow of her emotional pain.

8.6 Some immediate thoughts

8.6.1 On 22 January 2011

Working on Chapter 2 Literature Review, the initial consideration, I am aware that talking about not having preconceived ideas about experiences of others will be difficult for me because coming from a background which has the 'notoriety' of being

opinionated, from the perspective of the country I grew up in as well as the smaller 'household' I took my initial learning from, functioning according to the methodology of Rennie which has its grounding in the philosophy of Husserl will be a tough act to follow. But hopefully not impossible and I am strengthened by the knowledge that Rennie does voice his concern that a total transcendental attitude (McLeod, 2001, p38) may or will be impossible.

8.6.2 On 12 February 2011

Doing this on my own is restrictive and directive. I feel I am biased by my own thoughts, values and beliefs. I couldn't help but seeing certain strands within the data after having conducted the interviews, transcribing them before starting the analytic process. However I cannot also be either right or wrong. It's the bind the lone researcher is in, I have been reading somewhere. Of course I have to be able to and capable of showing I am 'fit' to conduct a substantial piece of research however a little bit of interaction with another human being to bounce ideas off on would be welcomed. Not to have constructive feedback from peers is a lonely place to find yourself in and might well be that through that and the fact that I am more or less 'biased' (or stuck in?) from the beginning I may have missed some crucial point?

8.6.3 In July 2011

This statement is a short deliberation of the many thoughts and feelings that flowed through mind and body while I was working on my thesis. I hope it has given you, the reader, a little insight into the tribulations of my journey. Of course there have been moments of triumph and glory when *the* category emerged or a new insight surfaced, but how do you verbalize an 'aha' moment, but with an 'Aha!'?

8.6.4 The final thought

I finished today the 21 August 2011. What have I gained personally from this study project? It has enriched my personal life by getting to know some wonderful people, by getting to know myself better, learning of my limitations but more so my strength of determination to complete this research despite some difficult setbacks.

Marijke, September 2011

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APPENDIX A

The Suicide Paradigm – research in context

Introduction

This overview will give an indication of the multifaceted and intricate nature of the phenomenon suicide.

To place my study in context I felt it would be helpful to address briefly a few key points around suicide to emphasize the difficulty concerning the work with this particular client group. In this chapter I will highlight the multi-causal, multi-faceted nature of suicide and the interaction and relationship of the unique individual with sociological, psychological, economic, and political forces in relation to the suicide phenomenon.

Suicide is a multi-faceted phenomenon in which the taboo factor is still very much prevalent. Self-inflicted death has a negative connotation when the word 'suicide' is used, however is associated with a positive and heroic meaning when it is paired with self-sacrifice. A poignant example is the downing of United Airlines flight 93 during 9/11 by its passengers to prevent greater loss of life. There are different types of self-inflicted death that most of us are aware of, such as 'by cop' (the suicidal individual taunts the police into shooting him), euthanasia, copycat suicides (an example of which was thought to be the well reported suicide by young people in Wales in early 2008, parasuicide (when attempts are made but not completed), mass suicides (Jonestown, 1978; Waco, 1993, Heaven's Gate, 1997), and the 'suicide bomber'. The category of 'suicide bomber' could be classified as 'murder-suicide' (Wikipedia, 2010), a kind of suicide which in itself can take various forms, murder to facilitate suicide, such as recent reporting in the media of parents who kill their family and then themselves, or suicide to facilitate murder which unfortunately too often happens in today's climate of terrorism. In my own circle of colleague practitioners we may speak of an impulsive suicide, or of a person being chronically suicidal. We may speak of passive suicide, when for instance it cannot be determined whether an accident was accidental or deliberate.

Whether it is through philosophical contemplation, political interventions, cultural values and beliefs, through religious condemnation, creative input in the form of literature and art, through the media, or whether it is a matter of education, industry, the public in general or through the urgency within the National Health Service, or from it being a subject of research, the topic of suicide remains a mystifying one and is determined by

factors such as socio-economic (e.g. unemployment), cultural (e.g. religious or lack thereof), biological (e.g. hormonal, ill mental health) and psychosocial (e.g. traumatic life events such as bereavement and divorce).

Recent statistics, suicide prevention and intervention strategies, suicide in history, assisted suicide and euthanasia, and the bereaved by suicide group have been highlighted in this overview for different reasons. Suicide placed in the context of history to demonstrate that suicide is not a present day phenomenon, 'assisted suicide and euthanasia' as it has been and is a relevant issue in the past decade and 'the bereaved by suicide' group who are often a forgotten entity in the aftermath of a suicide, concluding with an overview of possible causes of suicide.

Statistics and prevention/intervention strategies

The latest statistics issued by the World Health Organisation in January 2010 show an average world suicide rate of 10.07 per 100.000, which equates to one million suicides worldwide per year. WHO has quoted a worldwide increase of 60% in suicide rates in the past 45 years. The latest figures for the UK of 5706 for 2008, show an increase of 329 from the previous year (ONS, 2010), with rates for women consistently lower than for men, respectively 5.4 per 100.000 and 17.7 per 100.000 in 2008 (ONS, 2010).

Suicide remains a major public health issue and suicide prevention strategies continue to be high priority in the public health sector. The Department of Health (2005), recognizing the lack of a single approach to suicide prevention, developed a strategic approach aiming to reduce the suicide rate by 20% by 2010. Choose Life, a three-year 'National Strategy and Action Plan to Prevent Suicide in Scotland', also aimed at reducing the suicide rate by 20% by 2013, and was realized by The Scottish Executive in 2002. As part of the Choose Life program, ASIST training (Applied Suicide Intervention Skills Training) is incorporated in training programmes throughout the community, involving statutory and voluntary services.

Historical

Ancient Times

Albeit, suicide or self-inflicted death has been scrutinized throughout the Ages and perhaps the death of Socrates (399 B.C.) was the first recognized recorded suicide, although the scholars are still debating its authenticity. Socrates, feeling too old to contribute effectively to society, provoked his own condemnation. Plato, a pupil of Socrates, attributed a moral quality to suicide and felt that it was an 'act of laziness undertaken by those too delicate to manage life's vicissitudes'. In contrast to Plato the

Stoics later claimed that if an individual felt life was not worth living anymore through for instance ill health, to end that life would not be an expression or act of diminished moral virtue. Putting quality before quantity, the Roman Stoic Seneca, professed that:

'A wise person lives as long as he ought, not as long as he can'

(‘Suicide’ Stanford Encyclopaedia of Philosophy).

A belief which possibly resonates with those in favour of assisted suicide and euthanasia.

The Romans

Not being able to live with the disgrace of having lost a significant battle with the Romans, Mark Antony killed himself, and his wife Cleopatra, the last pharaoh of Egypt, took the same course of action and died in 30 B.C. These acts and many since are those recorded by Plato in his Laws as the exemptions to the above mentioned moral explanation of suicide. One exemption he spoke of that overrides the morality of suicide is that, in the case of extreme personal misfortune, which Mark Antony's defeat could be classed as, the act of suicide can be condoned. Throughout the following reign of The Romans suicide was a concept which was never far removed from the scene. The documented mass suicide at Massada (AD73) of the Sicarri, an extremist Jewish splinter group of 960 men, women and children is testimony to the fact that, when compared to for instance the mass suicide at Jonestown in 1978, individuals dread to fall into the hands of 'the wrong people'. Whereas the people of Massada did not want to be ruled by their conquerors, the Romans, after having fought a valiant but losing battle, the people of Jonestown were cajoled into murder and suicide through believing their leader Jim Jones that the world 'out there' was intrinsically bad. Whereas the first instance of mass suicide invokes a positive connotation of understanding and heroism, the second instance calls to mind horror, disbelief and terror. (Wikipedia-Encyclopedia).

A more recent ideology of 'not wanting to be ruled' by the 'wrong people' is the well-known case of the Nazi leader Joseph Goebbels who, at the end of the Second World War, together with his wife killed their six children. They then took their own life by taking pills he carried with him, to avoid prosecution by the allies.

