Understanding therapist experiences when organisational risk management protocols are implicated by the suicidal ideation and intent of clients

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Table of contents

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Declaration

I hereby declare that the work presented herein is my own, and has been developed under the supervision of Daphne Josselin, and that any other assistance or inspiration drawn from elsewhere has been appropriately referenced within the body of the text.

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Abstract

Background: Client suicidality has been identified as one of the most significant stressors experienced by therapists in their work (Deutsch, 1984; Chemtob et al., 1989). The anxiety occasioned thereby is liable to be heightened in organisational settings on account of the attendant sense of external observation, and awareness of the potential implications vis-à-vis reputation and status should the clinician 'fail' in their duty of care (Reeves & Mintz, 2001). However, literature attending to the therapist's internal process in such moments is sparse, with greater attention typically having been directed towards client 'risk factors'.

Aims: In addressing this gap in the literature, the current study seeks to illuminate the subjective experience of therapists confronted by client suicidality and associated requirements to attend to organisational risk management protocols.

Participants: Eight therapists were recruited from HE organisational settings in the UK, all of whom had previously worked with suicidal clients. Participants were aged 41 to 64, and currently practicing within a variety of therapeutic modalities.

Methodology: In-depth, semi-structured interviews were conducted, inviting participants to reflect upon past encounters with client suicidality that demanded attention to organisational risk management protocols. Interpretative Phenomenological Analysis (IPA) was subsequently used to identify pertinent themes across the transcripts (Smith et al., 2009).

Findings: Four superordinate themes, each comprising six subordinate themes, were identified within the participant narratives. The first theme, "Stirred up", highlighted that participants were often emotionally unsettled by their encounters with client suicidality. "Goldilocks and the Three Bears", the second theme, evidenced that participant efforts at risk management were experienced as either being 'too much', 'not enough', or 'just right'. The third theme, "It's good to ask for help", showcased the conclusion reached by participants in the wake of experiencing both isolation and organisational support when working with client suicidality. "Noisy, but unhelpful", the fourth and final theme, recognised that institutional expectations and anxieties occasioned by client suicidality often complicated the clinician's attempts at managing risk.

Discussion: Implications of the emergent themes for Counselling Psychology were explored, particularly with a view to understanding how best to manage therapist reactions when squeezed between needy suicidal clients and demanding protocols, thereby minimizing any interference in the therapeutic process.

Chapter 1: Literature review

1.1. Introduction

1.1.1. Suicide as a public health priority

Around 800,000 people are successful in their efforts to kill themselves every year, making for one death every 40 seconds, such that addressing suicide undoubtedly constitutes a significant public health priority at a global level (WHO, 2020). Furthermore, the World Health Organisation report that for every adult death by suicide, twenty other individuals are likely to have attempted to take their life. Berman et al. (2006) highlight suicide as ranking between 5th and 10th in terms of commonality as cause of death across Western nations. In the UK, the latest figures reported 6,507 suicides in 2018, which represents 11.2 deaths per 100,000 people (ONS, 2020). Suicide is, of course, an issue of direct relevance to the therapeutic community. A comprehensive, five-year Department of Health enquiry found that approximately one quarter (i.e., 24%) of those who successfully completed suicide had contacted UK mental health professionals at some point in the year prior to their death, amounting to around 1,500 cases per year that provided potential opportunities for intervention in mitigating distress and avoiding such outcomes (DoH, 2001). Luoma et al. (2002) produced an aggregated review of 40 studies from Europe, Australia, and the USA that is perhaps even more optimistic in this regard, identifying as many as 32% of suicide victims as having reached out to mental health services in the year before their death, and 19% in the month prior to taking their life, suggesting an even greater capacity to exert influence. It is in this context that the UK government has sought to pursue an agenda of suicide prevention and reduction, having announced in January 2015 an ambitious, some might say overambitious, ‘zero target’ for NHS suicides (Reeves, 2016).

1.1.2. Who to hold responsible?

Historically, within Western societies, Judeo-Christian belief systems positioned ‘God’ alone as possessing the right to ‘give’ and ‘take’ life, such that suicide (i.e., self-murder) was

deemed to be a grievous offence against creation (Szasz, 1986). If a death resulted from natural causes (i.e., God), that was the end of the matter, but where human hands had intervened (in cases of homicide or suicide), judgement needed to be meted out on the guilty in punishing actions considered to be morally repugnant. Religious influences ultimately shaped secular perspectives, and hence, “for centuries, English law designated suicide as a special crime, punished by mutilation of the body, sanctions on the place and manner of burial, forfeiture of property, and censure of family” (Litman, 1980, p. 841). As recently as the early Victorian era, those who took their life were sometimes still buried in unconsecrated ground at a crossroads far from town (symbolizing their disavowal by the community), a stake driven through their heart to guard against the escape of evil (Gates, 1988).

It was only towards the end of the Enlightenment, Szasz (1986) points out, that suicide came to be regarded as a manifestation of ‘madness’, and latterly, ‘disease’, rather than a sin or crime. Self-destructive individuals were subsequently to be protected from themselves, originally accomplished by placing them in an asylum, and latterly, through admission into inpatient hospital settings (Berman et al., 2006). However, although greater tolerance is manifest in modern attitudes towards suicide, Litman (1980) draws our attention to residual ambivalence, undercurrents of disapproval, and feelings of stigmatization on the part of the bereaved family. Society, continuing to label the choice of suicide undesirable, but freeing the troubled individual from responsibility for their actions, also exhibits an ongoing need to hold someone accountable for this ‘bad’ outcome. Subsequently, rather than the suicide victim being held at fault (or even their ‘disease’), this dubious honour often falls to their hapless caregiver. As a result, the therapist, usually so intent on facilitating client autonomy, is thrown into confusion, since pursuing such a course in this instance would be to render themselves blameworthy as an enabler of suicide. Thus, the client's suicidality potentially sees client and therapist at odds. The client may want to die. The therapist, informed by social expectations and legal imperatives, must keep them alive, regardless of the client's wishes, inevitably introducing tensions around power and control into the clinical dyad (Jobes & Ballard, 2011). The therapist, in many ways, is left in an impossible position. As Bongar and Sullivan (2013)

observe, they have been endowed with the status of healers by society, and hence, are expected to protect their clients from harm by effectively predicting the likelihood of their acting out suicidal fantasies, and then, intervening to short-circuit this possibility, warding off their client's internal demons. This cannot, of course, be done with any degree of clinical certainty, since, as Jobes et al. (1997, p.368) point out, "suicidal states are extraordinarily complex; self-destructive feelings are usually multidetermined and tend to wax and wane over time". There is no objective tool that can infallibly pin down somebody else's subjective decision-making, particularly at some later juncture, and even if it could, no clinician could have absolute confidence in their capacity to influence their client in the desired direction.

It was with an awareness of suicide as a pressing public health concern, and of the possible pressures experienced by therapists in organisational contexts wherein expectations often exist of averting client suicide altogether, that this literature review was undertaken. Intent on better understanding the impact of client suicidality as a stressor, this researcher set about exploring clinician experiences thereof, hopeful of hereby identifying any gaps in the literature where this project might make a useful contribution to the discipline of Counselling Psychology. Progress was initially slow. Given the breadth of writing on suicide, it proved challenging to identify search terms within PsycINFO that would adequately narrow the focus to this topic. Hence, a more old-fashioned search strategy was adopted, identifying a key group of writers within the field, the Aeschi Working Group (http://www.aeschiconference.unibe.ch/). This network of collaborators, the product of a 'think tank' conference held in Switzerland in the winter of 2000, are united by their ambition to improve the clinical assessment and treatment of suicidal individuals. Their texts were used as a jumping-off point to track down relevant literature, which was subsequently located online, yielding the understandings that follow.

1.2. An "occupational hazard"

> *What weighs on me in his case is my belief that unless the outcome is very good, it will be very bad indeed. What I mean is that he would commit suicide without any hesitation. I shall therefore do all in my power to avert that eventuality.*
>
> *Freud, 1963 [1926], pp.101-02*

In 1926, Freud penned these lines with reference to a young patient he was treating at the time, and in so doing, elucidated the existential pressure often experienced by the clinician when working with someone who poses a danger to their own life. The modern-day Counselling Psychologist experiences a similar 'weight' in treating suicidal clients, when a desire to empower individual choice, and foster individuation, sometimes comes into conflict with duty of care. Encountering such clients is not an altogether unusual occurrence either. A famous axiom amongst psychiatrists, Biermann (2003) observes, is that there are two types, those who have already lost a client to suicide, and those who will. Whilst this may be something of an exaggeration, Chemtob et al. (1989) did conclude that suicide was an "occupational hazard" for mental health professionals after discovering that 22% of surveyed psychologists, and 51% of psychiatrists, had experienced such a loss over the course of their career. The figure reported for psychiatrists was probably inflated by sampling bias on account of a lower rate of response as compared to psychologists, but these nevertheless represent substantial risks. Moreover, therapists will regularly encounter suicidal ideation and acting out, even where death is not the outcome, and this has been rated the most significant stressor in their work (Deutsch, 1984).

1.3. Freud's "bad" outcome

Within clinical suicidology, the literature, as Fox and Cooper (1998) point out, has devoted substantial attention to 'risk factors', aiming to support the clinician to better ascertain how acute is the threat of self-destructive behaviour, and thereby prime more effective

intervention, whereas there has been less focus on the impact of threatened and attempted suicide, successful or otherwise, on the treating clinician. Where the counsellor's experience has been emphasised, the literature has typically explored the impact of losing a client to suicide, examining clinical circumstances in which Freud's imagined "bad" outcome becomes reality. Such explorations have largely accented idiographic case reports and autobiographical essays (e.g., Kolodny et al., 1979; Gitlin, 1999: Biermann, 2003: Alexander, 2007), augmented by empirical studies involving survey questionnaires and semi-structured interviews (e.g., Chemtob et al., 1989; Kleespies et al., 1993; Hendin et al., 2000; Ruskin et al., 2004), and a few qualitative explorations utilising thematic analysis or grounded theory (e.g., Sanders et al., 2005; Tillman, 2006: Christianson & Everall, 2009). The unifying thread, throughout this body of work, appears to be the recognition that it constitutes an emotionally distressing, sometimes even traumatic, event for the clinician (Ellis & Patel, 2012).

Studies have consistently emphasized the potential stress occasioned by client suicide. Alexander et al.'s (2000) study of Scottish consultant psychiatrists found that, despite a mean of 17.5 years in practice, 33% suffered from low mood, insomnia, and irritability in the wake of such losses. Hendin et al. (2000) similarly highlighted emotional responses typically associated with grief (e.g., shock and disbelief; sadness; anger; guilt), with therapist reactions depending somewhat on their attributions of responsibility. Some felt ‘rejected’ and ‘betrayed’ by their client's decision, and angrily externalized blame, whereas others, more concerned about their own therapeutic performance in failing to guard clients from self-destruction, internalized the blame, feeling guilty as a consequence. Emotional involvement with, and attachment to, the suicide victim was found to be more important than relational status (i.e., being a family member) in informing the intensity of grief, increasing mental preoccupation therewith (Reed & Greenwald, 1994). The unexpected nature of suicide, and the belief that it is both unnatural and preventable, further complicates matters for bereaved survivors (Grad, 1996). Hendin et al. (2004) concluded that more severe distress, and overwhelming guilt, were experienced when therapists perceived their treatment decisions (e.g., failure to hospitalize; allowing the patient out on leave) to have contributed to the suicide, whether or not this

conclusion was justified. Such responses may be exacerbated where the therapist has an obsessive personality type (Gitlin, 1999), with a tendency to perfectionism and self-blaming attributional style (Ellis & Patel, 2012).

The clinician, of course, unlike the suicide perpetrator, continues to operate within an interpersonal context wherein they may feel concerned about external assessments of their worth. Hence, feelings of shame and embarrassment are also sometimes evident (Hendin et al., 2000), together with fears of being blamed by relatives or the employing institution (and subject to retribution), further reinforced where lawsuits are genuinely threatened, or case reviews are censorious. Unfortunately, aggrieved family members, harbouring unrealistic expectations about the capacity of therapy to avert suicide, and unwilling to acknowledge their own feelings of guilt, often do consider malpractice litigation when loved ones die under the care of a mental health professional (Baerger, 2001). Rather than this representing an indictment of the standard of care received, Gutheil (1984, p.2) acknowledges that “it is the bad outcome, combined with bad feelings, that leads to lawsuits”. Moreover, as Hendin et al. (2004) recognize, institutional administrators, fearful of being held accountable themselves, and potentially sued, may treat therapists as being ‘guilty as charged’. The death of their client is "commonly taken as prima facie evidence that the therapist, somehow or other, has mismanaged the case” (Jobes & Maltsberger, 1995, pp.200-01). In such a context, overblown persecutory anxieties in relation to the imagined judgement of colleagues, and their feared attack on the therapist's competence, are hardly surprising, particularly since they build upon realistic fears of being subject to retaliatory legal redress by the victim’s relatives, and fingered with blame within their own organisation (Tillman, 2006). In this game of pass the buck, nobody wants to be left "holding the parcel when the music stops" (Reeves, 2010, p.52). As Kolodny et al. (1979) recognize, a sense of being caught in the attentional spotlight in such moments can feel profoundly isolating for the clinician. Utilising the emotive concept of ‘betrayal’, they demonstrate how suicide-related blaming potentially cuts in multiple directions. Just as therapists may perceive themselves as having let down their clients in failing to avert a suicide (yet equally, experience themselves aggressed against by said clients in the act thereof), they

may also consider that they have betrayed institutional trust in their capabilities, and find that this is reciprocated in kind given a lack of organisational loyalty in guarding their back. Perhaps understandably, then, there is often an increased recognition of being subject to the whim of external factors beyond their control (Christianson & Everall, 2009).

The Impact of Event Scale (IES), which appraises intrusive thoughts and avoidance in response to stress using a standardized self-report measure, has been deployed by several researchers to assess subjective therapist reactions to suicide and suicidality. Chemtob et al. (1988) found that roughly half of surveyed US psychologists experienced intrusive symptoms of post-traumatic stress in the weeks after a client's suicide, comparable with those suffered by family members following the death of a parent. Kleespies et al. (1993), replicating and expanding upon their own previous study (Kleespies et al.,1990), discovered that trainees were a particularly vulnerable group, as the stress levels induced in psychology interns by client suicidal behaviour were higher than those highlighted in comparable studies of professional psychologists. A graduated increase in stress was exhibited in line with the increasing severity of behaviours (i.e., suicidal ideation; suicide attempt; suicide completion). A similar study by Yousaf et al. (2002) built upon these findings with a UK sample, highlighting 52% of psychiatric trainees, employed within the St. George's Hospital regional training scheme, as being 'clinically stressed' in the immediate aftermath of losing a client to suicide, with no evidence of a statistically significant reduction in symptoms with the passage of time. These results were further reinforced by Ruskin et al. (2004), since an 'important minority' of Canadian psychiatric trainees who participated in their study also approached clinical levels of emotional disturbance following client suicide, satisfying criteria for acute stress disorder (i.e., 22%) or PTSD (i.e., 21%). The impact of suicide was identified as being more severe when it occurred during training (rather than after qualification), and as correlating inversely with social integration within established professional networks as perceived by the clinician. As Gitlin (1999) observes, more experienced practitioners are likely to be buffered against loss by a mature professional identity, encompassing a sense of personal competence, and the respect of peers, whereas trainees may question their therapeutic abilities and suitability for

the work. Kolodny et al. (1979) spoke of the need for isolated trainee practitioners to receive support and absolution, since their confidence is often shattered by such events. "For the psychotherapist", Maltsberger (1992, p.173) points out, "the person is the principal therapeutic tool". Hence, client suicide "raises questions of professional adequacy that cannot easily be separated from questions of personal adequacy". Unlike with medical professionals, Jobes and Ballard (2011, p.54) elaborate, “there is no equipment failure, no pathogen, no virus to otherwise blame”, and hence, it is harder to dilute their sense of responsibility as the primary instrument of care.

1.4. ‘Holding on’ or ‘letting go’?

The literature suggests that a client suicide may trigger behavioural changes in a clinician, whatever their stage in the career lifecycle (Ellis & Patel, 2012). This may encompass ‘holding on’ tighter in the context of their existing clinical work to avoid an unwanted repeat occurrence. For example, Chemtob et al. (1988) highlight increased vigilance for and sensitivity to suicide cues, increased peer and supervisory consultation, and more conservative record-keeping. 42% of psychiatrists surveyed by Alexander et al. (2000) reported that they altered their approach in the wake of the event, managing potentially suicidal clients in a more structured manner, and adopting a more cautious and defensive approach vis-à-vis ‘risk’. Although certain changes in clinical practice may be justified, representing appropriate improvements in the clinician’s provision of care, Gitlin (1999) points out that this implementation of new procedures, this tightening up of their perceived hold over the situation, often reflects magical thinking. As such, the belief that these protections will guard against the recurrence of client suicide is perhaps more important than whether they do, in fact, serve this purpose. Thematic analysis by Tillman (2006) of interviews with twelve psychoanalytically inclined therapists highlights that counter-transferential anxiety is typically heightened by ongoing interactions with severely depressed and suicidal clients, prompting some clinicians to exert greater control in their therapeutic work with such individuals. Christianson and Everall (2009) observed that, feeling vulnerable and powerless in the wake

of suicides, Canadian school counsellors sought to regain a sense of control by wearing a professional mask, projecting an aura of strength, and forcing their grief underground. Compartmentalizing their emotional experiences offered temporary relief, enabling them to focus on the work tasks at hand in supporting other bereaved survivors (i.e., pupils; staff; parents). Desirous of avoiding future losses, therapists can sometimes become preoccupied with a suicide event, experiencing intrusive thoughts and dreams (Chemtob et al., 1988), consciously ruminating about the case in an effort to identify their “fatal mistake" (Sacks et al., 1987, p.218), and looking out for clues that might have alerted them to this outcome, which Gitlin (1999) argues convincingly is necessitated so as to bind their anxiety, facilitating an illusion of control in face of life's uncertainties. Tillman (2006) also highlights a heavy investment of time in reviewing such cases as therapists wrestle with feelings of guilt, essentially engaging in a superego-informed process of self-castigation, conditioned by deeply ingrained assumptions about clinical culpability in instances of client suicide. A compulsive urge to help other suicidal clients is not uncommon in seeking to ‘make good’ on earlier perceived failures (Sacks et al., 1987).

Other behavioural changes may implicate an attitude of ‘letting go’ with a view to avoiding future loss. Some clinicians become increasingly reluctant to work with suicidal clients, hesitant to accept such referrals (Hendin et al., 2000). Afflicted by self-doubt, they may suffer something of a professional crisis, questioning the capability of the profession to produce meaningful change in the lives of such clients, or at the very least, their own competence in treating such seriously ill individuals, possibly prompting considerations of career change (Tillman, 2006). In Alexander et al.'s (2000) study, 15% of surveyed psychiatrists considered taking early retirement. Inevitably, the therapist, as ‘suicide survivor’, is forced to confront the limitations of psychotherapy in treating severely disturbed clients, and to modulate any grandiose rescue fantasies they once entertained (Goldstein & Buongiorno, 1984). Loss of the client is compounded by a “loss of innocence about the world” (Sanders et al., 2005, p.203), with the clinician forced to confront the reality that their efforts do not always bear fruit. Previously, they may have been seduced by a conviction that the ‘good enough’

therapist could always avert suicide (Valente, 1994). However, having been disempowered by their client's decision to end their life, they must now come to terms with their lack of control over client self-determination. This has been described as the "ultimate narcissistic injury" (Gabbard, 2003, p.253), as it not only confronts the therapist with an external, relational loss, but simultaneously fractures their professional ego ideal, wounding their pride (Tillman, 2006). This twin bereavement, implicating both an interpersonal other, and an internalised self-object, makes for a more convoluted process of de-cathexis, further complicating the grieving process. As Kolodny et al. (1979) recognize, abandoning one's sense of therapeutic omnipotence involves a painful process of transformation and maturation. It demands blunting an overdeveloped sense of responsibility (Gitlin, 1999), and coming to appreciate the limits on one's capacity to influence the behaviours of others (Brown, 1987). Less severely distressed therapists have been found to be those who already possess such psychological flexibility, whose superego is less repressive, and hence, whose self-image is able to incorporate adversities as potential learning opportunities, rather than grounds for self-reproach (Hendin et al., 2004). Most clinicians are not so well-adjusted, however, and hence, the person who commits suicide typically leaves their “psychological skeleton in the survivor’s emotional closet” (Shneidman, 1981, p.30), condemning them to obsess over their potential contribution to the death, whether in having precipitated, or just failed to abort, this unfortunate outcome.

1.5. Weaknesses in the literature

This account of clinician reactions to client suicide exhibits good face validity, but the studies upon which it relies are not without flaws. Much of the literature is anecdotal, involving personal memoirs and case studies (Kolodny et al., 1979; Fox & Cooper, 1998; Biermann, 2003; Alexander 2007). The empirical research is compromised by small sample sizes, which render the reliability, validity, and generalizability of findings questionable. Hendin et al. (2000), for example, found only 26 therapists (who were victims of client suicide) to complete their semi-structured questionnaires and case narratives. Kleespies et al. (1990) surveyed 54 interns from the Veterans Affairs Medical Centre in Boston between 1983 and 1988, but only

9 had navigated a client suicide. It is doubtful to what extent results can be extrapolated from a single internship programme, serving a narrowly circumscribed client population. Even in Kleespies et al.'s (1993) elaborated study, only 33 of their 292 participants were client suicide survivors, and their subjects, although now from a variety of internship programmes, had all completed their training in Massachusetts. A study by Yousaf et al. (2002) was confined to 23 psychiatrists associated with one regional training scheme in the UK. It should be acknowledged, however, that some studies have managed to access a wider group of participants, with 81 sampled by Chemtob et al. (1988), 167 by Alexander et al. (2000), and 120 by Ruskin et al. (2004). The fact that questionnaire and interview studies have relied almost exclusively on self-report data to facilitate a retrospective analysis of emotional impact means that we must be cautious in our interpretations, since there is an associated danger of recall bias (Sanders et al., 2005), with results potentially compromised by our inability to measure reactions immediately following client suicide completion. Ruskin et al.'s (2004) study of graduates and trainees from the psychiatric residency programme at the University of Toronto sought respondents across a 15-year time range (1980-95). Alexander et al.'s (2000) research spanned an interval since suicide ranging from one month to twenty years, with a median of three years, and other studies similarly capture differences in elapsed time since the index event. Prospective studies, with cross-validation via supervisor and peer reports of observed impact, would resolve these difficulties, but it would take many years to build a satisfactory sample size, and expense might be a constraining factor. Interestingly, though, Sanders et al. (2005) found no clear pattern to the emotional responses reported by therapists when the period since suicide completion was factored in, which potentially challenges the premise that perceptions of distress lessen over time.

The self-selection of participants in the context of volunteer-based studies poses a further headache as regards representativeness. It means that we cannot easily estimate how typical questionnaire and interview respondents might be as regards the population of therapists whose clients take their lives. As Hendin et al. (2004) recognize, demanding study requirements might draw in a more highly involved and motivated group of clinicians than

normal. It might be that therapists unwilling to participate were more troubled by their experiences, but equally, that those who were more than ordinarily disturbed were attracted by study characteristics. Alexander et al. (2000) specifically focused on the most distressing experience of client suicide a clinician had encountered, and hence, may have sacrificed a more balanced perspective by their very design. Another concern as regards relevancy might be that most studies have gathered data relating to the experience of psychiatrists and clinical social workers, rather than psychologists. However, the experience of managing distress following a client suicide is clearly a common one, regardless of therapeutic discipline, so this need not trouble us unduly. More qualitative studies are, of course, inevitably restricted by sample size and selection bias. For example, selecting only psychoanalytic clinicians, and interpreting via the hermeneutic lens of psychoanalytic theory, Tillman (2006) is likely to have muted certain responses (e.g., the reactions of CBT therapists socialized in a more medical model of therapy, which might favour a different defensive style of managing the emotions elicited by a client death). Nevertheless, the aim of such studies is not generalizability to large populations, but rather, a deeper understanding of subjective experiences (Christianson & Everall, 2009). Validity is demonstrated where the author's arguments effectively persuade in line with the evidence, inspiring confidence in their conclusions, and reliability is shown where procedural design can easily be followed, the same framework applied for interpreting future data. Both Sanders et al. (2005) and Tillman (2006) benefit from the cross-validation and synthesis of thematic categories identified by independent coders analysing their data.

1.6. Neglect of the clinician's experience

Despite various empirical shortcomings, we appear to have a reasonably robust understanding of the "bad" outcomes Freud hoped to avoid. However, where this author would contend that we are less well-served by the literature is in comprehending the experience, and emotional reactions, of therapists in the moment as they are confronted with client suicidal ideation and intent and required to manage these risks. Clinical suicidology has primarily focused on providing conflicting guidance on the approach therapists should take with such

clients. On the one hand, a "suicide assessment" school of thought, fuelled by a paternalistic "prediction-prevention culture", with its "policy imperative" of suicide reduction (Reeves, 2010, p.44), suggests how best to utilise clinical tools and methodologies to assess risk factors (e.g., gender, age, employment status) as a means of guiding necessary intervention with clients in exercising one's duty of care (Joiner et al., 1999; Neimeyer et al., 2001; Ruddell & Curwen, 2002; Wingate et al., 2004). On the other hand, a group favouring "suicide exploration", opposed to the clinician-centred, authoritarian ethos of the medical model of crisis intervention, and its assumption of one-size-fits-all, which they perceive as creating little more than an "illusion of competence" (Rogers & Soyka, 2004, p.15), argue for the primacy of the therapeutic alliance, and a more patient-led and collaborative approach, focused on the meanings of the client's subjective narrative around life and death (Michel et al., 2002; Leenaars, 2006; Jobes, 2011; Michel & Valach, 2011). Clearly, whether the literature presumes that the clinician's role should be that of ‘interventionist parent’ or ‘dialogic adult’, what is beyond doubt is that it has typically focused on the outcomes of this approach for the client, with more limited attention directed towards the counsellor's internal process. Perhaps, as Reeves (2010, p.135) argues, this is symptomatic of the "treatment culture" that results from medicalizing suicidality, with a two-way relational interaction reduced to a one-way, tick-box exercise, such that the experience of the assessing clinician is rendered irrelevant, deemed not to be worthy of further exploration.

1.7. Squeezed between needy clients and demanding protocols

A small number of studies have, however, explored the emotional challenges with which therapists must grapple when working with suicidal clients, though most have simply involved theoretical explorations based on psychoanalytic theory. Birtchnell (1983), for example, recognized this anxiety-provoking experience as prompting responses ranging from therapeutic overinvolvement on the basis of ‘better safe than sorry’, to avoidance and denial, and sometimes even passivity, which we might conceptualize alternately as ‘fight’, ‘flight’, and ‘freeze’ responses. There is no desire to be rendered the ‘bad’ object, whether by the client,

whose suicide would represent a personal rejection, by external others (i.e., an accusing coroner, disapproving colleagues, or unfavourable press), or even by oneself (should one 'fail' to avert this outcome). Moreover, as Modestin (1987) points out, severely suicidal clients typically operate at a psychotic or borderline level of personality organization, exhibiting more aggression, helplessness, and despair than average neurotic clients, which often disrupts the therapeutic alliance on account of their hostility, and tendency to regressive dependency. Such clients try to involve themselves in symbiotic relationships from which it is difficult for either party to detach, subtly manipulating the therapist into offering the solicitude and caretaking they desire by making emotional demands that force them to become more personally involved than usual in the process of protecting or rescuing the suicidal individual (Birtchnell, 1983). Intense counter-transferential reactions are often aroused in the clinician on account of their client relying so heavily on projective identification as their defence mechanism of choice (Modestin, 1987). Unwanted feelings are pressed into the external object as a means of unconscious communication, and subsequently, the therapist becomes a receptacle for their most difficult emotional experiences. It is hardly surprising, then, that the clinician might feel a desperate compulsion to intervene, becoming overresponsive in an effort to ameliorate distress, or might push the client away to a safe distance to avoid ongoing contamination, or perhaps even experience them as needing to be "handled with kid gloves" (Birtchnell, 1983, p.27) to the point of inaction and inertia. Thus, Richards (2000) contends, the dynamics of early interpersonal relationships are liable to be acted out upon the stage of the therapeutic relationship. Attempting to establish consistency with their projections, the suicidal individual unconsciously 'nudges' their therapist towards fulfilment thereof (Joseph, 1988). Inevitably, where this goes unrecognized, it carries the risk of an undesirable, possibly even life-threatening, re-enactment, particularly in instances where the threat of loss sees aggression turned inwards upon themselves.

As Fox and Cooper (1998) recognize, overexposure to such intense transactions with chronically needy clients is likely to result in emotional exhaustion and burnout over time, with therapists suffering vicarious traumatisation. Confronted by a lack of observable progress in

their clients, and their own seeming inability to reduce their distress, they often feel isolated in these endeavours, and become increasingly cynical and dispirited. Where it proves impossible to fully work through their own counter-transferential responsiveness to suicidal material, there is a danger that, experiencing a heightened sense of life's fragility, they themselves will increasingly succumb to feelings of vulnerability, despair, and helplessness (McCann & Pearlman, 1990). Encountering suicidal fantasies and plans can also be unsettling for the therapist in the sense that it creates tension with established therapeutic principles. "Sacred rules" (Litman, 1994, p.273) relating to confidentiality may have to be broken with a view both to preserving the client's life and easing the therapist's state of mind. For the psychoanalytic clinician, it might be challenging to step into a more directive and supportive role in such instances, where a focus on client safety needs would trump other considerations, since this would be at odds with their primary objective, as highlighted by Litman (1994), of developing the client's autonomy and self-direction. Moerman (2012) similarly observes that risk assessment is often seen as incompatible with a person-centred paradigm, resulting in feelings of guilt when the caring professional contravenes their typical non-directive stance to safeguard their client's well-being. Clearly, regardless of therapeutic orientation, work with suicidal clients throws up the same angst-ridden philosophical tension between empowering freedom and preserving safety, the dilemma about when to let clients choose for themselves, and when to exercise responsibility in protecting them from harm. An ethic of care will often find itself in tension with our respect for client self-determination, and, as Birtchnell (1983) acknowledges, whether to indulge dependency needs, or encourage independent adult decision-making, will always remain a tricky question of clinical judgement.

Only a couple of studies have taken a more empirical approach to exploring counsellor emotional responses in the immediacy of work with suicidal clients. Richards (2000), for example, conducted a questionnaire survey of 100 therapists, with a small number of follow-up interviews. Responses supported the theoretical account of intense counter-transferential feelings, with clinicians reporting hopelessness, helplessness, and panic at the extent of client dependency. There was anxiety about the client's degree of self-destructiveness, and a sense

of failure owing to a lack of therapeutic progress, occasioning a loss of self-confidence. Clients were experienced as demanding and disparaging, attacking the therapy and attempting to sabotage the process by provoking a rejection. Invaded by the client's despair, anxiety, and aggression, clinicians recognized the danger of inappropriately stepping into a position of parental responsibility-taking, or prematurely ending the therapy, perceiving that the client would be better served by another professional, and perhaps, unconsciously, wishing to escape from their negativity and contempt. There is a very genuine danger, it seems, of being pressed into the service of the client's unconscious in the context of what Sandler (1988) refers to as the ‘actualisation’ of their childhood relational dynamics. This study was further backed up by a thematic analysis conducted by Reeves and Mintz (2001) following interviews with practising counsellors, which similarly identified clinician anxiety and anger, and a sense of professional impotence. Doubting their competence to work safely and appropriately with such clients, counsellors sought affirmation of their practice from supervisors in the wake of client disclosures of suicidal thought or intent. This desire for parental validation perhaps suggests some level of projective identification with client helplessness and dependency. Such clinical vulnerabilities are picked up upon by Winter et al. (2009) in their important systematic review and meta-analysis, which highlights that therapists often feel inadequately supported and trained to undertake this challenging work. Although this review largely focuses on the effectiveness of various therapeutic approaches in treating client suicidality, it also highlights barriers to the delivery thereof, recognizing that the ambivalence of clinicians in working with such clients carries a risk of adversely impacting upon their delivery of empathetic therapy.

An additional component highlighted by Reeves and Mintz (2001) was the interface between the relational context of the therapeutic dyad, and the wider organisational and cultural context. The employing organisation was recognized as shaping therapist decisions regarding when and how to break confidentiality. This proved to be a source of tension where policy required interventions that conflicted with the counsellor's own philosophical preferences, causing some to feel they were letting their clients down, or ‘betraying’ their trust. Echoing previous findings subsequent to actual suicide, clinician anxieties were heightened

by a sense of external observation, by their awareness of potential implications for their own reputation and status, and that of the organisation itself, should they 'fail' in their perceived responsibility to keep clients alive. The threat of possible litigation on account of negligent practice was experienced as a further source of pressure, conditioning some counsellors to be trigger-happy in breaching confidentiality, or referring clients elsewhere, in a desperate effort to mitigate just such an outcome. Clearly, there is a danger that fear of blame primes self-protective strategies in this regard. As Reeves (2010) suggests, such defensiveness is understandable in the context of a societal discourse, primed by factor-based suicidology, that views completed suicide as an individual or institutional 'failure'. Where it is naively believed that general trends applied to individual situations render suicide predictable, it is hardly surprising that counsellors subsequently place such a premium on 'getting it right', particularly when such an attitude is embedded in organisational protocols and procedures. Clearly, the communication of institutional expectations around risk management has the potential to be containing of the clinician's anxiety, supporting effective performance in their role, but there is also the danger that it accentuates self-consciousness should policy be experienced as over-evaluative and blaming.

1.8. Further weaknesses in the literature

Unfortunately, whilst our account of therapist experiences of client suicidality is coherent, there are significant limitations in the evidence base from which it is drawn. Birtchnell (1983) and Litman (1994) merely provide a theoretical literature review and personal interpretive account of therapist counter-transferential reactions, without seeking any empirical confirmation. Modestin (1987) bases his conclusions on the clinical records of 149 inpatients who committed suicide whilst under the care of two Swiss psychiatric institutions between 1960 and 1981, having scrutinized therapist progress notes as a means of determining the nature of their psychological exchange with patients, but provides no evidence of any structured, scientific approach in analysing this data. Richards' (2000) questionnaire survey of therapists working with suicidal clients was slightly more robust, involving a stratified random

sample drawn from the UKCP Register of Psychotherapists. However, the sample size was quite small. Only 35 of the 58 respondents had worked with suicidal clients, and only 5 were subsequently invited to attend a more in-depth interview. All were psychoanalytic or psychodynamic in orientation. However, the design of this study, as with those by Reeves and Mintz (2001) and Moerman (2012), who interviewed only 4 and 7 participants respectively, was qualitative, so generalizability was not the principal concern. Rather than ascertaining universal truths, applicable to all counsellors, the aim was to develop an understanding of subjective experiences as a window onto the topic. Hence, the samples in the latter two studies were 'purposive', aiming to minimise participant variations, and hereby ensure comparable experiences for analysis. Consequently, the range of these studies is necessarily delimited, since depth of insight, rather than breadth of applicability, was their priority.

Reeves and Mintz (2001) selected counsellors who were exclusively Caucasian, female, aged 40 to 50, and person-centred in theoretical orientation. It is unclear how these participants were recruited. Inevitably, the nature of this sample limits our capacity to extrapolate from their findings. Winter et al. (2009, p.38) question the reliability and validity of the analysis conducted, arguing that insufficient original data was included "to mediate between evidence and interpretation", and that the authors failed to outline their methodological approach (i.e., semi-structured interviewing; constant comparative method) in enough detail to facilitate future replication of their study. However, as Atkins et al. (2008) recognize, poor reporting of methods is not necessarily an indicator that the research itself was poorly conducted, and the nature of qualitative findings, which regularly derive understandings from the uniquely subjective, ensures that this study still has much to contribute, shining additional light on the challenges faced by clinicians when working with suicidal clients. Moerman's (2012) participant profile was slightly broader in terms of gender and age, but her research question focused exclusively on the experiences of person-centred counsellors in relation to risk assessment, and she recruited very narrowly from within her own professional network. Having lost two close friends to suicide, her thematic analysis must be interpreted cautiously, since these experiences of loss may have coloured her sense-making.

In this light, her study, which concludes that person-centred counsellors do ethically assess risk, regardless of their non-directive questioning style and focus on client autonomy, might be perceived as somewhat self-defensive, especially given the contradictory findings of Reeves et al. (2004) that counsellors often struggle to ‘name’ suicidal intent explicitly in their work with vulnerable clients.

1.9. Summary and problem statement

Past research identifies suicide and suicidality as an "occupational hazard" for therapists. Where the literature has focused on clinician experiences of said hazard, it has largely examined emotional experiences in the wake of such tragic events, highlighting the grief and trauma navigated post-loss, and attempts by self and other to assign responsibility for this “bad” outcome. Therapists who believe they are to blame typically experience self-doubt regarding their professional competence. Primed by anxiety about potential future losses, they may become vigilant and preoccupied, or avoidant and disengaged, and ultimately, must come to terms with the limitations of their personal influence. Literature attending to the therapist's internal process at an earlier stage, when first confronted by clients toying with the possibility of suicide, is sparser on the ground. That which does exist highlights the stress of working with such clients on account of their angry and helpless presentation, which can contribute to clinician burnout and vicarious traumatisation. The therapist, fearful of being judged a “bad” clinician should they ‘fail’ in their duty of care, is liable to become overinvolved or avoidant, or to feel impotent in face of the client's self-annihilatory urges. In this context, concern about "what happens next" often subsumes our focus on "what happens now" (Reeves, 2010, p.108). Conformity with protocols for organisational risk management may subsequently become our priority as we attempt to address our clients’ suicidal ideation and intent, with potential implications for the therapeutic alliance in that we begin "doing to" at the expense of "doing with" (Reeves, 2010, p.135). As Milton (2001) argues, our clinical sensitivity in helping clients make sense of their suicidal feelings may be compromised in such moments, when the action-oriented disposition of the Counselling Psychologist, augmented

by death-related anxieties, sometimes results in our becoming overbearing, more prone to impulsive interventions than would typically be the case. Equally, should we be tempted to disconnect or dissociate, to retreat into 'flight' or 'freeze' modes, our avoidance of strong feelings, defensiveness, and impotent passivity have been identified by Neimeyer and Pfieffer (1994) as just as likely to prove deleterious to effective crisis management. Clearly, our capacity to remain thoughtful and reflective about the client's material, and the underlying meanings communicated therein, is liable to be weakened in such moments, when there is a very real possibility that our reactions will "not only be problematic, but also suicidogenic" (Leenaars, 2004, p.101). These risks are typically exacerbated when our organisation is experienced as oppressive or condemnatory.

Given that our desperation to avoid being designated a "bad" clinician risks pushing us towards this very outcome, there is a pressing need to better understand clinician experiences in organisational contexts that require investment both in supporting suicidal clients and fulfilling institutional risk management requirements. To date, most of the literature attending to therapist responses to suicide and suicidality has been anecdotal, or a product of theoretical speculation. Many of the limitations exhibited by more empirical studies are difficult to address (i.e., small sample sizes; retrospective design; reliance on participant self-selection and self-report data). It is therefore considered that a qualitative methodology perhaps represents the best means of throwing light on the subjective experience of clinicians struggling to avoid Freud's "bad" outcome and pressured by the threat of negative organisational evaluation of their efforts. To this end, the research question that this thesis will seek to address is:

"***How do counsellors experience their responses within the therapeutic relationship when client suicidal ideation and intent prompts attention to organisational risk management protocols?***"

It is hoped that increased insight into reactions, both counter-transferential and personal, that interfere in the therapeutic process when clinicians find themselves squeezed between needy

clients and demanding protocols, can better inform their containment and management by future generations of clinicians. On account of the scarcity of previous studies focused on therapist reactions in the moment (e.g., Richards, 2000; Reeves & Mintz, 2001), and the lack of representativeness of selected samples, the researcher conceives that further qualitative investigation might be desirable in cross-validating existing study findings, and if possible, better incorporating the perspectives of male counsellors, and those from different cultural backgrounds and theoretical orientations, thereby yielding a more complete picture of clinical responsiveness in the face of such challenges.

Chapter 2: Methodology

2.1. Research context

The essential values of the discipline mean that the Trainee Counselling Psychologist is particularly well placed to undertake this research. As Kasket (2013) observes, an acknowledgement of the importance of subjectivity and intersubjectivity means that the lived experience of participants can be prioritized through an inductive, 'bottom-up' approach, given voice in the context of a maximally democratic, non-hierarchical, and collaborative relationship. Mindful of the experiences of our 'co-researchers', we can operate with appropriate awareness of interpersonal power dynamics. Clearly, client suicidality is a sensitive topic, and hence, protecting participant well-being has been at the heart of this endeavour in upholding the profession's humanistic identity (Cooper, 2009). This has required both an ethical stance vis-à-vis research practices, and substantial personal, methodological, and epistemological reflexivity in seeking to limit, if not eliminate, the impact of my own subjectivity. In-depth, qualitative interviews inevitably condition interactive effects as the consciousness of participant and researcher comes into contact. The mutuality of interpersonal influence provides the basis for what 'Jane' (cited in Etherington, 2004, p.32) recognizes as "circulating energy between the context of researcher and researched", and hence, we must remain cautious in interpreting, aware of the potential for associated distortions (e.g., should participant answers be driven by a desire to please). Counselling Psychology training equips us to remain curious and questioning in this endeavour, tolerant of emergent ambiguities, and consequently, facilitates the generation of nuanced, practice-applicable knowledge in fulfilment of Yardley's (2000, p.219) quality criteria of "impact and importance". Once disseminated, it is hoped that this study's findings will empower clinicians to better navigate their work with suicidal clients in respect of the ongoing emotional health of both parties, thereby supporting their self-actualisation as skilled professionals capable of making a positive contribution to society.

2.2. Research strategy

Operating from an interpretive phenomenological perspective (Willig, 2013), this qualitative study has sought to gain insight into the subjective experience of therapists confronted by client suicidality and associated requirements to attend to organisational risk management procedures. A phenomenological paradigm was considered the most appropriate medium for investigating the lived experience of participants through a return "to the 'things themselves'" (Husserl, 2001 [1901], p.168), and exploration of how they appear to individual consciousness. By focusing in on participant perceptions of their experience, the aim has been to elucidate their 'lifeworld' more fully (Langdridge, 2007), drawing out their unique construction of 'reality'. To follow Merleau-Ponty, this has meant empowerment of their voice "in an original singing of the world" (van Manen, 1990, p.13). As such, a contextual constructionist epistemological position has informed this research, recognizing that people's words provide access to their subjective interpretation of things (Madill et al., 2000). In ontological terms, the researcher favours critical realism, perceiving the external world as knowable, but only in limited ways, since knowing is always shaped by our field position, and associated standpoint on 'reality'. Disposing of object-subject dualism, the product of a Western obsession with demarcating inner from outer, and thereby tearing the universe asunder, the researcher recognizes that our 'Being-in-the-world' actually constitutes a "lived amalgam of the two" (Mendelowitz & Schneider, 2008, p.301). As such, existentially embedded in the intentional relationship between noema (i.e., what is experienced) and noesis (i.e., the way it is experienced), our efforts at phenomenology inevitably become a hermeneutic exercise in interpretation. Both inside (i.e., subjective consciousness) and outside (i.e., objective 'reality') can subsequently be illuminated through understanding the person in the act of perceiving (Langdridge, 2007), establishing some semblance of coherence out of what James (2007) [1890] termed the "blooming, buzzing confusion" (p.488), the chaos of things with which we find ourselves confronted.

2.3. Ontological position: Critical realism

The researcher is in agreement with Bhaskar's (1975) revindication of ontology (i.e., the intransitive nature of reality) as separate from, and not reducible to, epistemology (i.e., our transitive knowledge of reality), a philosophical problem grounded in the "epistemic fallacy" (p.36) as promoted by positivistic science, which mistakenly defines 'reality' as solely that which can be known empirically through scientific experimentation. As Fletcher (2017) points out, social constructionism is open to similar critique on the basis that it presents human discourse as a medium through and within which 'reality' is constructed in its entirety. Critical realism, therefore, diverges from these two extremes, and their respective glorification of the perceived object and perceiving subject, on the basis that both approaches are reductionist, framing 'reality' solely in terms of human knowledge, which functions either as lens or container thereof. Whilst recognizing the existence of a world 'out there', an external reality independent of our conceiving thereof, which can be accessed and known, it considers that our human awareness only skims its surface, capturing a superficial impression of reality's vastness and depth owing to the perceptual limitations by which our sense-making is constrained. Our understandings are partial and subjective, but nonetheless, some inevitably represent better approximations than others (Bhaskar, 2017).

Since reality manifests in the context of a three-tiered 'iceberg' structure (Fletcher, 2017), there is variability in the extent of its exposure to consciousness:

1.) Empirical Level: realm of experienced events, mediated by our efforts at phenomenal comprehension, and hence, by our perceptual filters and interpretative biases; subjective meaning-making and decision-making at this transitive level determines our actions in attempting to exert human causal influence on the world

2.) Actual Level: realm of occurring events, which manifest regardless of our experiencing or interpretation thereof; perception and understanding of the actual at the empirical level is variable in its degree of accuracy on account of the distorting effect of our filters

3.) Real Level: realm of underlying causal mechanisms; inherent objective and structural properties of the noumenal world that produce the actual events informing empirical experiences; hard facticity at this intransitive level results in the world exerting a causal influence on humans through inherent potentialities that function to enable or constrain

In summary, 'real' things exist in the world, but this is no guarantee that they are either sensed or known about. 'Actual' events emerge from the interaction of these real things, and the attendant 'empirical' data is subject to human interpretation, informing our sense-making and guiding our action (Bhaskar, 2017). To echo Korzybski (1995 [1933], p.58), "the map is not the territory it represents, but, if correct, it has a similar structure to the territory, which accounts for its usefulness". The mistake of positivism, in over-prizing the objective 'known' of scientific abstraction, is to believe that its 'empirical' maps are one and the same as the 'real' territory, whereas the mistake of social constructionism, over-prizing the subjective 'knower' in the context of a solipsistic individualism, is to believe that all 'empirical' maps are equally valid, leaving no way of differentiating the 'real' and finding one's way home.

To elaborate, both approaches commit cardinal errors in relation to the semiotic triangle that links being, knowledge, and symbolisation (Ogden & Richards, 2013 [1923]). Naïve realism assumes a single relationship between ‘signifier’ and ‘referent’, such that the subjective variations at the 'empirical' level are cut away, and the complexity of underlying meaning embodied in the ‘signified’ is sacrificed. Postmodern idealism, by contrast, removing the ‘referent’, the objective reality to which the ‘signifier’ refers, leaves behind only interpretations of the ‘signified’, all of which are now equally valid on account of the denial of Kant's ‘thing-in-itself’, and thence, any knowable domain of the 'real'. Thus, positivism renders us passive and powerless in the face of external stimuli, subject to one fixed ‘mapping’, whereas social constructionism overplays our world-defining power, and overwhelms us with infinite potential ‘mappings’ (Butt, 1999). Either way, we stand to look foolish through elevating the description (i.e., knowledge), or describer thereof, over that which is described (i.e., being). Critical realism aims to surmount this error through its ‘holy trinity’ of ontological realism,

epistemological relativism, and judgemental rationality. As such, it recognizes that, whilst intransitive objects of knowledge exist within the world, our perspectives on them, deriving from historically transient social contexts, and the criteria of truth and value associated therewith, are fallible, and subject to change over time. Regardless of the relative nature of knowledge, however, certain theories can be favoured in any given moment on account of stronger evidential support (Bhaskar, 2017).

2.4. Epistemological position: Contextual constructionism

Contextual constructionism acknowledges subjectivity as inherent to knowledge production (Willig, 2013), but rather than functioning as “isolated islands” (Brinkmann & Kvale, 2015, p.62), it is realised in “a fabric of relations” (Lyotard, 1984, p.15). As such, knowledge does not derive solely from the external world, nor is it generated exclusively from within, but rather, emerges out of the interaction between our experiencing consciousness and the outside environment. Thus, “constructionism replaces the individual with the relationship as the locus of knowledge” (Gergen, 1994, p.x). Our 'empirical' understandings are necessarily informed by sociohistorical and cultural context, and our individual standpoint therein, and a singular external reality is fragmented in the process of knowing, which generates multiple, internally constructed 'realities' (Ponterotto, 2005). As Kant (2007) [1881] points out, we use our mental apparatus to organize and interpret incoming sense impressions, which makes it challenging to parse out objective reality from the person experiencing and processing that reality, to separate observer from observed. Consequently, our understandings end up being “local, provisional, and situation-dependent” (Madill et al., 2000, p.9). Abstract universals are broken apart in a real world wherein every individual's experience is biologically and socially mediated (e.g., by gender, age, occupation, family status, etc.). The spatiotemporal ‘thrownness’ of human existence sees each person's particular instances of universality take on their own specific geohistorical trajectory, constituting the irreducible uniqueness of the concrete singularity (Bhaskar, 2017).

This highlights the problem of 'the one and the many' within Western philosophy, posing the question of how to come to know the universal within the particular. A potential solution was unearthed by Dilthey (1977) [1894] in his differentiation of 'Naturwissenschaft' (i.e., natural science) from 'Geisteswissenschaft' (i.e., human science). Whereas the former aimed for 'Erklaren' (i.e., scientific explanation), the latter focused on 'Verstehen' (i.e., empathic understanding of human behaviours). Rather than seeking generalizability, the emphasis hereby shifted to making sense of the meanings of 'Erlebnis' (i.e., lived experience) from the point-of-view of the individual protagonist (Ponterotto, 2005). It was recognized that insight could be generated by attending to the fine details of an individual's perspective on any given phenomenon, and depth, rather than breadth, became the focus, with an emphasis on the completeness of the subjective account, rather than its objective accuracy. The aims of a nascent contextual constructionism were both idiographic (i.e., comprehending the uniqueness and complexity of the individual) and emic (i.e., understanding responses specific to a given sociocultural context) (Ponterotto, 2005). Qualitative methods subsequently came to the fore as the most effective means of drawing out such meanings, usually demanding interactive dialogue between researcher and participant in co-constructing findings. In the context of this interdependent process, it is assumed that the researcher's understandings can never be entirely divorced from the transaction, exerting an inevitable influence on data generation, and subsequent analysis thereof. Whereas positivist researchers would view this as problematic, potentially contaminating what they consider should be a distant, impersonal activity (Etherington, 2004), contextualism deems an aim of 'objective' non-involvement to be absurd, and instead, encourages acknowledgement and articulation of the researcher's subjective position in the hope that it can be 'bracketed off' as far as possible, or at the very least, its impacts accounted for (Madill et al., 2000).

2.5. Methodological position: Interpretive phenomenology

A phenomenological methodology represents a snug fit with a critical realist ontology and contextual constructionist epistemology. As Butt (1999) points out, this discipline echoes

Bhaskar in recognizing that the research philosophies of realism and idealism (i.e., empiricism and intellectualism) are limited in their capacity to comprehend the human being. Merleau-Ponty (1964, p.159), for instance, emphasized that "science manipulates things and gives up living in them". In abstracting emotions from lived experience, divorcing them from context, it renders them meaningless. Social constructionism is envisaged as equally flawed, however, in its implication that the world is somehow constituted in its entirety by the cognitive power of a disembodied subject. Phenomenal description is subsequently envisaged as a means of healing this objective-subjective rift through a privileging of perception as "the background from which all acts stand out" (Merleau-Ponty, 2013 [1945], p.xi). The focus is hereby shifted from ‘comprehension’ to ‘prehension’. Rather than becoming hung up on the relative power of an inner, reality-shaping personhood or an outer, reality-defining world in imposing themselves on one another, the researcher remains accepting of the dynamic tension between the two. As Richardson et al. (1999, p.212) contend, "our nature or being as humans is not just something we find (as in deterministic theories), nor is it something we make (as in existentialist and constructionist views); instead, it is what we make of what we find".

Neither imposed from without, nor constructed from within, perception represents a pre-reflective process of enquiry into the 'real', best served by an open and questioning stance in grappling with an external context that resists our constructions (Butt, 1999). We hereby ask ‘being’ to speak for itself as far as possible, rather than allowing our pre-existing ‘knowledge’ to take precedence. As Eatough and Smith (2017) outline, the intention of phenomenology is that, by stripping away the prejudices acquired in the course of living, the biases and preconceptions (conditioned by science, tradition, and common sense) that constitute our ‘natural attitude’, and returning instead to a naïve consciousness of ‘things’ as they are encountered in the world, their taken-for-granted ‘essence’ will be exposed to daylight in the context of this more ‘phenomenological attitude’. Stepping beyond the contextual and personal, the aim is to capture the quality and texture of subjective experience from a first-person point-of-view, to describe, in simple terms, how the world is experienced by the participant's consciousness. Their sense-making in relation thereto is of primary interest,

rather than the phenomenon's underlying structure. However, it is hoped that, by clearing away some of the 'empirical' detritus and accessing the 'actual' moment of experiential contact, we will more clearly apprehend the 'real', and, to echo Blake (2004) [1863], see the "world in a grain of sand" (p.506). Thus, in the context of this study, we are not so much interested in the individual clinician's singular vantage point on the experience of navigating their organisation's risk management protocols in relation to suicidal clients, even if this is our starting point, but rather, in the invariant 'whatness' of this encounter with external reality, the underlying commonality linking all such experiences, which constitutes an envisaged endpoint to the Husserlian process of reduction.

Interpretative (or hermeneutic) phenomenology, in its concern with underlying meaning, and unwillingness to accept experiential accounts at 'face value', maintains an attachment to the 'real' (Willig, 2013). Whilst the researcher makes no claim to identify causality, to pinpoint the social and psychological structures underpinning experiences, there remains an aspiration not merely to describe something that exists in the world (i.e., the private feelings, thoughts, and perceptions of participants), but also, to understand their experiential account, to make sense of what is 'really' going on, and hereby "make meaning intelligible" (Grondin, 1994, p.20). In acknowledging that participant data does not constitute a direct representation of reality, but rather, a constructed version thereof, which is nevertheless 'real' for the experiencing individual, it is recognized that one must step outside the subjective account itself in order to reflect on its status as an account, and broader social, cultural, and psychological embeddedness, contextual boundedness, and historically contingent status (Eatough & Smith, 2017). Language and culture inevitably shape our modes of thinking and knowing, and hence, both the participant's experiential account, and the researcher's attempts at sense-making in relation thereunto, represent interpretative endeavours. Thus, the notion of a pure description of experience is chimerical, as description and interpretation are inseparable. Subsequently, as van Manen (1990, pp.180-81) observes, "the (phenomenological) 'facts' of lived experience are always meaningfully (hermeneutically) experienced". To follow Heidegger (2010) [1927], our relationships are not solely with

objective things, but with objective things that embody meaning as regards our situated status in the world, our existentially embodied ‘Dasein’.

As we "stretch forth” into the world (Spinelli, 2005, p.15), it is our “intentionality” that facilitates the emergence of phenomena, causing objects to become 'real' to our consciousness by informing our attention to, and orientation towards, these particular 'things' on the basis of how they appear to us subjectively. Thus, interpretation is embedded in the very moment of perception, implicit in the lived unity of the world in which we find ourselves caught up, the interconnected nature of ‘Being’ (Merleau-Ponty, 2013 [1945]). Therefore, as Moustakas (1994, p.28) reminds us, "self and world are inseparable components of meaning". A symbolic interactionist perspective (Blumer, 1969), moreover, brings an appreciation that participant interpretations are not simply idiosyncratic anomalies, since interactions between social actors inform the meanings we attach to events. The concept of ‘Being-in-the-world’, in healing the Cartesian dualism (of person/world, subject/object, mind/body, etc.), allows us to recognize that parts of a whole have no meaningful independent existence as parts when detached therefrom, and hence, individual explanations inevitably reflect patterns of human social discourse. In this context, the accuracy of participant accounts, and external validity of their perceptions in corresponding with 'reality', is not terribly important. Where the ‘essence’ of experiential phenomena can be drawn out, however, underlying, intransitive structures may be highlighted, and whilst this cannot facilitate the prediction of events, it does allow us to frame explanations in the context of specific structural potentialities (Willig, 1999).

2.6. Research method: Interpretative phenomenological analysis

Interpretative Phenomenological Analysis (IPA) is recognized as an effective strategy for developing a rich, fine-grained understanding of the internal world of participants, enabling the researcher to get as close to the ‘essence’ of lived experience as possible “via an examination of the meanings which people impress upon it” (Smith et al., 2009, p.34). It demands a detailed attending to, and systematic examination of, the contents of consciousness, with the aim of illuminating the implicit and unstated assumptions that inform

navigation of their individual ‘Lebenswelt’ (or 'lifeworld') (Smith & Osborn, 2015). Inductively grounded in the data, it involves entering the research process without a predetermined hypothesis, with the aim that human experience be voiced on its own terms, rather than fitted into predefined categories (Smith et al., 2009). However, embodying Heidegger's divergence from Husserl, IPA acknowledges that, no matter how ‘bottom-up’ our process, an ‘insider's perspective’ can never be directly or completely realized, since access to the other's world is mediated (and complicated) by our own sense-making (Smith & Osborn, 2015). Inseparable from the world we inhabit, we cannot take up a ‘God's-eye view’ or achieve transcendent knowledge, because our ‘Being-in-the-world’ is embodied and relational (i.e., situated in a particular personal, sociocultural, and historical context), and hence, subject to temporal and perspectival limitations (Langdridge, 2007). Detached, neutral exploration of the facts becomes an impossibility, and the researcher is subsequently recognized as playing an active role in interpreting the data, which cannot ‘speak for itself’. This occurs in the context of a two-stage process, or "double hermeneutic" (Smith & Osborn, 2015, p.26), which initially involves participants "trying to make sense of their world", and then sees the researcher "trying to make sense of the participants trying to make sense of their world". The first-order meaning-making of therapists reflecting on their experience of grappling with organisational risk management in relation to suicidal clients is thus complemented by a second-order account that seeks to provide a more critical and conceptually aware commentary in better understanding the personal and sociocultural nuances underlying the account (Willig, 2013). Thus, phenomenology is augmented by hermeneutics in the interests of accessing latent meanings that exceed the participant’s explicit claims, and these dual components of enquiry contribute a richer, 'warts and all' analysis, capturing experience in its totality (Smith & Osborn, 2015).

As an idiographic method, IPA involves detailed examination of particular cases. This required that the researcher undertake semi-structured interviews with a view to gathering first-person accounts of therapist experiences of managing risk in relation to client suicidality. Offering a loose framework, this approach nevertheless allowed the researcher to stay in tune with participants in flexibly following wherever their account might lead. Open dialogue aimed

to facilitate emergence of their experiential account, avoiding closed questions that might elicit yes/no responses, and leading ones that might favour the researcher's agenda. Unlike the nomothetic method, which seeks to identify universal laws applicable to worldly phenomena, this interview format intended to reveal something of the uniquely embodied perspective of the individual. However, given the ‘in-relation-to’ quality of ‘Dasein’, the immersed nature of our ‘Being-in-the-world’, this does not preclude extrapolation of generalizations from the particular, since our conception of the ‘individual’ hereby shifts towards involvement in, rather than separation and containment from, worldly phenomena (Smith et al., 2009). As Merleau-Ponty (2013 [1945], p.xxiv) opines, "man is in and toward the world, and it is in the world that he knows himself". He is a 'Being-with' (‘Mitsein’), informed by a ‘with-world’ (‘Mitwelt’) (Heidegger, 2010 [1927]), and hence, his experienced 'self' necessarily implicates the 'other'. Because we are dealing with a “person-in-context” (Larkin et al., 2006, p.106), the interweaving of individual identity with an already existent world of language, culture, and meaning ensures that the particularity of each person's life inevitably has something noteworthy to say about the world at large, and the centrality of certain themes therein, on account of our mutually constitutive relatedness thereunto (Eatough & Smith, 2017). However, as participant accounts are likely to encompass both convergence and divergence, sameness and idiosyncrasy, more general claims must be made cautiously (Smith & Osborn, 2015).

Ultimately, IPA was deemed the most appropriate method for this project owing to its alignment with the ontological and epistemological positioning of the research, and its suitability for in-depth exploration of the meaning-making of a small number of participants in relation to a specific experiential context. IPA offered the advantages of both methodological structure and flexibility, providing clear guidelines for how to go about conducting the study, but also a degree of latitude within these boundaries. Other qualitative methods were, of course, considered, but discarded on grounds of insufficiency of fit. Grounded Theory (Glaser & Strauss, 1967), for example, is a similarly inductive method to IPA, but has traditionally embraced more of a positivist epistemology in its quest to answer sociological questions. Although Charmaz (2006) has sought to address associated deficiencies in reflexivity through

integrating a more social constructionist perspective, it was felt that this approach remained overly theory-driven, concerned with deriving conceptual explanations of behaviour from the data, whereas IPA is more genuinely interested in the emergent experiential phenomenon (Willig, 2013). Discourse Analysis (DA) (Potter & Wetherall, 1987) was also given a hearing, but was ruled out on the basis that its primary focus is the role of language in constructing 'reality' and discursively positioning social identities. Whilst IPA accepts that understandings of the world are necessarily mediated by discourses, and our internal 'reality' hereby constructed, it also recognizes said constructions as constrained by external 'reality', and hence, it was considered less likely than DA to overlook the wider social and material context in which dialogue occurs (Willig, 2013).

Of course, IPA is not without limitations itself, and perhaps the most problematic of these is its assumption of "the representational validity of language" (Willig, 2013, p.94). The extent to which the linguistic medium is capable of accurately encapsulating what Burkitt (2003, p.331) describes as "the mute world of the sensible" is clearly open to question. Certainly, an individual's pre-reflexive experience cannot be accessed directly, distorted as it is by the participant's communication in relation thereto, and the conceptualisation and categorization implicit therein. Alternative descriptive potentialities mean that different versions of the same 'reality' will be created simply as a function of the words selected, and layers of meaning thereby contributed. However, this researcher would contend that IPA is not blind to the tension implicit in its ambiguity around 'discovering' versus 'constructing' reality (Willig, 2013), which it seeks to resolve through a both/and position, as opposed to either/or. Thus, there is no attempt to deny the subjective intentionality of both participant and researcher, and their respective contributions to the account 'constructed' herein, or to pretend that experiential events can be described in their purest form. We nevertheless aim to 'discover' what we can, both about the external experiential 'reality' of grappling with organisational risk management protocols in contexts of client suicidality, and about the internal 'constructions' of participants in relation thereto, whilst simultaneously acknowledging the inherent structural limitations on our capacity for 'discovery'.

2.7. Data collection

The researcher, who was working in higher education as a Trainee Counselling Psychologist at Birkbeck, University of London, requested volunteers from within the university sector, sending out a recruitment flyer (Appendix A) to peers within the BACP division for Universities and Colleges using its online e-mail forum (i.e., BACP-UC-Members@jiscmail.ac.uk). An interview schedule (Appendix B) was created following guidelines suggested by Smith et al. (2009), and subsequently piloted with two colleagues at Birkbeck. Although there was no intent to use the data hereby obtained in the research proper, interview procedures for informed consent and debriefing were followed in the context of a 'dress rehearsal' so as to manage any impacts ethically and render the experience as realistic as possible (Robson & McCartan, 2016). This pilot demonstrated that the interview protocol was effective in accessing the richness of detail required, but perhaps more importantly, enabled the researcher to refine his interview technique, highlighting the need to remain focused on eliciting experiential data, rather than being drawn into intellectualisation around suicide, which might sometimes have been more comfortable for the interviewees in defensively avoiding emotional vulnerabilities associated with this topic. The researcher also came to appreciate how the 'natural attitude' could creep in subtly and unintentionally (e.g., in choosing his own semantic label when summarizing back aspects of an interviewee's experience, potentially running the risk of shaping their subsequent description of events), and the necessity, therefore, of operating with greater care in this regard, allowing the experiential account to emerge on its own terms.

Eight participants were recruited, and individual semi-structured interviews, lasting between 60 and 90 minutes, conducted on a 'first come, first served' basis. In most cases, the researcher travelled to the participant's place of work for this purpose, and only in one instance was it necessary to book a private interview room on City, University of London, premises, since the participant preferred to meet on a non-work day. Basic therapeutic skills (e.g., empathy; unconditional positive regard; 'staying with' emotions; paraphrasing and summarising) were deployed in an effort to build rapport in the context of a 'conversational

style' of interviewing, hereby hoping to better facilitate the intersubjective emergence of meaning (Langdridge, 2007). The intent was of "wandering together with" fellow travellers (Brinkman & Kvale, 2015, p.58), sometimes acting as a guide and enabler in asking questions to evoke participant meanings, sometimes allowing them to take the lead in sharing their lived experience. Participants were asked to describe past encounters with client suicidality necessitating attention to organisational risk management protocols, articulating as much detail as possible in the interests of a rich, reflective personal account. Conscious of the possible asymmetries in power implicit in the interview situation (Kvale, 2006), the researcher clarified in advance that there were no 'right' or 'wrong' answers, and sought to position himself as a naïve listener, curious to learn from participants (Smith & Osborn, 2015). All interviews were recorded using a digital audio-recorder, and transcribed verbatim at a semantic level of detail, capturing not just the spoken words, but any false starts, significant pauses, laughter, etc., thereby evoking underlying meanings more fully.

In order to arrive at a better understanding of the 'essence' of participant experiences, the researcher engaged in a process of 'epoché' (or 'withholding from') whilst undertaking interviews, suspending his 'natural attitude' of taken-for-granted assumptions (Langdridge, 2007). The aim was to 'bracket off' any preconceived notions relating to client suicidality and organisational risk management protocols, hereby guarding against the imposition of researcher meanings that might have prejudiced participant sense-making and interfered in their description of the 'things themselves'. Achieving a phenomenological disposition of "non-interference and wonder" (Finlay, 2013, p.175), and allowing participant insights to appear to consciousness as if for the first time, is challenging, but was deemed a worthwhile endeavour, because failure to exhibit an open-minded attitudinal stance risks constraining authentic self-expression, such that the lived experience of participants would less readily be captured. It is impossible, of course, to turn off entirely what is known, but this researcher sought to maintain a "discovery-oriented mindset" nonetheless (McLeod, 2015, p.95), and to foster reflexive self-awareness by keeping an ongoing research journal (Appendix M), hoping that scrutiny of the process would enable any consistent patterns of bias to be identified, both in the interests of

displaying "sensitivity to context" (Yardley, 2000, p.219), and such that these could be accounted for in the analysis, hereby preserving the interpretative validity of his findings (Willig, 2013). The intention was to avoid “the psychologist's fallacy” (James, 2007 [1890], p.196), wherein a premature turning away from concrete experience is conditioned by assuming that the participant's subjective account can be subsumed within predefined, abstract categories of knowledge. In such instances, our interpreting mind becomes an obstacle to understanding the world (Ashworth, 2015).

2.8. Data analysis

In the data analysis phase, IPA shifts gears, its interpretative elements increasingly coming to the fore. No longer ‘bracketing off’ presuppositions to the same extent, some preliminary sense-making is undertaken in relation to interview transcripts, balancing the hermeneutics of empathy (which makes experience manifest on its own terms) with the hermeneutics of suspicion (which illuminates phenomena with the light of explanatory theory) (Ricoeur, 1970). As Smith et al. (2009, p.36) recognize, IPA looks to adopt a "centre-ground position", both stepping into the participant's shoes so as to view the world from their perspective in isolating essential features of the phenomenon, and also standing alongside them in puzzling through what is 'really' going on, refusing to take things at face value. For insight to be generated, Gadamer (1975) recognizes that the horizons of the text and its interpreter need to be fused; they must “enter the world of the text and make it their own by taking up possibilities inherent within it” (Willig, 2012, p.16). Inevitably, phenomenological interpretation subsequently represents a blending of perspectives. In this context, researcher interpretation can become useful in more fully disclosing participant meanings, and a critical evaluation of their descriptive account enables us to reflect on its positioning within the wider sociocultural and psychological discourse (Willig, 2013). Our challenge, then, is to reveal a phenomenon's hidden dimensions, whilst avoiding squeezing it into preconceived categories, and thereby imposing our own meanings. This requires an awareness that what we uncover through our interpretative process does not substitute for, or supplant, the original account,

invalidating what has gone before. The participant's rendering of things may be supplemented, amplified, or elaborated by revelation of the previously unknown, but said rendering should not subsequently be dismissed as "a disguise for what is 'real'" (Cohn, 2005, p.222). As Stainton Rogers and Willig (2017) point out, we are not dealing in certainties, or trying to have the 'last word', as understandings are always partial, and "something always remains un-understood" (Cohn, 2005, p.221). Rather, in mining the participant's material for clues about underlying meaning, our detective work simply aims to facilitate the 'shining forth' of phenomena of interest (Eatough & Smith, 2017).

To this end, thematic analysis (Madill & Gough, 2008) involved the researcher in a step-by-step process of identifying major experiential themes. A single transcript was initially marked up in the right-hand margin with wide-ranging, unfocused comments, highlighting descriptive, linguistic, and conceptual elements within the text (Smith et al., 2009). Appendix H serves as an exemplar. This transcript was read and re-read with a view to expanding the commentary and increasing the likelihood of identifying accurate meanings. At this stage, the challenge was to maintain a freshness of vision, allowing things to arise in consciousness as if for the first time. Phenomenological reduction demanded that the researcher apply a rule of ‘horizontalization’ in refraining from privileging any aspect of meaning in his description, treating all details as potentially being of equal value (Langdridge, 2007). Some degree of ‘verticalization’ followed, however, with emergent, higher-order themes captured in the left-hand margin, representing a higher level of abstraction, what van Manen (1990, p.91) refers to as "knots in the webs of our experiences". Subsequently, these chronologically derived themes were reordered, arranged into meaningful clusters in the interests of theoretical coherence. The researcher frequently revisited the transcript to sense-check identified meanings and validate tentative conceptual interpretations, making use of the ‘hermeneutic circle’ whereby a cyclical and iterative movement between different levels of analysis allows for a better appreciation of part-whole coherence, and gradual uncovering of layers of meaning inherent in the phenomenon (Langdridge, 2007). The thorough and systematic process embodied herein aimed to satisfy Yardley's (2000, p.219) quality criteria of "commitment and

rigour". However, recognizing that no analysis can hope to unearth the one 'true' meaning of the experiences described, the researcher's more modest ambition, was simply to present a legitimate interpretation of the data (Brinkmann & Kvale, 2015). This was realized via a summary table (i.e., Appendix J), containing quotes illustrating each theme, appropriately referenced back to the originating text. For ease of reference, the data was subsequently boiled down to a master table of themes (i.e., Appendix I). When analysis of the first transcript was complete, the researcher started again from first principles with the next. Once all the cases had been analysed, an integrated table of superordinate themes was created, reflecting the shared orientation of participants towards the experience of navigating organisational risk management in relation to client suicidality (i.e., Appendix L), again backed up by a more succinct summary version (i.e., Appendix K).

2.9. Sampling considerations

The sample was drawn from the university sector on account of the familiarity of this organisational context to the researcher, and his awareness that risk management protocols relating to suicide were applied therein. Recent media interest in student suicide, and its implications for mental healthcare provision within universities (Weale, 2016), had highlighted that managing suicidality was a genuine pressure for clinicians working in HE contexts. As Silverman (1993) recognizes, the tragedy of suicide, the second leading cause of death on university campuses, represents a significant challenge for such institutions, threatening as it does to disrupt their ongoing educational agenda. It appeared possible, moreover, that recent policy initiatives within the sector, notably 'Suicide-Safer Universities' (UUK/PAPYRUS, 2018) and 'Step Change: Mentally Healthy Universities' (UUK, 2020), were further exacerbating the pressures felt by clinicians in delivering against their responsibilities to suicidal clients, potentially contributing to an organisational climate more evaluative of their efforts in this regard. In 2018, Universities UK (UUK) and PAPYRUS, the Parents' Association for the Prevention of Young Suicide, a national charity aimed at preventing suicides in younger age-groups, published guidance aimed at supporting university leaders in preventing student

deaths by suicide, thereby creating ‘Suicide-Safer Universities’. Despite acknowledging that the 95 university suicides reported in England and Wales by the Office of National Statistics in 2016-17 represented a much lower rate than that evident within the wider age-adjusted population, UUK argued that “there is no room for complacency” (UUK, 2018). As recently as May 2020, this was followed-up by the launch of ‘Step Change: Mentally Healthy Universities’, a refreshed framework document aimed at fostering a “whole university approach” (p.3) to mental health and well-being, released by Julia Buckingham, Universities UK President, with a “call to action” for Vice-Chancellors to adopt the mental health of students as a “strategic priority” (p.4). This document emphasizes a university’s duty of care, championing the message of the ‘Zero Suicide Alliance’ that “one life lost is one life too many” (p.16). It is almost inevitable that such expectations will filter down through the institutional hierarchy, and hence, a sample of university counsellors potentially has much to say about the impact of organisational pressures on ongoing therapeutic efforts to support suicidal clients.

Sampling was somewhat ‘purposive’, as only participants who had worked directly with suicidal clients were recruited. However, ‘convenience’ was also accented in the sense that participants were self-selected, having responded to the researcher's e-mail invitation. Inclusion criteria required that all participants be qualified counsellors, professionally registered with BACP, UKCP, or BPS, with at least three years of post-qualifying experience, thereby increasing their likelihood of having encountered sufficient episodes of client suicidality to provide a rich and nuanced account. Satisfaction of these criteria was checked via a short telephone screening. IPA often looks for a homogenous sample in sociodemographic terms, some degree of uniformity between participants aiming to facilitate greater focus on group variations at a psychological level (Smith et al., 2009), but in this instance, it was deemed more important to recruit participants who shared the common experience at the heart of this investigation, rather than imposing any limitations in terms of age, gender, ethnicity, or theoretical orientation. Although idiographic studies do not aim for generalizability on the basis of a socially representative sample, it was considered preferable

that participants embody a breadth of these characteristics, as in ‘maximum variation sampling’ (Polkinghorne, 1989), thereby broadening the range of the findings.