The Middle Ages

Although the act of suicide was existent and documented, the word 'suicide' was not used as such until it appeared in Religion Medici, the writings of Sir Thomas Brown, in 1637 and took hold from then on (Murray, 1998). The chroniclers of the earlier Middle

Agnes would however not use the term 'suicide' or 'killed themselves' but would be evasive and hinting into a certain direction leaving it for the reader to determine what really happened, which resulted in different chroniclers explaining the situation in their own language using their own interpretation and thoughts. Murray (*ibid*) provides us with some interesting known examples of medieval accounts of the passing of men of standing. These accounts, more often than not, would have been different depending on the affiliation of the writer with the deceased. Accounts of the same, gaining pace through the decades, when the notion of suicide would change from being a disgrace to being an acceptable concept, are conveyed by Murray (*ibid*), who writes 'the air became hospitable to a classical ethos, respectful of suicide' (p53). Henry of Hohenstaufen is just such an example, Murray (*ibid*) writes. Henry died in 1242. He had rebelled against his father, the Emperor Frederick II of Hohenstaufen, was captured and imprisoned and thereafter the story of his death takes on three different views or 'traditions' (p51). One claims that Henry died of 'natural causes', a second version records his death as 'murder' and the third version is more veiled and refers to perhaps self-inflicted death or killed by the hand of his father. Hundred years later Boccaccio gave two versions of Henry's death: he died in prison or he threw himself of his horse from 'a bridge or a rock'. In the fifteenth century, Murray (*ibid*) further states, "when an Italian scribe gave Boccaccio's book a deluxe edition, the picture of Henry's suicidal fall became the one illustration to Henry's life story" (p53).

It appears that men would take their own life when avoiding facing the wrath of their elder as may have been the case with Henry or when they had fallen from disgrace, such as is claimed happened to John Beaufort, Duke of Somerset and grandfather of Henry VII who died in 1444, after 'he was forbidden to appear in the king's presence' (p58). Within the close circles of family and friends his death was related to as 'an unexpected infirmity' (p57), keeping it under the cloak of secrecy. However the historical authors of the time, in this case the prior from Crowland Abbey near Peterborough, phrased their account of the event differently and as Murray (*ibid*) noted the prior was not able to suppress his own loathing of John's act:

'a noble man of such high rankand being unable to bear the stain of so great a disgrace, he accelerated his death by putting an end to his misery.....preferring to cut short his sorrows, rather than pass a life of misery, labouring under so disgraceful a charge' (p58).

Murray (*ibid*) explains that the fact of the prior's obvious revulsion in describing John's death may well have been an indication how earlier chroniclers recorded similar events in a more obscure manner.

Ladies of the time are recorded to have taken their life while pining for a fallen husband or an unrequited or forbidden love, or because of being abhorred by their own behaviour. Donna Maria Coronel, wife of a powerful nobleman in Andalusia took her own life in 1369. Her husband Don Alonso left her for a year to go to Africa and during this time unable 'to resist her own unchaste desires' and 'rather than to yield to them, is said to have put burning coals into that Part which molested her' (Murray, 1998, p60).

Recording of suicides by those other than noblemen and women, the serfs or peasants was equally shrouded in secrecy, and shame was an equally major factor for surviving family members. Suicidants would retreat into solitude before attempting their final act. The girl who would fall behind the group seeking to be alone, the man who would wait until his family had retired for the night or the woman who waited for the husband to be away in the field, all waited to be alone to carry out their act (Murray, *ibid*). Clearly they did not look for a 'performance' in the public eye and aimed to be anonymous. This could divert the shamefulness of loved ones to the ignorance of others, feeding the taboo factor of suicide. This sentiment is not far removed from today's' feelings, thoughts and experiences of those 'left behind' I come across in my own practice when working with those bereaved by suicide. They report on their emotional loneliness, their shame and guilt of others not wanting to know, not wanting to hear, of blaming the bereaved.

The above is but a short impression of the abundant information available on suicide in The Middle Ages but hopefully gives the reader an idea of what 'suicide' meant in those days and to infer that the emotional philosophies embedded within the concept do not altogether differ so much from today's idea of the same.

Today

Although not exhaustive by any means the above shows that historically suicide is viewed from moral and or religious perspectives whereas more recent developments evolve through social and biological influences. The latter influences discussed later in the review.

Sociological – Emile Durkheim (1858-1917).

Durkheim's theory of suicide (1897) remains, it can be argued, a most important approach from a sociological viewpoint. It is explained as a function of society which he famously attributed to either positive or negative social changes, but which could not be justified individually. His argument centres on the fact that 'individual peculiarities could not explain social suicide rates' (p261). 'Peculiarities' being, suffering from deep grief or

intolerable shame. These influences, he stated, will be relatively the same in all cases and although important will not be determinant as causal for suicide, for instance quoting some of the examples he gives: 'one man kills himself while living in luxury, the other while living in great poverty or the soldier who takes his life after being punished for a crime he did not commit and the criminal who takes his own life because he got punished' and argues that 'the most contradictory and varied events in life can proceed a suicide' (p262). Durkheim (1897) concludes that none of them is the specific cause but reasonably may be seen as deep sorrows or great disappointments with no indication of how deep or intense these feelings may be to have the result of suicide. He further dismisses a relationship between suicide and the influence of environmental factors on the individual's biological constitution. Durkheim felt the biological and physical factors to the incidence of suicide to be ambiguous whereas the sociological factors were proven, by him, to be evident within the nature of society itself. A dubious, but perhaps for the era this theory was written in, example to underpin his statement Durkheim passes on that:

'if women kill themselves less often than men, it is because they are much less involved than men in collective existence; thus they feel its influence –good or evil- less strongly' (p263).

A less controversial example he gives is that suicide rates may fluctuate between months, with an increase in the first half of the year and a decrease in the second half of the year, which also manifests itself in the same seasonal fluctuations where social activity is concerned. And so, Durkheim states suicide is one of them, therewith classifying suicide as a social activity. Although his theory is still of great importance and gives a clear clinical framework for understanding suicide from a particular viewpoint I am not sure whether certain aspects will hold in today's cultural climate. For instance Durkheim further commented on the fact that certainly individual hereditary tendencies did not alone account for a predisposition to suicide but that cosmic factors may also have an influence. He even identified different latitudes with varying rates of suicide throughout Europe with the highest rate in the most temperate regions, arguing in the same breath that suicide actually flourishes in any climate.

From compassionate understanding to moral condemnation: suicide in Western Europe from 1500 till 1800:

In an excellent account of the history of suicide in Western Europe Minois (1995) remarks that through the Renaissance (15th and 16th Century) and the Enlightenment (mid 17th till mid-18th Century), revolutionary periods of cultural and artistic life, suicide

was thought of as an act that 'deserved to be approached without prejudice, as an undeniable tragic act, but one that must be understood without a priori condemnation' (p314) and although not entirely wiping away the associated feelings of guilt, it 'made it view opinion in more relative terms' (p115). However, with a focus on France he recounts that after the French Revolution (1789-1799), moral and political authorities strived to place suicide back in the realm of moral indecency, an act to be forbidden and condemned, and in doing so shifting it towards a status of individual and collective guilt. With this shift suicide was once again placed within the guilt-ridden philosophy of self-inflicted death of the earlier Middle Ages. They note that with the emergence in the 19th Century of psychiatry and sociology, individual, moral and mental failings (Durkheim's 'peculiarities') played a role alongside the lack and unfairness of the social structure of the time. Conversely, throughout these periods religious views did not change, and although not condoning, -burial took place in non-consecrated ground and on the edge of the cemetery-, and equally not condemning either, -opposed to confiscation of the family's estate or corporal punishment of the corpse-, and in general flowed with the tide of the time. Discussing these views recently with catholic family members and seeking the unofficial views of members of the Church of Scotland sentiments in relation to suicide, have remained largely unchanged. Minois (1995) refers to pronouncement of the Sacred Congregation for the Doctrine of the Faith of 1980 which proclaims that:

'all human beings must live their lives in accordance with God's plan.....suicide is just as wrong as is homicide. Such an action by a human being must be regarded as a rejection of God's supreme authority and loving plan. At times, however, as everyone realizes, psychological factors may lessen or even completely eliminate responsibility' (p317).

In the same document euthanasia, which I discuss later in the chapter, is prohibited. No matter the age, the illness or if the person is dying already, it is seen as opposing Divine Law.

The English Malady

In France the movement was to be strongly opposed to the idea of suicide, and to universally condemn it, in the first half of the 18th Century suicide in France was considered a crime to be punished further, burial in consecrated ground be denied, families to be ostracized. This was followed by a period of journalistic quiet, forbidden by law to report on it. Suicide was hardly mentioned, enforcing the taboo factor of suicide (p293). In England, on the other hand, it was considered 'news', elaborately

reported upon, views that helped normalize suicide at the time (Minois, 1995). This abundant reporting resulted in the thought that suicide rates in England had to be the highest in Europe. Contrary England's liberal views towards suicide it was not decriminalized until 1961 when the Suicide Act 1961 was passed.

'These Self-Murders are but too frequent here, and are committed by Persons of good Families, as well as by the Dregs of the People'

Baron Karl Ludwig von Poelnitz, 1733.

(In Minois, 1995, p294).

The seemingly abundance of suicides was apparently seen as a 'specifically English penchant' (p181) and was referred to as the 'English Malady'. The plentiful suicidal tendencies of the English were partly blamed on the country's 'unfavourable climatic and geographical conditions' (p181). Several more recent studies appropriate the influence of climate on the rates suicide and suicidal behaviour (Pretia, 1998; Pretia and Miotto, 1998; Lee, Lin, Tsai, Li, Tseng, Huan, 2006) in different geographical areas.

Assisted suicide or euthanasia

The legal definition:

'A form of suicide or euthanasia which involves a person other than the person taking his or her own life, and during which the other person assists in direct or indirect physical means in giving effect to the suicide or, in the event of a statutory definition, in a manner as set out in that statute'

(<http://www.duhaime.org/LegalDictionary>).

The medical definition:

'The voluntary termination of one's own life by administration of a lethal substance with the direct or indirect assistance of a physician. Physician-assisted suicide is the practice of providing a competent patient with a prescription for medication for the patient to use with the primary intention of ending his or her own life'

(<http://www.medterms.com>).

The brutality committed against the self by killing oneself, at times impulsively, at times well planned, but often secretly and lonely, a stepping out of life provides us with a different dimension where assisted suicide or euthanasia is concerned and different emotional and circumstantial factors play a role. Often the focus of assisted suicide is not a psychological ache but rather a physical pain. The person seeking assisted

suicide is seen to make a logical decision, arguably to seek self-control, relief of pain and to die with dignity.

'I believe often that death is good medical treatment because it can achieve what all the medical advances and technology cannot achieve today, and that is to stop the suffering of the patient'

Christiaan Barnard.

A dilemma will lie with the individual asked to assist. Apart from a fundamental belief that it is wrong to help/support in assisted suicide, as well as opposing Divine Law, a doctor may well find it impossible because of his oath to the profession to heal rather than hasten death however desperate the situation may be.

Different terms are becoming increasingly commonplace in use. In passive euthanasia the individual's death is moved along by withdrawing further medical support and letting nature take its course. We speak of active euthanasia when the person has requested death and a direct action to do so follows. Voluntary passive euthanasia is the term used when a person is given a means to kill themselves, through a prescription or instructions for using helium or carbon monoxide gas. When a person has not clearly asked for support in dying, for instance when in a coma and when recovery has been ruled out life support may be turned off and one would speak of involuntary euthanasia. In December 2005 a private bill to give rational thinking but terminally ill people the right to assisted suicide put forward by the Scottish liberal democrat Jeremy Purvis was blocked and in May 2006 the House of Lords blocked a similar bill. Opposite values and beliefs, on the one hand it would be unreasonable to expect people to go on painfully suffering a terminal disease and on the other hand to declare that under any circumstance to say that a life is not worth living anymore, (<http://www.religioustolerance.org>) gave way to heated debates and perhaps a status quo may never be reached and therefore a legal solution.

The United Kingdom parliament decriminalized suicide with the Suicide Act 1961 which interestingly in the official title of the Act mentions neither Scotland nor Northern Ireland. 'An Act to amend the law of England and Wales relating to suicide, and for purposes connected therewith' (http://en.wikipedia.org/wiki/Suicide_Act_1961). The law however does not decriminalise those who assist in someone's suicide. The news agency Reuters reports on 25th February 2010 that prosecutors consider that new guidelines should focus on the motivations of the person who assists in the suicide. These considerations are a direct result of the well documented efforts of Debbie

Purdie, a multiple sclerosis sufferer, who has been championing a change in the law for many years and actually stating that a change in the law in favour of those who assist and in this case her husband, may well prolong her own life (<http://uk.reuters.com>).

The dark side of assisted suicide, I personally find disturbing, is the uncontrolled available access to and promoting of material relevant to assisted suicide on the internet, such as the internet suicide chat rooms and web sites with hints for those who want to cut life short.

Bereaved by Suicide

A group forgotten in the direct aftermath of a suicidal act are those left behind. Facilitating a 'bereaved by suicide' group on a regular basis, I am confronted with the raw and complicated grief they endure. In this group the participants find a safe platform where they can share their anguish about the loss of a loved one and try to understand what has happened, to make sense of their feelings of guilt, shame and shock; in the group they are able to find support and share the drama of losing a loved one to suicide. They often report feeling abandoned by the world around them, they feel rejected and are suffering from stress, anxiety and report being treated for depression. Direct family members, each grieving in their own way, refuse to mention or deny the immediate family member to acknowledge the deceased, address the circumstances and are inclined to cover up the cause of death. One of my clients recently left a note at the end of her counselling sessions and with her permission I convey an excerpt of the content using pseudonyms:

"My youngest son, Peter, was diagnosed with paranoid schizophrenia in his early twenties. He endured this illness until he took his own life, aged 36 years of age. Myself, and my family cannot describe the devastating loss, and bewilderment we feel. There are no words... Life since has been very difficult, and very sad. Nothing is the same. There is huge hole left in my heart, and my life. I wasn't able to talk to my family about him, because they couldn't deal with it, as they were hurting. I was very apprehensive going for my first appointment, but she [the counsellor] put me at my ease, and I felt I could talk about Peter and my feelings, knowing in that room it was confidential. I have found it very emotional, and I was exhausted when I went home....I had a great need to talk about my son, and my feelings, and I have been able to do so in confidence, to someone who listened and gave me support....."

From: Margaret (November, 2010).

This client's statement is testimony to one of the fundamental beliefs of counselling: listen and hear.

In a recent study on group work and one-to-one counselling for bereavement Vlasto (2010) concludes that support groups for the bereaved 'replicate social settings in the outside world and are therefore perceived to be more normal, suggesting that the normalising of grief which occurs in a group does not take away the pain but that it demonstrates through social comparison and mirroring that the pain can be endured' (p64). Vlasto's conclusion supports my own experiences of working with this client group.

In the last decade more literature has become available which concentrates on the general reader (Fine, 1997; Wertheimer, 2001; Lukas and Seiden, 2007) and may be helpful for the bereaved by suicide. The literature addresses individuals' experiences in the wake of a suicide, the impact a suicide has on direct family members and the wider community, it looks at the prevalence of suicide, the support available, in short, a well-informed body of literature is now available. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) gives their diagnostic criteria (308.3) for an acute stress disorder as 'having been exposed to a traumatic event in which both the following were present:

the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and

the person's response involved fear, helplessness and horror' (p431).

Some of the dissociative symptoms (DSM-IV) following the traumatic event are recognizable symptoms I have experienced in working with the bereaved by suicide group as well as in my work with individual clients, such as the traumatic event is persistently re-experienced, difficulty sleeping, impairment in social, occupational functioning, not being able to involve family members for support. Herself bereaved through suicide by a family member, Fine (1997), quoting from the DSM-IV, states that the 'level of stress resulting from the suicide of a loved one is ranked as catastrophic-equivalent to that of a concentration camp experience' (p36). A clear and strong statement of the appalling and shattering effect a suicidal act has on individuals and their surroundings.

Although pertinent literature about and support for those bereaved by suicide is increasingly available, there still appears to be a stronger focus on the suicidant,

evident in for instance the strategies for the prevention of suicide and more disturbingly, the unfortunate internet guidelines with regard to suicide.

The suicidal mind

Shneidman (1996), a prominent American suicidologist, stands firm in his belief that suicide is to be attributed to psychological pain which he refers to as 'psychache' (p4) and states that it is a result of disturbing psychological needs. With this belief he may have answered the eternal question of: Why suicide? To understand suicide he continues; we should concentrate on the most important question which is to ask the suicidal person where they hurt. Not trying to understand it by means of statistics, brain structure or mental health. It is important to remember that psychache is not the only component that may lead to suicide and Shneidman further introduces 'lethality' as a synonym for suicidality and states that disturbance (anguish) is 'the motivation for suicide and lethality the fatal trigger' (p8). Of course there are exceptions to his theory and Shneidman refers to other variables that need to be taken into account such as for instance cultural differences, suttee (India), hara-kiri (Japan), the different approaches of Islam, Judaism and Christianity, all basically denouncing self-killing, which is seen as going against God's will, or the terrorist bomber, who, driven by political motives and paradoxically altruistic ideas of offering their lives in the fight for their beliefs and commitment to their comrades (Pedazur, 2005), commit suicide while murdering others. The latter suicidant operates from a cognitive behavioural framework and supports the explanation of Joiner (2005) who argues that the desire for death alone is not sufficient, there needs to be the capability to kill oneself and in doing so overcoming the natural instinct for survival and a fear of death. This suggests an element of bravery and strength perhaps applicable to the mind-set of the suicide bomber, who may be driven by their leaders' promise of a divine afterlife.