2.10. Ethical considerations

The research has sought to comply with BPS ethical guidelines. Approval for the study (Appendix C) was initially secured from the Research Ethics Committee within the Psychology Department of City, University of London, informed by the ethics application detailed in Appendix D. Given that all participants were experienced counsellors, engaged in regular supervision, it was anticipated that the potential for psychological distress would be minimal, and certainly no more than encountered in everyday life as a function of their counselling duties. However, it was recognized that the topic of suicide did have the potential to elicit emotional discomfort. Therefore, where distress became apparent during an interview, participants were to be provided with the option of discontinuing the meeting, though this never became necessary, and potential sources of therapeutic and supervisory support were to be discussed. There was no obvious methodological benefit in concealing research aims, so the nature of the study was fully disclosed prior to participant involvement via the information sheet that constitutes Appendix E, thereby allowing for informed consent, which was obtained in writing (Appendix F). After each interview, the participant was fully debriefed (Appendix G), and provided with an opportunity to ask questions about the research. Participants were notified of their right to withdraw their dataset from the study without penalty at any time prior to data aggregation. Audio-recordings were encrypted and securely stored post-interview. They will be retained for five years after publication (in line with journal requirements), and then destroyed. In the interests of confidentiality, all transcripts were anonymized, with names and identifying details redacted. It was agreed with participants that a copy of the researcher's completed doctoral thesis would be shared with them (if they so wished), thereby providing them with access to his findings.

2.11. Reflexive considerations

Clearly, psychologists “are not, and cannot become, the neutral, dispassionate observers that both empiricism and rationalism would have us be” (Packer & Addison, 1989, pp.19-20). Nevertheless, it is hoped that, by disclosing my preconceptions about the topic under investigation, so far as these are accessible to consciousness, I can both prevent these from interfering too much in my analytic process and inform any future audience about potential biases prior to their engagement with my account. As such, I would like it to be known that I am a 40-year-old, Caucasian male, and at time of writing, have worked as a therapist for over nine years, primarily in higher education. Over this period, I have regularly encountered clients presenting with suicidal ideation, though less often with the active intent of killing themselves. During my traineeship in New York in 2009-10, however, one of my very first clients engaged in dramatic suicidal acting out. On one occasion, he left a suicide note, which required active intervention on my part in locating him and ensuring that he returned home safely. This behaviour preceded a hospitalisation, and subsequent psychotic break. The episode was experienced as highly stressful and emotionally exhausting, and it kindled an interest in better understanding this topic. As I subsequently became more experienced in my clinical practice, I observed a shift in my attitude towards client suicidality. In my early years as a practitioner, I was highly anxious in attending to risk management protocols. Fearful of being deemed a “failure”, or labelled a “bad” clinician, should a client take their life, I was liable to become overinvolved in attempting to enact my duty of care. Over time, however, I began to perceive that both the therapeutic alliance, and my client's capacity for responsibility-taking, were undermined where I focused excessively on risk management. Whilst still recognizing a need to step into the role of ‘interventionist parent’ on occasion, I increasingly came to perceive that clients were better served where I continued to adopt the stance of ‘dialogic adult’. Hence, I came to favour “suicide exploration” over “suicide assessment”, and to feel that suicidal distress was more likely to be ameliorated where clients were supported to grapple with their subjective sense-making around life and death, express their feelings, and learn better strategies of emotional self-management, rather than where an overbearing attitude of ‘predict

and prevent' was adopted. I have also sometimes experienced management as communicating impossible expectations that counsellors 'keep suicidal clients alive', which I recognize as within our relational influence, but not within our absolute control, since clients cannot be monitored 24/7, and might impulsively choose to exercise their free will in this regard between sessions. As such, I consider it unfair should any therapist, diligently performing their ethical duties, be subjected to judgement or blame, required to shoulder excess responsibility for their client's aggressive acting-out against themselves, their suicidal manifestation of 'anger turned inwards'. At some point, it is necessary to accept the limitations on our capacity to shape client choices for better or worse.

Moreover, I must own that I have sometimes experienced organisational risk management as more concerned with 'guarding one's back', rather than 'doing the therapeutic work' that might more effectively do so, often constituting little more than a box-ticking exercise. This attitude possibly prevented me from securing a job for which I applied in the past, because I failed to say the 'right' thing at interview. It is possible, then, that there might be a subtle agenda informing my study in wanting to prove a point that over-attention to organisational risk management procedures with suicidal clients can be detrimental to both the therapeutic alliance and outcomes of counselling. Given awareness of this subject position, it has been important to minimise its interference in data collection and analysis. This was achieved by piloting my interview schedule with colleagues at Birkbeck, University of London, to ensure that questions were sufficiently open-ended and non-directive, encouraging participant elaboration of their personal experiences of client suicidality and associated risk management, rather than conformity with researcher direction-setting. Appreciating that 'bracketing' is difficult to achieve, particularly for the 'insider researcher' who already possesses knowledge and presuppositions about the experience under investigation (Corbin Dwyer & Buckle, 2009), I have also sought to remain reflexively aware throughout the process, setting aside a 'natural attitude' that might steer interview content or colour my thematic analysis, and keeping a research journal (Appendix M) in order to reflect on any influence I might be exerting on the process, thereby turning the hermeneutic lens on my own subjectivity

so as to minimize the interference of personal prejudices in my representation of participant material (Langdridge, 2007). By opening up my reading of the data for critical interrogation by my supervisor on several occasions, I have also sense-checked interpretations as plausible, thereby assuring the "transparency and coherence" of my findings (Yardley, 2000, p.219). It is hoped that the clarity with which I have outlined my ontological and epistemological stance, and the methodological practicalities of my approach, will lend credibility to the account that follows, facilitating easy replication should any future researcher wish to undertake a similar study building upon my findings.

Chapter 3: Analysis

3.1. Overview

Interpretative Phenomenological Analysis (Smith et al., 2009) of the semi-structured interviews undertaken with my eight research participants required a systematic examination of the material hereby elicited. This process resulted in identification of four superordinate themes, each populated by six subordinate themes. Taken together, these themes capture the breadth of participant experience when organisational risk management protocols are implicated by the suicidal ideation and intent of clients:

1. ***"Stirred up"****: emotionally unsettled by encounters with client suicidality*

2. ***"Goldilocks and the Three Bears"****: experiencing risk management as either 'too much', 'not enough', or 'just right'*

3. ***"It's good to ask for help"****: experiencing both isolation and organisational support when working with client suicidality*

4. ***"Noisy, but unhelpful"****: grappling with the institutional expectations and anxieties occasioned by client suicidality*

A master table of superordinate and subordinate themes is showcased in Appendix K, with a further summary table, incorporating quotes selected from the originating text to illustrate each subordinate theme, constituting Appendix L.

During the process of writing-up, a balance has been sought between analysis of the data, and illustrative quotations, thereby honouring the "double hermeneutic", and demonstrating the extent to which interpretations are grounded in participant accounts. Sometimes, a greater breadth of accounts has proven more representative of the phenomenal reality, illuminating the various subtleties of participant experience, the divergence and

difference. At other times, it has felt more appropriate to explore transcript extracts of more limited range, perhaps because the language or insights contained therein were particularly resonant, or because they opened up new vistas in relation to the research question. With a view to preserving anonymity, each participant was given a pseudonym, and all names and identifying details were omitted when quoting directly from their transcript. The location of the quoted text was identified using a three-number system, referencing the participant, page number(s), and line number(s) (e.g., 1, 62, 1903-08).

3.2. Participant demographics

Detailed below are demographic details for each participant (i.e., age; gender; theoretical orientation), and the pseudonym assigned for purposes of anonymity:

Participant Number	Pseudonym	Age	Gender	Theoretical Orientation
1	Phoebe	56	Female	Psychodynamic
2	Athena	57	Female	Psychodynamic
3	Jocasta	59	Female	Integrative/Humanistic
4	Penelope	44	Female	Integrative (CBT & Psychodynamic)
5	Iris	53	Female	Integrative/Person-centred
6	Gaia	41	Female	Integrative/Existential
7	Hera	64	Female	Integrative/Humanistic
8	Astraea	48	Female	Cognitive Analytic

3.3. Findings

3.3.1. Superordinate Theme 1: "Stirred up"

The first superordinate theme speaks to the extent to which participants are emotionally unsettled by their encounters with client suicidality. The title, "Stirred up", is drawn from Athena's interview, wherein she describes how her capacity to identify appropriate risk management strategies was compromised by anxiety about a client's well-being, her clarity of thought clouded by the immediacy of risk:

> *because it stirs up such anxiety… especially if it's quite acute, and the student is… is threatening to commit suicide imminently… that anxiety that gets stirred up in… in me can… prevent me being able to think clearly…*
>
> *Athena; 2, 27, 756-62*

Being "stirred up" is suggestive of a degree of emotional turbulence, an internal agitation (as with the swirling movement of a stirred cup of coffee). In such circumstances, triggered by the perceived imminence of loss, it is understandable that Athena's rationality might temporarily be undermined, a norm of intellectual order subsumed by emotional chaos. Suicidal clients certainly have the capacity to get under a clinician's skin, as illustrated by the following subordinate themes:

3.3.1.1. *"You're on high alert inside"*

Anxiety was experienced by most participants regarding the possibility of losing a client to suicide. Both Phoebe and Gaia observed this emotion as something they were "left holding" by their clients, suggestive that this was not fully their own, but perhaps more rightfully belonged to their clients on account of their flirtation with death:

> *I think I'm anxious anyway if I think somebody is… suicidal… I hold… I hold that anxiety…*
>
> *Phoebe; 1, 5, 146-47*

> *in the latter case, I was very much left holding the anxiety…*
>
> *Gaia; 6, 85, 2450-52*

Joining the client in their existential struggle vis-à-vis whether to remain invested in ongoing existence, clinicians are often left nursing concerns, presumably because it is difficult to reconcile themselves with the client's possible choice of death, yet they lack any capacity to influence such outcomes between sessions. Faced with the threat posed by suicidality, they are understandably rendered hypervigilant in navigating attendant uncertainties:

> *one can never relax with that student… I never know what will… you know, in theory, I never know what will have happened to that student when I go home after one week's session before next week's session…*
>
> *Athena; 2, 38, 1069-75*

> *you're on high alert inside…*
>
> *Astraea; 8, 88, 2526-27*

It appears that Athena is always slightly on edge when working with suicidal clients, guarding herself against the possibility of bad news from week-to-week. Astraea echoes this state of heightened attentiveness in acknowledging being "on high alert inside", watchful and uptight in her desire to avoid outcomes of suicide. This state of anxiety can prove quite all-encompassing, intruding into the clinician's external life:

> *so, although I can switch off, and I do switch off between sessions, that student will come into my mind periodically during the week at odd times at home…*
>
> *Athena; 2, 38, 1085-87*

> *because I could worry… I could… I could stay awake all night worrying every night until I came back to meet with my client, but actually, it's not… it's gonna be quite harmful to me, and it's not making any difference whatsoever… and sometimes, of course, that's easier, erm, you know, said than done…*
>
> *Jocasta; 3, 12, 325-34*

Despite attempting to "switch off between sessions", Athena finds it impossible to prevent concerns from unexpectedly pushing themselves to the forefront of her mind. Moreover, even though Jocasta recognizes her worrying as both ineffectual in influencing client well-being, and potentially detrimental to her own state of mind, she concedes that it is difficult to

disengage from rumination altogether. At the root of such intrusions appears to be the clinician's fear of Freud's 'bad' outcome becoming reality:

> *and I guess… touch wood… I've never lost someone, and I guess part of me thinks, 'it's… it's gonna happen', and I guess that's what gets triggered for me when I think it's close… 'is this gonna be the one?'…*
>
> *Penelope; 4, 76, 2181-95*

> *'I live in fear every day that someone is gonna kill… a client's gonna kill themselves'… it hasn't happened yet on… eh, in terms of one of my clients… or someone that I was, kind of, responsible for, if you know what I mean… that's not happened… but, yeah, I live in fear of it every day…*
>
> *Astraea; 8, 3, 66-78*

Both Penelope and Astraea are keen to point out that they have never lost a client to suicide (i.e., "that's not happened"), hereby distancing themselves from such aversive outcomes, and any negative judgements associated therewith, but there is also a sense of this threat hanging over them like a sword of Damocles. Penelope's internal dialogue continually sees her speculating that "it's gonna happen", every encounter with client suicidality causing her to question, "is this gonna be the one?", and Astraea similarly "lives in fear" that one of her clients will actively follow through on their plans. Such outcomes might not have happened "yet", but are presented as though inevitable, perhaps testifying to the limits of clinical influence over client self-determination. However, a discomfort at just letting things run their course is hinted at by Penelope's use of "touch wood", which is an historic device, originally intended to prevent malevolent spirits in the trees from hearing our wishes and undermining our future hopes. Superstitious beliefs of this ilk, though divorced from their original context, and no longer genuinely believed to serve said function, nevertheless suggest a desire to control the uncontrollable in avoiding unwanted negative outcomes.

3.3.1.2. *"Absolutely on the edge"*

Participants were troubled to witness their client's despairing state in contemplating the possibility of suicide. A common motif was that of heights, with the implication of danger for the client in potentially falling to their doom:

> *that assessment, although I only met him once… erm, really stayed with me… just the sense of him being absolutely on the edge…*
>
> *Phoebe; 1, 73, 2232-34*

> *troubling… (pause)… troubling to see somebody… on… the tightrope… that one step…*
>
> *Phoebe; 1, 73, 2242-50*

> *it's like sitting on edge with somebody…*
>
> *Hera; 7, 4, 94*

> *it's like they're looking over the edge, and I am… sit… with them… at that…*
>
> *Hera; 7, 11, 297-99*

> *as if you're looking over a cliff… you know, that actually… there could… this could be an end…*
>
> *Hera; 7, 11, 317-18*

For Phoebe, the memory of a client she assessed, who killed himself six months later, was not easily forgotten on account of his having been "absolutely on the edge", suggesting a tangible proximity to the abyss, a teetering on the brink. The image of an existential "tightrope"-walk perfectly captures her perception of threat in observing a risky performance on the high-wire trapeze, whereby "one step" either way might prove fateful. A sense of distance communicated in being the audience to such an act perhaps speaks to Phoebe's experience of lacking control in relation thereto, since the performer's survival is solely dependent on his own skill in traversing the rope. For Hera, there is greater closeness to the client in sitting alongside, and "looking over the edge" together, contemplating the chasm below into which they are tempted to leap, but also possible nervous tension, as suggested by the fact that she is not just sitting "on the edge", but rather, "on edge", with the double meaning of proximity to

the precipice, but also uneasiness about what might transpire, recognizing that the client's fall might prove terminal, that "this could be an end".

Athena acknowledges the emotional difficulty posed by joining the client in their "struggle" with death, confronting their lack of hope and urge towards self-annihilation:

> *but there's no doubt that there is a deathly part to the work that stirs up some despair in me… and… and a difficulty that now this is in the room, it's… there's something now between us in this work that is… we're going to be struggling with death, as well as life…*
>
> *Athena; 2, 15, 420-27*

> *so, that in itself… the presence of that deathly part in the room is inevitably going to have an impact on both of us… it's going to dampen our… well, my… my mood… 'cause it's always got to be kept in the room…*
>
> *Athena; 2, 16, 438-44*

> *I think it's possibly one of the hardest emotions to sit with, because the work is there in order to find the more hopeful part of the student that's engaged with life… and when there is despair, I feel that that part of the student becomes extremely small… that… that part that is engaged with life… and I think that despair can be projected into me, and it can feel quite hopeless…*
>
> *Athena; 2, 80-81, 2287-3302*

In resonating with the client's despair and hopelessness, Athena appears to be infected thereby, her spirits understandably "dampened" by the necessity of keeping their suicidality in focus. She personifies death as an embodied presence "in the room", perhaps akin to the Grim Reaper, something which (or someone who?) has entered into her interactions with the client, which must be "kept" therein, acknowledged, and grappled with. By making death more manifest in this way, Athena communicates a sense of its offering tangible resistance (as a person might), of its coming "between us in this work", with the need to engage actively therewith in fulfilling her risk management responsibilities precluding an easier exchange more dedicated to the client's struggles with 'Being-in-the-world'. She finds it difficult to "sit with" the client's despair, and might prefer to escape from this unpleasant companion, who drains the hope out of first the client, and then herself (by identification therewith), leaving her with less

leverage in the therapeutic work through shrinking the capacities of both parties to feel positively engaged with life.

3.3.1.3. *"There's always doubt"*

Most participants struggled with a lack of certainty over whether suicidal clients would follow through on their self-destructive inclinations, finding it difficult to tolerate their lack of control in relation to these choices:

> *I suppose the best that I can do is make an appointment for next week, and hope that they come… and I think that's difficult, 'cause we don't know… we can only trust that our clients are okay between now and next week…*
>
> *Jocasta; 3, 10, 263-70*

> *I think, for me, and, I think, this is true for a lot of people that, the thing is the not knowing… that, for me, whatever happens, however tragic it is, then you can act, and you can get on with something… erm… so, the not knowing is… is a hard part…*
>
> *Jocasta; 3, 12, 319-22*

Jocasta is typical in her acknowledgement that it is the "not knowing" between sessions, and where clients fail to attend, that is experienced as most challenging when working with suicidality. Interestingly, it is the intangible and insubstantial, the unknown, which is experienced as most "hard". Having nothing to push against, nothing to offer the containing security of resistance, is more unnerving. Tangible realities, "however tragic", can be engaged with, or responded to, in some way. Things can be taken in hand, such that one is no longer hostage to imaginal speculations, and associated anxieties. In the absence of the soothing offered by substantive certainties, Jocasta must rely instead upon "hope" and "trust", putting her faith in the client's ongoing commitment to life, which is, of course, our sole recourse where we lack the confirmation provided by the other's immediate presence, and the comfort and reassurance provided thereby. Clearly, uncertainties are liable to be greater where there is less visibility vis-à-vis the client's emotional state whilst they are out of contact:

but you're still left with that, 'it could be, right?'… and then you go home… and it's the weekend… and it's family time… and everything's going on normal… but you know, at the back of your mind, you're thinking, 'ohh, this is what I left today'… and there is… there are days where I do… I… I actually, honestly, go, 'just please let them be okay this weekend'… I've actually said that to myself… I'm very conscious of saying that, yeah… 'just let them be okay'… just hopefully they'll stick… hang in there, and we'll see each other next week, and, of course, that's what happens… (chuckling)… but I don't think it's a guaranteed thing…

Penelope; 4, 95-96, 2744-61

The reality of the client's existential freedom forces Penelope to acknowledge the possibility that 'it could be, right?', that their choice to remain alive is never a "guaranteed thing", and subsequently, residual concerns intrude into the normality of her family life, resulting in low-grade discomfort and uneasiness throughout the weekend. This suggests that counsellors are sometimes unable to let go of their attachments to work, to hold a boundary around their outside interests, and hence, their problems from the day cannot entirely be left behind, continuing to lurk in the background. Penelope's beseeching the universe to "just please let them be okay" speaks to an intolerance of loss, and desire that this be avoided, that some higher power might hear her prayers and preserve the client's well-being, enabling them to "hang in there" until the following week. Such lingering apprehensiveness may similarly manifest where clients fail to voice suicidality, yet the clinician's gut instinct suggests "there's something not right":

it's the people that don't say it, and you have this real gut about it, and you kn… think there's something not right, and you're… they're not saying it… the… that really worries me…

Iris; 5, 46, 1312-14

you know, you never know… in these situations… I think, as a counsellor, having experienced that, there's always doubt…

Iris; 5, 52, 1490-95

When things are left unsaid, there is liable to be greater anxiety, as the clinician experiences an unspoken threat, yet is denied any capacity to influence the situation favourably. This was

compounded for Iris after a young man in her care, who displayed no signs of suicidality, took his life some months after their work together was concluded. Thus, as she recognizes, “there’s always doubt”, since we cannot anticipate a client’s life trajectory post-therapy.

3.3.1.4. *“I felt so helpless”*

A sense of being powerless to help was commonly communicated in relation to suicidal clients, who were often experienced as uncooperative:

> *when I asked her if she had a plan, she said, 'yes', but she didn't want to tell me about it… and it's interesting… I took that to supervision… and my supervisor said, 'that's quite a kinda push-pull, isn't it?'… erm… sort of, sharing… admitting… the suicidal ideation, and I'm not going to tell you any more about it…*
>
> *Jocasta; 3, 7, 185-93*

Jocasta identifies the frustrating “push-pull” dynamic of ‘now you see me, now you don’t’ that suicidal clients can sometimes evoke, opening up to some degree, but then backing off in refusing to “tell you any more about it”. Such conflicted attachment processes, which similarly play themselves out beyond the counselling room, can leave the clinician feeling “isolated”, carrying awareness and responsibility very much alone owing to their client’s unwillingness to approach others in disclosing their vulnerability:

> *'cause she wasn't talking to anyone… so, each week, I'd say, 'have you spoken to the nurse?'… 'have you gone to the chaplain?'… 'have you spoken to your tutor?'… 'do you speak to your mother?'… 'no', 'no', 'no', 'no'… it was all 'no'… so, she was restricting her food… she was self-harming… she had suicidal thoughts… she was buying detergent… and there was… noth… no one was intervening… so I felt so helpless, and so isolated with her…*
>
> *Penelope; 4, 111-12, 3197-3215*

Penelope’s client is presented as resistant to helping herself, leaving academic and pastoral staff oblivious to her distress. Listing the possible sources of interpersonal support her client was failing to access, she communicates a growing desperation in face of ongoing non-

compliance with these suggestions, her anxiety exacerbated by her experienced powerlessness in witnessing the client "deteriorating in front of me" (4, 113, 3240).

Where clinicians proved helpless to affect change in the disposition of their suicidal clients over time, this typically invited a degree of self-doubt. Gaia, for example, found herself wrestling with the meaning of her work:

> *because you sort of think… 'are we helping?'… 'are we…?'… you… you know… I mean, I'm sure we… I'm sure we are on some level… but it… but it's, erm… we're helping… we're all there… we're all giving support, and we're being there… and we're offering our presence, but he's not any happier for it… I mean… erm… he might be happier than if we weren't all there, but… he's still suffering a lot…*
>
> *Gaia; 6, 69, 1975-88*

Her client, sunken into a recurring pattern of overdosing, showed no signs of improvement, leaving Gaia despondent in questioning, "are we helping?". This speaks to the core question of what clinicians consider therapy to be. It is clear from Gaia's commentary that she conceives it to involve more than just "giving support" and "offering our presence". Rather, she aims to produce an ameliorative shift in the client's state of being (i.e., rendering him "happier"). With the client "still suffering a lot", Gaia subsequently exudes a sense of uncertainty as to the value of her therapeutic endeavours. Her tone conveys disappointment at not having been able to facilitate resolution of his suicidality, suggestive of emotional attachment to this outcome. Although Gaia's use of "we" is accurate, since the client was tapping into support from a variety of different services, none of whom had made a tangible difference to his mood, this alignment with the collective might also be construed as somewhat defensive, a means of sharing out responsibility in the event of suicide. An emphasis on safety in numbers possibly reflects Gaia's feelings of vulnerability, the implication of a group struggle to alter his intractable emotional state enabling her to feel less exposed vis-a-vis her own difficulties in this regard. Other clinicians were similarly frustrated by limitations on their capacity to exert influence:

there can be irritation… there can be impatience… there can be, why aren't… what I give you… why isn't it enough to keep you alive?... why did you not tell me that you were feeling like this?... why did you go and do it quietly by yourself, and get to this point of crisis?... why didn't you let me help you?... but, of course, that's all part of his difficulties… is… is feeling so awful about his feelings that he can't bring them… erm… but that stirs up great feelings of helplessness in me… powerlessness… failure… err, all sorts of feelings of… of why?... and… and wanting to get to the point where he's feeling better…

Athena; 2, 70-71, 1997-2017

Anger typically arises where we hit against unwanted limitation. In this instance, Athena experiences her desired agenda for the client, reaching "the point where he's feeling better", to be blocked, her nose bent out of joint by his failure to respond to her therapeutic investment. Therapists can become attached to the notion that their interventions will prove curative, which sometimes results in a sense of entitlement to realise this aim, such that Athena feels slightly scorned when "what I give you" proves insufficient to short-circuit her client's suicidality. Her impatience and exasperation are subsequently embodied in repetitively questioning "why?" with regards to the client's perceived resistance to being helped. Interestingly, this results in a self-denigrating attribution of responsibility in judging herself a "failure", as not being "enough to keep you alive". Her "powerlessness" is a potent image, conveying a sense of being denuded of strength by her reliance upon the client's capacity for change, which brings to mind the old adage that 'you can lead a horse to water, but you can't make it drink'.

3.3.1.5. *"I do carry a weight around all the time"*

Participants generally experienced their work with suicidal clients as challenging and burdensome, representing something of an emotional load to be carried:

if I were not doing this work, or if I were to leave the university, some great weight would be shifted from me… so, I think I do carry a weight around all the time…

Athena; 2, 40, 1119-28

the feeling of responsibility that I might be the only person that that student is… seeing, or talking to… feels quite onerous…

Athena; 2, 83, 2371-76

> *because I can feel the only link between life and death for that student… it might not be the case, but that's how it can feel…*
>
> *Athena; 2, 84, 2398-99*

Athena recognizes that escaping from her therapeutic commitments would immediately lessen the "great weight" on her shoulders, the "onerous" burden of responsibility she feels in positioning herself as the "only link" keeping the client tethered to life. Faced with the social isolation and regressive passivity of clients who are "in their room, on their own, all the time" (2, 84, 2403) between sessions, sometimes struggling even "to feed themselves" (2, 84, 2412-13), Athena understandably experiences existential pressure to resist their impulse towards death particularly keenly.

Even where a clinician lacks immediate awareness of suffering under the weight of the client-load they are carrying, work with suicidality may be exerting a cumulative negative impact, gradually building up within their psyche:

> *I am being confronted with death on a daily basis… and that's going to have an impact… it, sort of, slowly filters into you, I think…*
>
> *Athena; 2, 11, 290-300*

> *but I must also be aware that it is going to be a pressure, and it's not possible to process everything that I am internalizing…*
>
> *Athena; 2, 12, 324-25*

The deleterious effect of Athena's ongoing confrontation with death is not realized overnight, representing more of a 'drip, drip' over time, which "slowly filters into you". In recognizing that "it's not possible to process everything that I am internalizing", one imagines a filtration system that cannot perfectly clean out the suicidal impurities encountered "on a daily basis", such that this undigested waste material, this unprocessed emotional sediment, grows progressively larger with each passing week, creating more "pressure" on the system, eventually resulting in it becoming clogged and overwhelmed.

The weariness that emerges in work with suicidality may stem, at least in part, from a level of neediness that gets under the therapist's skin, such that they begin to experience client demands as "too much" or label themselves as "not enough". Athena showcases the intrusive boundary-crossing liable to inspire the former verdict:

> *and I got that e-mail during the Christmas break, after New Year… erm, which brought him into my home… you know, and… into… into my thinking, and level of concern, and meant that I then got in touch with the organisation, and… erm… you know, one doesn't want that, but it's inevitable… partly because we do… I do check in on my organisational e-mails during the week… so, it brings the suicide into my personal life… I… I choose to do that… but actually, I have to do that really… I couldn't function just…*
>
> *Athena; 2, 41-42, 1159-85*

In an era of e-mail, Athena recognizes the invasion of her personal life by the threat of client suicide as "inevitable". However, there is also something quite uncomfortable in having this "brought into my home", the client pushing himself into her thoughts like an unwelcome guest, drawing on emotional energy she would no doubt prefer to be lavishing on loved ones over the holiday period. Even if this case of 'breaking and entering' is a product of genuine distress, it simultaneously represents an unwanted imposition. Interestingly, there appears to be some tension for the clinician in locating responsibility for this intrusion, as she first takes ownership thereof in acknowledging that she chooses to "check in on my organisational e-mails during the week", before recognizing that she "couldn't function" properly in her role without doing so, suggesting that the institution's expectations and best interests partly undergird her decision-making. Thus, there is possibly a sense for Athena of excessive requirements imposed both by her client and employers. By contrast, as Hera demonstrates, it is also possible to position ourselves as deficient in ameliorating suicidal distress:

> *so sometimes, I guess I can sit and feel… erm… inadequate…*
>
> *Hera; 7, 99, 2835-36*

> *this is much, much too much for… this is, erm… this is somebody with immense pain and difficulty… and I really, really don't know what to do or say to help them…*
>
> *Hera; 7, 105-06, 3020-33*

because there is nothing… nothing that I can say… I can't mend this with them…

Hera; 7, 109, 3130-42

this needs more than… more than me, maybe…

Hera; 7, 117, 3352-56

The problems communicated by such clients seem so momentous to Hera that she cannot easily "mend this with them". Something is experienced as broken, and gluing a fragmented psyche back together is far from straightforward. Interestingly, Hera's attribution as to why client distress cannot easily be pacified sees responsibility assigned in both directions; she concludes that such clients represent "much, much too much" to handle, exhibiting such "immense pain and difficulty" that they are hard to contain, whilst also labelling herself "inadequate", considering that they need "more than me, maybe". Either way, there is a temporary mismatch between supply and demand in such instances, causing Hera to doubt herself, to question her capacity to make a positive difference to client well-being.

3.3.1.6. *"Everything in me doesn't want them to die"*

Unsurprisingly, clinicians are invested in keeping their clients alive, desirous of fostering an ongoing attachment to life:

however much I am accepting how terrible they feel, and that the best option for them feels, if they were to end their lives… if they were to be dead and not go on… I don't want them to kill themselves… I suppose, I would like them to wait and see…

Jocasta; 3, 23, 636-50

Jocasta empathizes with her clients' emotional impulses towards self-annihilation, their desire to escape from "how terrible they feel", but she is simultaneously opposed to their enacting such suicidal urges. The terminal decision to "not go on" is contrasted with her preference that clients "wait and see", recognizing that their opting out of the journey would preclude finding out whether processes of 'becoming' might yet yield improvements in their state of 'being'.

Strength of “attachment” to the suicidal individual is typically at the root of such clinging on by the clinician in refusing to accept the inevitability of their client’s death:

> *being affected, but not infected, is the… phrase that, you know, I'm sure you've heard, which is… is so important… but it is a struggle, especially if you have a strong attachment to the student…*
>
> *Athena; 2, 18, 504-13*

> *the ones that I… are very loveable… that I really feel strongly attached to, and… and… and more consciously concerned about… that's quite hard to bear sometimes, the feeling that they want to kill themselves, because everything in me doesn't want them to die…*
>
> *Athena; 2, 19, 526-33*

Athena recognizes the difficulty of resisting being emotionally “infected” when vulnerable clients are experienced as “very loveable”. Love speaks to a level of attachment wherein boundaries between self and other are felt to break down somewhat, perhaps allowing psychological content that is not one’s own to enter inside, just as a foreign disease agent invades a host environment. Clearly, where the other party inspires aversion, where it is uncomfortable “to be in the room with you” (2, 19, 519), such ‘joining with’ is less likely. In these instances, Athena is immunized against infection, whereas her guard is lowered when clients are more likeable. External intrusion is suggested by becoming “more consciously concerned” (i.e., “infected” by anxiety) and finding the prospect of the client’s death “hard to bear” (i.e., carrying additional weight that is not her own). Of course, when we are “strongly attached” to something (e.g., a limb), we experience ourselves as one and the same with that thing, such that the prospect of loss is more painful to tolerate. The fact that “everything in me doesn’t want them to die” suggests such an all-encompassing level of identification with the client, such an absolute investment, that it has become difficult to differentiate self from other, to simply remain briefly “affected” by their suicidal distress.

Such attachment can result in the clinician becoming increasingly assertive in their efforts to keep the client alive, struggling to contain their own anxiety:

I think that's what happens when I then… am more assertive, in like, 'well, what are we gonna do today?'... and 'what's gonna be the plan now?'... 'we've got ten minutes left of the session… you're leaving… what are we gonna do?'...

Penelope; 4, 40, 1147-55

I felt like each week I could see physically almost a deterioration… erm… she spent a lot of time crying in the session, and… I guess, with her each desperation each week, I was getting more, 'we have to do something'…

Penelope; 4, 112, 3224-27

In rattling off questions (e.g., “what are we gonna do today?”; “what’s gonna be the plan now?”), Penelope conveys an acute desire to take control, to engage in immediate action to halt her client’s “deterioration”. There is a sense of urgency, of running out of time to affect change (i.e., “we’ve got ten minutes”). Penelope’s Freudian slip, whereby “each deterioration” becomes “each desperation”, hints at her own increasingly frantic state. Discomfort in being with the client’s suicidal distress creates a felt need to respond, “to do something” ameliorative before sending her back out into the world.

3.3.2. Superordinate Theme 2: *“Goldilocks and the Three Bears”*

The second superordinate theme focuses on participant experiences of organisational risk management. Echoing Robert Southey’s famous British fairy-tale, “Goldilocks and the Three Bears”, as referenced by Gaia, efforts to protect the client from suicide are deemed to be ‘too much’, ‘not enough’, or ‘just right’:

there's a bit of a, kind of, 'Goldilocks and the Three Bears' scenario here, because there's also another client who I've worked with, who… who reported… was a 'client of concern' at the beginning… who reported suicidal feelings, and… I worked that through with him in the first session… you know, I would like permission to sort of speak to your GP… and, erm… he was sort of su… surprised, and… and kind of impressed… and he said, 'oh, okay… really, would you do that?'… and, erm… and that has… has actually gone, you know, really well…

Gaia; 6, 95-96, 2739-52

This ‘just right’ example, whereby the client is “surprised” and “impressed” by the clinician’s offer to connect with his GP, accepting this in “the spirit in which it was being offered” (6, 98, 2809), is presented as the rare exception. Of course, the “Goldilocks” fairy-tale focuses on an intruder who is unable to exercise self-control when encountering food belonging to others, which speaks to how efforts at risk management, in disclosing client details to third parties, might potentially be experienced as invasive, seeing the clinician breaking into the client’s psychic house, and not just stealing their porridge, but sharing it with others, with risk of compromising the relationship in the process. Given the interpersonal stress occasioned when organisational risk management is deemed “too much” (i.e., unnecessarily intrusive) or “not enough” (i.e., insufficiently supportive of client needs), it is perhaps understandable that the clinician is appreciative when such interactions prove “straightforward” (6, 98, 2807), facilitating effective therapeutic engagement. As the following subordinate themes illustrate, however, such smooth progression does not represent the norm:

3.3.2.1. *“This is not gonna happen in five or six sessions”*

Participants often expressed concern about the perceived insufficiency of organisational investment in mitigating suicide risk. Phoebe, for example, experienced conformity with institutional expectations in this regard as not being nearly enough:

> *I'd discussed safety, I'd given out the Samaritans number, and I'd recorded it… so, that was the institution's agenda… I know that… you know, in terms of just basic good practice… sort of, almost like hygiene… ha… that hygiene factor is… that's kind of something that you just do… but to me is not… it's not really about that…*
>
> *Phoebe; 1, 38, 1149-65*

Phoebe recognized herself as having complied with “basic good practice” in relation to the suicidal client she had assessed. In other words, she had discussed how the client might keep himself safe from harm, referenced other options for ongoing support, and documented having done so. Characterizing this as “almost like hygiene”, a means of washing herself clean of

blame, she considered that such avoidance of organisational infection is “all that the institution will be bothered about” (1, 41, 1241) in adequately meeting her obligations. However, “the hygiene factor” also carries a connotation of something habitual, like washing one’s hands after using the lavatory, “something that you just do”, not requiring significant thought or investment. For Phoebe, then, guarding herself and the organisation against contamination in this way is just par for the course, and institutional satisfaction therewith “misses the point” (1, 41, 1249) that the client’s life is at risk, not just the organisation’s reputation. Presumably, her own preference is to purge the germs of suicidality from the client themselves, going above and beyond in the interests of their psychological well-being, rather than simply wiping down surfaces after their departure.