Firestone (1997), also approaching suicide from a cognitive behavioural framework, introduces us to his 'Continuum of Self-Destructive Thoughts and behaviour' (p128) in which he explains that our 'inner voice' or our 'self-critical thoughts' may result in 'self-annihilating thoughts', leading in a worst case scenario to suicide. Suicidal thinking according to Beck et al. (1979) found its motivation somewhere between a 'need to escape' and 'communication' (p86 in Duffy and Ryan, 2004).

O'Connor, Rasmussen and Hawton (2010) in an extensively referenced article investigate the role of perfectionism and acute life stresses on the incidence of depression, anxiety and self-harm (suicidal intent). They found that 'as SPP (socially prescribed perfectionism) levels increase, even modest levels of acute stress can be

pernicious' (p57). An important finding, they continue, as it suggests that the incidence of self-harm may be raised even when socially prescribed perfectionists suffer from lower level stress factors.

Other theorists, explaining the urge to self-inflicted death from a different, but equally valid, point of view and belief as already briefly touched upon, such as socio-economic (e.g. unemployment and further explanations of Durkheim), cultural (e.g. religious or lack thereof), and psychosocial (e.g. traumatic life events such as bereavement and divorce) factors, may focus on biological (e.g. hormonal, ill mental health, genetics) factors.

Biological factors

It is prudent to mention at this stage that there is some evidence to suggest that biological factors have an influence on suicidal behaviour. Marusic and Farmer (2001) explored the influence of genetic risk factors on suicidal behaviour in Europe, in particular Slovenia, which is the correlation between alcohol and genetic propensity. They further aimed to argue that suicidal rates are not just socio-economically determined and interestingly found a possible link between high alcohol consumption, alcohol related psychiatric disorders and suicide rates by examining the history of wine-growing in Slovenia.

Investigating the effects of familial, psychiatric and socio-economic risk factors on the incidence of suicide in young people Agerbo, Nordentoft and Mortenson (2002) found that mental illness and a history of suicide in the family contributed greatly to suicide in this particular group. This partly supports a more recent paper by Askiskal (2007) who stated that 'affective disorders, particularly depression, represent the most prevalent substrates for suicidality, yet have not been given sufficient space in the education of psychiatrists and primary care givers' (p400). Conversely, commenting on a study by Baca Garcia et al. (2000 in CayKoylu et al., 2004), who found that there is 'no significant difference between gonadal (gender determining) hormone levels of those attempting suicide and controls in the first week of the menstrual cycle' (p463), they suggest that in the period when gonadal hormone levels are low, serotonin levels are lower and therefore suicide attempts may occur through heightened impulsivity. However, CayKoylu, Capoglu, and Ozturk (2004) investigated the relationship between menstrual cycles and suicide attempts, but were not able to identify a conclusive link between low oestrogen/progesterone levels and suicide attempts.

Discussing the influence of biological factors with a psychiatrist he believed there may be a genetic component, a connection between generations. From his own practice he

recognized the effects of drugs, for instance anti-psychotic drugs of which the side effects may be internal restlessness, a feeling, he stated, was unpleasant and difficult to cope with. Any mental health problem depending on its cause may be a risk to suicidal attempt he concluded.

Biological factors determining suicidal ideation, is a subject area in its own right, as indeed many of the different aspects of suicide are. They no doubt will continue to be investigated.

Concluding comments

So, what then exactly is suicide? We know it is defined as self-inflicted death, a violent act towards the self, self-murder. Although true, this appears too simplistic a definition as the above gives an insight into the many variables, the complexity and the ambiguity that surrounds this bewildering phenomenon. Explanations of suicide often focus on the clinical aspect of its concept but equally often fail to address the deep and complicated grief that accompanies it for all those involved and concerned. Religious objections which regarded suicide as self-murder, disregarding the will of God, encouraged the Church to acknowledge suicide as a sin and be treated as such. A view not necessarily practised anymore in today's religious thoughts. More often than not my experience has been that the suicidant is not condemned anymore but is rather shown compassion, although their act is not condoned. Biological factors may lead a person wishing to end their life, and the voice of those wishing to take control of their life through assisted suicide and/or euthanasia when suffering from a terminal illness has become increasingly more vocal in this past decade.

Suicide is a multi-causal, multi-facetted phenomenon with the interplay of unique individual and sociological, psychological, economic and political forces. Being mindful of this multifarious, difficult nature of suicide and the individual cultural inheritance we each carry, it stands to reason that working as practitioners with this particular client group deserves to be investigated in order to determine the impact on them.

APPENDIX B

Table I. Classification of Main Category I

and her Categories showing the number of respondents (Rs) and total number of meaning units (MUs) contributing to each category.

Main Category I: Experiencing the Therapeutic Encounter

Categories:	MUs	Rs
1. Moving away from the critical moment		
a) Providing /offering safe and consistent space <i>keeping calm/compassionate; being comfortable with self; no panic reaction; facilitate client's understanding of feelings; acknowledge/hear the sadness; understanding the 'why'; accepting the client's position; attuning to client demeanour'; staying with; being honest; giving hope; feeling a mutual trust; empowered to make decisions</i>	43	8
b) Naming and exploring 'it' <i>addressing 'it' carefully; using client's language; being direct; not avoiding; exploring/verbalizing intent; looking at choices; exploring the meaning of suicide; exploring different choices/ plans/triggers</i>	35	8
c) Facilitating the loop of options <i>enabling client to open up; negotiating; making 'contracts'; exploring options; working through the 'do I or 'do I not'</i>	18	7
d) Experiencing new awareness <i>'fascination' of a trusting relationship; limits of responsibility; trust of own insights; not 'flipping' into medical model; pulling in external help; the challenging demands of the encounter/importance of encounter</i>	13	5
2. Negotiating the therapeutic boundaries		
a) Carrying the burden of responsibility for self <i>not wanting to take risks; being wary of consequences awareness of impact on self; feeling weary/vulnerable/'wobbly'; questioning self; awareness of keeping self safe</i>	29	5
b) Acknowledging the duty of care to the client <i>Feeling concern/responsibility; taking (appropriate) action;</i>	17	6

Categories:	MUs	Rs
<i>seeing' other choices; keeping a check; mutual respect; involving other professionals; facilitating the clients' process; being more directive</i>		
c) Weighing the balance between over involvement and under involvement <i>c1.doubting their ethical position; 'flaky' and 'elastic' boundaries; reacting to client's wishes (in)appropriately; being aware of deep involvement consequences;</i> <i>c2. reaching out beyond 'official' boundaries; sending emails; phoning the client; speaking through a mediator; texting</i>	11	3
3. Stepping outside the person-centred approach – 'being directive' <i>'got her to ring the GP'; 'felt something needed to be done'; 'needed to make someone else aware'; 'would ask specifically'; 'actually be quite directive'; 'let's talk suicide; 'talk to me about this'; 'ask what helps'; 'will be more direct – not my usual way of working'</i>	9	3
4. Engaging in the therapeutic dyad		
a) Holding the vagueness <i>Trying to find a truth; questioning motives; finding reasons; attempting to stay with process; avoiding complacency; coping with uncertainties; working with inferences; feeling ambivalent; inferring; reflecting</i>	19	7
b) Reacting to 'gut feeling' <i>'it just comes to me'; using common sense; I 'know' having a sense; reacting to the 'alarm bells'; having a 'knowing'</i>	8	14
c) Feeling 'in limbo' <i>(being caught between the knowing and the not knowing) Being left wondering/assuming; feeling emotional manipulation; feeling anxious; trying to hold on to others' reassurances; the invisibility of feelings and thoughts; feeling an 'un-balance'</i>	20	7
d) Staying with vivid images - listening to clients' narrative <i>e.g. 'she witnessed a suicide; they had the plan laid out 'they walked into the sea'; 'everything was in place, she had a rope....'; I kind of relived exactly that morning the phone call that I got; 'can see her face clearly '</i>	14	7

Categories:	MUs	Rs
<p>e) 'Being human' <i>providing hope; not having all the answers; showing compassion and own 'angst'; not providing promise but options for hope;</i> <i>trying to be as 'real' as possible; able to give 'small parts of me';</i> <i>to be a human being, nurturing and open; it's about communicating with them; 'the relationship with us that kept her coming'; not seeing client as an 'object'; not being distanced; meeting the person in 'that place'</i></p>	12	7

APPENDIX C

Table II. Classification of Main Category II

and her Categories showing the number of respondents (Rs) and total number of meaning units (MUs) contributing to each category.