Subjective divergence around what even constitutes risk can create subtle strains between the individual clinician and their organisation:

> *so, I don't tend to flag that often… but when I… but… but… I've often felt I've wanted to, I guess… I've often felt I wanted to flag more than I do, but, erm, whenever I've checked it out, it seems like I shouldn't be, and, that's kind of the message I've got, so I don't…*
>
> *Penelope; 4, 13, 355-73*

> *so, I think the difficulty for me sometimes is, erm… when someone says something that on… you know, on paper… activates all of the kind of alarm signals… underneath it, there is a sense that, you know, maybe this is part of a, sort of, an ongoing dynamic of, sort of, drama… but at the same time… I don't want to mi… you… I don't want to miss anything… and so I… so, it's… so, it's difficult to take supervision that says, 'well, maybe sit with this for a minute, and sort of… before going in guns blazing'…*
>
> *Gaia; 6, 34, 957-72*

Clearly, it can be challenging to conform to group norms out of keeping with one’s own interpersonal reactions to a client. Both Penelope and Gaia experience their concerns as being downplayed. Penelope would like to flag the seriousness of client risk more often within her team, but she has been advised to restrain herself from doing so. Gaia is similarly directed to resist her immediate impulses towards managing risk (i.e., “sit with this for a minute”) on the

basis that the “alarm signals” to which she is responding might not be indicative of genuine suicidality, but ways in which the client invites interpersonal attention. Such supervision, discontinuous with her own emotional responsiveness, is “difficult to take” on account of her risk aversity, her preference not “to miss anything”, which requires taking any threat seriously. Penelope’s description of her internal struggle highlights that “there’s always a tension” when clinician and organisation are misaligned in assessing risk:

> *on the one hand, I think, 'am I exaggerate?'… 'am I being over-emotional in my response to the client's stuff?', or, erm… so, I guess, I hold that on the one hand, and then, on the other hand, I think, 'no, I'm not'… 'it is serious'… so, I… there's a… there's always a tension… there's always a tension of… I feel really worried about something… and then I get told, 'don't worry', 'it's fine'… erm… it just… it just feels very… I just feel a bit all over the place…*
>
> *Penelope; 4, 14-15, 391-413*

> *and, I guess, that's where I switch between thinking, 'am I being over-dramatic?', and then I feel a bit… not ashamed… but a bit like, 'oh, you're fussing again'… 'you're worrying too much'…'you, err… I don't know what it is'… and then, on the other hand, I move into… 'that's my clinical judgement'… 'that's my assessment'… 'that's what I think about'… even if… my line manager says, 'don't worry… everything's fine'… so, I do… I move in-between those two… and it's really difficult sometimes to find where I can sit…*
>
> *Penelope; 4, 21-22, 595-610*

Is it any wonder that Penelope is “a bit all over the place”? She feels “really worried” about her clients, and yet is told, “don’t worry… everything’s fine”, her anxieties hereby left unprocessed and uncontained. On the one hand, Penelope judges herself in accordance with group prerogatives (i.e., as “over-emotional” and “over-dramatic” in her responses, “fussing” unnecessarily); on the other, she is staunchly defensive of her “clinical judgement” of the client’s suicidality as “serious” enough to warrant attention. She wants to fit in with her colleagues, but also to remain true to herself and her clients’ perceived needs, and subsequently experiences it as difficult to centre herself, to “find where I can sit” between these competing poles. This conjures up an agitated child with ‘ants in their pants’, whose parents

expect that they sit still, causing them to experience an internal back-and-forth between their genuine emotional state and a desire to please these judgemental others.

Not only are there differences of opinion over whether claims of client riskiness are justified, but there are also concerns about restrictions on the overall availability of support. The complexity of client issues sometimes causes clinicians to despair at what can be achieved within the confines of “five or six sessions”:

> *so, someone will present to me with a serious borderline personality disorder… err, eating disorder… erm, really difficult relational issues… and they're currently quite seriously self-harming, and suicidal ideation is daily… and so, when I assess that as a clinician, I think… (sharp intake of breath)… 'oh my God'… 'this is not gonna happen in five or six sessions'… 'what is the… what is the point?'… and then I move between, 'well, what is the point?'... 'well, they can get some help with something'…*
>
> *Penelope; 4, 63-64, 1815-26*

Penelope’s fluctuation between a perception of the futility of even engaging with such clients (i.e., “what is the point?”) and an acknowledgement that this is as good as it gets (i.e., “well, they can get some help with something”) highlights how confronting limitation can inspire extremes of both despondent disengagement and acquiescent acceptance.

3.3.2.2. *“Don’t want to stand on any landmines”*

Erring on the side of caution in taking the threat posed by client suicidality seriously, clinicians appear to tighten up their game when confronted by such risks:

> *yeah… don't want to upset… don't want to set anything off… that I will… don't want to stand on any landmines, I suppose… or don't want the client to either… erm… so, tend to slow down… I'm aware my voice becomes… slightly quieter… slightly slower…*
>
> *Phoebe; 1, 45-46, 1373-94*

Phoebe clearly becomes more tentative, “less freewheeling” (1, 44, 1354), when interacting with suicidal clients. The rationale of “not wanting to set anything off”, not wanting “to stand on

any landmines", provides an insight into her efforts to "slow down", to proceed with greater care, as one might when edging one's way through a minefield. Phoebe is wary that one false move could result in destructive outcomes for both parties, as indeed it might if the therapeutic relationship were compromised, and the client subsequently chose to take their life. Client suicidality similarly prompts Gaia to adopt a 'safety first' attitude:

> *and I think, sometimes, the worry is when, erm… a supervisor or line manager will, sort of, say, 'yes, but I wonder if that's, you know, part of… part of this person's general presentation'… I'll sort of go… (pause)… 'yeah, but also, eh, you know, if… if they're generally presenting in a way that they want to, kind of, electrocute themselves in the bath, then I think we… we… we, kind of, owe it to them… whether or not they say that to everyone to… to try to… eh… to take that seriously… we have to take some of this on face value…*
>
> *Gaia; 6, 33-34, 942-57*

Clearly, two views of suicidality are in conflict here. One takes a client's suggestion that they might "electrocute themselves in the bath" at "face value" as a conscious communication of their desire to escape from current life distress. The other views such communications as an unconscious attempt to elicit attention, and hence, unlikely ever to be enacted. Whereas Gaia prefers to assume that the client's 'currency' reflects its real worth, her supervisor and line manager are more doubtful, considering that the actual threat is less than that printed on the banknote. Such variability in interpretation perhaps explains different levels of clinical comfort in working with client suicidality. Gaia is on the more risk averse end of the spectrum, anxious that her inaction might contribute to a client's death. Subsequently, she allows herself to be "played a bit" (6, 54, 1553) in being drawn into the interpersonal drama, considering that delivering "lacklustre therapy" (6, 37, 1039), which fails to provide insight into the client's patterns of relating, is not "really the worst outcome in the world" (6, 54, 1552), particularly if a bona fide suicide is sometimes averted in the process.

Gaia highlights that a clinician's focus on risk management is not shaped solely by concerns about client welfare, but also by loyalties to their employing institution:

I'm dealing with my experience of the client… but, also… and my duty to the client… but, also, my duty to the organisation, and, erm… so, for example, I always in my supervision will prioritize any issues of risk… erm… and I tend to be quite conservative about that, and I tend… and, I think, that's possibly 'cause I worked in IAPT for a long time, and there was, erm, such a culture of, sort of, being defensive against poten… potential litigation…

Gaia; 6, 3-4, 75-85

and so, you know, you do feel that you have to do your part to make sure that we're… eh… you know… (pause)… not 'looking after ourselves', because that does make it sound, sort of, sinister in some way… not, sort of, 'watching our backs', but, erm…

Gaia; 6, 25, 699-702

A sense of "duty to the organisation" creates a "conservative" and "defensive" attitude towards risk in seeking to avoid institutional exposure to external judgement for not having 'done its job' in protecting client well-being, and the financial and reputational repercussions of "potential litigation". However, accenting institutional interests seems to sit uncomfortably with Gaia, as suggested by her apparent awkwardness in trying out expressions to describe the rationale underlying this approach. Both "looking after ourselves" and "watching our backs" are considered, but subsequently dismissed like ill-fitting clothes, perhaps because they reduce risk management to a self-centred activity premised on averting external criticism, whereas Gaia's own motivations also have the client's interests at heart. Although she clearly feels that she must "do her part" in guarding her organisation from Phoebe's metaphorical "landmines", there appears to be resistance to this being the central thrust of her endeavours. As such, the self-protective element tacit in referring suicidal clients to their GP almost seems to taint this action in her eyes:

on a particularly jaded day, you think, 'well, I'm gonna tell his GP… what's the GP gonna do with it?… you know… it's gonna sit in a file… it's gonna be, sort of, on record… it's gonna be a paper-trail, and… and… where…'… you know… it can feel like, you… you're just, so that the buck doesn't have to stop anywhere…

Gaia; 6, 23-24, 659-68

an evasion of something, or a, kind of, a… a sharing out of, sort of, culpability or… or responsibility… erm… so that everyone's part gets diluted…

Gaia; 6, 24, 672-77

By creating "a paper-trail", Gaia perceives herself as participating in "an evasion of something", merely steering herself and her institution clear of blame should the client's suicidality be enacted. Given that a GP referral is not considered likely to be of tangible benefit to the client, Gaia's existential experience is one of avoidance, of engaging in something for show, such that "the buck doesn't have to stop anywhere". The idea that "everyone's part gets diluted" is particularly telling. Dilution suggests a watering-down, weakening the concentration of perceived "culpability" in the hands of any one party by sharing it around, such that nobody can be held accountable.

3.3.2.3. *"Keeping them in the wider organisational mind"*

Clinicians often identified a sense of reassurance in flagging up suicidal clients to colleagues, thereby facilitating additional support. Penelope, for example, welcomed the opportunity to communicate her concerns to the wider counselling team:

I guess, by flagging, I've alerted the whole team… so if anybody accesses our system… I mean, within the team… they would see that… I feel like it's covering your back… yeah… you've covered your back… you've made this flag, which means you've been concerned, and you've brought it to… everyone's attention…

Penelope; 4, 16, 449-61

The idea of "flagging" suggests a communication of danger to others. Red flags were historically raised by ships preparing for battle, or on land to identify flood risks when waters reached a certain level. Nowadays, red flags at the beach warn of serious hazards in the water. Thus, Penelope experiences herself as doing her duty in having "alerted the whole team" to the client's vulnerability, bringing her concerns to "everyone's attention", such that they could be appropriately responsive in a crisis. There is a sense of hereby having "covered

your back", which suggests that Penelope is also guarding herself against criticism, having mobilised reinforcements to protect the client's well-being in her absence. She can rest easy, having shared responsibility for sentry duty with others. No longer alone in managing risk, she draws comfort from strength in numbers, and unlike Gaia, who we earlier found to be uncomfortable with the idea of "watching her back" (in theme 2.2), appears more reconciled to the aspect of self-interest implicit herein.

Depending upon how risk is managed within the institution, sharing of responsibility may sometimes extend beyond the confines of the counselling service itself, encompassing the wider Student Services team:

> *the more people that are brought-in to support… erm… the… obviously, the better… and… and helps the student to feel that he's held in lots of people's minds, not just mine…*
>
> *Athena; 2, 29-30, 825-32*

> *it's keeping them in… in the wider organisational mind…*
>
> *Athena; 2, 37, 1041-46*

Athena is appreciative of being able to link in with colleagues, creating a feeling of "joined-up-ness" (2, 24, 658) with other parent figures in the client's life. It is presented as containing, both for the student and clinician, when more people are "brought-in to support", embedding the suicidal client in a network of care. Seeking to keep them "in the wider organisational mind", there is an implication that it is not only practically helpful to do so, preventing them from slipping through the cracks, but also beneficial at the level of consciousness. It can be soothing for the client to know that they are "held in lots of people's minds, not just mine", and the relief thereby offered in sharing the load with others simultaneously reduces the pressure on the clinician. Passing over responsibility to colleagues within the institution, if only temporarily, often serves to release tension:

> *I'm saying to… to Student Services… it's not the end of term yet, 'cause it was the Wednesday… there's still another couple of days… there's a two-week break… you'll be able to find out whether she's alive and okay… it's up… it's over to you…*
>
> *Jocasta; 3, 65, 1867-70*

and it was great, because obviously, we were in a medical setting, and confidentiality was there in the sense of, err, we didn't discuss with the nurses and doctors the content of what we were saying in our one-to-ones… but I could very well go back to the nurse after, and say, 'there are… there is a lot of suicidal ideation today, or even self-harm, thoughts, whatever'… you know, 'I just wanted to hand that over, keep that in mind'…

Penelope; 4, 24, 675-82

In breaching client confidentiality to liaise with Student Services, Jocasta hoped that they would be able to chase up a suicidal client who had dropped off her radar, checking in that "she's alive and okay" prior to the upcoming holidays. Her declaration that "it's over to you" conveys a sense of hereby letting go of this burden of worry. Clearly, the preference of clinicians is to share the containment of suicide risk with others. Hence, Penelope valued the looser boundaries of confidentiality when working in the NHS, which was held at a group level in relation to issues of risk, enabling communication about patient suicidality and self-harm with medical staff. The ability to "hand that over" suggests having the capacity to pass on the baton of her concerns, and take a breather, in the knowledge that others would run the next leg in her stead, taking over responsibility in her absence.

3.3.2.4. *"Does everyone know?"*

Clinicians often experienced it as beneficial to put suicidal clients in contact with external professionals in the interests of minimizing risk. Astraea presents GP referral as akin to a golden ticket, freeing her up to focus on therapy without additional anxieties:

if they're registered with the GP, and I can get them an urgent appointment, that's my ideal…

Astraea; 8, 107, 3054-56

I mean, to put it very bluntly, if the client… (chuckling)… if you've told the GP the client's suicidal, and the client kills themselves, then, eh… it's the GP that's gonna be more criticized…

Astraea; 8, 48, 1358-61

it's covering your back…

Astraea; 8, 48, 1365

Communicating with candour, Astraea stresses that much of the motivation underlying her enthusiasm for disclosing suicidality to the client's GP relates to the avoidance of blame. Should the client subsequently take their life, "it's the GP that's gonna be more criticized", since their "statutory responsibility" (8, 46, 1318) trumps that of the clinician. Effectively, then, this is a question of passing the buck to another professional, thereby reducing her own liability, which explains why the GP is "the go-to person" (8, 46, 1322-23) in such instances. "Covering your back" is suggestive of being under attack, with the GP effectively enlisted to ward off bullets, and potentially take one for the team, as the clinician takes evasive action in sheltering from enemy fire.

However, referring externally is not solely about escaping blame, and lessening the pressures on the clinician. It is also experienced as helping to manage client vulnerabilities:

> *well, I believe in it… I do think… I do think… that having the Samaritans number, and knowing where the emergency walk-in centre is… could well come in handy… you know, at two in the morning… so, I do believe in it…*
>
> *Phoebe; 1, 40-41, 1228-37*

Phoebe is keen to emphasize that her conformity with risk management protocols is not premised solely on fulfilling organisational expectations vis-à-vis 'hygiene', that she does "believe in" their value to the client. Differentiating herself from the organisation's perceived lack of care in instituting such procedures, rather than from the procedures themselves, she possibly hereby intends to pre-empt criticism by distancing herself from any implication of going through the motions. Gaia, by contrast, sounds a slightly discordant note, as efforts to tap the client into a wider network of support appear, in her eyes, to acknowledge defeat:

> *and I guess it makes you realise that… that part of what risk management is about is about an attempt to control… when you haven't been able to change… you know what I mean… it's… it's sort of, erm… what can we do to alert as many different people to the fact that there's a danger here…*
>
> *Gaia; 6, 14, 384-88*

if you haven't, in your eight to ten sessions, been able to help this person get to a point where they don't want to kill themselves, then everything else is just kind of… erm… partly for the benefit of the organisation… partly for the benefit of your own peace of mind… partly for, sort of… erm… 'does everyone know?'… 'maybe someone else has something they can do?'…

Gaia; 6, 14-15, 401-14

The tension earmarked here is between therapy's ambition of altering the client's psycho-emotional state, and risk management's "attempt to control" client behaviour. Gaia recognises that efforts "to alert as many different people to the fact that there's a danger" only become necessary if "you haven't been able to change" the client's orientation vis-à-vis life and death. There is something slightly dispirited in Gaia's tone, as though her need to spread the word, to ensure that "everyone" knows, is a mark of failure. Clearly, 'success' for her is nothing less than a wholesale transformation in the suicidal client's perspective, and although managing risk somewhat shares this agenda (i.e., "maybe someone else has something they can do?"), it is positioned as second best, done partially "for the benefit of the organisation", and partially for her "own peace of mind".

3.3.2.5. *"Being pulled off course"*

Risk management obligations are sometimes experienced as running the risk of compromising the therapeutic relationship. Gaia highlights one client who reacted particularly negatively to the suggestion that she contact his GP:

he was worried he would be sectioned… he was worried about all of these sorts of things… and, of course, I couldn't give him any guarantees about what would happen after we'd alerted his GP… erm… and so, that had the effect of kind of shutting down a lot of… mmm, potential, sort of, therapeutic interventions… and after that, he… you know, he kept insisting, 'no, no, no, no, no, no, no, no, no… I don't… I don't wanna kill myself… I'm not gonna kill myself… I'm not gonna kill myself'… and I… I wasn't sure I believed him…

Gaia; 6, 17-18, 482-97

Gaia's encounter with this client, who denied (previously admitted) suicidality, and refused permission to contact his GP when this possibility was brought to the table, was clearly disconcerting. In "shutting down" dialogue on this topic, he rendered Gaia uncomfortable, robbing her of any capacity to exert influence. His repetitive disowning of suicidal sentiments (i.e., "I don't wanna kill myself"; "I'm not gonna kill myself") suggests slamming the door in her face, which inevitably left her harbouring suspicions that 'thou dost protest too much'. Heavily defending something, after all, typically suggests that there is something to defend. Subsequently, having received mixed messages, Gaia was faced with something of a quandary, pulled in different directions by her competing obligations to protect the client's welfare and respect his autonomy:

> *and what if something really did happen?… and… what would my part in that be?… and how do you claw that back without, erm… without impinging on someone's autonomy?… how do you protect and also respect their boundaries?… and what are you supposed to say if someone says, 'no, I… I don't', you know… 'I was just… I was just speaking… it was just a figure of speech… I don't actually want to kill myself'?… what part of what they say do you believe, and what part do you not, essentially?…*
>
> *Gaia; 6, 19-20, 543-66*

The client's ambivalent signals left Gaia angst-ridden, concerned lest something untoward occur when risk had not been fully explored owing to his blocking her efforts to do so. Questioning her own culpability should he later take his life, she wanted to "claw back" their capacity to discuss suicidality. The notion of "clawing" suggests both that something important had been lost, and a certain desperation in attempting recovery, perhaps even the animalistic urgency of a struggle to preserve life. Her desire not to intrude upon her client's free will was subsequently in tension with her unwillingness to let go of his original claims regarding suicide, such that she was left uncertain and confused (i.e., "what part of what they say do you believe?"), unsure which version of his account to afford greater credibility.

There was concern, moreover, that if she pursued matters vis-à-vis the client's suicidality by insisting upon disclosing to his GP, he might find this "persecutory":

> *it pulls you out of a relationship… a straightforward relationship with the client… it… erm… it sort of pulls you back into, sort of, an agent of an organisation in some sort of way… and it can collaborate to a sort of dynamic where someone feels that they are being persecuted…*
>
> *Gaia; 6, 21, 585-92*

Gaia experienced herself as akin to a parent "saying a child was crying wolf, or something" (6, 18, 513), and certainly, the analogy to Aesop's fable, "The Boy Who Cried Wolf", is insightful in this instance. The client claimed to have raised a false alarm, to have been disingenuous in his initial claims of suicidality (i.e., no wolf), leaving Gaia unsure whether to trust him, because he had hereby established himself as unreliable. However, in a twist from the fable, it was believing (rather than disbelieving) the client regarding the absence of risk that might see his life endangered should he subsequently be devoured by his own internal wolves. In both cases, however, it was the inaction of others that was liable to prove damaging, even if the responsibility ultimately lay with the victim. Gaia's difficulty rested in the fact that something stood to be lost both in failing to take the client's suicidality seriously (i.e., his life), and in pursuing risk management over-vigorously by referring him to the GP (i.e., their relationship). Interestingly, a fable is a moralistic tale intended to serve an educative function, usually delivered by an older authority figure to a child, and Gaia feared that she would be experienced in just such a capacity by the client, operating in a punitive manner in relation to misbehaviour in effectively "reporting someone to the headmaster" (6, 49, 1394). Thus, the requirements of risk management pulled her out of "a straightforward relationship with the client", potentially into a position of 'doing to', rather than 'doing with'.

Complexity was introduced in not being able to focus solely on the client's emotional material, but instead, functioning as the "agent of an organisation". Subsequently, Gaia worried that the client would experience her as an "old-fashioned, kind of mental institution person, out to catch him in a net" (6, 93, 2658-59), which brings to mind the 'Child Catcher' from "Chitty Chitty Bang Bang", particularly given the client's anxieties about somehow being entrapped and imprisoned (i.e., sectioned). Clearly, in enacting organisational prerogatives,

there is a risk that we are felt to be imposing something unwanted, rather than looking after client needs, with the attendant danger of short-circuiting the very dialogue that is perhaps most crucial to maintaining their safety. The problem, as Gaia identifies, is that clients tend to project their models of parenting onto our efforts at managing risk:

> *you are identified by the clients very much as either part of a paternalistic, caring, 'looking after you' organisation… or a kind of oppressive, you… you know, conflict-ridden… ha… erm… controlling institution… so you're a… you're a functionary of… of either of those relationship…*
>
> *Gaia; 6, 94-95, 2706-21*

Thus, Gaia experiences herself as reduced to a "functionary" of the organisation, a mere representative of the system, rather than an authentic other. What she represents in this capacity is determined by how a client makes sense of their own interactions with systems, and if they are prone to perceiving them as "oppressive" and "controlling", the clinician will be seen through this lens. In other words, the client's interpretative vulnerabilities get in the way of genuine, subject-subject relating. In such circumstances, where risk management lands somewhat awry, the clinician may find themselves scrabbling to get things back on track:

> *so, I ended up talking through… you know, what were his reservations about our contacting the GP… what were… erm… you know, what the benefits might be… was it about his relationship with his GP?… (sigh)… eh, eh, you know… eh… and then, before you know it, you're not talking about what he's come to talk to therapy… you… you know… he's come to therapy to talk about any more… so I think what it often felt like is that I was being pulled off course in a… in lots of different directions from… from what he was actually… he had actually come to talk about…*
>
> *Gaia; 6, 22, 609-26*

Gaia ends up investing a significant amount of energy to convey her care for the client, "working quite hard" (6, 21, 603) to compensate for the unsettling impact of earlier attempts at managing risk and win him round to GP involvement. Sighing despondently, she appears not to be altogether persuaded of the value of doing so. As she recognizes, such efforts potentially disrupt the client's own agenda, resulting in the therapeutic dialogue "being pulled off course", shifted away from his preferred focus.

3.3.2.6. *"Going through the motions"*

Risk management was sometimes perceived to be something of an "empty gesture" (6, 5, 133), unlikely to make a difference to client well-being:

> *it's sort of ticking… ticking boxes, but also, sort of saying… (pause)… kind of like, handing over the situation to a protocol… sort of going, 'well, okay… so, we've done this… we've done this… we've done this… we've done this… we've done…'… like having a fire drill, or something, you know… we've taken attendance… everyone's, kind of, exited the building in an orderly fashion… erm… and, we've… we've done all we can… but at the same time, sometimes you… you, sort of, think, 'could we be doing more?'…*
>
> *Gaia; 6, 12, 325-43*

> *I guess I identified as being part of a sort of faceless machine that couldn't actually offer him much substantive help, that was sort of going through the motions…*
>
> *Gaia; 6, 92, 2644-46*

Rather than offering a more personally invested response to the client, Gaia insinuates that, in "handing over the situation to a protocol", outcomes have effectively been entrusted to a procedure, constituting an abdication of genuine responsibility-taking. She is hereby reduced to a "faceless machine", simply "going through the motions" in robotic fashion. In this vein, one might imagine risk management within the organisation functioning like an automaton, everything whirring away to produce the impression of thoughtful action, but not undergirded by the conscious care of an authentic other. Thus, the superficial illusion of help-giving is communicated, enacted for the sake of external appearances, but without anything "substantive" being delivered. The allusion to "having a fire drill" is particularly telling, conveying the threat of death should there be an actual "fire" (i.e., suicidal client), but equally, that this is simply a "drill", a means of practicing in advance of the real thing. Hence, Gaia's level of anxiety about the client's well-being is minimal, and it is more just a case of ticking things off to demonstrate conformity with expectations. Gaia's perception seems to be that this represents an insufficient investment in ensuring the client's safety, and that perhaps they could "be doing more" to prevent him from setting himself alight.

Referral to the client's GP is experienced as being of particularly questionable merit as far as Gaia is concerned in addressing their suicidality:

> *that's always the bit that dismays me, because I sort of think, 'God, I mean, I don't know what my GP would do with that information'… (chuckling)… 'they would just, sort of, look at it, and chuck it in a filing cabinet'… you know, I… I don't know what happens from there…*
>
> *Gaia; 6, 43, 1213-17*

> *I can't think what even a very resourceful GP, what resources they might have to deal with a situation that… that we don't have, and that we haven't… tried, and that we don't know of… erm… what do I feel about it?... (long pause)… dreary… (laughter)…*
>
> *Gaia; 6, 47-48, 1351-58*

There is "dismay" and sardonic humour at the prospect of passing on details about a suicidal client. Gaia imagines a dismissive attitude towards risk should her own GP receive such a referral letter, their lack of engagement signalled by just "chucking it in a filing cabinet". Subsequently, there is a sense of pointlessness to this course of action, perceived as a rather tokenistic, throwaway gesture, "a nothingy thing to do" (6, 45, 1294). Superficially, she has done her duty in passing responsibility to a medical professional, and yet, given the perceived likelihood of a cursory attitude towards risk management, Gaia is left feeling that she has hereby offered the client a "fob off" (6, 46, 1298), substituting in something inferior in the spurious expectation that their GP will provide superior care and containment to that available from the clinician herself. Even if the client's GP was "very resourceful", Gaia is dubious about their capacity to deliver anything of a different order of magnitude to that available from a counselling service. Subsequently, this protocol leaves her feeling "dreary", connoting a bleak hopelessness. Such a reaction does not seem unreasonable, as there is something quite nihilistic in being required to perform an action one perceives as futile.

Superordinate Theme 3: *"It's good to ask for help"*

The third superordinate theme encompasses the divergent poles of isolation and organisational support experienced by participants when seeking to manage risk in relation to client suicidality. The title, "It's good to ask for help", is drawn from Athena's interview, wherein she describes her dawning realisation that it is better not to try to cope omnipotently with the challenges of such work:

> *and I think, with experience comes the feeling that, far from being judged, it's more mature and professional, and helpful for everybody, including the student, to share the experience… and to get help… you… you know, it's good to ask for help…*
>
> *Athena; 2, 28, 790-97*

Experience has taught Athena that opening up to colleagues about suicide risk is not to be feared, but rather, that it is often helpful to share the load, accenting interdependent functioning in co-operating with others to manage client distress. Curiously, her articulate rationale for help-seeking (i.e., "it's more mature and professional, and helpful for everyone") is juxtaposed with a simpler, almost childlike formulation that "you know, it's good to ask for help", which possibly provides a window into the sense of existential exposure and vulnerability in face of client suicidality that often encourages clinicians to seek out peer reinforcement. As exemplified by the following subordinate themes, however, there are complexities around accessing support owing to confidentiality requirements and the discomfort of some organisational colleagues where such issues are concerned:

3.3.3.1. *"Handcuffed"*

Clinicians sometimes struggle with the restrictions on disclosure of client suicidality imposed by confidentiality requirements:

> *so even if a tutor says, 'you know, I referred you that student last week… did they come?'… we're allowed… we can't say… I have to say, 'well, I'm sorry, I can't even tell you if they've*

come or not'… which is really hard when the tutors are responsible for their student's welfare in college…

Penelope; 4, 26, 725-36

Penelope appears to be particularly aggrieved that she "can't even" confirm to a tutor the attendance for counselling of a student they had previously referred, with the implication being that she perceives it as stingy and withholding not to be able to provide this reassurance and put their minds at rest. Having to respect confidentiality seems to represent an unwanted muzzling of Penelope's capacity to communicate about risk:

I hate it, because it… to me, it negates teamwork… and it negates, erm, the welfare team working together…

Penelope; 4, 53-54, 1530-34

and there are times when I could say something that would really help them understand what's going on for the student, and I can't, so it just… it just… I just feel… helpless…

Penelope; 4, 55, 1575-81

Able to attend welfare meetings, but constrained from contributing usefully thereunto, Penelope clearly believes that this is not in the best interests of her clients, as she is denied the opportunity to share her understandings vis-à-vis student suicidality, despite often being best placed to offer an opinion. Rendered "helpless" to put her point across, she is not enamoured by the encumbrance of confidentiality, arguing that "it negates teamwork" by imposing restraints on her self-expression.

At the root of Penelope's frustrations is the fear that her inability to disclose might contribute to a student's death:

(sigh)… it's just terrible… 'cause I would be mortified if she came up as having tried to kill herself, or been successful… it's just… it's just… it's ridiculous…'cause, by rights, if I was able to talk to her tutor months ago, I could… we… at least, I could have brought them… her to their attention… it really… I feel like my hands are handcuffed…

Penelope; 4, 115, 3310-21

it's horrible… ha… not being able to move, or do anything… it just feels infuriating…

Penelope; 4, 116, 3329-30

Penelope claims that she would be "mortified" were it to emerge that her client had even attempted to kill herself, suggesting excessive personalization of, and responsibility-taking for, these actions, and an unreasonable degree of shame and embarrassment as a consequence. Little wonder, then, that she is so contemptuous of the limitations on her capacity to intervene protectively, which render the situation "terrible" and "ridiculous". Her sense of being "handcuffed" implies that she feels shackled, constricted in her range of movement, and prevented from grasping hold of the situation in the manner desired. There is rageful emotion (i.e., "it just feels infuriating") at being unable to pursue her preferred course of action, and a sense of entitlement, as she claims that, "by rights", she should have been able to bring this client to their tutor's attention months ago, thereby tapping her into wider support. Of course, this is not the case, as such actions would have infringed her client's confidentiality, but it just goes to show the strength of feeling triggered when tensions manifest between the clinician's 'responsibility to' and the client's 'freedom from'.

3.3.3.2. *"Everybody's head goes underneath the water"*

Clinicians are often left feeling isolated and unsupported in the process of managing risk. Iris, for instance, experienced herself as "a wee bit put out to dry", left exposed and flapping in the wind by the 'powers-that-be' after learning that one of her former clients had killed himself in the wake of a romantic break-up:

I was… eh… eh… you know… felt a wee bit put out to dry, 'cause nobody could help me on it… but… but I didn't actually say, erm… I didn't know whether, when I was asked by the Procurator Fiscal, whether I should be handing in my notice or not… I didn't know… there had been mixed messages about it… and, erm, I contacted… erm… BACP, who weren't actually very useful about it… 'oh, we don't have any dealings with anything like that'… 'you'll have to go to your, err, legal department… you know… erm… in the institution'… well, our legal department is rubbish, because they… our… our university won't actually… erm… err… even

pay for insurance for counsellors… erm, so, then, it was left again…'what do I do to make sure that I'm ethically correct?'…

Iris; 5, 78-79, 2232-51

There is a sense for Iris of lacking clear direction, that it's all "a bit grey" (5, 75, 2156), with BACP encouraging her to abide by the rules of her employing organisation, directing her to consult the legal department within her institution, and her organisation then passing the buck back to BACP, directing her "to do what your ethical framework body says" (5, 81, 2311-12). With nobody taking ownership in providing her with answers, either pleading ignorance or washing their hands of responsibility, palming it off on somebody else, she is left unsure how "to make sure that I'm ethically correct", and hence, has come to expect that "there isn't a lot of support" (5, 81, 2309-10) where client suicidality is concerned.

Iris gives the impression of feeling somewhat abandoned in dealing with issues of client suicidality, left to get on with things on her own:

when this murky word, 'suicide', does come into it, everybody's head goes underneath the water, and you're left there, wondering, 'what… what am I to do that's correct?'…

Iris; 5, 81, 2324-27

above the water… and they're all underneath it… swimming away merrily… and I'm… they're not wanting to know anything about it…'oh, you'll be able to do it'… 'you'll manage"…

Iris; 5, 81-82, 2331-37

The idea of "murky" waters suggests that, where suicide, and the threat thereof, is implicated, it is harder to see clearly what one is getting oneself into, particularly from an ethical perspective, engendering fear of dangers lurking beneath the surface. Alongside this uncertainty about unseen threats, Iris also hints at a feeling of having been cut adrift and deserted by others, since "everybody's head goes underneath the water", and they're all "swimming away merrily", shouting a few encouragements from a distance, but generally "not wanting to know anything about it". Presumably, their merriment is a product of being off the

hook themselves, having escaped the danger of being picked off by sharks, whereas the clinician remains exposed in open waters, unsure of the appropriate direction in which to swim for safety, effectively constituting a sitting duck.

Iris is not the only clinician who experiences herself as required to manage client suicidality single-handedly, as Jocasta echoes her account, highlighting the way in which a colleague's aversion to suicidality left her similarly very much alone in this process:

> *she wanted the problem to go away… she wanted rid of the problem, which wasn't really supporting me… I didn't feel, in my role… and I suppose I felt there was a little bit of, she wanted rid of my problem… you know, not just the student… but, as she did of me, as well…*
>
> *Jocasta; 3, 31-32, 890-98*

Jocasta experienced her senior colleague as desirous of distancing the organisation from responsibility, seeking to get her suicidal client off campus as quickly as possible. Her own preference was to assist him in grappling with his suicidality, rather than simply ejecting him from the institution, and subsequently, she appeared not to feel understood or supported by her colleague, left questioning why she even "got in touch, really" (3, 33, 942). In fact, Jocasta experienced herself as reduced to a "problem", her colleague's lack of effort to engage with the issue communicating that she herself was somehow unwanted, which perhaps speaks to the discomfort felt by many in confronting death.

3.3.3.3. *"That steadies me up"*

Participants were appreciative of managerial support within their organisation when working with suicidal clients. Both Phoebe and Iris spoke at length about the positive impact of managers who understood their predicament in responding to such challenges:

> *I could appeal to (name of senior manager) and (name of Head of Student Services)… and that I'd get a fair hearing… so… so that steadies me up…*
>
> *Phoebe; 1, 52, 1578-87*

and this year, because we've had a seconded manager… and, it's been like chalk and cheese… absolute… because, the main difference is, is that she understands working in Student Support, and that has been a huge, huge, huge difference… erm… that, you know, she's had personal experience of that pressure on you in a different field of Student Support… but she's understood it… and, she's like, 'no, enough'… 'if you're saying that's enough, that's enough'… and what she's done is allowed that waiting-list to grow in the hope that the university will actually recognise we need more counsellors…

Iris; 5, 21-22, 604-17

An ability to turn to senior managers who are deemed "grown-up" and "reasonable in their expectations" (1, 50, 1529-38), trusting that their maturity will allow for a "fair hearing", is experienced by Phoebe as a steadying influence, providing her with a sense of solid ground under her feet. It is almost as though she trusts in the good judgement of one parent to protect her from the arbitrariness of the other. Iris similarly contrasts different styles of management as "chalk and cheese", her current manager, seconded to cover a maternity leave, found to have greater experiential empathy for the difficulties of working with suicidal clients on the basis of previous work in a Student Support context. Comprehending the pressures of the role, and also having "done some homework" (5, 23, 661) vis-à-vis the ethics of caseload management within the profession, this manager had been willing to hold protective boundaries in the best interests of her clinical team, recognizing that "if you're saying that's enough, that's enough", and subsequently pushing back at an institutional level, letting the waiting-list grow so as to communicate that the counselling service was under-resourced to properly manage suicide risk.

One of the functions of effective management, as highlighted by Penelope and Gaia, is to contain clinician anxieties by ensuring that risk management is undertaken in line with organisational expectations:

so, I felt reassured that after… at the end of the day, I could get to say to my line manager, this is what's happening… she'd make sure everything's okay… that I've done all the things that I needed to… and, in a sense, although I still worried, I've felt I've done… I'm covered… I've done what I need to do…

Penelope; 4, 4, 97-104

I guess, I'm never using the risk management protocols and procedures on my own… so, I'm always kind of talking it through with my supervisor, line manager…

Gaia; 6, 89-90, 2565-74

and I guess that's helpful from a, kind of, an organisational perspective, that I sort of think, 'well, I'm… you know, I'm… I'm doing the right thing by the organisation'…

Gaia; 6, 90, 2591-93

Penelope experiences her line manager as providing reassurance by checking that "I've done all the things that I needed to". Functioning like a parent who puts things in order at the end of the day, "making sure everything's okay", her manager allows her to feel that "I'm covered", suggestive of an enveloping containment, offering protection against imagined threats. Clearly, it can be soothing to be told that one is not at risk of blame should anything untoward occur. Gaia similarly finds it helpful not to be promulgating risk management "on my own", valuing the steer provided by management in enabling her to feel that she is "doing the right thing by the organisation", and hence, is unlikely to be pulled up for letting anyone down. A sense of being 'in this together' hereby takes the pressure down a notch or two.

3.3.3.4. *"Being able to offload"*

Supervisory containment and reassurance in relation to suicidal clients was identified by several participants as a crucial buttress when navigating this difficult work:

in hearing from my supervisor and my peers, their thoughts about how I'm managing the student, and how they might have ideas that I haven't thought about… about how the student's feeling, and how I could… other things I could think about with the student… erm… in me being able to offload, and then leave supervision feeling, 'phew', you know, 'I'm… I'm… I'm doing okay'… or, 'oh, that's a good idea'… 'I could think about that next time with the student'… erm… so, it… I've shared the load… I feel relief… I've distanced myself again at a time when I might have been feeling a bit too immersed in the student's feelings… so, I've now maintained that boundary again between myself…

Athena; 2, 50, 1422-35

well, first of all, I talk about obviously all of this in supervision… erm… so that's my go-to place to just be able to air stuff out…

Penelope; 4, 85, 2443-44

Athena experiences a range of benefits through engaging in supervision. Not only does she encounter a different perspective in so doing, hereby contributing “ideas that I haven’t thought about”, and thus facilitating the therapeutic task, but she is also “able to offload”, which suggests the emotional burden carried when working with suicidal clients, and advantages experienced in the sharing thereof. There is a risk of overidentifying with the client’s distress, becoming “a bit too immersed” in their feelings, and hence, it is something of a relief for Athena to be able to establish self-protective distance and separation via supervisory exploration of the client’s material. As a result, she has “maintained that boundary again”, stepping back onto the dry land of her own identity, such that she is no longer drowning in the client’s emotional soup. Penelope similarly conveys a sense of supervision as enabling an emotional freshening up and letting go, since it is her “go-to place to just be able to air stuff out”, which potentially carries the connotation both of voicing what was previously unsaid, but also of ‘airing the laundry’, getting rid of the damp and cobwebs, breathing new life into things. Athena recognizes that such disentanglement from the emotional detritus of therapy is particularly necessary if one is dealing with overlapping material in one’s personal life:

> *and the other thing I was going to say is… my own experiences, of course, in my external life, which, actually, over the past year, have involved my partner having cancer… so although it's not terminal, I have come into touch with… life and death… and, you know, the reality of death in a very personal way… so, I had to, therefore, process that quite a lot in my supervision in order not to be too infected…*
>
> *Athena; 2, 20-21, 556-72*

Forced to confront “the reality of death in a very personal way” in the context of her partner’s cancer diagnosis, such that a concept typically relegated to the realm of fantasy was made much more tangible as regards her own interpersonal attachments, Athena recognized that there was a greater need than usual for supervisory processing of her emotional responses in order not to become “too infected” by the despair and hopelessness of her suicidal clients, echoing as it did certain aspects of her own feeling state over the past year.

However, the value of supervision does not reside solely in relieving the clinician of difficult emotions, as it also has something to contribute vis-à-vis its affirmation of the therapeutic work undertaken with suicidal clients:

> *I think I use my supervision a lot… to hold that tension… erm… because it's almost like I need another voice… to… and another conversation… a conversation which isn't… which puts the client back in the middle… back to that… back to the client being in the middle…*
>
> *Phoebe; 1, 17, 503-16*

> *there's something reassuring about, sort of, saying to my supervisor, 'yes, they've… they've talked about suicide, but they've talked about it in this way, and that's why I'm not actively concerned', and having someone else say, 'that sounds about right, but keep checking in'… you know… erm… so, it allows me to, kind of, have said it… to have, sort of, taken it from my mind, put it, sort of, in the public domain, and… and move on with the rest of the work…*
>
> *Gaia; 6, 31-32, 887-904*

Phoebe sometimes experiences organisational pressure to prioritize student throughput over immediate client needs, which creates “tension” given her own orientation to be responsive to the distress she encounters. Supervision, however, serves to bolster the clinician’s perspective, facilitating a conversation “which puts the client back in the middle”. It enables a refocusing on therapeutic priorities that may temporarily have been shunted away from centre-stage by internal organisational dynamics, offering “another voice” to balance out competing influences. For Gaia, supervisory confirmation that she is on the right track (i.e., “that sounds about right”) in her assessment of client risk similarly constitutes “something reassuring”. It is akin to a confirmatory thumbs-up from a parent, and whereas she might previously have been ruminating internally about whether she should be more concerned about a suicidal client, having reported her reasoning to her supervisor, and had her risk assessment validated “in the public domain”, any lingering doubts are taken “from my mind”, her anxieties dissipated, freeing her up to “move on with the rest of the work” unhindered.

3.3.3.5. *"It's like a sort of basket, holding you"*

When confronted with client suicidality, "great relief" was often experienced by participants in sharing the burden of responsibility with others:

> *initially, as a counsellor, one can be quite omnipotent, and be reluctant to share the support… and it's a great relief, I think, to realise, one day, that actually, it's so important… it's so much more helpful for the student, but also for myself, to share the load…*
>
> *Athena; 2, 25, 696-703*

> *my experience in the past, before private practice, was always about teams… working in clinical teams… there was something about a team supporting a person… and I found that very reassuring… and, I think, the clients do too if they're supported by a team…*
>
> *Penelope; 4, 116, 3334-42*

Initially "reluctant to share the support", Athena's recognition that there was no need to 'pull the strings' alone appears to have been a valuable lesson, facilitating a healthy opening up to relationship in acknowledging the limits of her capacity to contain client suicidality. Echoing the point that providing care in conjunction with others is beneficial, and indeed, "reassuring", for both client and clinician, Penelope similarly recognizes the advantages of "working in clinical teams". Further insight into the reasons why is offered by Athena:

> *it's like a sort of basket, holding you… there is actually a lot of help out there…*
>
> *Athena; 2, 30, 849-53*

The imagery of a "basket, holding you", is reminiscent of a childhood cradle, something which functions in an almost womb-like capacity, which speaks to the way in which the supportive containment of others can prove soothing.

When she feels backed up by the organisation, Athena is better able to support suicidal clients, experiencing a firmer foundation from which to operate. Her account, in many respects, serves to reinforce the old proverb that 'many hands make light work':

> *it lightens my feeling of burden… it helps me feel that I'm not alone, 'cause I'm sharing this, and just, it acts as another reminder that I'm not wholly responsible for this student's staying alive, that there are others who are helping me…*
>
> *Athena; 2, 65-66, 1866-83*

We can almost imagine Athena lightening her backpack by sharing out the "burden" of client suicidality with her colleagues, recognizing that the weight of responsibility need not fall on her shoulders alone. Proceeding unsupported for too long, she acknowledges, would likely undermine her caregiving capacities:

> *if I was holding it by myself… and say I had ten students I was holding by myself, I wouldn't last very long, I don't think, in… in the work, and I would quickly become depleted by it, and would begin to feel very deprived myself… and then I would not be in a position to help the student, because I'd be too preoccupied with my own feelings…*
>
> *Athena; 2, 67, 1906-18*

The idea of "holding it by myself" conjures up the image of a mother, lacking assistance in tending her demanding infants. "Depletion" is suggestive of the emotionally drained state that results from giving out too much energy and receiving too little in return, and "deprivation" further emphasizes a sense of her own unmet needs, perhaps even hinting at a perception of deliberate withholding by others. Clearly, Athena needs to be embedded in relationships that provide interpersonal succour in face of such challenges.

Another benefit of being organisationally embedded, as recognized by Gaia, is the guidance and reassurance that can be derived from peers:

> *it's on the one hand comforting to be able to… to… (pause)… to have sort of proof-readers, in a way… to have people you can go out to, and say, 'have I done ev… ev… ev…?'… you know, 'we got this covered?'…*
>
> *Gaia; 6, 10, 283-87*

Having colleagues function as "proof-readers" is a telling description, as it conveys Gaia's desire to check for errors, to ensure that she has done everything possible to look after the client's best interests, thereby avoiding being subject to the criticism of her 'markers', and

hopefully passing the test (i.e., keeping the client alive). There is anxiety about whether sufficient action has been taken to mitigate unwanted outcomes, and hence, consultation with others is "comforting" in that it provides a second opinion, allowing for minor corrections where necessary, and easing her doubts where not.

3.3.3.6. *"Being affected, but not infected"*

Tapping into the support of colleagues is not the only means of remaining grounded when working with suicidal clients. It is also necessary to engage in self-protective boundary-setting in the interests of self-care:

> *well, there's always a knowledge that it's not me… so, knowing that, which I think is part of the training, to be able to separate myself from that… is, of course, always a relief… you know, that in the end, it's… the student feeling suicidal, not me…*
>
> *Athena; 2, 16-17, 457-68*

> *being affected, but not infected, is the phrase that, you know, I'm sure you've heard, which is… is so important…*
>
> *Athena; 2, 18, 504-09*

Athena's professional role requires that she be able both to emotionally join with, and then separate out from, her clients, rather than becoming overidentified, which would prove disruptive of her effectiveness as a clinician. Subsequently, she understands the importance of "being affected, but not infected", of empathizing with her clients, but remaining cognisant of her psychic differentiation therefrom. As observed earlier, in theme 1.6, "infection" suggests the danger of being invaded by a disease agent, which might prove damaging to us as host, particularly if its unique signature is not easily distinguishable from our own cells. The dangers of excessive attachment, of course, inevitably point to the value of non-attachment. Where we are only "affected", we observe the otherness of the client's emotions, and hence, our immune system can better do its job of targeting foreign intrusion.

Both Athena and Iris comprehend that it is not always possible to close the door to "infection" entirely, and hence, self-care sometimes demands rebalancing the equation:

I need to constantly check in on myself… that… to… in supervision, to make sure that I'm always processing it… and to keep my work-life balance, you know, as balanced as possible… make sure that I am keeping things like Pilates, or choir, or whatever brings me joy, into my life, to balance the fact that I am being confronted with death on a daily basis…

Athena; 2, 10-11, 283-95

you have to be absolutely rigid in times like these about self-care… erm… and really do what you need to do… and, you know, my supervisor's great… erm… but, also, erm… I… I think, grounding yourself, and having, eh, that… erm… normal situation… normal grounding… having to do the dishes… having to go shopping… all that normal stuff helps to ground you in situations like this… to give you, dare I say, mindlessness…

Iris; 5, 82-83, 2361-71

Acknowledging that "being confronted with death on a daily basis" risks unbalancing her emotional equilibrium via ongoing exposure thereto, Athena seeks to preserve her work-life balance in hopes of offsetting client despair and hopelessness with "things like Pilates, or choir, or whatever brings me joy". For Iris, when the pressures of working with client suicidality build, she similarly recognizes the necessity of self-care. The need to be "absolutely rigid" in this regard is an interesting turn of phrase, particularly given that care is typically associated with a degree of interpersonal pliancy, but perhaps this speaks to having been over-flexible in the first place, absorbing too much of the suicidal client's emotional material, which now necessitates a firmer stance in stemming the flow, effectively slamming shut her contact boundaries with the world, closing the door so as to prevent further "infection". Space is hereby held for the normality of family life. The idea of hereby "grounding" herself suggests the benefit of having a solid, stabilizing surface beneath her feet, of retreating into the safety and security of 'being' (i.e., "having to do the dishes"; "having to go shopping"), in preference to the quicksand, the underlying 'nothingness', of death. In a context divorced from the pressures of work, she has the freedom for "mindlessness", in contrast to a very mindful focus on client suicidality, facilitating her disconnection therefrom.

Where rebalancing the equation proves impossible, an alternative might be to find ways of tolerating current circumstances in the hope of future improvement, seeking solace in the prospect of ceasing to undertake work with suicidal clients:

> *one of the ways I deal with it is to think, you know, how long will I do this work for?… perhaps put a boundary around it… perhaps think that in six… seven years' time, I might think about… re… retiring… or work… moving away from student work, because of the high level of suicide… you know, I might not… but it's my way of putting a boundary around it…*
>
> *Athena; 2, 12, 329-42*

Like her suicidal clients, Athena contemplates finding a way out, if not in quite such a terminal manner, and it is the thought of being able to escape, of ceasing to support a student population, or retiring altogether, and thus, being able to "put a boundary around it", that facilitates continued investment. In asserting her control over the "boundary" conditions, the notion of being able to opt out functions as a safety valve. Sometimes, however, reflection on the need to "step away" from such work is more in earnest:

> *the minute one… one detects infection in oneself, I think is the time to question whether I need to stop this work, or have a break, and… and address that… I… I mustn't… you know, that would be unprofessional and unethical to do it if I were getting too infected myself… too depressed by it…*
>
> *Athena; 2, 44, 1246-57*

Athena acknowledges that, if she became "too infected" by client distress, decisive action might be required in distancing herself from the source of the problem. She must reflect, in such instances, on her "ability to do the job", and whether it might be better, both to stem the "infection" within herself, and in order to avoid "infecting" others, to quarantine herself (i.e., "step away") and disinfect her polluted mind (i.e., "have therapy") (2, 44-45, 1259-69). Although framed as a question of ethics, contemplating closing the door on this client group, with the implicit rejection implied therein, might also provide Athena with a necessary sense of choice over her ongoing engagement in this difficult work.

3.3.3. Superordinate Theme 4: *"Noisy, but unhelpful"*

The fourth and final superordinate theme highlights the struggles experienced by participants in grappling with institutional expectations and anxieties occasioned by client suicidality. Phoebe's verdict on these externalities, "Noisy, but unhelpful", sums up how clinicians experience their organisations in their worst moments:

> *you know, I feel that in supervision, we hold the client in mind… erm… and the client is central… but… but the institution, it doesn't… it just… just feels… depends on the quality of your manager… quality of your manager's manager… whether the Vice-Chancellor sees something in the newspaper… erm… (pause)… whether the person you see happens to be, erm, the PA to the Head of HR… erm… erm, you know, it just all… it just all seems… I don't know… noisy… noisy, but unhelpful, and not… often very real…*
>
> *Phoebe; 1, 25, 749-71*

Disenchantment is experienced when Phoebe's employer is not perceived to "hold the client in mind", which is what she herself endeavours to do, both in her therapeutic work and with her supervisor. Her critique of organisational "noise" is that it distracts from the centrality of her focus on the client's well-being, compromising the quiet stillness required in undertaking potentially life-saving work. Not only does it intrude, but it also appears to be experienced as somewhat arbitrary, informed by institutional power dynamics (i.e., depending upon "whether the Vice-Chancellor sees something in the newspaper", or one's client is "the PA to the Head of HR"), and the effectiveness of one's manager in filtering out external influences. Clearly, significant institutional pressures are awakened by client suicidality, and the following subordinate themes will attempt to provide insight thereunto:

3.3.4.1. *"The third chair in the room"*

Organisational expectations and anxieties are, perhaps inevitably, experienced by participants as encroaching into their clinical territory. A sense of external interference is beautifully evoked by Phoebe's allusion to a "third chair", which suggests a competing voice, internalised from the institution, intruding into her sessions:

it feels like the institution is in the third chair in the room sometimes, and that… can be quite hard to shut that off… erm, and it… feels like an additional pressure…

Phoebe; 1, 5, 134-40

and I've worked in different institutions… and I've experienced that third chair… sometimes it's out in the corridor, and the door's shut, and it's just me and the client… erm, and other times, it's kind of parked in the doorway… ha ha… (laughter)… and other times, it's kind of… as… as close as… in the room as… I allow it…

Phoebe; 1, 6, 161-73

The idea of a "chair" is suggestive of the organisation as an embodied presence, requiring a seat at the table, observing the therapeutic interaction, and demanding to be heard. The institutional voice hereby made manifest is a source of tension through its communication of competing interests. It provides a reminder that client neediness and vulnerability also exist outside the therapy room, as represented by the waiting-list. An easy life would require that Phoebe only focus on meeting immediate demands in the room, but organisational realities require that space also be created for new clients. In representing the currently disenfranchised other, the voice speaking from the "third chair" therefore imposes stress, obliging Phoebe to manage her own finite resources in satisfying these different priorities. “Parked in the doorway” speaks to her route out being blocked, and hence, suggests a somewhat oppressive presence, Phoebe’s laughter possibly masking the anger hereby elicited. Although she exercises some degree of control over the closeness of organisational intrusion, Phoebe’s preference is clearly to work in institutional settings wherein internalised expectations are less forceful, and she is less weighed down by additional anxieties beyond those occasioned by the suicidality of current clients.

Organisational pressures, as highlighted by Phoebe, are often in the direction of systemic “throughput” (1, 47, 1441), towards disengaging clients from therapy as quickly as possible, thereby creating space for new assessments. The organisation requires that she keep her clinical work "short" and "neat" (1, 33, 997), minimising the length of therapeutic contracts, and “avoiding dependence, because that takes longer” (1, 48, 1462-66). Subsequently, she finds herself squeezed by management, whose explicit concern is to

ensure that the institution “isn't in the papers as having had somebody die while they were on the waiting-list” (1, 48-49, 1483-85), thereby avoiding bad publicity and associated reputational damage. Sometimes, the organisation succeeds in “pushing” her around, “unsettling” her view vis-à-vis the client’s best interests:

> *I think the institution can kind of push the client… push you… (hand gesture, indicating being pushed)…*
>
> *Phoebe; 1, 17, 520-21*

> *and I found that more unsettling… erm… because then I started to think, 'well, maybe there is something'… 'maybe it is dependence'… 'no, but it is ridiculous'… it's kind of… I'm any port in a storm… this is a ridiculous way of thinking… but it rocked me at the time…*
>
> *Phoebe; 1, 69, 2100-14*

> *well, to start with, I was a bit floored… and I did kind of examine my conscience, and think, 'well, maybe he is getting dependent?', and 'is that a bad thing?', and 'is that… is that going to cause, umm…?'… and so, it did wobble me…*
>
> *Phoebe; 1, 72, 2197-2200*

Phoebe clearly finds herself buffeted by organisational influences. In particular, she appears to be destabilized by concerns expressed by her line manager about the length of her contracting with suicidal clients. Describing their fraught interactions, Phoebe’s linguistic choices provide the flavour of a boxing contest, suggesting an aggressive confrontation of wills in which she finds herself “rocked”, “wobbled”, and even “floored”. Knocked off her feet by the weight of her manager’s arguments, she is momentarily afflicted by self-doubt, examining her conscience (i.e., “maybe he is getting dependent?”) before standing her ground and fighting back (i.e., “this is a ridiculous way of thinking”). The capacity of the contest to sway so dramatically suggests that the claims made on both sides of the ring are not without some validity (i.e., the immediate neediness of suicidal clients versus the necessity of assessing clients on the waiting-list).

Sometimes, the institution is not just experienced as unsupportive and misdirected in its priorities, but actively “hostile” towards clinician efforts at managing risk:

'it's one thing having pressure from external… like the papers… but another, having pressure from within your own institution'… which is what we're getting from the media office… it's kind of like bizarre… we're all working for the same organisation, and yet we're getting… it feels hostile from the media office here…

Astraea; 8, 73-74, 2097-2115

it's all a bit of a loose cannon… eh… especially here… I mean, it wasn't like this at (former employer)… like, a bit like everyone's just going off… (chuckling)… shooting from the hip…

Astraea; 8, 75, 2152-59

Astraea is clearly rendered uncomfortable by the perceived attack of her own organisation's media office on the counselling team, which she experiences as confounding given that "we're on the same side", questioning bemusedly, "how 'bout work with us?" (8, 74, 2124-25). Rather than pulling in the same direction, the media office is experienced as adversarial in its approach, treating the counselling service itself as the problem, presumably because they perceive client suicidality as posing a threat to their own agenda of positively representing the university's external brand. The danger posed by an enemy within is perfectly captured by Astraea's allusion to "a loose cannon". Just as a ship's cannon, similarly purposed to the organisation's media function in guarding its vessel against outside threats, might cause injury to its own crew should it break free of its moorings, and roll around the ship's deck unpredictably, the uncontrolled responses of the media office are deemed liable to cause damage internally as well. The experience of ill-considered aggression is further evoked by Astraea's reference to their "shooting from the hip" (i.e., without removing their firearm from its holster), just as might a gunslinger in frontier America, hereby rendering his discharge quicker, but less accurate, liable to hit the wrong target.

3.3.4.2. *"Sound and fury, signifying nothing"*

There can be an impatience with institutional reactions as potentially distracting from immediate client needs. Using the device of "noise" to illustrate the impact of organisational

anxiety, Phoebe captures the sense in which institutional reactions might draw her attention, disrupting her therapeutic focus:

> *so, there's a noise… there's… there's anxiety rattling around, and now it's come tumbling down to me… erm, and I'm supposed to hold it, really…*
>
> *Phoebe; 1, 63, 1939-51*

The idea of "rattling" conveys a sense of the "noise" as stemming from something moving around, thereby causing a disturbance, perhaps suggestive of the way in which anxiety transfers between people, pushed from one individual to another within the organisation. We might also note that a "rattling" sound is often caused by something relatively small and insubstantial that has broken off, which nevertheless creates a lot of noise in its ricocheting about, attracting attention to the damage sustained, which might possibly communicate Phoebe's experience of organisational anxieties as disproportionate to the risk. Similarly, a 'rattling cough' often sounds much worse than it is in practice. Whether justified or not, the anxiety ends up "tumbling down" to her, suggesting its arriving suddenly, clumsily, unexpectedly. There is nothing thoughtful or controlled about the organisation in such moments, and the onus is then on Phoebe to stop the "rattling", requiring that she "hold" the anxiety, burdening herself with the emotional weight thereof, rather than passing it on.

It is, of course, easier for Phoebe to take seriously the work she is currently undertaking, rather than giving credence to unknown risks and unsubstantiated anxieties outside the room. Concern about an immediate human relationship inevitably carries greater weight than that elicited by an imagined future one, and hence, "noise" associated therewith appears to be experienced as less "real":

> *it depends on how the client is… but it feels authentic and real, and the rest feels like noise and stupidity… it just feels stupid… (raucous laughter)… whereas, actually, the work with a client never… never feels stupid… (laughter)… but the institution frequently feels stupid…*
>
> *Phoebe; 1, 23-24, 705-12*

in a way, even if the work is really difficult, and I feel very anxious and very worried about the client… erm… (pause)… it feels authentic, I suppose… it feels real… whereas, I think, quite a lot of the institutional dynamics feel a bit concocted, or a bit… (pause)… a bit about other stuff…

Phoebe; 1, 24, 716-27

The organisation's concerns are diminished by Phoebe as "stupid", and the word "concocted" wonderfully conveys her sense of this noise as somewhat made-up, as not entirely genuine. Phoebe's raucous laughter suggests a release of tension in criticising the organisation, and given the oft-defensive nature of humour, perhaps hides a depth of anger that is typically left unexpressed owing to her need to conform with institutional expectations. Her view of organisational "noise" as inauthentic is further accented in reflecting upon managerial efforts to discourage longer-term therapeutic work with a suicidal client:

somehow that was being called into question in a therapeutic way… when actually, it was a management issue… but it was masquerading as a therapeutic… that I'm encouraging dependence…

Phoebe; 1, 71, 2163-76

The experience of a "masquerade" suggests some disconnect between surface presentation and underlying reality, implying something hidden or misrepresented. Phoebe's manager is perceived as seeking to push an agenda around systemic throughput, a value proposition different from her own, but to pass this off as being appropriate from a therapeutic perspective, which riles Phoebe, infringing as it does on her own clinical jurisdiction. Clearly, where different priorities are in competition, efforts at influencing often carry a political dimension, and hence, as Phoebe observes, interactions can become "a bit about other stuff". This not only tests her patience, but leaves her struggling to attach any value or significance to the organisational "noise" she experiences:

and… isn't there a poem?... isn't there… noise… noise and something… signifying nothing…

Phoebe; 1, 26, 791-93

Digging a little deeper, it appears Phoebe was referencing a line from Shakespeare's Macbeth. The main protagonist, having been informed of his wife's suicide, proclaims that:

> *Life's but a walking shadow, a poor player that struts and frets his hour upon the stage, and then is heard no more. It is a tale, told by an idiot, full of sound and fury, signifying nothing*
>
> *V, V, 24-28, Shakespeare, 2007 [1623], p.1911*

If we unpack the implications of this reference, it appears that the "sound and fury" embodied in organisational "noise" is perceived by Phoebe as lacking in meaning. Presumably, her manager is the "idiot", strutting to ill-effect on the stage. We might also speculate that this reflects a nihilistic commentary on institutional anxieties about preventing client suicide. Just as Macbeth's machinations come to nought following his climactic battle with Macduff, so the organisational "noise" is perceived as inconsequential, making little difference in the client's choosing to remain alive, unlike the therapeutic work undertaken with the clinician, which, by implication, is more likely to prove helpful. A more subtle inference might be that, enduring the distraction of organisational politicking external to the counselling room, Phoebe's objectives are compromised, just as Macbeth's path to the throne is blocked. Not only is she prevented from properly supporting suicidal clients, but the significance of her work is hereby implicitly questioned. It would not be entirely surprising if this provoked an undercurrent of murderous rage, a desire to overthrow her manager in asserting her own control (i.e., to become 'king'). Unable to attain these ends, however, she is forced, like Macbeth, to accept her helplessness before the Fates, resigning herself to the futility of it all.

3.3.4.3. *"Thrown under the wheels of the car"*

Participants were fearful of being blamed in the event of a client's suicide. Anxiety about being held accountable was rife within Phoebe's institution in particular:

I think there's a huge institutional fear… and I think my current manager feels that… erm, that there might be blame… and the blame will be flying around… and, as long as none attaches to her, it doesn't really matter where else it is…

Phoebe; 1, 10-11, 297-311

it seems like a lot of anxiety that somehow someone will point the finger…

Phoebe; 1, 12, 344-45

you could be thrown under the wheels of the car…

Phoebe; 1, 51, 1574

The idea of blame "flying around" hints at a possible game of 'pass the parcel' as highlighted by Reeves (2010, p.52), wherein responsibility is quickly shifted around the circle on account of nobody wanting to be the unlucky loser left "holding the parcel when the music stops". This communicates a sense of environmental insecurity, since a desperation to avoid being found the guilty party results in the parcel of blame being unfairly thrust in Phoebe's direction as her manager attempts to sidestep accountability. A lack of trust in her peers within the institution is further communicated by the concern that “someone will point the finger”, like an eyewitness identifying the culprit in a police line-up, drawing the focus of attention to the supposed misdemeanours of others. Destructive consequences are envisioned in hereby being “thrown under the wheels of the car”, forced to accept liability in someone else’s stead. This metaphor not only communicates the potentially damaging consequences of this eventuality, which might spell the end of her organisational career, resulting in her being ‘killed off’ institutionally, but also indicates that this outcome, in being "thrown", is envisaged as a deliberate action, informed by the desire of colleagues to save their own skin. Launched sacrificially in front of an approaching vehicle, there is a risk that Phoebe will subsequently be crushed by the "wheels" of institutional judgement.

Astraea similarly highlights the trepidation felt when operating within a blame culture wherein she faced a constant risk of criticism:

you got blamed if… if, erm, something happened to your client while you were seeing them… so, erm, like an overdose, or… if somebody was successful in ending their life… you… you know, you were attacked for that…

Astraea; 8, 6, 165-72

'well, why didn't you contact them after they missed the session?'…'you knew they were… you had some risk… why didn't you do that?'… and it's kind of like… 'I know… I need to do that… it's…'… this hasn't actually happened… it's just a con… it was just a constant fear, and other people have been criticized for that…

Astraea; 8, 11-12, 315-35

Within Astraea's former organisation, being subjected to blame was almost experienced as an inevitability. If something untoward had happened to a suicidal client under her charge, she was fully expectant of receiving both barrels, particularly if risk management responsibilities had been neglected. The notion of being "attacked" conveys the unwelcome prospect of enduring managerial aggression, potentially experiencing fierce condemnation and shaming, such that her "constant fear" is perhaps understandable. Lingering concerns about the possibility of judgement likely inform Astraea's attempts to distance herself from imagined criticisms for failing to do her duty, clarifying that "this hasn't actually happened". Such concerns are no doubt exacerbated by having witnessed others on the receiving end of censure, subject to reproach for neglecting to take appropriate action in managing risk.

3.3.4.4. *"It can be a bit knee-jerky"*

A vulnerability is sometimes experienced to reactive organisational politics, raising the spectre of criticism and job loss when it proves impossible to work miracles within the institution in preventing suicides altogether. Gaia, for one, appears to feel squeezed between hysterical media headlines complaining that "there's not the support", accusing mental health systems of "having failed individuals" (6, 26, 726-28), and the internal reality that "budgets are being cut" (6, 25, 698-99), producing a sense of "incredible organisational vulnerability" (6, 25, 698). Exposed to judgement, and not wanting to justify media condemnation, or confirm the public's worst fears, she seems rather embattled, seeking to meet expectations, yet lacking

the resources to do so effectively. If this equation is not challenging enough, further complication is thrown in by not always feeling backed up by the institution:

> *and, I remember, you know, the… the… the… hmm… sort of language that used to go around IAPT, and fortunately, really, really, really doesn't in this service, but was, 'remember, if anything happens, the NHS does not have your back… you have to have good insurance, because they will throw you to the wolves'… (chuckling)…*
>
> *Gaia; 6, 28, 788-93*

> *it was always very… ver… you know, made very clear that if… if anything went wrong, you, individually, would… (chuckling)… be held responsible…*
>
> *Gaia; 6, 103, 2969-71*

Particularly when working within the NHS, Gaia experienced that her employers "did not have your back". When retreating in the face of attack, a soldier's back is an area of vulnerability, as they could easily be picked off from behind by an enemy sniper. Subsequently, they rely upon retaliatory fire from soldiers on their own side to reduce the likelihood of being shot. Not only was such protection not forthcoming in instances of client suicide, but it was highly likely that, "if anything went wrong, you, individually, would be held responsible", that they would "throw you to the wolves". This notion is suggestive of abandonment, of being sacrificed for the greater organisational good, just as European folktales told of throwing passengers off a sleigh pursued by wolves, thereby facilitating escape as the pack set about devouring the victims. With friends like this, who needs enemies! A sense of underlying insecurity is underscored by the need "to have good insurance", since one would be fighting off the "wolves" (i.e., litigation) on one's own.

Doubts about the extent to which she can trust in her organisation's ongoing support are similarly shared by Astraea:

> *I think, a suicide happens, and it's all in the paper, and we're… and it's really bad… we've been… erm… criticized by… the Coroner, or criticized by… the… the student's parents, and it's in the press… I think that would be… if we get more of that, I th… I think we'd be very vulnerable…*
>
> *Astraea: 8, 69, 1966-77*

It is envisioned that the institution might turn against the counselling service should a client take their life, that external criticism that made its way into the press might render the service vulnerable to "being overhauled" (8, 70, 1993). This is suggestive of an unsettling deconstruction, the risk posed when something is taken apart and put back together again, with no guarantees that all the parts will be retained as before. The fear implicit in this, then, is that Astraea herself might not survive the refit:

> *it can be a bit knee-jerky, I think…*
>
> *Astraea; 8, 66, 1890*

> *let's do it cheaper, or somethi… like, some strange… ex… excuse to get rid of… it's scapegoating, I think…*
>
> *Astraea; 8, 66-67, 1899-1904*

Astraea imagines being subject to a "knee-jerk" reaction, anxious lest a suicide within the organisation condition something of an institutional reflex, rather than a more thoughtful and controlled response, potentially kicking her out of the organisation altogether. There is trepidation about possible "scapegoating", about the counselling team being singled out for unwarranted blame, victimized on account of the reputational damage incurred, which might be used as justification for the institution's cost-cutting agenda:

> *you know, a fear of… 'so, we're all gonna get… sacked, and replaced by an IAPT service'…*
>
> *Astraea; 8, 68, 1941-43*

> *a sense of that… we're all gonna lose our jobs, yeah…*
>
> *Astraea; 8, 68-69, 1957-61*

Continually operating under the threat of redundancy should a client take their life is hardly the best existential circumstance to soothe Astraea's frazzled nerves.

3.3.4.5. *"It's a no-win situation"*

Overloaded with clients with a view to managing suicide risk, clinicians were often forced to make difficult choices between competing priorities. For example, faced with anxiety about waiting-list clients not yet seen, matched with concern about those already on the books, Phoebe found herself wrestling with a tension about whose needs to put first, much like a parent struggling to determine which of their demanding children required more immediate attention, and who could go without:

> *for instance, erm, if I'm sitting with someone, and they were actively suicidal a couple of weeks ago… they're a bit better... things seem to have settled down a bit… erm…then I'm aware that… I've been in a meeting, say, in the morning… and… so part of me is with the client, but the other part is thinking, 'we've got three 'at risk' people on the waiting-list, one of them's been waiting three weeks'… can I afford to let this person… go without an appointment?…*
>
> *Phoebe; 1, 15, 434-44*

In navigating this complex balancing act, the experiential reality is one of feeling stretched, torn in different directions. Phoebe is left conflicted, as "part of me is with the client", but equally, part of her is reflecting on how to squeeze new assessments into her already congested schedule, preventing her from being fully present with the client she is supporting most immediately. These difficulties are exacerbated by the way contracting is managed within her service, where choices about length of therapy are left in the hands of the individual clinician. This facilitates greater flexibility in responding to client needs, but it also means that responsibility for balancing internal and external risk rests more exclusively with Phoebe, who must weigh up what she can "afford" to invest in any given client, which carries the implication of possible costs to be borne if she gets this wrong:

> *we work in a time-aware way… we don't at the moment have a rationed number of sessions… which… is very positive overall… but it does mean that it comes down much more to your judgement in a way… there's nowhere to hide…*
>
> *Phoebe; 1, 4, 112-18*

Greater freedom of choice is experienced as exposing, because it simultaneously entails taking on greater liability for outcomes, removing the concealment of collective accountability in the event of a suicide. “Your judgement” is very much on show, and, with “nowhere to hide”, Phoebe appears to feel vulnerable to potential blame.

It is not only the needs of different clients that are in competition, however, as another variable that can be flexed is the clinician’s own time. As Astraea observes, when a counselling service becomes overloaded, as regularly occurred at her previous institution, this establishes a potential dilemma for the clinician between flexing their time boundaries to prioritize client welfare, and holding them more self-protectively in their own best interests:

> *you were stuck between a rock and a hard place… so you had the counsellors that protected themselves, and they'd book clients in… in three weeks sometimes… I mean, I supervise someone from there now… and sometimes, she's not able to see somebody for another four weeks… so what I used to do, if someone was at risk, which they often were, is… I'm not gonna book them in… in three, or two, or four weeks… I'm gonna book them in wherever… like, the soonest I can… in my lunch hour… so that's what I'd do… to avoid suicide…*
>
> *Astraea; 8, 127-28, 3642-73*

The notion of being “stuck between a rock and a hard place” evokes Astraea’s sense of being trapped between two unpalatable options (i.e., either tolerating not seeing vulnerable clients for numerous weeks, or congesting her schedule to accommodate these clients by working over capacity). As such, she considers that “it’s a no-win situation” (8, 129, 3689); either she runs the risk of uncontained client distress, or overburdens herself, and likely suffers burnout. The notion of continually sacrificing her “lunch hour” is particularly stark, signifying as it does a choice to prioritize her suicidal client’s psychological nourishment over her own physiological sustenance with a view to minimizing the likelihood of unwanted consequences. Thus, Astraea plays the martyr, willing to tolerate short-term losses vis-à-vis her own physical well-being rather than risk the terminal loss of a client. Unfortunately for some clinicians, even these decisions are taken out of their hands:

> *I would have a space for administration work, like a supporting letter… and I would look at my calendar, knowing that I had that space, and she'd put an assessment in, and I'd have a student sitting there, saying, 'I'm ready to be seen' kind of thing… and there was umpteen days that I was seeing seven hours of counselling because of that…*
>
> *Iris; 5, 19, 526-35*

> *it was just done… you're booked, and you've got a student… when you've literally… it was within a five-minute space, and somebody… she'd pop somebody in… and there's that poor person, sitting there, waiting to be seen… so, what do you do, you know?... and that put us under a moral obligation…*
>
> *Iris; 5, 20, 551-62*

Being arbitrarily imposed upon by management, having additional clients booked-in for assessment without consultation, was clearly experienced by Iris as an unwarranted invasion of her boundaries, eating into time intended for use in catching up on her administrative responsibilities. There was no persuasion, no leveraging; "it was just done", robbing her of control over her own schedule. This clearly left Iris feeling wronged, but also in something of a bind, struggling to push back on account of a sense of "moral obligation" when the client is literally "sitting there, waiting to be seen". In such circumstances, as a clinician invested in helping, she found it difficult to resist the human pressure of a vulnerable other anticipating her support, but simultaneously recognized that there was a price to be paid in accommodating herself to client vulnerabilities. Unable to extricate herself from this situation, Iris exudes frustration at her manager's apparent obliviousness to her needs, and disrespectful attitude in treating her time so expendably. Their expectation that assessments be done "at any cost" (5, 19, 544-45) suggests a preparedness to exchange clinician well-being for the possibility of averting suicide in the student population. Both Phoebe and Iris highlight the negative consequences of such an institutional disposition:

> *if I'm in that headspace for too long, I'll burn out… and that's always kind of at the back of my mind… that… is not a good place to feel that the demands are so much greater than my resource…*
>
> *Phoebe; 1, 20-21, 609-19*

I was really lucky to be able to stay in the university… I was… I was nearly on sick leave, and I've never been on sick leave…

Iris; 5, 24, 682-88

Phoebe recognizes inevitable repercussions from becoming clinically overextended, as she is liable to "burn out" if she finds herself "in that headspace for too long". In reality, a clinician's vitality is a limited commodity, and if they find themselves unreasonably stretched by work for too long, if "the demands are so much greater than my resource", this disparity is likely to prove unsustainable, eventually leaving them terminally under-resourced for the task. Facing just such a "breaking point" (5, 25, 697), close to fracturing and falling apart, Iris even considered resigning to escape the pressures of work, as, despite her normally robust constitution, she was "nearly on sick leave".