Main Category II: Experiencing the Self within the Therapeutic Encounter

Categories:	MUs	Rs
1. The perceptive self		
a. <i>Perceiving the client's psyche-ache</i> <i>a1. sensing:</i> <i>scared; all-consuming; frightened;</i> <i>panicky; no way out; hurt;</i> <i>withdrawal; loss of control; feeling trapped/stuck;</i> <i>sensing the 'soreness'/ sadness/pain</i> <i>a2. observing:</i> <i>taking in the 'angst'; turmoil ; panic; confusion; strength;</i> <i>dejection; sadness; the anxiety; the fear; the stuckness</i> <i>a3. absorbing and responding;</i> <i>feels incredible; harrowing; keeping a distance;</i> <i>feeling confident; not feeling guilt; feeling myself changing;</i> <i>'doing everything possible'; dealing with guilt;</i> <i>understanding the sense of it; in touch with own vulnerability</i>	53	10
b. <i>Emotional reacting to client's hurt</i> <i>b1. helpful experiencing:</i> <i>calmness; empathy; believe in hope; relief;</i> <i>being still inside; 'there is an energy'; feeling comfortable/</i> <i>positive; not afraid to go 'there'</i> <i>b2. anxiety provoking responses:</i> <i>feeling:</i> <i>trapped; held to ransom; manipulated;</i> <i>frustrated; guilt; deskilled; consumed/absorbed;</i> <i>scared, withdrawn; swallowed up; concerned;</i> <i>disconnected from practice/self; disorientated; helpless;</i> <i>saddened; less tolerant; nervous; anger</i>	97 29 68	10 9 10

Categories:	MUs	Rs
<p><i>Being:</i> <i>stunned; at a loss; shocked by own reaction;</i> <i>a few steps behind; tearful</i></p> <p><i>Doing:</i> <i>taking a step back; trying to make sense of</i></p> <p><i>Having:</i> <i>lack of concentration; difficulty in focusing;</i></p>		
<p>c. Physical reacting to client's distress</p> <p><i>Exhaustion; weary; a heavy feeling in my stomach;</i> <i>feeling sick/ 'sore'; heart beating faster; drained;</i> <i>'freezing'; shaky; shaken up; breathless</i></p>	29	8
<p>d. Expressing of felt anguish</p> <p>d1. non verbally: <i>hesitant demeanour; showing embarrassment/perplexity;</i> <i>quiet manner; voice trailing; voice up/animated; change in</i> <i>tone of voice; strength of voice; inner self talk (sending</i> <i>good thoughts); sharp intake of breath; swallowing back;</i> <i>long silences; pensive; sighing;</i> <i>short laugh; smiling; pointing at chest ('something about what I</i> <i>feel'); gesturing; slumping in chair</i></p>	39	10
<p>d2. verbally: <i>difficult to encompass; why?; 'I don't know'; 'a wee bit';</i> <i>O my God; 'it is even painful trying to express how they feel';</i> <i>counselling is difficult; feeling the laughter; feeling it very deep,</i> <i>right in my stomach</i></p>	12	7
<p>d3. using metaphoric language; <i>their skin is peeled off; being stripped bare;</i> <i>moving a ton of bricks; not taking 'it' home;</i> <i>black ball in the pit of my stomach; being on 'full alert';</i> <i>fear of being swallowed up; pussy-footing around;</i> <i>the heaviness of it; in the back of my head;</i> <i>wanting to break free; rooted in approach ;</i> <i>staying with the drama of it; incandescent with rage;</i> <i>keeping feelings at bay; there was a bubble going on;</i> <i>swallowing emotions; the day that stepped over the mark;</i> <i>alarm bells going of in my head; having to be on my toes;</i> <i>striking home powerfully; hit by a bus;</i> <i>stunned like a rabbit; it jangled me;</i></p>	32	6

Categories:	MUs	Rs
<i>being transported to another place; body softens</i> <i>d4. Imagining</i> <i>that picture stirs up so much distress in me;</i> <i>seeing her face as clear as a bell;</i> <i>could see her skin, completely and utterly;</i> <i>seeing [client] baring their soul;</i> <i>seeing the stripping of the flesh;</i> <i>imagining the bareness; seeing the bones</i>	5	3
2. Connecting with self and client – engaging the ‘wounded healer’ <i>using own experience; feeling open-minded/ confident/calm;</i> <i>being human; having a deep understanding;</i> <i>empowering the client; considering the responsibility;</i> <i>mindful of becoming complacent/comfortable; discussing</i> <i>alternative solutions; being composed;</i> <i>being real/genuine; showing a deep understanding;</i> <i>being aware of own vulnerability; connected with own trauma;</i> <i>being conscious of/ acknowledgement of one’s limitations</i>	35	10
3. The curious self <i>Being intrigued; fascinated; feeling voyeuristic;</i> <i>speculating on intent; wondering; being interested/ delving</i> <i>deeper;</i> <i>finding a new awareness</i>	12	5
4. The resilient self – finding tranquillity <i>becoming stronger/determined;</i> <i>finding confidence; not fearful; belief in hope;</i> <i>found calm; keeping fear at bay; looking at art;</i> <i>listening to music/‘books’; writing poetry;</i> <i>staying grounded; praying ; gardening;</i> <i>feeling strength through self talk; self monitoring;</i> <i>taking time out; acknowledgement of stressors</i>	34	9

Appendix D

Table III. Classification of Main Category III

and her Categories showing the number of respondents (Rs) and total number of meaning units (MUs) contributing to each category.

Main Category III: Seeking Solace – ‘finding understanding’

Categories:	MUs	Rs
1. The supervisory ‘backbone’ <i>getting guidance; being supported; checking practice; addressing effectiveness; explorative; necessity for self; seeking confidence/trust/reassurance; feeling validated; helpful; getting new insights; seeking comfort; discussing subtleties of the moment</i>	30	8
2. Sharing the burden a. through human exchange: <i>sharing responsibilities; understanding; keeping self safe; being/feeling held in the sharing helpful; trusting; disclosing feelings</i>	13	7
b. spiritually: <i>writing poetry; indwelling/be with oneself; quiet prayer; handing over to God; feeling comforted; feeling guided; trust in self; humour; exercising; massage; personal therapy</i>	11	4
3. Finding knowledge – receiving understanding <i>Through being part of a team; being able to discuss; practical help; opportunity to ‘offload’; accessing specialist help; sharing with the ‘right’ people; pulling in ‘external’ knowledge/reading; obtaining understanding; informative</i>	25	5

APPENDIX E

Table IV. Classification of Main Category IV

and her Categories showing the number of respondents (Rs) and total number of meaning units (MUs) contributing to each category.

Main Category IV: Grounding in Knowledge

Categories:	MUs	Rs
1. Intuitive understanding – cognizant questioning		
a. Counsellor's understanding of client's focus: <i>for things to go away; the right thing to do; their freedom of choice; death is appealing; an option; their survival instinct; is there a plan</i>	27	9
b. Counsellor's values/beliefs: <i>a terrible waste; value life; worth saving; can't allow; seeing other choices; feeling angry; morally wrong; hindering or helpful being respectful; feeling strength; faith in the client; acknowledge uniqueness of clients; acknowledge client's right to choose</i>	34	9
c. Counsellor's spiritual belief: <i>core belief in the other's choice; being accepting through faith; not condemning; death is not the end of everything; not a sin; a mortal sin, should not end a life; an easy way out</i>	18	5
d. Counsellor's understanding of their personal-professional split: <i>no fit with professional framework; clients' choice; acknowledge clients' perspective; respectful cannot separate the two; the two are integrated; difficult to moderate; doubting self; getting caught up in the theory; feeling dis-ease</i>	11	8

2. Drawing from personal experience		
<p>a. Gaining from own fragile state</p> <p><i>a1. Escaping the blackness (positive thinking): acknowledging other choices; exercised choice; taking back my power; Realizing others are with you; hope; admitting 'the feeling'</i></p> <p><i>a2. Being caught in a despairing state (negative thinking): they can't see; it feels so bad; hiding/keeping the secret; no other way out; desperation; no life value; hesitation to revisit; search for understanding; hiding feelings; there was nothing; the blackness; hopelessness; pointless; impulsivity of acting; extreme levels of feelings; rejecting vs embracing of life; way out</i></p>	11	4
<p>b. Gaining from events within family/friends units</p> <p><i>b1. Grown in understanding: able to be relaxed enough; being at a deeper level; personal encounters become influential/form the theme for; holding feelings of uneasiness/ boundaries; no panic; feeling competent/comfortable; opening other doors; enabling client; acknowledging client experience; using 'recognizable' language; (own experiences makes happier); growing ability to recognizing 'signs' in clients</i></p> <p><i>b2. Acknowledging and understanding traumatic effects: the shock; perplexity; difficult dependency behaviours; getting biased; feeling detached; acknowledgment of blame/guilt</i></p>	26 9	8 4
3. Wearing the cloak of counselling		
<p>a. Professional development through working with suicide</p> <p><i>Becoming/being enabled; positive acknowledgement of person-centred approach; feeling comfortable/confident; gaining insight</i></p>	4	3
<p>b. Verbalizing observation of suicidal intent</p> <p><i>Naming it; not difficult; something I do regularly; knowing when to say it; being comfortable; being cautious; reflecting back; give clarity; using clients' language; exploring; providing options; tuning in to perceived needs; rarely introducing 'it'</i></p>	36	5