3.3.4.6. "Rage against helplessness"

Clinicians can sometimes be angered by their confrontation with an unsympathetic and demanding workplace. Phoebe, for example, recounted having been rendered "furious" by the institutional response to the suicide of her former client:

and I came in to hearing about the death, and then she'd sent me an e-mail, saying, 'I've… I've looked over your notes, and they're exemplary'… and I remember just being furious, and thinking, 'well, the client's dead… ha ha… it doesn't matter about my notes'… that's kind of, yeah… (becoming tearful)… sorry, I'm really upset thinking about… erm… (sobbing)…

Phoebe; 1, 8, 237-43

it was like, 'is that your first thought?'… this man has died, and your first thought is, 'let me look at the notes… to check that we're not going to get into trouble'…

Phoebe; 1, 9, 270-73

There is disappointment that her manager's "first thought" was to ensure that the institution was safe from blame. Emphasizing that she "went into my filing cabinet, and took and copied my notes" (1, 8, 233-37), like a nosy parent rifling through their child's bedroom drawers

without permission, Phoebe communicates a sense of managerial intrusion. Her tone is pained in observing organisational self-interest, the avoidance of "trouble", as taking precedence over a respectful pause to regret this tragic ending. Phoebe appears less angry about the death itself than about her manager's insensitivity in relation thereto, and her uncontained tearfulness possibly confirms a lack of empathy experienced in their handling of this loss, since her grief is clearly yet to be fully worked through. An instrumental focus on potential threats to the institution is clearly felt to be in tension with her own more humanistic valuing of life (i.e., "well, the client's dead… ha ha… it doesn't matter about my notes"). Such frictions can be accentuated when experiencing caseload pressures, particularly where management appear to be operating with double standards:

> *there's a sense that… that she's not pulling her weight… and that makes me really angry when I'm having these difficult conversations in my head… erm, and she's slacking, I suppose… so that makes me irritable and bad tempered… erm… so I think what happens is she gets a lot of my… rage against helplessness, I suppose…*
>
> *Phoebe; 1, 18-19, 550-66*

> *and then, she's almost like the lightening conductor…*
>
> *Phoebe; 1, 20, 589-90*

When Phoebe is already having "difficult conversations in my head" about the relative prioritisation of existing clients considered to be at risk and new waiting-list assessments, it is hard to stomach demands from her manager, whom she is aware has availability in her own schedule, that she take on further vulnerable clients herself. This inevitably has a flavour of "not pulling her weight", such that the burden falls on others, who have to pick up the "slack" resulting from her failure to contribute to the team effort. Phoebe's subsequent bad-tempered irritability, her "rage against helplessness" speaks to the anger experienced when lacking agency, when hitting against the limitation of organisational power dynamics that prevent her from challenging her boss. The image of her manager as "lightening conductor" is suggestive of the explosive charge of the clinician's anger, but also that it becomes concentrated in this

one direction, perhaps because her manager stands out so much in the vehemence of her advocacy for rationing therapeutic support.

The excessive nature of managerial demands can sometimes prompt clinicians to push back in offering resistance, asserting their boundaries self-protectively. Phoebe extends her “third chair” metaphor in recognizing the hard work that can be required to keep the intrusion of external expectancies out of her dealings with suicidal clients:

> *and other times, it's kind of… as… as close as… in the room as I allow it… so sometimes I have to work quite hard to say, 'no, you're not… this isn't appropriate… you need to go to the other side of the door, and be shut'…*
>
> *Phoebe; 1, 6, 168-78*

Clearly, it is possible to exercise some degree of control over the attentional focus given to internalized organisational requirements, but Phoebe nevertheless experiences it as something of a battle to shut out this unwelcome interloper, to insist upon its going “to the other side of the door”. As Iris demonstrates, when it is not just one’s mental space that is invaded, and one’s free time between sessions is no longer sacrosanct, it can be necessary to put one’s foot down more dramatically in making a point about acceptable limits:

> *well, in a nutshell, I lost the plot one day… I'd gone from, erm, back-to-back, two suicidal… err, people… and then we… I ended up with somebody… very much on the autistic spectrum, and it's very difficult, as you're aware… and, err, then, I looked at my calendar, knowing that I had half an hour, where I was gonna take myself for a walk, and just debrief myself kind of thing… just, settle down, and ground myself… and, she'd put somebody in… and, I absolutely lost it… and I said, 'no'… 'this is it'… 'this is not good enough'… I said, 'you have to work out what you're gonna do, but I'm not doing it'…*
>
> *Iris; 5, 21, 586-98*

“Back-to-back” clinical sessions, followed by loss of the “half an hour” she had set aside for herself, conveys a sense of Iris as squeezed in a vice, lacking sufficient space in her day to decompress. Having to “debrief myself”, she appears to be similarly left wanting vis-à-vis relational support in processing difficult client material that might function as a safety valve in

letting off steam. In such circumstances, it is hardly surprising that she “lost the plot”, temporarily misplacing her self-composure. No longer willing to read from the script of compliance, to accept having her free time infringed, she refused to meet with the client unexpectedly shoehorned into her diary, standing her ground in resisting managerial imposition. Thus, clinicians sometimes feel a need to hold their boundaries, regardless of the necessity of managing suicide risk, deeming the costs of continuing to invest to be too high.

3.3.5. Summary

Four superordinate themes, each comprising six subordinate themes, have been explored in detail via close analysis of illustrative quotations from the eight transcripts. The first theme, “Stirred up”, highlighted that participants were often emotionally unsettled by their encounters with client suicidality. “Goldilocks and the Three Bears”, the second theme, evidenced the way in which efforts at risk management were experienced as either being ‘too much’, ‘not enough’, or ‘just right’. “It’s good to ask for help” was the conclusion reached by participants in the context of the third theme, which revealed both the isolation and organisational support experienced when working with client suicidality. However, the fourth and final theme, “Noisy, but unhelpful”, recognised that the institutional expectations and anxieties occasioned by client suicidality often complicated attempts at managing risk.

3.4. Reflexive considerations

IPA acknowledges that the dynamic process of research is always shaped by the researcher’s interpreting eye. Perception and explanation are intertwined, and hence, our attempts to describe a phenomenon inevitably involve a making sense thereof that distances us from the original experiential reality of the other. Regardless of how scrupulously bottom-up our process might be, an ‘insider perspective’ can only ever be approximated (Smith & Osborn, 2015). Subsequently, unlike Giorgi (1992), I consider that a purely descriptive position, devoid of my own influence on meaning-making, is unattainable, and that chasing such a chimera represents wasted effort. Nevertheless, it remains my ethical duty to operate

with awareness of my function in 'translating' participant accounts. The oft-vaunted notion of ‘bracketing off’ is impossible to achieve, and subsequently, I cannot speak from ‘nowhere’, so it is worth considering any ways in which my preconceptions about the phenomenon under investigation might have influenced this analysis. Such deliberation is particularly pertinent on account of my having been a counsellor within various HE institutional contexts over the past nine years, where I have regularly encountered client suicidality and the necessity of undertaking risk management. As van Manen (1990) observes, it is often more problematic to know too much about a phenomenon than too little. Therefore, with a view to being transparent about my personal process in relation to the evolving research project, I have kept a reflexive journal to capture my thoughts over the course of the study, thereby consciously acknowledging my involvement in this endeavour. The excerpts showcased in Appendix M illuminate different stages of my journey.

Perhaps understandably, over the course of this analysis, I have often found myself grappling with the risk of interpretation subsuming description. The more ‘complete’ descriptive analysis I initially produced substantially exceeded word count limitations, necessitating making dramatic cuts, including shedding an entire superordinate theme. Not only was this painful, but it also felt somewhat capricious. Aligning with the aims of IPA, I have, of course, sought to be rigorous in my choices, guided by a focus on the phenomenological experience of the counsellor. However, it is likely that decision-making has also been steered by my own interest to some extent, with certain voices gaining greater airtime because they addressed the research question more directly or provided particularly eloquent and insightful accounts. By originating the research topic, the researcher unavoidably limits the terms of exploration, and this is only accentuated as selections are made that inform its subsequent framing. As Finch and Mason (1990) recognize, the experiences of more articulate participants tend to be prioritized in qualitative analysis, since we are seduced by the power of language, and the richness of data associated therewith. What is more, our sense-making, by its very nature, proves dislocating. Shrinking the ‘territory’ into a more concise ‘map’ (Korzybski, 1995

[1933]), it inescapably conditions a loss of idiographic meaning, distancing us from each participant's unique experiences.

Where editorial choices are left in my hands, the likelihood increases that the material selected will tell the story from a vantage point that suits my narrative intent. Therefore, we should at least remain quizzical when certain subordinate themes were not replicated across all participants. For example, 2.5, "Being pulled off course", and 2.6, "Going through the motions", were mostly derived from Gaia's account of some of the potentially negative aspects of organisational risk management requirements, whilst 4.2, "Sound and fury, signifying nothing", originated mainly in Phoebe's experience of organisational 'noise' as inauthentic and unhelpful in its impact. Although I have never experienced myself as being 'pulled off course' in the therapeutic work by the necessity of undertaking risk management, I do share Gaia's stance that much of what clinicians are required to do in mitigating risk (e.g., contacting the client's GP) is unlikely to prevent suicide, and hence, might be affected more for the sake of appearances in guarding the organisation against reputational risk. Equally, whilst I might not be as cynical as Phoebe in viewing organisational noise as 'signifying nothing', I do share her experience that institutional anxieties, genuinely felt or not, can prove obstructive of clinical efforts at caretaking vulnerable clients, potentially hindering the amelioration of suicidal distress. Now, on the one hand, these themes are certainly present within the data, if only narrowly so. The language used by Gaia, for example, lends credence to the experience of risk management as an inauthentic, box-ticking exercise (e.g., "empty gesture"; "having a fire drill"; "faceless machine"; "fob off"), suggesting that such an interpretation is not arbitrarily imposed. I would argue, moreover, that these themes justify inclusion as a counterpoint to accounts emphasizing more positive features of organisational risk management. On the other hand, I must entertain the possibility that my desire to include them stems at least in part from their aligning with my own views. Subsequently, I have tried to bring the hermeneutics of suspicion (Ricoeur, 1970) to bear on these themes as far as possible in the Discussion chapter which follows hereafter, dissecting the implications thereof with an even greater degree of criticality than applied elsewhere.

Chapter 4: Discussion

4.1. Further exploration of themes

Identified themes will now be further dissected with reference both to the extant research literature, and to any psychologically relevant, theoretical writings that might further illuminate the experiential process of participants. In keeping with the aims of IPA, the researcher has lent heavily upon phenomenological and existential authors to this end.

4.1.1. "Stirred up"

The first superordinate theme showcases the clinician's confrontation with the existential given of death (Yalom, 1980), to which they are inevitably exposed by the freedom of action of their suicidal clients, whose emotional state forces them to wrestle with uncertainty about outcomes (1.3, *"There's always doubt"*) and lack of control in relation thereto (1.4, *"I felt so helpless"*). Looking death in the eye gives rise to existential uneasiness (1.2, *"Absolutely on the edge"*) and anxiety about loss (1.1, *"You're on high alert inside"*), with the clinician's attachment to preserving their client's life (1.6, "*Everything in me doesn't want them to die"*) resulting in a sense of burden owing to their investment in the success of this endeavour (1.5, *"I do carry a weight around all the time"*). Athena's inability to switch off between sessions, Astraea's hypervigilance, and Jocasta's sleeplessness all confirm the heightened anxiety previously identified in clinicians interacting with suicidal clients (Richards, 2000; Reeves & Mintz, 2001). Penelope's frantic assertiveness, her sense that "we have to do something" (4, 112, 3227) to ward off suicide, to 'fight' for her client's survival, echoes the therapeutic overinvolvement highlighted by Birtchnell (1983) and Milton (2001), whilst Athena's temporarily compromised rationality, her inability to think clearly, hints at being immobilised by a 'freeze' response (Neimeyer & Pfieffer, 1994).

So, what is it exactly about the possible death of a client that informs the clinician's anxiety? One possibility, as suggested by Phoebe's troubling experiences of witnessing clients "absolutely on the edge" (1, 73, 2238), is that, in looking out over the abyss together, the

clinician's own death anxieties become activated. Tillich (2000 [1952], p.35) argued that "anxiety is finitude, experienced as one's own finitude". Kierkegaard (1980) [1844] similarly positioned our 'dread' of non-being as root cause, recognizing how, standing before a precipice, we might experience a fear of falling, but simultaneously, an awareness of our intentional capacity to jump to our doom. Acknowledging our absolute sovereignty in choosing life or death, he labelled the acute anxiety associated therewith as the "dizziness of freedom" (p.75). Heidegger (2010) [1927] held that the demise of others could not be anticipated with authentic intensity, and thus, it is the reality of our own 'Sein-zum-Tode', our 'being-towards-death', by which we are unsettled. Recognition of the client's freedom to act reminds us of our own, and thence, of our finitude.

Of course, client suicidality not only confronts us with our freedom, but also with our limitations. In the context of a psychotherapeutic career, we necessarily assume some level of responsibility for ameliorating client distress and avoiding outcomes of suicide. Where such an eventuality has not yet been realized, Freud's (2001) [1926] concept of 'signal anxiety' subsequently becomes relevant, implicating as it does an anticipatory experience, an anxiety occasioned not by actual loss of the object of affection, but rather, by its imagined future loss. After all, the client's survival is not "a guaranteed thing" (Penelope; 4, 96, 2760-61). "There's always doubt" (Iris; 5, 52, 1495). Freud considered such anxiety to manifest in response to the infant's helplessness, its difficulty in exerting control over its environment. As such, the anxiety functions as a warning, signalling a potential threat. Subject to maternal absence, the child experiences a 'catastrophic reaction' on account of apprehension about its continued security (Goldstein, 1995 [1939]). Like the child reaching for its mother, when encountering the client during sessions, the clinician can seek to exert influence with a view to placating their fears of loss, grappling with the client's subjectivity to this end. An objective other can be engaged with. Between sessions, however, the clinician is returned to the status of the infant - helpless, without anything to grasp hold of in their client's absence, and hence, beset by a shapeless anxiety. As Jocasta opines, "the best that I can do is make an appointment for next week, and hope that they come" (3, 10, 264-68). In the meantime, she must endure "the not knowing" (3,

12, 320). Learning to live with uncertainty, to tolerate the limits of clinical influence over client self-determination, echoes Sanders et al.'s (2005) findings post-suicide vis-à-vis clinician's growing acceptance that therapeutic efforts don't always bear fruit, and similarly, Christianson and Everall's (2009) recognition of being at the whim of uncontrollable externalities.

Attachment to the client's survival is problematic, as the clinician only has finite control in relation thereto, yet has become invested in a specific outcome, resulting in unavoidable feelings of guilt vis-à-vis whether they have done enough to avert this eventuality. Having attained Klein's (1997) [1946] depressive position, wherein a desire for reparation replaces earlier aggressive phantasy, informed by fears of the imagined damage thereby inflicted, such a flood of self-contempt should not be unexpected, as revealed in Gaia's questioning the value of her therapeutic endeavours ("are we helping?"; 6, 69, 1975-76), Athena's sense of failure ("why isn't it enough to keep you alive?"; 2, 70, 2002-03), and Hera's perceived inadequacy in not knowing "what to do or say" (7, 106, 3033). The clinician's experience of incompetence when struggling to make therapeutic progress with suicidal clients has previously been recognized as depleting self-confidence (Richards, 2000), prompting efforts to secure supervisory reassurance (Reeves & Mintz, 2001), and this study reinforces the sense of vulnerability, exposure, and self-doubt associated therewith. For Heidegger (2010) [1927], of course, guilt ('schuldig') was a fundamental component of 'Dasein', which is, after all, a 'with-world' ('Mitwelt'), inviting our functioning as a 'Being-with' ('Mitsein'). Feelings of anxiety suggest that we have become "caught up in a structure of care about the world; that is, it is not a matter of indifference for us" (Moran, 2000, p.241). Thus, the imagined death of a client, apart from activating awareness of our own mortality, also induces anxiety on account of our egoistic investments in the world (i.e., our attachment to our interventions as curative), threatening as it does to undermine our moral self-affirmation, and thence, the chosen meanings of our existence as realised in the sphere of work.

The challenge posed by work with suicidality is complicated by the interpersonal vulnerabilities of the clients themselves. Athena's account of being invaded by client despair and hopelessness, and Penelope's feelings of overwhelming helplessness and isolation,

provide clues that suggest projective identification with emotional material experienced as intolerable by the client's psyche, split-off and projected into the clinician (Klein, 1997 [1946]). The difficulty of avoiding emotional 'infection' noted by Athena reinforces the existing literature, wherein Modestin (1987) has previously highlighted the capacity of clients with a psychotic or borderline level of personality organization to get 'under the skin', rendering clinicians vulnerable to intense counter-transferential reactions. Athena's reference to the threat posed by a more "loveable" suicidal client is interesting here. As previously observed, 'love' speaks to a level of attachment wherein boundaries between self and other are felt to break down, perhaps allowing psychological content that is not one's own to enter inside. Athena subsequently develops such an all-encompassing level of identification with her suicidal client that "everything in me doesn't want him to die" (2, 19, 533), the absolute nature of her investment making it difficult to differentiate self from other. This is suggestive of the symbiotic relating often sought by suicidal clients (Birtchnell, 1983), and can be further illuminated by Fromm's (1957, p.16) differentiation of "symbiotic union" from more "mature love". The latter is a "union under the condition of preserving one's integrity, one's individuality… the paradox occurs that two beings become one, and yet remain two", whereas the former involves a softening of ego boundaries in the context of merger and fusion, compromising the wholeness and freedom of both parties.

Overidentification was not the only difficulty faced by clinicians, however. Jocasta's 'push-pull' client, for example, aligned with the findings of Richards' (2000) study, wherein suicidal clients were experienced as attacking the therapy, attempting to provoke a rejection, unconsciously 'nudging' the clinician to behave in accordance with their interpersonal expectations (Joseph, 1988). Athena's intrusive client, who e-mailed over the Christmas holidays, fits the pattern described by Birtchnell (1983), whereby suicidal clients were found to subtly manipulate their therapist into displays of solicitude, eliciting greater investment through demands for protection and rescuing. Penelope's client, who "wasn't talking to anyone" (4, 111, 3197-98), and Athena's client, struggling even "to feed themselves" (2, 84, 2412-13), both exhibited a regressive dependency liable to disrupt the therapeutic alliance

(Modestin, 1987). Subject to such pressures, Hera's fluctuation between viewing certain suicidal clients as "much, much too much" (7, 105, 3020), and considering that they need "more than me, maybe" (7, 117, 3356), subsequently carries the flavour of an overwhelmed mother tending her needy infant, unsure whether difficulties reside within their child ('too much') or themself ('not enough'). This echoes the finding of Hendin et al. (2000) regarding therapist attributions of responsibility post-suicide, where some felt 'betrayed' by their client's decision, externalizing the blame, whereas others experienced guilt at having failed to prevent this occurrence. Klein's (1997) [1946] notion of where we locate the 'bad' object when functioning from a paranoid-schizoid position is possibly implicated here.

4.1.2. "Goldilocks and the Three Bears"

If our first superordinate theme was largely framed by the clinician's struggle with the existential polarity of life and death, and the emotional impact engendered by their clients' flirtation with the latter option, our second theme captures clinician sense-making vis-à-vis their responses in managing the risks thereby communicated, and hence, touches more centrally upon existential givens of freedom and meaninglessness (Yalom, 1980), as expressed by the clinician's responsibility-taking (and avoidance) in relation to the vulnerable other, and their assessment of the value of organisational efforts to protect client well-being. As such, "Goldilocks and the Three Bears" provides a useful scaffold, highlighting the self-evaluative aspect in the clinician's weighing up whether interventions are 'fit for purpose' (i.e., is the porridge 'too hot' or 'too cold'?). In this context, merit was often found in erring on the side of caution, thereby avoiding destructive outcomes for client, clinician, and organisation alike (2.2, *"Don't want to stand on any landmines"*). Suicidal clients were subsequently flagged up, both to colleagues (2.3, *"Keeping them in the wider organisational mind"*) and external professionals (2.4, *"Does everyone know?"*), in the interests of minimizing risk. Nevertheless, organisational investment in risk management was sometimes deemed insufficient, failing to provide enough mitigation against suicide (2.1, *"This is not gonna happen in five or six sessions"*), or alternatively, considered to be overbearing, imposing something unwanted on

the client (2.5, "*Being pulled off course"*). It was also questioned whether risk management was merely enacted for the sake of organisational appearances (2.6, *"Going through the motions"*), and hence, whether it genuinely served the client's best interests.

In the wake of completed client suicides, the literature has found treating clinicians to become increasingly vigilant, and more conservative in their practice (Chemtob et al., 1988). The current study suggests that this defensive attitude does not necessitate an actual loss, however, as many clinicians who have merely encountered suicidal ideation and intent are similarly wary about possible "landmines" (1, 45, 1378) in their path, primed by an anticipatory 'signal anxiety' to the threat of client self-destruction. Notifying others of the danger (e.g., line managers; colleagues; the client's GP) appears to be reassuring. Whether this serves a useful purpose as regards reducing suicide risk is unclear, though some clinicians rationalize this to be the case, and there are likely some advantages to communicating a wider sense of containment and care. What is beyond doubt, however, is that a feeling of "joined-up-ness" (2, 24, 658) with others serves to modulate clinician anxiety. It is possible, as with the new procedures typically introduced following successful client suicide, that belief in the value of such practices reflects magical thinking (Gitlin, 1999), and that the clinician's conviction that they are hereby guarded against suicide risk is more important than the truth of the matter. As Yalom (1980, p.41) observes, the basic human group was "formed out of fear of death: the first humans huddled together out of fear of separateness, and a fear of what lurked in the dark". Thus, in having alerted others to the client's vulnerability, it is likely that clinicians feel less isolated in face of the insurmountable threat posed by their client's free will.

This retreat into the group not only modulates death anxieties, but also dissipates overwhelming feelings of Heideggerian responsibility ('schuldig') in the context of our 'Being-with' ('Mitsein') suicidal clients for whom our interventions might (or might not) prove ameliorative. Penelope and Astraea both reference the idea of 'covering your back', and the need to do so is reinforced by the fact that the individual clinician is not only guarding themselves against criticism, but also fulfilling their "duty to the organisation" (6, 3, 76-77), seeking to prevent their institution being exposed to judgement. In this context, referring clients

to their GP is quite clearly “an evasion of something” (6, 24, 672), sidestepping more absolute designations of responsibility, and steering the clinician and their institution clear of blame. Reeves (2010) has previously highlighted the appeal of ‘passing the buck’ to another professional. The nuance provided by this study is perhaps in highlighting the variable emotional responsiveness of clinicians to the opportunity hereby provided to escape from their depressive anxiety and existential guilt. Whereas Astraea, embodying a more pragmatic instrumentalism, recognizes the benefit to herself and the organisation, as “it’s the GP that’s gonna be more criticized” (8, 48, 1360-61), Gaia, exemplifying greater idealism, appears more unsettled by an experience of avoiding responsibility, whereby “everyone’s part gets diluted” (6, 24, 677). Thus, similar experiences (i.e., noema) take on different flavours (i.e., noesis) depending upon a clinician’s orientation vis-à-vis responsibility-taking.

Risk management, and its procedural requirements, potentially create a tension. The establishment of official suicide protocols attempts to formalize clinical responsibilities that might serve the interests of both suicidal clients and the therapist’s organisation. Thus, it is not entirely clear who is benefitting therefrom, and what is more, the clinician is hereby required to conform with group norms that might not always be aligned with their own preferences. Reeves (2010, p.44) has previously discussed the tension between a “suicide assessment” school of thought, more contiguous with the “prediction-prevention” interests of the organisation, and a “suicide exploration” school of thought, more concerned with a collaborative focus on the client's meaning-making around life and death. What this study clarifies is that the clinician may judge organisational requirements in relation to suicidality either as doing too little for needy clients (i.e., neglectful parenting) or as imposing too much in compromising client freedoms (i.e., intrusive parenting). Clearly, getting the balance right is tricky, and there are understandable fears, both about displaying too little attention to client welfare, and about respecting their autonomy insufficiently. The latter risk, as highlighted by Gaia’s worries about shutting down the dialogue, “being pulled off course” (6, 22, 620), speaks to concerns voiced by Reeves (2010, p.135) that we begin "doing to" at the expense of "doing

with". It also chimes with the observation of Jobes and Ballard (2011) that enacting our duty of care risks introducing issues of power and control into the clinical dyad.

Avoiding too heavy-handed an approach may be particularly pertinent with suicidal clients, since a survey of clinicians conducted by Richards (1999) found that a significant number of said clients had experienced persecutory relationships during childhood, and as a consequence, continued to be tyrannized by attacking internal objects. This is borne out by Gaia's counter-transferential response when she requested permission to disclose suicidality to a client's GP, as the reaction hereby provoked caused her to feel she was behaving punitively, operating like an "old-fashioned, kind of mental institution person, out to catch him in a net" (6, 93, 2658-59). Where a client has been subject to 'I-It', subject-object relating whilst growing-up more often than an affirming 'I-Thou' mode of interaction (Buber, 1958), there is a risk that we will be experienced as "oppressive" and "controlling" (6, 94-95, 2711-15) owing to their interpretative vulnerabilities in projecting previous models of authoritarian parenting. Clearly, should the interpersonal discourse break down owing to an over-vigorous pursuit of risk management, this might pose a risk to client safety if they become less willing to disclose suicidality in future for fear of the consequences of doing so.

Blindly complying with organisational risk management prerogatives not only threatens the client's autonomy, but may also be experienced, at least by some clinicians, as rendering their endeavours meaningless. May (2015 [1950], p.180) identifies "automaton conformity" as a mechanism of escape from our situation of isolation and anxiety. It serves as a means by which "to get rid of the individual self, to lose one's self; in other words, to get rid of the burden of freedom" (Fromm, 2011 [1941], p.152). As previously noted, it is a welcome relief for some clinicians to lessen their burden of responsibility by notifying the client's GP as to their suicidality. For others, like Gaia, however, this is nothing but a superficial illusion of help-giving, and in following through thereupon, she feels herself reduced to a "faceless machine", simply "going through the motions" (6, 92, 2644-46). This is the essence of Sartre's (2003 [1943], p.68) "la mauvaise foi", his concept of living in "bad faith", whereby we adopt an external persona at odds with our true selfhood and fail to live in an 'authentic' manner that

both acknowledges, and properly grasps hold of, our freedom. Sartre uses the example of the café waiter who is 'play-acting' his role, who "deliberately imitates the mechanical movements he associates with perfect serving" (Moran, 2000, p.388), his mimicry betraying his actions as a learned performance, and Gaia's notion of "handing over the situation to a protocol" (6, 12, 327) echoes the abdication of responsibility-taking implicit herein. This might be enough to protect the organisation's reputation in the event of a suicide, but there is a sense that these actions are tokenistic, that what is required to mitigate suicide risk most effectively is a more authentic investment of care.

4.1.3. "It's good to ask for help"

Our third superordinate theme focuses on the existential given of human isolation (Yalom, 1980), and how it can be addressed by retreating into the collective. Clinicians are often left feeling unsupported in the process of managing suicide risk owing to the preference of others to avoid association with, and responsibility for, such issues (3.2, *"Everybody's head goes underneath the water"*). It is subsequently experienced as reinforcing to be able to turn to various parenting structures for containment and reassurance, whether that be managers (3.3, "*That steadies me up"*) or supervisors (3.4, *"Being able to offload"*). Sharing responsibility with others provides a relief from the burden of existential guilt and anxiety (3.5, *"It's like a sort of basket, holding you"*), such that clinicians can feel frustrated when restricted from doing so by confidentiality requirements (3.1, *"Handcuffed"*). Where the sense of security implicit in joining defensively with something bigger than the individual self is not accessible, an alternative coping mechanism is to prioritize self-care, limiting excess identification with suicidal clients via self-protective boundary-setting (3.6, *"Being affected, but not infected"*).

"To the extent to which the child emerges from the world, it becomes aware of being alone, of being an entity separate from all others" (Fromm, 2011 [1941], p.29). Individuation, giving rise to consciousness, proves to be a mixed blessing, contributing an awareness of death, and the ultimate groundlessness of our existence. We confront an external world that is, as Fromm recognizes, "overwhelmingly strong and powerful, and often threatening and

dangerous". It is the attendant sense of exposure and vulnerability that is captured by Iris when she speaks about being "put out to dry" (5, 78, 2233) in the wake of her former client's suicide. "Everybody's head goes underneath the water" (5, 81, 2325-26), and they're all "swimming away merrily" (5, 82, 2335). Kolodny et al. (1979) have previously highlighted the sense of profound isolation felt by clinicians after the death of a client, but the present study suggests an additional layer as regards a sense of active abandonment, which again brings to mind the sense-making of the helpless infant in their mother's absences. As Yalom (1980) notes, there is loneliness and anxiety in having to function as one's own parent. Nobody can subsequently affirm our 'goodness', that we are on the right track, leaving Iris uncertain about whether she is "ethically correct" (5, 79, 2251).

Fromm (1957, p.7) considered isolation to be the primary source of our anxiety: "being separate means being cut off, without any capacity to use my human powers. Hence, to be separate means to be helpless, unable to grasp the world - things and people - actively". The baby responds to the experience of separateness by reaching out for contact, by clinging behaviour that attempts to re-establish its sense of security. Thus, as Yalom (1980, p.363) points out, our "major buttress against the terror of existential isolation", from the very beginning, resides in our attaching to, and relating with, the world. Being part of a larger whole allows us to feel more insulated from dangers. It is just such insulation that clinicians crave in turning to managers and supervisors for support. The managers who are most appreciated are those who best protect them from threatening externalities, ensuring that they are not overloaded with clients. Supervisors are similarly valued for facilitating effective boundary-setting from a psycho-emotional perspective. Operating in the same manner as an emotionally responsive mother, providing the interactive space necessary to digest difficult affective experiences (Bion, 1970), they enable the clinician to re-establish a healthy distance from client material when they have become "a bit too immersed" (2, 50, 1431). Thus, the organisation is sometimes experienced "like a basket, holding you" (2, 30, 849), offering necessary containment of the clinician's primitive anxieties.

Previous studies have confirmed that clinicians seek increased supervisory affirmation in the wake of successful client suicides (Chemtob et al., 1988), but also when clients simply disclose details of their suicidal thoughts and intent (Reeves & Mintz, 2001). The need for a confirmatory thumbs-up from a parent figure is reinforced by this study, embodied in Gaia's freedom to "move on with the rest of the work" (6, 32, 904) once her risk assessment has been validated by her supervisor, and Penelope's sense of reassurance when her line manager confirms that "I've done all the things that I needed to" (4, 4, 102-03). Group belonging appears to be an effective buffer against distress, as highlighted by Ruskin et al. (2004), who identified emotional disturbance following client suicide as correlating inversely with social integration within established professional networks. This study further confirms the value of embeddedness in relationships that provide interpersonal succour in face of client suicidality, enabling a sharing of the load that guards against emotional depletion. Athena's recognition that "it's good to ask for help" (2, 28, 796-97) suggests a modulation of therapeutic omnipotence (Kolodny et al., 1979), but without requiring an actual suicide to achieve this maturation in the direction of interdependence.

The literature has previously emphasized the discomfort of clinicians when "sacred rules" (Litman, 1994, p.273) relating to confidentiality are broken with a view to preventing suicide. Interestingly, though, this study highlighted an opposite source of disquiet, with Penelope struggling with restrictions on disclosure, finding it infuriating when "handcuffed" (4, 115, 3321) by confidentiality requirements in instances where she would have preferred to be able to communicate with others about risk. Reeves (2010) emphasizes that the decision to break confidentiality can be stressful, as it not only contradicts the notion of client empowerment, but also threatens the trust that constitutes an essential cornerstone of therapeutic relating. Clearly, however, the prospect of losing a client to suicide can be equally unnerving, and hence, clinicians are just as liable to be angst-ridden when required to maintain confidentiality (in respecting the client's 'freedom from') as when required to break it (in manifesting their 'responsibility to').

Unfortunately, disclosing client suicidality to others is not always possible. In such circumstances, this study suggests the importance of managing contact boundaries with clients with a view to avoiding excessive emotional 'infection'. Intense transactions with chronically needy clients have been observed to result in emotional exhaustion and burnout over time (McCann & Pearlman, 1990; Fox & Cooper, 1998). Where we invest too heavily in a 'with-world' ('Mitwelt') characterised by vulnerability, despair, and hopelessness, losing our sense of psychic differentiation, there is a danger of being damaged by our excessive attachment thereunto. Self-care is subsequently highlighted by this study as a crucial means of retaining distance and separation. Thus, Athena speaks about preserving her work-life balance, and Iris recognizes the value of grounding herself in the 'mindlessness' of day-to-day activities, thereby disconnecting from a focus on death. In the wake of suicides, Christianson and Everall (2009, p.162) found that Canadian school counsellors credited self-care with facilitating their "staying in the game", and similarly, this study found the capacity to "put a boundary around it" (2, 12, 330-31), to detach from therapeutic work with suicidal clients, sustained clinician energies to continue this challenging endeavour.

4.1.4. "Noisy, but unhelpful"

The final superordinate theme revisits existential givens of freedom and meaninglessness (Yalom, 1980), but whereas our second theme found clinicians largely accepting of risk management protocols, if occasionally questioning the sufficiency of these interventions, and their value in facilitating client well-being, the current theme highlights a more truculent disposition in the clinician as regards organisational requirements, with a flavour of being unfairly 'done to' by management (Benjamin, 2018). There is a sense of not feeling terribly well looked after by their institution, imposed upon by intrusive expectations and anxieties (4.1, *"The third chair in the room"*), by 'noisy' reactions experienced as distracting unhelpfully from the immediacy of client needs (4.2, *"Sound and fury, signifying nothing"*). Overloaded by clients with a view to managing suicide risk, some clinicians experience themselves as forced into making difficult trade-offs between prioritizing client

safety and preserving their own sanity (4.5, *"It's a no-win situation"*), left angered by the demands of an unsympathetic workplace (4.6, *"Rage against helplessness"*). Moreover, there is a feeling of vulnerability, a fear of being subject to blame in the event of client suicides (4.3, *"Thrown under the wheels of the car"*), that reactive organisational politics might even see them lose their jobs (4.4. *"It can be a bit knee-jerky"*).

Kinder (2005, p.22) observes that counselling delivered within an institutional context "is different to traditional counselling or therapy in the sense that whenever a client is seen, there is one other 'person' present - the organisation". Phoebe's allusion to a "third chair in the room" (1, 5, 1345) captures the reality of a competing voice, internalised from the institution, entering into her sessions with an agenda of encouraging systemic throughput via nagging reminders vis-à-vis the neediness and potential vulnerability of waiting-list clients. Reeves and Mintz (2001) have previously identified how clinicians, seeking to comply with risk management protocols, sometimes feel forced to operate in ways perceived to conflict with therapeutic best practice. Phoebe, Iris, and Astraea certainly appear squeezed by the process of managing risk, and fulfilling their duty of care, though perhaps more by unreasonable organisational expectations around use of their time than by the requirements of a medicalized, tick-box encounter. The problem appears more that they are expected to perform miracles, both in terms of the number of clients seen for assessment, and the pace at which these highly vulnerable individuals are subsequently progressed through the system and discharged. It is not so much the protocols of risk management that are at issue, though "suicide exploration" (as opposed to "assessment") inevitably takes more time (Reeves, 2010), but rather, whether effective risk management is even possible within contextual limitations. These clinicians are overstretched, torn between competing priorities in managing risk both inside and outside the room.

This stressful experience inevitably results in tensions with the managerial staff communicating these demands, with contention over whose needs to prioritize (i.e., clients currently in therapy, or those on the waiting-list). "It's a no-win situation" (8, 129, 3689). Do clinicians flex their time boundaries, and work overcapacity, with a view to accommodating

vulnerable clients, or operate more self-protectively in preserving their energy levels? As Yalom (1980) points out, no inherent meaning inheres in the universe. It offers no blueprint of values to inform our moral judgements. Thus, Phoebe is more attached to therapeutic principles which suggest that suicidal clients need longer-term treatment to ameliorate their distress, her manager to pragmatic concerns about ensuring that unknown risks on the waiting-list are assessed as quickly as possible. Neither argument is morally redundant. Subsequently, we must be cautious of Phoebe's dismissal of organisational 'noise' as inauthentic, as "sound and fury, signifying nothing" (Shakespeare, 2007, [1623], p.1911). Certainly, there is liable to be truth in the fact that the "rattling around" (1, 63, 1943) of institutional anxieties, and the demands associated therewith, are a distraction from an immediate focus on suicide prevention. However, it does not follow that said anxieties are "concocted" (1, 24, 727). They may simply speak to a different designation of what is important. For Phoebe, of course, focusing on what can be controlled, the 'authentic' relationship with the client in the room, whilst diminishing externalities as unimportant, makes sense as a coping strategy when overwhelmed by competing demands.

Much organisational anxiety appears to stem from fears of being blamed in the wake of client suicide, which could potentially give rise to narcissistic splitting and projection with a view to evading culpability (Klein, 1997 [1946]). This might account for Phoebe's perception of blame "flying around" (1, 10, 306), her persecutory anxiety that "someone will point the finger" (1, 12, 344-45), which has previously been captured by Reeves' (2010) notion of a game of organisational 'pass the parcel'. Astraea's experience of her institution's media office as actively hostile, as coming out "shooting from the hip" (8, 75, 2158-59), further suggests being on the receiving end of paranoid-schizoid responses within the institution, whereby 'badness' is externalized in preserving a sense of internal 'goodness'. Previous studies in the wake of actual suicide have highlighted clinician fears of being blamed by their employing institution, which often proved justified, since organisational administrators, desperate to deflect accountability elsewhere, were quick to label therapists 'guilty as charged' (Hendin et al, 2004). Such worries may serve to augment the anxieties about suicidality discussed earlier.