c. Acknowledging the vulnerable professional		
c1. Recognizing and holding boundaries: <i>Checking own reactions; mindful of others' involvement; confidentiality issues; holding responsibility, flaky; inappropriate decisions; over involvement;</i>	17	6
c2 .Acknowledging and holding the process: <i>Fleeting connections; facilitating; giving self time; holding hope; policing self; staying with</i>	7	5
c3.limpart on the professional: <i>Feeling bad; being unclear; being concerned; taking it seriously; reproaching self; processing traumatic information; not feeling responsible; fear; visualizing; emotional; questioning feelings/actions; relief; feeling wary/ burdened; lingering memories; feeling inadequate/ swallowed up; deep involvement</i>	38	7
4. Pursuing knowledge		
a. Accessing (focussed) training	22	8
<i>local authority workshops; workshops on national/ international level; national suicide prevention training</i>		
b. Experiencing (focussed) training		
b1. 'Lifting the veil' – a positive experience: <i>gives insight; highlights importance of the relationship; emphasizes level of responsibility; brings it into the limelight; helps to facilitate thought processes; takes it out of the dark corner; feeling supported</i>	30	8
b2. 'The missing link' – a negative experience: <i>Recognizing lack of adequate training (the missing link; not high on the agenda; touched on it; addressed to some extent; vague recollection of it; feelings of inadequacy/uncertainty/fear</i>	27	8
c. Influence of (focussed) training on practice		
c1. Learning to wear the professional cloak of counselling: <i>being made aware of difference between theory and practice; insight into clients' existence; ways of managing thoughts and feelings; feeling 'safe'; being able to differentiate between different narratives of clients</i>	10	4
c2. Impact of (focussed) training on self in practice: <i>learning to find support; what 'to give' to clients of self (disclosure); learning how 'to be'; becoming comfortable, not</i>	17	4

<i>feeling tongue-tied; questioning self; revisiting/recall of previous experiences; trusting self/instincts; developing personal strength/ confidence</i>		
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APPENDIX F

Participant Research Information Sheet

‘The Emotional Impact and Consequences of Expressed Suicidal Ideation on the Person-Centred Counsellor’.

In fulfilment of my thesis for the Doctorate in Counselling Studies I am undertaking a study into person-centred counsellors’ experiences of working with clients presenting traumatic life experiences, in particular suicidal ideation.

The aim of this study is to determine how the practitioner’s working with suicidal clients impacts on their personal and professional life and how and what they perceive the emotional, physiological and professional short- and longer term consequences to be and how they deal with these. Keeping in mind the sensitive nature of the topic the criteria for the participant group has been set for experienced counsellors with more than five years of supervised practice, working according to BACP’s Ethical Framework for Counselling and Psychotherapy, and who will have the means to access professional help in case issues may arise from the interview.

I will ask you to participate in a one to one-and-a-half hour audio-taped interview with me at a safe, private, and adequately soundproofed location agreed upon by yourself during which we will enter into a dialogue on the above. I may ask subsequent questions, either by post, telephone, or email to clarify your statements when necessary. The acquired data will be stored in a secure locked filing cabinet and my personal laptop computer is password protected. The audio-tapes will be destroyed when my research is completed, accepted, and published as a dissertation. Final completion date is summer 2012.

Confidentiality is a high priority, limited by the event of you disclosing a serious offence, having breached the ethical guidelines of The Ethical Framework for Good Practice in Counselling and Psychotherapy of the BACP (2007) and/or I am legally bound to disclose information by a court of law.

Only the researcher and the research supervisors at The University of Manchester will have access to the tapes which will otherwise be kept in a secure, locked filing cabinet. The tapes will be transcribed and coded, or pseudonyms used, in order to protect your identity and not to be recognizable from the data. The content of the tapes will not be used other than for the purpose of this research project. After completion of the transcript you will be presented with a copy for your perusal and you will have the choice to omit any text you feel is unsuitable and/or you have the choice/right to withdraw the transcript for further research purposes, however once the thesis reached completion data cannot be amended. It is the intention to publish the findings of this study, in either the appropriate journal, through a poster, presentation, or workshop at a conference. You will be informed of this beforehand, however utmost care will be taken to ensure you cannot be identified. Participation is voluntary and you have the right and are free to withdraw from the project at any time without giving a reason and no detriment to yourself.

Participation in the research project is voluntary; however any expenses incurred by you in relation to your participation will be reimbursed.

In case something goes wrong or should you experience any distress as a result of this interview please contact me in the first instance and I will ensure you find an appropriate agency or you can contact our professional association, The BACP. Further, my supervisor for this project is Dr. William West (william.west@manchester.ac.uk) at The University of Manchester, School of Education & Humanities, tel.: 0161-2753397) who you are welcome to contact should any concerns arise for you during or after participating in this research or in case you may have to raise a formal complaint about the conduct of the research to please contact the Head of the Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL.

Thank you for your participation.

Marijke Moerman,

Tel: 01786 826771

Marijke.moerman@manchester.ac.uk or MottenM@aol.com

4th Year DCouns.

University of Manchester

APPENDIX G

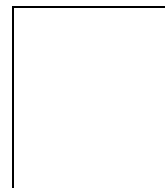
Participant Research Consent Form

‘The Emotional Impact and Consequences of Expressed Suicidal Ideation on the Person-centred Counsellor’.

After having read and discussed the attached Information Sheet and you feel happy to participate in the outlined research carried out by Marijke Moerman please complete and sign the consent form below:

- 1 I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and have been able to ask questions which I feel have been answered satisfactorily.
- 2 I understand that my participation in this research is voluntary and that I am free to withdraw from the research at any time without having to give a reason.
- 3 I understand that the interviews will be audio/video-recorded and that I can request the recording to be stopped at any time.
- 4 I agree to the use of anonymous quotes, but have the right to withdraw these if I wish to do so.

- 5 I am aware that this research may be published in a journal, at a conference and in the dissertation. My identity will remain anonymous through the use of pseudonyms and/or codes and I will be shown the relevant abstract for approval before publication.



Name in block capitals:.....

Signature:.....Date:.....

Name of Researcher:.....

Signature:.....Date:.....

APPENDIX H

Participant Research Consent Form for Audio-Taped Interview

‘The Emotional Impact and Consequences of Expressed Suicidal Ideation on the Person-centred Counsellor’.

1. I agree to relevant parts of the transcript produced following the interview between myself and the interviewer/researcher (Marijke Moerman) to be included in her paper as explained in the PARTICIPANT RESEARCH INFORMATION SHEET, of which I have received and read a copy. I am aware I can withdraw from the research at any stage without giving an explanation.
2. I am informed that this material will be read by the academic supervisors of the interviewer/researcher (Marijke Moerman) and maybe presented to other counselling researchers. I am further aware that anonymity will be maintained at all times.
3. After reading the transcript I have indicated below the part(s) I do not wish to be included or wish to have altered in the final report to protect my anonymity.
4. I am aware that my participation in this project is a time defined process and that once the thesis is completed any data cannot be amended.

Transcript exclusions and/or alterations indicated by page number, or line number and or paragraph:

Name:.....

Signature:.....Date:.....

Phone/Address or email contact:.....

Signature Researcher:.....Date:.....

APPENDIX J1

Interview Schedule

For the Semi-Structured Interviews with Participants

Note: This interview schedule is an informal, initial guide for me as interviewer, in order to gently steer the participant back to the focus and respond to issues I wish to hear more about for this study.

Question 1:

I would just like to check that you have had at least one client who has expressed suicidal ideation during your time as a counsellor? yes/no.

Question 2:

Please tell me about your experience of suicide or suicidal ideation.

From this I need to extrapolate what the first was or ask the next question if it is not clear.

Question 3:

- a. What was your first experience?
- b. Was this professional or personal?

Question 4:

Depending on the above answer:

- a. What was your first professional experience of a client who has expressed suicidal ideation?
- b. If you have had more than one client who has been suicidal, which has had the biggest impact on you both professionally and personally?

Question 5:

- a. How did your experience of suicide impact on your professional life at the time?
- b. How do you think it affected you in your personal life at the time?

Question 6:

During your first professional encounter of working with a client who expressed suicidal ideation,

- a. what kind of support did you seek; this can be both professional and personal – but try not give them a hint – let them ask if it is professional or personal,
- b. What kind of support did you receive?

Question 7:

During your initial training to become a counsellor, what kind of specific training did you get for working with clients who were expressing suicidal ideation?

Question 8:

If they had had specific training:

- a. How do you think it has helped, and if not:
- b. Was there anything else in your training which you think has helped prepare you to deal with clients who are expressing suicidal ideation?

Question 9:

If you have had more than one client who has expressed suicidal ideation, how do you think your first experience has?

- a. helped your work with future clients expressing suicidal ideation,
- b. Hindered your work with future suicidal clients.

APPENDIX J2

Revised Interview Schedule

For the Semi-Structured Interviews with Participants.

Note: This interview schedule was a slightly revised one. After conducting the first three interviews, it became obvious that the focus questions felt slightly too broad in outline. This schedule too, was a guide for me as interviewer.

Question 1:

First of all can you tell me a little bit of your personal knowledge or experience of the concept, suicide?

Question 2:

Would it be difficult for you to introduce the word 'suicide' early in the therapeutic relationship? If yes or no: can you elaborate a little bit?

Question 3:

How has your own experience (or background experience, gained knowledge) with 'suicide' influenced the way you react to a client who expresses suicidal intent.

Question 4:

If, then how do your own values and beliefs impinge on your work with suicidal clients?

Question 5:

What do you feel are the immediate consequences of working with suicidal intent? Do you look for support?

Question 6:

Have you perceived any enduring changes of how you experience yourself, others, the world, because of working with suicidal ideation?

Question 7:

What do you feel are the immediate consequences professionally when confronted with suicidal ideation?

Question 8:

Have you perceived any long term changes professionally, if so in what way? Can you perhaps elaborate?

Question 9:

How does the meaning of the action (intent, attempt, completed) of the client influence you?

Question 10:

How has your professional development influenced you in the way you react to the client?

Question 11:

How do current stressors influence your reaction to the client?

Question 12:

How do you feel about the training you received concerning this issue during your initial training?

Question 13:

What do you define trauma to be? (Not always asked)

APPENDIX K

Table 3: Dissemination of Main Categories for perusal and feedback

MAIN CATEGORIES DISSEMINATION				
TO:	MCAT	SENT	RECEIVED	COMMENTS
Colleague, Enhanced Social worker	ONE	4/6/11		<p>I have just finished reading your draft categories and found it to be a powerful, well written piece of work. It has really made me understand what an important roll counsellors Have in peoples' lives. Being a social worker, I am aware of power imbalances and also the need to maintain boundaries to but it is also refreshing to read that this can happen without the counsellor losing their own humanity!</p> <p>I often reflect upon the fact that professionals are people first and professionals second!</p> <p>It also struck me how hard counsellors work, in terms of applying theory to practice, for their clients and I don't think this is appreciated that often. However I think what you have written clearly demonstrates that your participants are skilled at what they do, even if they don't believe they are.</p> <p>I look forward to reading the rest of your thesis.</p>
Participant Eva	ONE	5/6/11 verbal/email		No response per 30.08.2011
Colleague/ Peer group	ONE	2/6/11	7.6.11	Wow! Your findings are really interesting and well laid out and clear. So impressive, and really useful too. I do think you have a real gift for drawing your categories together in a warm and helpful way. This is important work Marijke and I look forward to reading it as a whole and the inevitable papers and book chapters which also emerge. I think warmth is a key word here, although there are tables and meaning units etc., there is still a personal connection aspect to it which I love.
Participant Vanda	TWO	5/6/11	9.6.11	Beautifully written

Friend in Education/ PhD student	TWO	5/6/11	8.6.11	Marijke's exploration into the impact of expressed suicidal ideation of clients on their counsellors makes very interesting reading. Her study is very thorough and her interviewees seem really to have opened up and trusted her as they were being interviewed. The result is a detailed analysis of how counsellors, both as professionals and in their private lives, cope or try to cope with feelings of discomfort and powerlessness when dealing with suicidal clients. I imagine counsellors reading the study will surely be able to identify with the interviewees' responses and stories and, apart from giving us an insight into the more or less taboo world of suicide, as such Marijke's research may have some therapeutic value as well.
Participant Anna	TWO	5/6/11	14.6.11	Very informative for me; never read research but I really enjoyed reading this.
clinical supervisor	THREE	30/5/11	6.6.11	Very interesting; 'text a bit staccato, but doesn't really matter'
Participant Mary	THREE	ASKED PERMISSION 5.6.11 BY EMAIL; accepted/sent 6.6.11		No response per 30.08.2011
Participant Julia	THREE	ASKED PERMISSION 5.6.11 BY EMAIL/accepted/sent 10.6.11	Feedback received verbally 15.6.2011	'The phrases in the tables get you thinking'; 'it was enjoyable to read'; I was impressed and got drawn into what was expressed. There was learning in it, revisiting of what I did before. It is good to write from the 'spoken word'.
Participant Janine	FOUR	2/6/11	14.6.11	Your work has been good for me to read. It provides support which formal training does not provide.
academic supervisor	FOUR	2/6/11	Response 8.6.11	The findings you sent long plenty good enough. I especially liked the tables; I would encourage you to think about whether you can put all the categories into one figure?
Psycho dynamic colleague	FOUR	5/6/11	Response 13.6.11	The narrative chapter was interesting and made a lot of sense.

APPENDIX L

Recommended Reading

Lori Schiller and Amanda Bennett (1993). *The Quiet Room*.

Carla Fine (1997). *No Time to Say Goodbye. Surviving the Suicide of a Loved One*.

Gail Griffith (2005). *Will's Choice. A Suicidal Teen, a Desperate Mother, and a Chronicle of recovery*.

Ann Smolin and John Guinan (1993). *Healing after the Suicide of a Love One*.

Kay Redfield Jamieson (1999). *Night Falls Fast -understanding suicide-*.

Christopher Lukas and Henry M. Seiden (2007). *Silent Grief. Living in the Wake of a Suicide*.

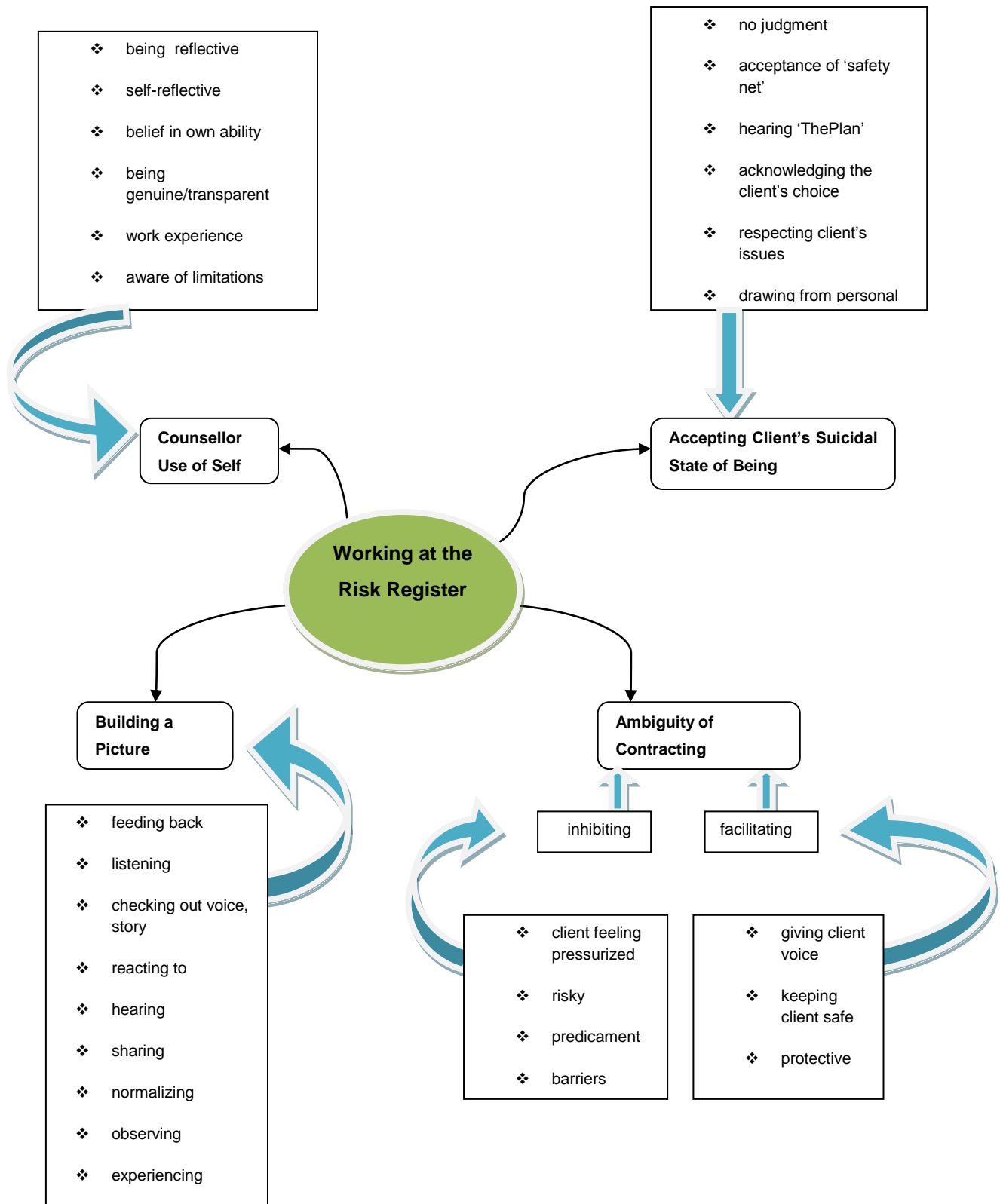
David Webb (2010). *Thinking about Suicide: Contemplating and Comprehending the urge to Die*.