Sullivan (2010) [1940] suggests that self-realisation of the ego is fulfilled in interpersonal relationships. From our earliest days, we seek maternal affirmation of our 'goodness', undertaking activities on a conditional basis in pursuit of the security implicit in parental validation. Therefore, we are apprehensive of disapproval, threatened by organisational disapprobation. As Sartre (2003) [1943] recognizes, our consciousness of self emerges out of our being-for-others, our 'être-pour-autrui'. Hence, there is always a dialectical relationship between the individual and their community, which provides us with "a third-person perspective on ourselves" (Moran, 2000, p.389). Subsequently, our anxieties sometimes function as a useful superego warning of potential judgement, highlighting threats to our esteem within the group that might undermine ongoing social belonging.

Reeves and Mintz (2001) have previously highlighted how clinician anxieties are heightened by a sense of external observation, and their awareness of potential implications should they 'fail' in their perceived responsibility to keep clients alive. Feelings of vulnerability and rage are hardly surprising given the early developmental material triggered by the danger hereby posed to the clinician's reputation and status. Phoebe's fear of being "thrown under the wheels of the car" (1, 51, 1574), Gaia's concern that "they will throw you to the wolves" (6, 28, 792), Astraea's insecurity that "we're all gonna lose our jobs" (8, 69, 1961), all speak to the anticipation of destructive consequences, of being unfairly aggressed against, possibly even annihilated, should a client take their life. The clinician's sense of exposure to potential blame appears to be accentuated by hysterical media headlines, accusing mental health systems of "having failed individuals" (6, 26, 726). Hallam (2002) draws our attention to media-generated public anxiety in the wake of suicides, which are deemed to reflect negatively on mental health services. As Reeves (2010) has previously argued, a factor-based suicidology runs the risk of encouraging a belief that all suicides can be mitigated, fostering a pressurized culture of prevention and reduction. In such a context, managers may sometimes be experienced as overly demanding, overburdening their counselling staff in their desperation to avoid a black mark against the institution's name. The accounts provided by Phoebe and Iris subsequently carry a flavour of parental intrusiveness, and invasion of boundaries, such

that pushing back against managers experienced as hated, persecutory objects is perhaps understandable (Klein, 1997 [1946]). Sometimes, as Phoebe recognizes, it is only possible to vent, as institutional power dynamics provide dissuasion from challenging her boss, leaving her to "rage against helplessness" (1, 19, 565-66), as does the disempowered infant. However, self-protective anger can only be repressed for so long, and subsequently, may break through dramatically when a tipping point is reached, as occurred for Iris when she temporarily "lost the plot" (5, 21, 586), refusing to accept unreasonable managerial demands. As a self-determining adult, of course, both resistance and acquiescence are viable options.

4.2. Clinical implications

Given the stress and anxiety occasioned in confronting client suicidality, and the sense of helplessness conditioned by a lack of control in relation thereto, a clear implication of this study is the need for clinicians to embrace their "negative capability", to learn to tolerate uncertainty "without any irritable reaching after fact and reason" (Keats, 1988 [1817], p.539), to accept the limits imposed by client self-determination. Of course, this is not to promote therapeutic nihilism, or discourage efforts to support the choice of life over death. It is simply to let go of excessive attachment to this outcome in moments when it is not open to clinical influence, modulating our primordial "being-guilty" ('schuldig'), and acknowledging our finite control over reality, thereby dispensing with an overly omnipotent self-ideal. Ceasing to be "caught up in a structure of care about the world" (Moran, 2000, p.241) should not be our aim, however, since the notion of an uninvested clinician goes against everything we know about the healing properties of authentic therapeutic relating. Rather than replacing 'attachment' with 'detachment', we are aiming for a synthesis of the two, realized via a third position of 'non-attachment', which is characterized by "commitment to the path, without attachment to the outcome" (Zimberoff & Hartman, 2002). As such, we should display "mature love" for our clients, whilst guarding against "symbiotic union" (Fromm, 1957, p.16), and any softening of ego boundaries that might facilitate our being invaded by their hopelessness and despair. Of course, such 'infection' sometimes proves unavoidable, and hence, supervision constitutes a

crucial medium to facilitate disentanglement from any emotional detritus of therapy that has yet to be filtered from our consciousness.

When working with suicidal clients, it is important to avoid being pushed into a paranoid-schizoid position oneself, whereby one responds with retaliatory anger, blaming the client for being 'too much', or grow overly self-doubting, considering that one's efforts are 'not enough'. Such sentiments, reminiscent of Kleinian splitting, were sometimes manifested by clinicians towards their own institution in relation to risk management, which was perceived as 'not enough' (i.e., neglectful parenting) or 'too much' (i.e., intrusive parenting), and hence, we must be wary of possible knock-on effects in aligning with the suicidal client's psyche. Given the likelihood that short-term therapy will often not prove 'enough' for suicidal clients in light of their insecure attachment style, it is essential that there is absolute clarity regarding the therapeutic offer (i.e., length of contract; possibility of extension), and that therapist communications accord with organisational practice in this regard so as not to provide mixed messages, enabling clear boundaries to be held. There should be referral options in place for clients who cannot be contained in short-term therapy, with some flexibility in 'holding' them whilst they wait for access to alternative support in order to fulfil the organisation's duty of care, guarding against feelings of abandonment that might provoke suicidal acting out of aggressive feelings thereby triggered. Equally, given the possibility that suicidal clients might experience risk management as intrusive through the lens of their oft-persecutory internal objects, we must be cautious of being overly heavy-handed in our approach, 'doing to' at the expense of 'doing with'. Adopting an affirming, 'I-Thou' stance, and attempting to reach consensual agreement as far as possible, is likely to be helpful. Of course, navigating the tensions between client welfare and autonomy is not always straightforward, and although dialogic, adult-adult interactions are preferable, it will sometimes become necessary to step into the role of interventionist parent.

In terms of managing risk, this study suggests that clinicians find it reassuring to flag suicidality to organisational colleagues and external professionals in the interests of widening the net of containment. Concerns were raised that conforming to institutional protocols might

constitute an “empty gesture” (6, 5, 133), and certainly, where client welfare is concerned, the value of GP referral is questionable. However, it should be remembered that clinicians possess dual responsibilities, and ‘passing the buck’ is certainly not ‘empty’ from the point-of-view of their organisation, which they are duty-bound to protect from adverse judgement. It is profoundly sensible, moreover, for a clinician to ‘cover their back’ in steering clear of future blame should a client take their life. Thus, this activity is not meaningless; it is just that its meaning largely accents an instrumental self-interest. To the extent that such referrals dissipate the clinician’s anxiety, this may also serve a useful purpose in modulating an immobilising sense of threat. Furthermore, this does not have to mean relating with the client in ‘bad faith’. Certainly, if we believed that GP referral represented ‘job done’, we would most definitely be abdicating our responsibility. However, there is no reason that we cannot remain authentically invested in our efforts to keep suicidal clients alive, whilst simultaneously enacting aspects of risk management that are perhaps more for the sake of organisational appearances. This can be a case of both/and, rather than either/or. Phoebe’s concept of ‘hygiene’ is helpful here, as it suggests the unthinking basics to which we conform in guarding the organisation against contamination, yet should not preclude our investing more to purge the germs of suicidality from the client themselves.

Given the sense of vulnerability and isolation that can be experienced when working with suicidal clients, it is important that clinicians are provided with sufficient organisational support to navigate these challenges. This is not a question of blindly affirming the clinician’s practice, but rather, of joining them in the struggle, offering reassurance and containment. Sharing the emotional load with others can guard the clinician against emotional depletion, and hence, integration within an extended professional network should be embraced as a mature progression in the direction of interdependence. Clinicians must also be mindful of self-care, limiting excessive identification with suicidal clients through self-protective boundary-setting, and hereby remaining “affected, but not infected” (2, 18, 504). Of course, the organisation also has its part to play. Managers must protect clinicians against overload, avoiding shoehorning new assessments into already overcrowded diaries with a view to

mitigating suicide risk. Ethical limits regarding client contact hours (i.e., no more than 4-5 per day as per BACP guidelines) need to be respected, and where there are unreasonable expectations of clearing waiting-lists sooner than this allows, the need for investment in hiring additional counsellors should be communicated to the organisational hierarchy.

Where too much is demanded, clinicians may need to hold boundaries with their institutions, not just their clients. This is not to say that the voice speaking from the "third chair in the room" (1, 5, 1345) should be disregarded, but simply that other-directed clinicians must also factor in their own needs, such that both conformity with, and resistance to, its urgings may be appropriate in any given moment. There will always be pressure from employing institutions to make good on their duty of care. However, it is not acceptable that clinicians be placed in a "no-win situation" (8, 129, 3689), forced to trade client safety against their own emotional well-being. Organisations need to accept the reality of contextual limitations, rather than exploiting their clinical resources, preserving therapist energy levels in the interests of avoiding burnout. It is important, however, that clinicians also remain open to constructive dialogue with management around how best to organize their time in addressing the quandary of competing priorities (i.e., supporting clients currently on the books; assessing risk on the waiting-list). The healthiest climate to facilitate such a conversation is a non-blaming one. In such a context, everyone strives to avoid suicides, whilst accepting that these are not always predictable and preventable, and subsequently, in the event of an actual death, there is no need to palm off responsibility on others in a desperate attempt to escape the threat of judgement, as none is forthcoming unless found to be justified by a case review.

4.3. Critical appraisal of the research

There had been a scarcity of research exploring clinician responses when client suicidal ideation and intent prompt attention to risk management protocols, and hence, this research sought to fill that gap. Interpretative phenomenological analysis (IPA) was deemed an appropriate research method to provide sufficiently rich and complex data. In reflecting upon the limitations of this approach, we should be clear that this is not a quantitative study,

and hence, had no ambition of delivering generalisable results, confirming or refuting some a priori theory, or identifying universally applicable, objective 'truths'. The sample was small and 'purposive', rather than random, as only participants who had worked directly with suicidality were recruited, hereby ensuring comparable experiences for analysis with a view to illuminating the subjective experience of clinicians struggling to avoid Freud's 'bad' outcome and pressured by the threat of negative organisational evaluation of their efforts. The epistemological standpoint adopted, which adheres to the principle that 'diverse perspectives can provide a fuller understanding of social psychological phenomena' (Madill et al., 2000, p.17), means that the research should not be evaluated on the basis of positivist conceptions of reliability and validity. Rather, as Cho and Trent (2006, p.320) contend, it is about "determining the degree to which researchers' claims about knowledge correspond to the reality (or research participants' constructions of reality) being studied". Guba and Lincoln (1992) proffer 'dependable' and 'credible' as more suitable terms when conducting qualitative research. 'Dependability' designates that similar, or not contradictory, conclusions could be drawn by another researcher following the decision-trail of the study in question, whereas 'credibility' suggests that the data is described faithfully by the researcher, such that the reader will recognize experiences as emerging plausibly from the data. It is hoped that the transparency of process presented herein has rendered this study 'dependable', and that the use of illustrative quotations from participant transcripts throughout the analysis aids 'credibility' on the basis that interpretations are thoroughly grounded in the data. Thus, whilst "empirical generalisability" may not be attainable, "theoretical transferability" is within our reach on account of having provided a "rich, transparent, and contextualised analysis" of participant accounts, which can, in turn, "enable readers to evaluate its transferability to persons in contexts which are more, or less, similar" (Smith et al., 2009, p.51).

Clearly, in volunteer-based studies, the self-selection of participants poses a possible headache as regards representativeness. We cannot easily ascertain the typicality of our interview participants, how accurately they embody the wider population of therapists struggling with client suicidality, and the risk management protocols implicated thereby. For

example, the requirements of involvement might have attracted a particularly motivated group of clinicians. Non-participating therapists may have been more troubled by their experiences, or alternatively, above average levels of disturbance may have inclined participants to make their voices heard. Of course, there was no intention that this study would capture a statistically representative sample of the therapeutic community. Selection bias, and reliance upon self-report data, must be tolerated as restrictions associated with qualitative research in general, inevitably impacting upon the 'transferability' of findings. Perhaps of greater disappointment was the fact that all the participants were Caucasian females. It had been hoped to incorporate the perspectives of male counsellors, and those from ethnic minority backgrounds, which had similarly been missing from previous studies, thereby yielding a more complete picture of clinical responsiveness. Unfortunately, the predominant demographic profile of clinicians within an HE environment meant that failure to capture greater experiential diversity was consequent upon 'convenience sampling' that invited self-selection, allied with the researcher's ethical commitment to accept participants on a 'first come, first served' basis. The study did, however, incorporate perspectives from clinicians integrating a variety of different therapeutic orientations within their practice (i.e., psychodynamic; humanistic/person-centred; existential; cognitive behavioural), broadening the potential range of the findings. Earlier studies had typically limited themselves to a delineated clinical community in the interests of a more homogenous sample. Reeves and Mintz (2001) and Moerman (2012) solely interviewed clinicians who were person-centred in orientation, which runs the risk of skewing their data. For example, concerns about breaching confidentiality were highlighted in these studies, yet were not generally in evidence in the current research, which might speak to specific tensions between interventionist risk management and the non-directive philosophical stance at the heart of the person-centred paradigm. Smith et al. (2009, p.49) recognize that studying a more heterogenous sample should not be problematic, so long as the variation thereby introduced "can be contained within an analysis", and in this instance, the greater breadth vis-à-vis theoretical orientation serves to fine-tune earlier findings.

Not to discount the limitations identified thus far, but it is also worth acknowledging that, as with any unique lens, our narrow demographic of Caucasian female participants does provide useful illumination in relation to this very group of clinicians. Thus, it is possible that the insights provided by this study as regards subjective constructions in relation to suicidality and risk management are particularly relevant to women (i.e., reflecting feminine understandings in relation thereto), and that they also throw light on a Western mentality as regards responsibility and blame. Gilligan (1982) highlights two different adult 'voices', recognizing that an integrated maturity encompasses both a masculine disposition towards individuation and a feminine disposition towards relatedness. Because women are typically more responsible for childcare, the interpersonal dynamics of identity formation are different for boys and girls. Whereas girls experience themselves as being alike, and hence, less differentiated from, their same-sex mother, retaining a greater sense of continuity with and ongoing attachment to the external world, boys, in defining themselves as masculine, tend to separate from their mother, undertaking a "more emphatic individuation, and a more defensive firming of experienced ego boundaries" (Chodorow, 1978, pp.166-67), no doubt building upon innate evolutionary predispositions in these divergent directions. Subsequently, Gilligan (1982) argues that men are prone to favour excess autonomy and separation as their coping strategy in dealing with loss (i.e., 'letting go'), whereas women deal with the same challenge via excess heteronomy, remaining overly fused with the other (i.e., 'clinging on'). Albeit that societal gender dynamics vis-à-vis child-rearing have shifted somewhat in recent years, particularly amongst the more affluent, as efforts have been made to establish greater equality in the workplace, and not withstanding that some men have a more highly developed anima, some women a more highly developed animus (Jung, 2014 [1936]), the argument that this study represents a gendered artifact is not without merit.

It is interesting to note that tendencies towards therapeutic over-involvement (i.e., 'clinging on' to the relationship) have been identified, yet this study failed to unearth any evidence of participants coping with their anxieties via avoidant disengagement (i.e., 'letting go' too readily), as might be more common in men. Excess attachment and responsibility-

taking in situations wherein participants lacked control constituted a source of anxiety and burden. Intent on caring for vulnerable suicidal clients, female clinicians sometimes ran the risk of burnout, of being subject to advantage-taking by institutions more invested in their own reputational interests than the well-being of their counselling practitioners, echoing the dangers of excessive self-sacrifice that Gilligan (1982) ascribes to many women. A fundamental tension evident here is that between responsibility to self and responsibility to others. Unlike men, who typically place the world in relation to themselves, the women in this study regularly placed themselves in relation to the world. Their struggle was sometimes to learn the virtue of holding boundaries in manifesting greater self-care, rather than overlooking their own needs (i.e., claiming their lunch break, rather than squeezing in yet another client). More positive aspects associated with relatedness also characterized this study, the danger of 'giving too much' matched with the benefits of security-seeking, of receiving interpersonal succour through the sharing of responsibility, through turning back towards the collective in accessing the containment and reassurance of managerial and supervisory structures, and hereby guarding against emotional depletion. Confidentiality requirements were subsequently experienced as frustrating in so much as they got in the way of relational means of containing distress. This orientation towards the group might also have contributed to heightened feelings of guilt. Less comfortable with separateness, it may be that women are more attuned to their 'être-pour-autrui', their being-for-others (Sartre, 2003, [1943]), more apprehensive of disapproval that might undermine their social belonging. Given a greater female orientation towards relational care, it is perhaps hardly surprising that our sample is so skewed in relation to gender, as such roles, both within HE Counselling Services, but also within the care sector as a whole, are regularly the preserve of women.

The "double hermeneutic" (Smith & Osborn, 2015, p.26) evidenced within this study is intriguing from a gender perspective, since it sees a man making sense of the reported experiences of female participants. Perhaps it should not be surprising, then, that the researcher points out the dangers of excess investment in the 'with-world' ('Mitwelt') of suicidal clients, and the consequent importance of managing contact boundaries with a view to

maintaining psychic differentiation, highlighting the protective value of separation when seeking to avoid emotional 'infection'? Equally, it might be speculated that his maleness underlies the observation that other-directed clinicians might need to offer resistance, to push back, in instances where their institutions demanded too much of them. Of course, the findings undergirding such suggestions have not been manufactured, and female participants within the study were clearly sufficiently integrated to embody divergent strengths, manifesting both a feminine orientation towards interdependence (i.e., "it's good to ask for help"; 2, 28, 796-97) and a more masculine disposition towards individuation and independent functioning (i.e., "being affected, but not infected"; 2, 18, 504). They voiced the importance of self-care themselves, even if their own advice sometimes went unheeded. They also manifested assertiveness when pushed too far. As far as possible, moreover, the researcher sought to remain balanced, such that, whilst recommending that ego boundaries be held sufficiently firmly to guard against "symbiotic union" (Fromm, 1957, p.16), there was no encouragement to replace 'attachment' with 'detachment', but rather, recognition of the value of synthesizing these two extremes in manifesting a "mature love" for suicidal clients. The benefits of remaining self-contained were acknowledged, but so were the merits of operating interdependently in the context of something larger than oneself.

It is not only in relation to gender that this study provides unique insights. The anxieties around blame manifest in this sample, the fears that "someone will point the finger" (1, 12, 344-45) should a client take their life, and wariness about being designated the 'bad' object in the wake of such a loss, may also elucidate a peculiarly Western phenomenon. Thomyangkoon and Leenaars (2008), in surveying Thai psychiatrists whose clients had taken their lives, reported that these clinicians were less likely to report feelings of anger, fears of reputational damage or lawsuits, or considerations of discontinuing work with suicidal clients. This suggests that responses to suicide and suicidality must be understood in cultural context. Within Thai society, Buddhist principles accenting interpersonal acceptance tend to encourage harmonious human relating, and "a concomitant avoidance of overt acts that express anger, displeasure, criticism, and the like. The 'cool heart' is the ideal; the 'hot heart' is to be avoided"

(Klausner, 2000, p.70). Such sensibilities render scapegoating less likely, inhibiting individualistic attributions of blame and responsibility. Of course, it is open to debate whether this constitutes a mature move in the direction of 'non-attachment', an acceptance of what is beyond the clinician's control, or an avoidant disengagement from responsibility-taking, and repression of difficult emotions that might give rise to interpersonal conflict. It is possible that Thai society is more likely to deal with the 'bad' implicated in Kleinian splitting via a retreat into idealisation in the interests of group cohesion, rather than via the narcissistic splitting and projection more prevalent in the West. Regardless of these technicalities, what is clear is that the experience of suicide as a 'hot potato' is somewhat culturally informed. Thus, powerful feelings of guilt ('schuldig') may only be a fundamental component of 'Dasein' in certain contexts. It is plausible that such reactions might be informed by Western individualism, and the values implicit in the UK's Christian/Protestant heritage. As such, efforts to avoid responsibility (e.g., by 'passing the buck' to the client's GP) may not be universal, and might, in fact, constitute Western cultural artifacts informed by a desire to escape designations of 'badness' in circumstances where a client genuinely did choose to end their life.

4.4. Suggestions for future research

As previously indicated, this study was unable to capture the experiences of male clinicians, or those from non-Caucasian racial groups, when working with client suicidality necessitating attention to risk management procedures. It is hoped that future research can address this shortfall, possibly requiring that investigation be extended beyond HE organisational settings given the predominantly Caucasian female demographic of clinicians currently found therein. Grad et al. (1997) previously discovered that female therapists whose clients took their lives experienced more guilt and shame, and required more consolation, than their male counterparts, who coped by suppressing their emotions to a greater extent. Jacobson et al. (2004) similarly identified gender differences in scoring on the Impact of Event (IES) subscales following client suicide, with female social workers exhibiting more intrusive thoughts, whereas their male colleagues scored higher on avoidance. It would be intriguing to

discover whether these gender differences in relating with death also translated to a differentiated experience of working with client suicidality, and institutional evaluation in relation thereto, more generally. Another avenue of investigation might be that of organisational context. Although this study chose to focus on clinicians working in HE, an environment both familiar and accessible to the researcher, other organisational settings (i.e., IAPT; NHS; GP surgeries) were referenced by participants. It could be that variations in culture in different institutional contexts play a role in how risk management is experienced. This study provided insufficient data to draw conclusions in this regard, and hence, future research might usefully augment our understanding of such influences. Given the paucity of research into the experience of clinicians required to undertake risk management in response to client suicidality, it might also be valuable for researchers simply to revisit this same topic with a view to cross-validating or challenging the conclusions reached herein, thereby fleshing out our knowledge base.

4.5. Dissemination of findings

It is hoped that an awareness of the clinical implications of this study can make a practical difference to clinicians struggling with client suicidality, and the management of risk in relation thereto, both within HE Counselling Services and wider institutional contexts. To this end, it is important to consider how this might be achieved. As a starting point, the researcher intends to submit articles for publication in 'Counselling and Psychotherapy Research' (CPR), an international, peer-reviewed journal, dedicated to linking research with practice in counselling and psychotherapy, and published by Wiley under the auspices of the British Association for Counselling and Psychotherapy (BACP). However, given the pressures of delivering psychotherapy in organisational contexts, it is recognised that, despite this journal being accessible to the therapeutic community within the UK, such a 'route to market' might only reach a limited, perhaps more academically inclined, audience of practitioners, since others may not experience themselves as having sufficient time to read around the literature on this topic. With a view to engaging more directly with the therapeutic community, it might

subsequently be worth looking out for opportunities to deliver poster presentations or facilitate discussions at professional events organised by BACP, BPS, or Universities UK, particularly with an eye on any symposia focused on risk or suicidality.

Furthermore, given that some of the clinical implications of this study potentially require a shift in institutional attitudes towards risk management, necessitating managerial buy-in, it is acknowledged that reaching clinicians alone may not be enough, since they are unlikely to possess sufficient organisational influence to affect change. Therefore, it is also worth considering higher impact and more inclusive strategies of engagement. Within the HE sector, for example, this might mean seeking to connect with a broader cross-section of university personnel via AMOSSHE, the Association of Managers of Student Services in Higher Education, which aims to promote the development and sharing of best practice within Student Services in the UK through collaboration with influential sector groups and policymakers. Delivering a workshop or presentation at the AMOSSHE National Conference might offer an opportunity to get these messages across to Student Services leaders. It is imagined that there might be similar managerial forums within NHS and EAP contexts, though these are less familiar to the researcher. If there were any possibility of fostering improved dialogue between clinicians and administrators, this might be particularly beneficial in building mutual understanding of the respective pressures faced at different systemic levels, enabling more effective solutions to be reached in better serving everyone's interests, and guarding against the 'drama triangle' dynamics (i.e., victim-persecutor-rescuer) which this study has demonstrated are sometimes liable to play out in the triangulation between suicidal client, treating clinician, and the expectations and anxieties of the wider organisation. With a view to maximizing the impact of these findings, efforts at dissemination might also be considered further afield, perhaps moving into the international HE marketplace in seeking to make an imprint at the annual convention of the American College Personnel Association (ACPA), the leading student affairs association in the US, or the annual conference and exposition of NAFSA: Association of International Educators, formerly known as the National Association

of Foreign Student Affairs, the world's largest non-profit association dedicated to international education and exchange.

4.6. Final reflexive observations

In reflecting upon the impact of this research on my identity as an aspiring Counselling Psychologist, I revisited Kasket's (2013) seminal paper to remind myself of the values inherent to our profession, and two words immediately riveted my attention: "negative capability" (p.65). I had forgotten that this was considered a distinguishing characteristic of our discipline, and hence, my conclusions vis-à-vis the value of such a capacity to tolerate uncertainty in work with suicidal clients had emerged independently. In retrospect, I believe that my own reduced anxiety in working with suicidality over time probably stems from having fostered such a capability in coming to accept the limits of my influence. The importance of a capacity to remain calm in face of suicide-related clinical ambiguities has certainly been reinforced for me, but also an awareness that not everyone shares this disposition, and that more anxious others might misconstrue my composure as a lack of care, as insufficient investment in risk management procedures designed to protect an organisation's interests. I suspect that an unwillingness to bend over backwards in demonstrating my commitment to 'covering my back' may previously have cost me a job when I failed to say what was expected at interview. Subsequently, I am liable to benefit from the recognition that preserving client lives and protecting organisational interests need not be an either/or equation. Such realisations are, of course, facilitative of my progression towards more integrated 'ego' functioning, wherein both 'superego' (i.e., responsibilities to others) and 'id' (i.e., responsibilities to self) can be afforded appropriate prioritisation.

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City, University of London
Department of Psychology

Participants needed for research into counsellor experiences of working with client suicidality

We are looking for volunteers to take part in a study investigating counsellor experiences when organisational risk management protocols are implicated by the suicidal ideation and intent of clients.

Should you agree to participate, you would be asked to engage in a semi-structured interview with the intent of eliciting your experiences when working with client suicidality in an HE organisational context.

Your participation would involve meeting with the researcher on one occasion for approximately 60 to 90 minutes.

For more information about this study, or to take part,
please contact:

Adam Cox (Doctoral Researcher): *adam.cox@city.ac.uk*

Dr Daphne Josselin (Supervisor): e-mail redacted

This study has been reviewed by, and received ethics clearance from, the Psychology Department Research Ethics Committee, City, University of London [PSYETH (P/L) 16/17 219].

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on: (tel. no. redacted) or via e-mail: (e-mail address redacted).

Appendix B: IPA interview schedule

Demographic information:

Age?
Gender?
Theoretical orientation?

General questions:

Could you tell me about your experience of working with client suicidality within higher education?

How does an awareness of client suicidality change how you work?

What expectations are there (if any) within your organisation when working with suicidal clients? How does this effect you?

Questions about recent experience:

Could you tell me about your most recent experience of working with a client who presented with suicidal ideation or intent (in as much detail as possible)?

How did you go about working with them?

How were organisational risk management protocols/procedures implicated in the work? How did this effect the work itself?

Possible Prompts:
Can you tell me more about your feelings during the work?
Can you tell me more about your thought processes during the work?
What happened next? What was that like for you?
What comes to mind as we're talking about this client?
How do you make sense of this experience?

To what extent does this represent a typical experience of working with a suicidal client within your organisation?

Questions about typical experience:

Could you tell me about a more typical experience of working with a client who presented with suicidal ideation or intent (in as much detail as possible)?

How did you go about working with them?

How were organisational risk management protocols/procedures implicated in the work? How did this effect the work itself?

Possible Prompts:
Can you tell me more about your feelings during the work?
Can you tell me more about your thought processes during the work?
What happened next? What was that like for you?
What comes to mind as we're talking about this client?
How do you make sense of this experience?

Questions about most memorable experience:

Could you tell me about your most memorable experience of working with a client who presented with suicidal ideation or intent (in as much detail as possible)?

How did you go about working with them?

How were organisational risk management protocols/procedures implicated in the work? How did this effect the work itself?

Possible Prompts:
Can you tell me more about your feelings during the work?
Can you tell me more about your thought processes during the work?
What happened next? What was that like for you?
What comes to mind as we're talking about this client?
How do you make sense of this experience?

Are there any other experiences of working with suicidal clients that particularly come to mind?

Closing questions:

To what extent, and in what ways, has your approach to client suicidal ideation and intent evolved over time?

Before we complete the interview, is there anything further that you'd like to add?

Appendix C: Ethics approval letter

Psychology Research Ethics Committee
(address redacted)

11 September 2017

Dear Adam Cox and Daphne Josselin

Reference: PSYETH (P/L) 16/17 219

Project title: Understanding therapist experiences when organisational risk management protocols are implicated by the suicidal ideation and intent of clients

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval
Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period, you will need to apply for an extension using the Amendments Form.

Project amendments
You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants
(b) Change, or add to, the research method employed
(c) Collect additional types of data
(d) Change the researchers involved in the project

Adverse events
You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee (e-mail address redacted), in the event of any of the following:

(a) Adverse events
(b) Breaches of confidentiality
(c) Safeguarding issues relating to children and vulnerable adults
(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

(name redacted)
Co-Chair

(name redacted)
Co-Chair

(e-mail addresses redacted)

Appendix D: Ethics application form

Psychology Department Standard Ethics Application Form:
Undergraduate, Taught Masters and Professional Doctorate Students

This form should be completed in full. Please ensure you include the accompanying documentation listed in question 19.

Does your research involve any of the following? ***For each item, please place a 'x' in the appropriate column***	**Yes**	**No**
Persons under the age of 18 *(If yes, please refer to the Working with Children guidelines and include a copy of your DBS)*		x
Vulnerable adults (e.g., with psychological difficulties) *(If yes, please include a copy of your DBS where applicable)*		x
Use of deception *(If yes, please refer to the Use of Deception guidelines)*		x
Questions about topics that are potentially very sensitive *(Such as participants' sexual behaviour, their legal or political behaviour; their experience of violence)*		x
Potential for 'labelling' by the researcher or participant (e.g., 'I am stupid')		x
Potential for psychological stress, anxiety, humiliation, or pain		x
Questions about illegal activities		x
Invasive interventions that would not normally be encountered in everyday life (e.g., vigorous exercise, administration of drugs)		x
Potential for adverse impact on employment or social standing		x
The collection of human tissue, blood, or other biological samples		x
Access to potentially sensitive data via a third party (e.g., employee data)		x
Access to personal records or confidential information		x
Anything else that means it has more than a minimal risk of physical or psychological harm, discomfort, or stress to participants.		x

If you answered 'no' to <u>all</u> the above questions your application may be eligible for light touch review. You should send your application to your supervisor who will approve it and send it to a second reviewer. Once the second reviewer has approved your application, they will submit it to (e-mail address redacted) and you will be issued with an ethics approval code. <u>You cannot start your research until you have received this code.</u>

If you answered 'yes' to any of the questions, your application is NOT eligible for light touch review and will need to be reviewed at the next Psychology Department Research Ethics Committee meeting**.** You should send your application to your supervisor who will approve it and send it to (e-mail address redacted). The committee meetings take place on the first Wednesday of every month (with the exception of January and August). Your application should be submitted at least <u>2 weeks</u> in advance of the meeting you would like it considered at. We aim to send you a response within 7 days. Note that you may be asked to revise and resubmit your application so should ensure you allow for sufficient time when scheduling your research. Once your application has been approved you will be issued with an ethics approval code. <u>You cannot start your research until you have received this code.</u>

Which of the following describes the main applicant? *Please place a 'x' in the appropriate space*	
Undergraduate student	
Taught postgraduate student	
Professional doctorate student	X
Research student	
Staff (applying for own research)	
Staff (applying for research conducted as part of a lab class)	

1. Name of applicant(s). (All supervisors should also be named as applicants.)
Adam Cox (student) Dr Daphne Josselin (supervisor)
2. E-mail(s).
adam.cox@city.ac.uk (supervisor's e-mail redacted)
3. Project title.
Understanding therapist experiences when organisational risk management protocols are implicated by the suicidal ideation and intent of clients
4. Provide a lay summary of the background and aims of the research. (No more than 400 words.)
Prior to the Enlightenment, suicide was viewed as a sin or crime. Only thereafter, did it come to be viewed as manifesting "madness", and latterly, "disease", the troubled individual hereby freed from responsibility for their actions (Szasz, 1986). However, their choice continued to be labelled undesirable. Society felt an ongoing need to hold someone accountable for this "bad" outcome. In filling this void, treating clinicians, endowed with status as healers, were increasingly expected to protect their clients from harm by predicting their likelihood of acting out suicidal fantasies, and intervening to prevent such occurrences (Bongar, 2002). Any completed suicide is subsequently labelled an individual or institutional "failure" (Reeves, 2010). As a result, the modern-day Counselling Psychologist often experiences acute existential pressures when working with suicidal clients. The clinical literature identifies two main schools of thought when considering effective strategies for intervention. The first, prioritizing "suicide assessment", seeks to identify "risk factors", deploying clinical tools and methodologies to this end (Joiner et al., 1999; Neimeyer et al., 2001; Ruddell & Curwen, 2002; Wingate et al., 2004). The second, emphasizing "suicide exploration", focuses on the client's subjective meaning-making, aiming to explore their narrative account of life and death (Rogers & Soyka, 2004; Leenaars, 2006; Jobes, 2010; Michel & Valach, 2010). Although these approaches embody differing assumptions about the clinician's role, they both accent client experiences and outcomes. Literature attending to the therapist's internal process is far sparser. Those explorations that have been undertaken suggest that encounters with suicidal ideation and intent are highly anxiety-provoking for the treating clinician (Deutsch, 1984; Chemtob et al., 1989).

Faced with suicidal clients, concern about "what happens next" often subsumes the therapist's focus on "what happens now" (Reeves, 2010). Conformity with protocols for organisational risk management typically become the priority, with potential implications for the therapeutic alliance (Reeves & Mintz, 2001). Clinical sensitivity in supporting client sense-making may be compromised in such moments (Milton, 2001). There appears to be a pressing need, then, to better understand therapist experiences in organisational contexts wherein client suicidality creates possible tension between the need for "suicide assessment" and "suicide exploration". This research therefore aims to explore clinician responses within the therapeutic relationship when client suicidal ideation and intent prompts attention to organisational risk management protocols. It is hoped that greater awareness of reactions that interfere in the therapeutic process can better inform the containment and management of such responses.

5. Provide a summary of the design and methodology.

This qualitative study will operate from an interpretive phenomenological perspective (Willig, 2013), and contextualist epistemological position (Madill et al., 2000), seeking to gain insight into the subjective experience and meaning-making of therapists confronted by client suicidality and associated requirements to attend to organisational risk management procedures. Interpretative Phenomenological Analysis (IPA) will be employed to gain a rich, fine-grained understanding of the internal world of participants, with the ambition of getting as close to the 'essence' of their experience as possible (Smith et al., 2009). As an idiographic method, IPA involves detailed examination of particular cases, so will require the researcher to undertake semi-structured interviews with a view to gathering first-person accounts of therapist experiences of client suicidality.

6. Provide details of all the methods of data collection you will employ (e.g., questionnaires, reaction times, skin conductance, audio-recorded interviews).

Data collection will occur in the context of individual semi-structured interviews, lasting approximately 60-90 minutes. Between six and eight participants will be interviewed. Questions will ask participants to describe past encounters with client suicidality, and to reflect on different aspects of these experiences, with follow-up prompts encouraging them to articulate as much detail as possible in the interests of a rich and reflective personal account. All interviews will be digitally recorded and transcribed verbatim. Interview transcripts will be subject to thematic analysis (Madill & Gough, 2008).

7. Is there any possibility of a participant disclosing any issues of concern during the course of the research? (e.g., emotional, psychological, health or educational.) Is there any possibility of the researcher identifying such issues? If so, please describe the procedures that are in place for the appropriate referral of the participant.

Given that all participants will be qualified counsellors with at least three years of experience, and engaged in regular supervision, it seems unlikely that any issues of concern will be disclosed that have not already been addressed via the appropriate channels. However, if I perceived that issues of risk (e.g., suicidality) relating to current clients working with the participant were not already being adequately addressed, I would respectfully remind them of their professional responsibilities in this regard and engage in dialogue around potential referral/reporting options in the best interests of their clients. If there was any unwillingness on the part of the participant to disclose to the appropriate authorities in such instances, it would be necessary, after consultation with his research supervisor, that the researcher did so (where possible).

8. Details of participants (e.g., age, gender, exclusion/inclusion criteria). Please justify any exclusion criteria.

The researcher will aim to recruit between six and eight participants from the university/college sector. Sampling will be somewhat "purposive" in the sense that participants will be recruited who have worked with client suicidality in an organisational context. Inclusion criteria will require that participants be qualified counsellors, professionally recognized by BACP, UKCP, or BPS, and with at least three years of post-qualifying experience, thereby increasing the likelihood of their having encountered sufficient episodes of client suicidality to provide a rich and nuanced account. There will not be any exclusion criteria in terms of age, gender, ethnicity, or theoretical orientation. Although idiographic studies like this do not aim for generalizability, it is hoped that attracting participants embodying a breadth of sociodemographic characteristics will broaden the scope of any findings.

9. How will participants be selected and recruited? Who will select and recruit participants?

The researcher, who is currently working in higher education as a Trainee Counselling Psychologist at Birkbeck, University of London, will request volunteers from within the university/college sector, reaching out to peers within the BACP division for University and College Counsellors using its online e-mail forum (i.e., BACP-UC-Members@jiscmail.ac.uk). Participants will be self-selecting in responding to this e-mail invitation from the researcher. Interested parties will be provided with a participant information sheet. A telephone conversation with prospective participants will subsequently be used to screen out any who do not fulfil the inclusion criteria. This conversation will also provide them with an opportunity to ask any questions prompted by their reading the participant information sheet. Participants will be recruited (and interviewed) on a 'first come, first served' basis.