Alison Wertheimer (2001). *A Special Scar*.

APPENDIX M Mind map

Appendix M. Mind Map, Assessing Risk

The Person-centred Counsellor's Experience of Assessing Risk in the Suicidal Client



APPENDIX N

Research focus: Suicide. An exploration of themes significant to the topic.

1st year Doctorate Assignment. The University of Manchester.

Issues of over-involvement, empathy and the 'as if' condition of empathy gleaned from an earlier exploration of the topic in preparation for this study.

Defining over-involvement

Mearns and Thorne (1988) define over-involvement as existing 'when meeting the counsellor's emotional needs and wishes has become of equal or greater concern than meeting those of the client'. Although this definition relates to the therapeutic relationship, it could have just as important a bearing on the relationship between the researcher and her research project. In being a counsellor I fulfil the emotional and motivational need in myself by offering support to another individual in a constructive and more importantly, empathic way, but keeping boundaries intact and be reflective of self and practice. As a qualitative researcher I collect data in the same manner using the core conditions and reflection of self. Just as there is the potential to lose the boundaries in a counselling relationship through being emotionally overpowered by the content of the client story it is equally as possible to become lost in boundaries in the research process, for instance not being able to sustain the commitments of the research project, withdrawing from the process and consequently not meeting the needs of participants.

The latter being an issue which has ethical implications (BACP, 2004, pt.3, p.4). Etherington (2001, 2004 in Scott, 2006) refers to negative effects of being engaged in reflective research with reference to losing control of data, a getting lost in the vastness of research. Although this sounds rather of being stuck in the practical side of research rather than the emotional element which seems to accompany over-involvement and its potential serious consequences, such as, fear, burnout, anxiety, vicarious traumatising. Lennie and West (undated paper, handout 2006) refer to 'being stuck' in the research process as a dilemma the researcher is faced with. (pg.4).

The role of empathy

Scott (2006), referring to Cartwright (2002) and Kvale (1999), states that "heuristic research acknowledges that data collected from interactions such as research interviews is inter-subjective, a co-creation between interviewee and researcher, rather than being objectively

true” (p.6) and continues with quoting Ashworth and Lucas (2000) that “gathering such data the approach of the researcher must be empathic” (p.6).

Rogers (1951) addresses empathy as an ‘understanding of the client whereby the practitioner perceives the world as the client sees it and to perceive the client as she sees herself, to assume the client’s internal frame of reference’. When I feel empathy for a client I define this as a deep ‘felt’ understanding, Gendlin’s (1981) ‘felt sense’, of the client’s experiences and feelings. This deep ‘felt’ understanding might originate from my own experiences, however with an awareness of avoiding a strong emotional over-involvement with the client’s felt experience. In person-centred counselling this inner experience can be communicated to the client if appropriate (Rennie, 1998).

Bondi (2003) reflects on the concept of empathy in research identifying the importance of the researcher recognizing the participants’ experience and being able to understand their feelings, being “emotionally present” (pg.71), but still differentiate between and be vigilant to their own feelings and reflect on self. This view resembles the ‘as if’ position as explained by Rogers (1959), Greenberg et al. (1993), Ridge, Martin and Campbell (1999).

Bondi (2003) further argues that when this process of empathy also encompasses the processing of unconscious communications and making these available we speak of identification. Referring to Winnicott (1965, 1971) she claims that for the “psychotherapist this process begins with the introjections of aspects of the emotional experience of the other, or with being receptive to the other’s projections, in much the same way as identification” (Pg.71).

The 'as if' condition

Inherent in empathy is the 'as if' condition (Rogers, 1959), sensing the clients' feelings and emotions and perceiving its causes as the clients perceive these with the practitioner realizing she experiences equally 'as if'.

If this 'as if' state is lost, then there is a state of identification (Rogers, 1959). And this is the state where I feel the boundary is overstepped from empathic understanding to sympathetic involvement and the practitioner 'identifies' with the client, a condition Barrett-Lennard (1965) describes as 'sympathetic identification' and defined by Mearns and Thorne (1988) as 'false empathy'.

The 'as if' condition of empathy has been explained differently meaning the same by many, for instance "the therapist takes in and tastes the client's intentions and feelings" (Greenberg et al. 1993. p.104 in *Counselling The BACP Counselling Reader*, 2001). In the same breath and more poignant Greenberg et al. (1993) query what it would be like "to be in and walk around in the clients' shoes" (p.104).

The concept of identification

Ridge et. al. (1999) challenge the 'as if' condition of empathy with the concept of 'conscious identification' whereby the counsellor is reminded in the session through the sharing by the client of particular issues that have a bearing on the counsellor's remembering of past painful experiences. The authors rightly point out that conscious identification could be hindering to the counsellor's ability to be empathic, one of the core conditions. Theoretically this might well present a threatening concept to the very basis of the person-centred approach. They claim that the counsellor in overstepping that boundary might merge emotionally with the client (over-involved) and lose sense of self or become detached because of being reminded of own experiences and consequently become under-involved in fearing over-involvement, not giving the client the care and attention needed in the 'face of pain' (Mearns and Thorne, 2000). Not considering these possibilities in research could leave vulnerable participants feeling abandoned and rejected.

Walking the fine line

Vanaerschot (1990, in *Counselling The BACP Counselling Reader*, 2001) expands on this dilemma of walking the fine line between keeping your distance but at the same time being appropriately empathically involved. He argues that to have direct knowledge of the client's phenomenological world is not possible and that the counsellor's knowledge of the client's experiences are based upon the counsellor's perception of the client and therefore it might

be difficult not to refer back to the counsellor's own phenomenological world in her striving to understand the client. This thought supports Douglas and Moustakas' (1985) explanation of phenomenology as 'encouraging a kind of detachment from the phenomenon being investigated' (p.43), however, at the same time getting lost in the process of descriptive analysis. As opposed to heuristic inquiry where the researcher is involved in dialogue in the form of a free flow with self and the participant in which both participate at depth. The question then arises of who 'holds' the process.

Although I believe in the heuristic process from a researcher point of view a certain amount of caution is necessary to keep a clear 'separateness', also suggested by Kottler and Brown (1992, in *Counselling The BACP Counselling Reader*, 2001), in order to maintain emotional boundaries and to keep the self safe. Indeed, Rogers, (1959, in *Counselling The BACP Counselling Reader*, 2001) proposes that the counsellor needs to be aware of the division of feelings and thoughts of self and those of the client. The challenge is to stay emotionally in tune to understand the client's experience without getting swept into the action of the process.

When the researcher gets too involved, caught up in the emotional impact of the client's story and identifies with this narrative (introjection), she loses her stance, is not able to maintain a degree of detachment to take stock of what is happening, the focus is lost, she becomes over-involved and is unable to be fully with the other. Bondi (2003) explains this fluctuation between appropriate detachment and empathic involvement as an "oscillation between participation and observation". (p.72).

Personal involvement/self disclosure influence

However, to fully understand the client or research participant there is a definite need to extract from own experiences. Edward S. Bordin (1955) (in Truax and Carkhuff, 1967) proposed that some personal involvement was necessary to fully understand, however also stressed that to still be able to differentiate between one's own experience and that of the subject one needed to maintain a certain level of detachment. This process however can easily lead to self-disclosure with a subsequent effect on the client/participant, as the power differential might well change. Self-disclosure comes from a need to share with the other one's own experience, an area which might lead to over-involvement as the participant might begin to feel 'responsible' for the researcher, changing the relationship and crossing the boundaries. Others have argued that self-disclosure and intimacy will lead to more self disclosure, commitment and equality of participants (Oakley, 1981 in Roberts, H. ed. 'Doing Feminist Research', 2001. Etherington, 2001, in Scott, 2006). If not careful this might lead to unethical practice, when self-disclosure is used to gain more data only.

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