10. Will participants receive any incentives for taking part? (Please provide details of these and justify their type and amount.)

No. Participation will be voluntary and non-incentivized.

11. Will informed consent be obtained from all participants? If not, please provide a justification. (Note that a copy of your consent form should be included with your application, see question 19.)

Yes. There is no obvious methodological benefit to concealing research aims, so the nature of this study will be fully disclosed to participants prior to their involvement, thereby allowing for informed consent, which will be obtained in writing.

12. How will you brief and debrief participants? (Note that copies of your information sheet and debrief should be included with your application, see question 19.)

Recruited participants will be e-mailed a participant information sheet, thereby briefing them in advance of their interview on the implications of their involvement in the research study. Prior to the interview commencing, the participant will be invited to ask any questions they might have. The researcher's answers will aim to be factual, rather than conjectural, so as not to prejudice data collection by steering the participants later sharing of information. After the interview is completed, the participant will be invited to ask any further questions that may have arisen, and will be provided with a debrief sheet, further clarifying the aims and objectives of the research, and directing them towards appropriate support if required.

13. Location of data collection. (Please describe exactly where data collection will take place.)

Data will be collected within various higher and further educational counselling services within the UK. The researcher will travel to meet with participants at their workplace. Exact locations cannot be known in advance until participants have volunteered for the study.

13a. Is any part of your research taking place outside England/Wales?		
No	X	
Yes		If 'yes', please describe how you have identified and complied with all local requirements concerning ethical approval and research governance.

13b. Is any part of your research taking place <u>outside</u> the University buildings?		
No		
Yes	X	If 'yes', please submit a risk assessment with your application or explain how you have addressed risks.

Risk will be mitigated by meeting participants at their place of work (i.e., counselling premises within their university/college) during normal working hours (i.e., 9am-5pm on a weekday).

13c. Is any part of your research taking place <u>within</u> the University buildings?		
No	X	
Yes		If 'yes', please ensure you have familiarised yourself with relevant risk assessments available on Moodle.

14. What potential risks to the participants do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

It is anticipated that the likelihood of participants experiencing psychological distress will be minimal. The stresses occasioned by the interview will certainly be no worse (and likely much less!) than those encountered in their everyday working life as a function of their counselling duties. However, the topics of suicide and suicidality do have the potential to elicit emotional discomfort (e.g., if a participant's client had taken their own life). If a participant did become emotionally overwhelmed during an interview, this researcher would provide them with the option of discontinuing the meeting, they would be encouraged to process their responses further in supervision, and options would be discussed for seeking local therapeutic support. No health and safety risks are envisioned.

15. What potential risks to the researchers do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

The researcher has worked as a counsellor for seven years, and hence, is familiar with issues of suicidal ideation and intent. Therefore, he does not envisage becoming emotionally distressed on account of these interviews. However, he intends to remain engaged in personal counselling, and to attend regular supervision, with a view to safeguarding himself should he experience any unanticipated emotional reactions. The researcher will be meeting unknown participants in alien locations, but this is considered to be a minimal safety risk on account of the fact that these participants are qualified counsellors, and the intention will be to meet them on neutral ground at their place of work.

16. What methods will you use to ensure participants' confidentiality and anonymity? (Please note that consent forms should always be kept in a separate folder to data and should NOT include participant numbers.)

Please place an 'X' in all appropriate spaces

Complete anonymity of participants (i.e., researchers will not meet, or know the identity of participants, as participants are a part of a random sample and are required to return responses with no form of personal identification.)	
Anonymised sample or data (i.e., an *irreversible* process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates.)	
De-identified samples or data (i.e., a *reversible* process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location.)	**X**
Participants being referred to by pseudonym in any publication arising from the research	**X**
Any other method of protecting the privacy of participants (e.g., use of direct quotes with specific permission only; use of real name with specific, written permission only.) ***Please provide further details below.***	

17. Which of the following methods of data storage will you employ?

Please place an 'X' in all appropriate spaces

Data will be kept in a locked filing cabinet	**X**
Data and identifiers will be kept in separate, locked filing cabinets	**X**
Access to computer files will be available by password only	**X**
Hard data storage at City University London	
Hard data storage at another site. *Please provide further details below.*	**X**

I have purchased two lockable filing cabinets for this purpose.

18. Who will have access to the data?

Please place an 'X' in the appropriate space

Only researchers named in this application form	**X**
People other than those named in this application form. *Please provide further details below of who will have access and for what purpose.*	

19. Attachments checklist. *Please ensure you have referred to the Psychology Department templates when producing these items. These can be found in the Research Ethics page on Moodle.

Please place an 'X' in all appropriate spaces

	Attached	**Not applicable**
***Text for study advertisement**	**X**	
***Participant information sheet**	**X**	
***Participant consent form**	**X**	
Questionnaires to be employed		**X**
Debrief	**X**	
Copy of DBS		**X**
Risk assessment	**X**	
Others (please specify, i.e., interview schedule)	**X**	

20. Information for insurance purposes.

(a) Please provide a brief abstract describing the project

Counselling Psychologists are often confronted with acute existential pressures when working with clients who pose a threat to their own life on account of suicidality. This research study aims to address a gap in the literature as regards the therapist's internal process in such moments. Employing an IPA methodology, it will seek to explore clinician responses within the therapeutic relationship when client suicidal ideation and intent prompt attention to organisational risk management protocols. It is hoped that greater awareness of such reactions might better inform their containment and management, minimizing their interference in the therapeutic process.

Please place an 'X' in all appropriate spaces

(b) Does the research involve any of the following:	**Yes**	**No**
Children under the age of 5 years?		**X**
Clinical trials / intervention testing?		**X**
Over 500 participants?		**X**
(c) Are you specifically recruiting pregnant women?		**X**
(d) Excluding information collected via questionnaires (either paper based or online), is any part of the research taking place outside the UK?		**X**

If you have answered 'no' to all the above questions, please go to section 21.

If you have answered 'yes' to any of the above questions you will need to check that the university's insurance will cover your research. You should do this by submitting this application to (e-mail address redacted), before applying for ethics approval. Please initial below to confirm that you have done this.

I have received confirmation that this research will be covered by the university's insurance.

Name ……. Date……

21. Information for reporting purposes.

Please place an 'X' in all appropriate spaces

(a) Does the research involve any of the following:	**Yes**	**No**
Persons under the age of 18 years?		**X**
Vulnerable adults?		**X**
Participant recruitment outside England and Wales?		**X**
(b) Has the research received external funding?		**X**

22. <u>Final checks.</u> Before submitting your application, please confirm the following, noting that **your application may be returned to you without review** if the committee feels these requirements have not been met.	
Please confirm each of the statements below by placing an 'X' in the appropriate space	
There are no discrepancies in the information contained in the different sections of the application form and in the materials for participants.	**X**
There is sufficient information regarding study procedures and materials to enable proper ethical review.	**X**
The application form and materials for participants have been checked for grammatical errors and clarity of expression.	**X**
The materials for participants have been checked for typos.	**X**

23. Declarations by applicant(s)		
Please confirm each of the statements below by placing an 'X' in the appropriate space		
I certify that to the best of my knowledge the information given above, together with accompanying information, is complete and correct.		X
I accept the responsibility for the conduct of the procedures set out in the attached application.		X
I have attempted to identify all risks related to the research that may arise in conducting the project.		X
I understand that **no** research work involving human participants or data can commence until ethical approval has been given.		X
	Signature (Please type name)	**Date**
Student(s)	**Adam Cox**	**12/07/2017**
Supervisor		

Reviewer Feedback Form

Name of reviewer(s).			
E-mail(s).			
Does this application require any revisions or further information?			
Please place an 'X' the appropriate space			
No Reviewer(s) should sign the application and return to (e-mail address redacted), ccing to the supervisor.		**Yes** Reviewer(s) should provide further details below and e-mail directly to the student and supervisor.	

Revisions / further information required

To be completed by the reviewer(s). PLEASE DO NOT DELETE ANY PREVIOUS COMMENTS.

Date:

Comments:

Applicant response to reviewer comments

To be completed by the applicant. Please address the points raised above and explain how you have done this in the space below. You should then e-mail the entire application (including attachments), **with changes highlighted** directly back to the reviewer(s), ccing to your supervisor.

Date:

Response:

Reviewer signature(s)

To be completed upon FINAL approval of all materials.

	Signature (Please type name)	**Date**
Supervisor		
Second reviewer		

Appendix E: Participant information sheet

Understanding therapist experiences when organisational risk management protocols are implicated by the suicidal ideation and intent of clients

We would like to invite you to take part in a research study. Before you decide whether you would like to take part, it is important that you understand why this research is being conducted, and what would be the requirements of taking part. To this end, please take time to read the following information carefully, and discuss it with others if you wish. If anything is not clear, or you would like more information, please feel free to contact the researcher, or his supervisor, at the e-mail addresses detailed below for clarification.

What is the purpose of the study?

This research study is being conducted in satisfaction of academic requirements for award of a Professional Doctorate in Counselling Psychology from City, University of London. The aim of the study is to explore counsellor experiences when organisational risk management protocols are implicated by the suicidal ideation and intent of clients.

Recent media interest in student suicide, and its implications for mental healthcare provision within universities, highlights that managing client suicidality is a genuine pressure for clinicians working in a higher educational context.

However, much of the literature on suicide focuses exclusively on client risk factors, and the experience of the assessing clinician has often been overlooked. By addressing this gap in the literature, it is hoped that the researcher can throw light on counsellor experiences in working with client suicidality, informing a better understanding of impacts on the therapeutic relationship when organisational risk management protocols are called into play.

The anticipated completion date for this study is September 2019.

Why have I been invited to participate?

In order to have been invited to participate, you must have self-selected in choosing to reply to my request for volunteers as posted to the online e-mail forum (i.e., jiscmail) of the BACP division for Universities and Colleges.

You must be a qualified therapist, professionally recognized by the British Association of Counselling and Psychotherapy (BACP), the UK Council for Psychotherapy (UKCP), or the British Psychological Society (BPS). You must have at least three years of post-qualifying experience, and currently be employed in higher education in the UK, with experience of working with suicidal clients in this context. You must have a regular contract for supervision in place in line with professional requirements.

Between six and eight participants will be recruited for this research study.

Do I have to take part?

No. Participation in this study is entirely voluntary. It is up to you to decide whether to take part. If you do decide to take part, you will be asked to sign a consent form.

Even after giving your consent, you can decide to withdraw your data from the study, without being penalized of disadvantaged in any way, and without being required to give any reason for your decision, up to the point after which data analysis has been completed. It would be challenging to separate out individual data after this point of aggregation and integration. Data analysis is anticipated to be completed by December 2018.

You can opt against participating in part, or all, of the study. For example, should you experience any question during your semi-structured interview as being too personal or intrusive, you can choose to avoid answering said question.

What will happen if I take part?

Should you choose to participate in the research study, you will be asked to engage in a semi-structured interview with the intent of eliciting your experiences when working with client suicidality in an HE organisational context. You will meet with the researcher on one occasion for a maximum of 90 minutes. The researcher will arrange to travel to your place of work, or some other suitable location, to conduct the interview. It is anticipated that interviews will be completed by the end of April 2018. All interviews will be audio recorded and transcribed.

What do I have to do?

You are simply required to meet with the researcher for between 60 and 90 minutes, and to engage in a semi-structured interview, wherein you will be asked to share your experience of times when organisational risk management protocols have been implicated by the suicidal ideation and intent of clients in the course of your counselling work in higher education.

What are the possible disadvantages and risks of taking part?

The semi-structured interview will make a small demand on your time (up to a maximum of 90 minutes). It is recognized that client suicidality might also be experienced as a sensitive topic by some counsellors on account of past experiences, potentially evoking powerful emotions. There is possibility, therefore, that taking part in this study could result in psychological distress. If you perceive that this is likely to be the case, please do not participate. If any distress should arise unexpectedly in the course of your interview, you will be offered the opportunity to discontinue the meeting, and the researcher will discuss referral options for therapeutic support, ensuring that you have sufficient, appropriate information to best look after your personal well-being thereafter.

What are the possible benefits of taking part?

It is hoped that counsellors who participate in this study will benefit from the development of greater self-awareness in relation to their work with suicidal clients, particularly in contexts wherein organisational risk management protocols are implicated. Your involvement will also benefit the wider counselling profession within HE and beyond, since the study's findings aim to deliver an improved understanding of clinician reactions in such moments, which will hopefully inform the greater sensitivity of counsellors in containing and managing responses that might interfere in the therapeutic process, enabling us to operate with greater sensitivity in our relating with suicidal clients.

Will my taking part in the study be kept confidential?

Yes. All audio-recordings of participant interviews will be encrypted, password-protected, and securely stored on a data-stick in a locked filing cabinet. In order to guarantee confidentiality, all transcripts will be de-identified, with names and personal details redacted. Transcripts will be stored as password-protected computer files on the researcher's laptop. During data analysis, only the researcher and his supervisor will have access to these de-identified transcripts. The researcher intends to submit an article for publication, and therefore, hard data will be retained for five years post-publication in line with journal expectations. After this time, all audio recordings will be destroyed.

What will happen to the results of the research study?

The results of this study will be written-up as part of the researcher's doctoral thesis, with the ambition being that this will be completed by September 2019. It is also intended that an article will subsequently be submitted for publication in a peer-reviewed journal. Should you be interested in receiving a copy of the researcher's completed doctoral thesis, this will be forwarded to an e-mail address of your choice. Please be assured that your confidentiality and anonymity will be respected, and you will not be identified, either in the researcher's doctoral thesis, or any subsequent publications.

What will happen if I do not want to carry on with the study?

You can decide to withdraw your data from the study, without being penalized of disadvantaged in any way, and without being required to give any reason for your decision, up to the point after which data analysis has been completed. It would be challenging to separate out individual data after this point of aggregation and integration. Data analysis is anticipated to be completed by December 2018.

What if there is a problem?

If you have any problems, concerns, or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy, and wish to complain formally, you can do this through the University Complaints Procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee, and inform them that the name of the project is: *Understanding therapist experiences when organisational risk management protocols are implicated by the suicidal ideation and intent of clients*

You could also write to the Secretary at:

(name redacted)

(address redacted)

E-mail: (e-mail address redacted)

City University London holds insurance policies which apply to this study. If you feel that you have been harmed or injured by taking part in this study, you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?

This study has been formally approved by, and received ethics clearance from, the Psychology Department Research Ethics Committee, at City, University of London [PSYETH (P/L) 16/17 219].

Further information and contact details

The researcher, and his supervisor, can be contacted by e-mail at the addresses detailed below to answer any enquiries you might have about this study.

Adam Cox (Doctoral Researcher): *adam.cox@city.ac.uk*

Dr Daphne Josselin (Supervisor): *(e-mail address redacted)*

Thank you for taking the time to read this information sheet.

Appendix F: Informed consent form

Title of study: *Understanding therapist experiences when organisational risk management protocols are implicated by the suicidal ideation and intent of clients*

Ethics approval code: PSYETH (P/L) 16/17 219

Please initial box

1.	I agree to take part in the above City, University of London, research project. I have had the project explained to me, and have read the participant information sheet, which I can keep for my records. I understand this will involve: • being interviewed by the researcher • allowing the interview to be audio-taped	
2.	This information will be held and processed for the purpose of answering the following research question: "How do counsellors experience their responses within the therapeutic relationship when client suicidal ideation and intent prompts attention to organisational risk management protocols?" I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part, or all, of the study, and that I can withdraw my data from the study, without being penalized or disadvantaged in any way, and without being required to give any reason for my decision, up to the point after which data analysis is complete.	
4.	I agree to City, University of London, recording and processing this information about me. I understand that this information will be used only for the purpose set out in this statement, and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act, 1998.	
5.	I agree to take part in the above study.	

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Researcher	Signature	Date

If you have any further queries about the study, please contact **Adam Cox** (Researcher): *adam.cox@city.ac.uk*, or **Dr Daphne Josselin** (Supervisor): *(e-mail address redacted)*

Appendix G: Debrief form

Understanding therapist experiences when organisational risk management protocols are implicated by the suicidal ideation and intent of clients

DEBRIEF INFORMATION

Thank you for your participation. Now that your semi-structured interview has been completed, I would like to tell you a bit more about this study.

The main purpose of the study is to better understand clinician experiences when organisational risk management protocols are implicated by the suicidal ideation and intent of clients. Client suicidality has been identified as one of the most significant stressors experienced by therapists in their work, and some have gone so far as to label client suicide as being an "occupational hazard" on account of its frequency of occurrence. Clearly, therapists are confronted with acute existential pressures when working with any client who poses a threat to their life, where the expectation that one exercise duty of care, and the perception that completed suicide represents an individual or institutional "failure", may come into tension with the typical therapeutic desire to empower client autonomy.

This being so, there appears to be a pressing need to better understand therapist experiences in organisational contexts wherein client suicidality creates a possible tension between the need for "suicide assessment" and "suicide exploration". It is hoped that a greater awareness of reactions that interfere in the therapeutic process when clinicians find themselves squeezed between needy clients and demanding protocols, might better inform the containment and management of these responses.

The semi-structured interview you have just completed was designed with the purpose of drawing out your own subjective experiences in moments where you have needed to grapple with a dual need to engage therapeutically with a suicidal client, whilst also attending to the risk management expectations of your HE institution. It is anticipated that identifying the themes prevalent in your account (and aggregating this data with those themes highlighted by other participants) will shed light on the essential nature of this experience.

Should you have found exploration of your experiences in working with suicidal clients to have been distressing in any way, you might feel the need to discuss them with somebody. It is suggested, in the first instance, that you explore these issues with your clinical supervisor. Personal therapy might also be a suitable forum for further exploration, and if so, the researcher would be happy to help you think through your options in this regard. Another useful resource for making sense of this topic is "Counselling Suicidal Clients" (2010) by Dr Andrew Reeves.

I hope that you have found your interview experience to be an interesting and positive one. If you have any further questions about the study, please do not hesitate to contact us via e-mail at the addresses detailed below:

Adam Cox (Doctoral Researcher): *adam.cox@city.ac.uk*
Dr Daphne Josselin (Supervisor): *(e-mail address redacted)*

Ethics approval code: [PSYETH (P/L) 16/17 219]

Appendix H: Participant 1 - Extract of thematic analysis

Blue = descriptive/conceptual
Red = linguistic

Participant 1: Pages 4-6

Themes	Transcript	Exploratory comments
	94 R: umm… 95	Differentiation of staff/student suicides Suicide as part of the work Especially difficult to be confronted with the death of a young person/taken "before their time"?, loss of imagined future?, against the natural order?... part of sociocultural expectations vis-à-vis death
Threat of suicide	"there" - present, existing, real 96 P: student suicides… erm, so it's there… and there is something 97 about the death of a young person… 98	
	99 R: umm, hmm… 100	
Death of younger clients as more disturbing	101 P: which I think is particularly… it has a particular kind of… 102 emotional punch to it… 103 "punch", fighting to keep client alive, suffering a blow to the agenda of the work	Death of younger person as inflicting greater emotional distress, as suggested by its "packing a punch"
	104 R: umm, hmm… 105	
Threat of suicide	fragmented, "punch drunk"?, floored by weight of emotional reflections	
Squeezed by organisational pressures/ expectations	"there" – repetition of idea of being present/real 106 P: I suppose… erm… so, my… yeah… so, it's there… it's 107 sometimes difficult, because… and I think we'll probably talk about 108 this more… because of the pressure on the service… 109 "pressure", sense of being squeezed	Suicide as part of the work Pressure on the service to support sheer volume of clients therapeutically – implication of scarcity of resources of time to undertake the work Anticipation of time pressure/limitation as important topic
	110 R: umm… 111	

Valuing absence of limitation on length of therapeutic work	112 P: erm, we work in a time-aware way… we don't at the moment 113 have a rationed number of sessions… which… is very positive… 114	Consciousness of time in the therapy Negotiable length of contract Lack of fixed limit of sessions Valuing absence of limitation on length of therapeutic work
	115 R: umm… 116	
Exposed to potential judgement in the event of client suicide	"overall", sense of reservation, not entirely happy 117 P: overall… but it does mean that it comes down much more to your 118 judgement in a way… there's nowhere to hide… 119 "nowhere to hide" – sense of exposure and vulnerability	Responsibility to decide on length of contract/onus on therapist/burden on shoulders Exposure to judgement/no hiding place
	120 R: umm… 121	
Torn between competing priorities	122 P: erm, and you're balancing… the risk… that… that you think the 123 individual is at against the knowledge of the length of the waiting- 124 list… 125 known vs. unknown, certain vs. uncertain, present vs. future, inside vs. outside	Balancing act/state of tension Weighing risk/need in the room against potential risk/need outside the room Feeling torn between competing priorities – obligation to clients in therapy vs. obligation to conveyer belt of people waiting for therapy
	126 R: umm… 127	
Anticipation of being judged for not holding time boundaries	128 P: erm, the questions that, particularly my manager, who comes 129 from a very different background, might be asking about why I'm 130 seeing someone for the length of time I am… 131	Pressure from above/management Different values/approach of manager on account of different background Anticipation of being judged for giving too much/not holding time boundaries
	132 R: umm… 133	
Institutional intrusion into the therapeutic work	134 P: erm… so, it… so, it… it feels like the institution is in the third 135 chair in the room sometimes… 136 "third chair in the room" - powerful image, triangulation, additional dynamic to manage, sense of intrusion and observation	Monitored/needing to account for decisions regarding length of therapy offered Institutional intrusion into the therapeutic work/competing voices to be managed
	137 R: right… 138	

Difficulty in ignoring institutional expectations	lack of control 139 P: and that… can be quite hard to shut that off… erm, and it… feels 140 like an additional pressure… 141	Difficulty in ignoring institutional expectations/messages Pressure to comply with expectations Pulled in different directions
	142 R: and… and what's that like for you to experience this sense of a… 143 a third chair in… in the room while you're working with someone?… 144	
Anxiety in managing competing demands/ responsibilities	taking her time/thoughtful and reflective, mirroring her preference to be unrushed with her clients 145 P: erm… (pause)… I think it feels… it makes me anxious… makes 146 me anxious… and, I think, I'm anxious anyway if I think somebody 147 is… suicidal… I hold… I hold that anxiety… 148 repetition of "anxious", overbearing sense of concern on account of external intrusion – direct impact in grasping onto or taking "hold" of anxiety, taking possession/ownership of this emotion	Anxiety in managing competing demands/ responsibilities, exacerbated by threat of institutional judgement Pre-existing anxiety around wish to prevent suicide Holding the tension/needing to tolerate these anxieties
	149 R: umm… 150	
Anger at institutional intrusion into the therapeutic work	151 P: erm… and it also makes me angry… 152	Anger at institutional intrusion into the therapeutic work, not feeling appropriately supported by management
	153 R: umm… 154	
Difficulty in holding tension between client needs and managerial expectations	"hold" as communicating weight/burden, too much on her hands 155 P: because it's hard enough to hold the client without having to 156 hold… erm… a lack of understanding… 157 pause in searching for the right words, perhaps not wanting to come off as overly critical/cautious about framing of organisation's role in the process	Difficulty in being with client suicidality/ holding tension between life and death Increased difficulty when pressures of job not understood by management/greater throughput demanded at expense of those already within the system Danger of choice to invest in relationship being judged negatively by manager
	158 R: umm… 159	
	negative experience located associated with one individual, only "immediate manager" to blame, not absolute experience of institution repetition of "difficult", emphasizing challenging nature of experience 160 P: by my immediate manager… erm… and that's… that is… 161 difficult… it is difficult… and I've worked in different institutions…	Difficulty of holding tension between competing needs/priorities Different levels of intrusion into the work in different institutional contexts

Different levels of intrusion into the therapeutic work	162 and I've experienced that third chair… sometimes it's out in the 163 corridor, and the door's shut, and it's just me and the client… 164 "out in the corridor" - less intrusion in other institutions	Sometimes able to shut out noise of managerial expectations in prioritizing relationship with suicidal client
	165 R: umm, hmm… 166	
	pathway blocked 167 P: erm, and other times, it's kind of parked in the doorway… ha 168 ha… (laughter)… and other times, it's kind of… as… as close as… 169 in the room as… 170 laughter/humour as serving a defensive function, reflecting frustration/anger at intrusion into the work	Sometimes subject to more intrusive managerial expectations Observed/monitored/blocked Closeness of external expectations becoming oppressive
	171 R: right… 172	Degree of control over intrusion/extent to which clinician allows themselves to attend to managerial expectations/resistance Necessity of hard work to hold internal boundaries/prevent intrusion of competing priorities from interfering in therapy
Degree of control over intrusion through holding boundaries in face of external demands	some degree of control 173 P: I allow it… so sometimes I have to work quite hard… 174 effortful resistance/battle to prevent intrusion, holding a "hard" line/imposing boundary	
	175 R: umm… 176	
Modulation of intrusion by more understanding authority figures	telling off/lecturing aspect of self that has been internalized from the institution, like a child trespassing in the drawing room, keeping intrusion in check 177 P: to say, 'no, you're not… this isn't appropriate… you need to go to 178 the other side of the door, and be shut'… since my immediate 179 manager has got a much better manager, who was a counsellor, 180 and, in fact, was my supervisor for many years… she came from 181 (first higher education employer)… (senior manager's name)… I've 182 been less anxious… 183	Holding boundaries/shutting out noise Experiencing internalised managerial demands/intrusion as inappropriate Modulation of intrusion by more understanding authority figure Counselling training as providing others with greater understanding of therapeutic pressures Authority figure trusted on account of pre-existing supervisory relationship Reduced anxiety stemming from greater protection/more accepting context
	184 R: umm, hmm… 185	

Participant 1 - Table of Master Themes

Superordinate Theme #1.1: "I wonder if you're going to make it": encountering client suicidality

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Subordinate Theme #1.1.1: "I hold that anxiety": burdened by fear of possible suicide, and pressure of responsibility to avoid this outcome

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Subordinate Theme #1.1.2: "Exposed to the awfulness of it": suicide threat as more disturbing in younger clients

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Subordinate Theme #1.1.3: "The hairs on the back of my neck go up": physiologically unsettled by suicide risk

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Subordinate Theme #1.1.4: "I feel really bothered": rendered uneasy by confrontation with suicidality

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Subordinate Theme #1.1.5: "Absolutely on the edge": troubled to witness despairing clients walking the "tightrope" between life and death

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Subordinate Theme #1.1.6: "An absolute end": confronting the terminal nature of suicide

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Subordinate Theme #1.1.7: "He hadn't used our service": distancing self from responsibility

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Superordinate Theme #1.2: "It's unethical to kind of do it half-way": responding to client suicidality

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Subordinate Theme #1.2.1: "Not neat": accepting the attachment difficulties of suicidal clients

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Subordinate Theme #1.2.2: "Being with": providing a secure connection with a view to avoiding outcomes of suicide

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Subordinate Theme #1.2.3: "Staying safe": fostering client capacities to manage risk with a view to avoiding outcomes of suicide

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Subordinate Theme #1.2.4: "Don't want to stand on any landmines": holding back in the therapeutic encounter to avoid outcomes of suicide

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Subordinate Theme #1.2.5: "I ended up seeing him all year": accommodating to client needs with a view to avoiding outcomes of suicide

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Subordinate Theme #1.2.6: "It was pulling me out of my role": discomforted by accommodating to the needs of suicidal clients

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Superordinate Theme #1.3: "Noisy, but unhelpful": encountering the institutional expectations and anxieties occasioned by client suicidality

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Subordinate Theme #1.3.1: "There's anxiety rattling around": experiencing noisy reactions to client suicidality within the organisation

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Subordinate Theme #1.3.2: "It's like a boundary dispute": organisational anxieties as occasioning intrusion from outside the service

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Subordinate Theme #1.3.3: "Blame will be flying around": experiencing organisational anxieties around accountability for client suicide

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Subordinate Theme #1.3.4: "Keep it short": organisational anxieties as occasioning pressure towards systemic throughput

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Subordinate Theme #1.3.5: "The third chair in the room": organisational expectations and anxieties as intruding into the clinical work

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Subordinate Theme #1.3.6: "The demands are so much greater than my resource": torn between competing priorities

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Subordinate Theme #1.3.7: "Sound and fury, signifying nothing": impatience with inauthentic organisational noise as distracting from client needs

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Subordinate Theme #1.3.8: "A lack of understanding": feeling unsupported by the organisation, and subject to unreasonable expectations

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Subordinate Theme #1.3.9: "It doesn't matter about my notes": disbelief at prioritisation of organisational interests in the wake of suicide

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Superordinate Theme #1.4: "Difficult conversations": responding to institutional expectations and anxieties occasioned by client suicidality

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Subordinate Theme #1.4.1: "Thrown under the wheels of the car": anxiety about being held accountable in the event of client suicide

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Subordinate Theme #1.4.2: "It rocked me": destabilised by organisational pressure to favour systemic throughput

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Subordinate Theme #1.4.3: "Rage against helplessness": anger at the demands and limitations of an unsympathetic organisational context

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Subordinate Theme #1.4.4: "That stays outside of the door": resisting organisational intrusion into the clinical work, sometimes occasioning conflict

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Subordinate Theme #1.4.5: "Well, you've done what you can": disenchantment with the organisation's level of investment in mitigating suicide risk

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Subordinate Theme #1.4.6: "That steadies me up": supportive others as modulating organisational intrusion and containing anxieties

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Sub-Theme #1.4.6.1: Managerial staff

Sub-Theme #1.4.6.2: Supervisor

Sub-Theme #1.4.6.3: Colleagues

Subordinate Theme #1.4.7: “That’s all I can do really”: accepting relative lack of control in no longer struggling against limitations

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Participant 1 - Detailed Table of Themes

Superordinate Theme #1: "I wonder if you're going to make it": encountering client suicidality

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Subordinate Theme #1.1: "I hold that anxiety": burdened by fear of possible suicide, and pressure of responsibility to avoid this outcome

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Transcript Ref:	Quote:
1, 3, 80-1	*erm… and… (pause)… it feels a big responsibility…*
1, 4, 112-18	*erm, we work in a time-aware way… we don't at the moment have a rationed number of sessions… which… is very positive overall… but it does mean that it comes down much more to your judgement in a way…*
1, 5, 146-47	*and, I think, I'm anxious anyway if I think somebody is… suicidal… I hold… I hold that anxiety…*
1, 8, 221-25	*and I saw at least two people there who… (pause)… had well worked-up plans… and were clearly at risk, and I never… never felt any of that anxiety… I felt the anxiety that I felt about… the client, and the safety of the client…*
1, 22, 671-72	*and I think… I think, working with suicide, it… you always do hold stuff… 'cause it's an individual relationship, isn't it?…*
1, 58, 1775-84	*and I was worried, because… 'cause he did so much climbing, I was worried that he was desensitized to… to the fear factor…*
1, 74-75, 2272-85	*well, I suppose my anxious is, 'have I done all I can?', whereas the troubled is… to be with somebody in… in a place of such despair... leaves me troubled that somebody could be in that place…*
1, 79-80, 2425-39	*and just… her extended family's all in another country, and not close… she's… it's just her and her mum… erm… so she couldn't go back… so I was worried about Christmas… because she'd been drinking a lot… she was drinking, and she'd been buying drugs on the internet… and had got to the point where she couldn't sleep… and she was running out of money… so there was kind of a whole stack of things…*
1, 81, 2473-79	*and it was my last day of work before Christmas… and I was thinking, 'this is going to be, but there's nobody around'…*
1, 82, 2505-07	*and then, as the tale unfolded, I was thinking, this is really… potentially… there are not many breaks here… I can't see any easy…*

1, 83-84, 2553-64	*and then, as she was able to talk more… so, the kind of session changed… and it felt… started to feel less despairing… it felt like her thinking… the little bit of her that had brought her through the door… was actually starting to work again…*
1, 84, 2568-72	*yeah… yeah, that reassured me…*
1, 86, 2625-30	*and I was aware of a huge sense of relief that… when she came back, and said, 'no, no, I'm…'*
1, 86, 2639	*yeah… she kind of popped into my head a couple of times…*

Subordinate Theme #1.2: "Exposed to the awfulness of it": suicide threat as more disturbing in younger clients

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Transcript Ref:	Quote:
1, 3, 81-2	*and… (pause)… I think there's something about them being young as well…*
1, 4, 96-106	*and there is something about the death of a young person… which I think is particularly… it has a particular kind of… emotional punch to it, I suppose…*
1, 75, 2289	*and again, often because they are so young, there's an element of…*
1, 76, 2318-34	*erm… and to see people who are young, for whom life might change, and for whom there's potential change and growth… they've not been grinding around their core therapeutic issues for fifty years… (laughter)… you know… (laughter)… again, there's a potential… erm… and a life… that might have a lot of joy… and… and meaning… and creativity… just to feel none of that… just to feel… to be so lost…*
1, 76, 2343	*and to be so lost, so young, I think…*
1, 77-78, 2356-84	*yeah, not… I mean, that's not to… (pause)… that's not to play down an older person… but… but it might be that there's more of a story… that I can make more intellectual sense… and I suppose, because I use intellect… well, it's my most… intellectualizing is… is my most cherished defence… ha ha… erm, it allows me to make more sense of it for myself at an intellectual level maybe, whereas with the young, it just… I can't use that particular defence, so that leaves me exposed to the awfulness of it…*

Subordinate Theme #1.3: "The hairs on the back of my neck go up": physiologically unsettled by suicide risk

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Transcript Ref:	Quote:
1, 39, 1183-99	*but, it's… it's much more visceral than that… I… well, the hairs on the back of my neck go up, and I'm like, 'ah yes'… though sometimes people will answer… and actually on paper… and they'll come in with their CORE score… and on paper, you'll be thinking, 'why am I seeing this person when his CORE scores are like that?'… and 'why are they not telling me the truth?'…*
1, 40, 1204-17	*but, I kind of… I know… I just get an itchy feeling at the back of my throat, and I just think, 'ah, this is one that I… bothers me'… and I tend to go with that really…*
1, 81, 2468-73	*well, she sat down… and the hairs on the back of my neck went up… so, I thought 'this is going to be…'*
1, 87-88, 2676-92	*I've become more… trusting of my instincts… I think, the more I've seen, the more I've… tended to go with my instincts, even if, on the surface, erm… there's nothing to set alarm bells ring… you know, if there's nothing tangible… like, there's not a high CORE score, or there's… so, I do tend to just go much more with my instincts now… I tend to just…*
1, 88, 2697-2713	*I think… I think I've seen more… I think it's experience… maybe… yes, it is experience… erm… that… yeah… just seen quite a lot of it, and… just more experience of…*

Subordinate Theme #1.4: "I feel really bothered": rendered uneasy by confrontation with suicidality

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1, 44, 1331-32	*'cause I don't know what it's about, but I feel really bothered'…*
1, 44, 1340-44	*yeah… and try and… work out what it was that left me feeling uneasy…*
1, 84, 2578-83	*erm… and I did think, 'I wonder if I'll see you'… 'actually, I wonder if you're going to make it'…*
1, 85, 2609-14	*well, the Sunday night, I looked at my list for Monday, and thought… umm… I remember this… I wonder… and I was aware of feeling uneasy on Sunday night…*
1, 85-86, 2615-24	*and then, when I came in, and she didn't come, I thought, 'well… that's… I've not heard anything… there's not been a message… from (name of COO), who's our Chief Operating Officer, saying there's been a student death'… erm, so… but then there wouldn't necessarily be if she'd killed herself off… and wasn't on campus… erm, so I was aware of feeling uneasy…*

Subordinate Theme #1.5: "Absolutely on the edge": troubled to witness despairing clients walking the "tightrope" between life and death

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1, 73, 2231-38 *yeah, I think… I mean, there's… there's… there's the guy who then went on to die… erm, to kill himself… and I… that… that assessment, although I only met him once… erm, really stayed with me… just the sense of him being absolutely on the edge… absolutely on the edge…*

1, 73, 2242-50 *troubling… (pause)… troubling to see somebody… on… the tightrope… that one step…*

1, 73-74, 2250-60 *and I saw somebody just before Christmas as well… who I'm seeing tomorrow… and again, that really troubling sense… when you get a final year chemist saying, 'well, I've been researching how to get arsenic on the internet', and you're thinking, 'yeah, you have the plan', 'you have been thinking about the means'… and just, 'you are in a very troubled place… a very despairing place'… and that leaves me troubled…*

1, 74, 2264 *troubled, more than anxious, I think…*

1, 74-75, 2272-85 *well, I suppose my anxious is, 'have I done all I can?', whereas the troubled is… to be with somebody in… in a place of such despair... leaves me troubled that somebody could be in that place…*

Subordinate Theme #1.6: "An absolute end": confronting the terminal nature of suicide

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Transcript Ref: Quote:

1, 8, 239-43 *and I remember just being furious, and thinking, 'well, the client's dead'… ha ha… 'it doesn't matter about my notes'… that's kind of, yeah… (becoming tearful)… sorry, I'm really upset thinking about… erm… (sobbing)…*

1, 9, 261-70 *and the fact that I'd said that if his relationship broke down, or if his studies were compromised in any way, that I felt he… he would be very seriously at risk very quickly… and that was what had happened… his relationship had broken-up, and he'd killed himself… so, the fact that I'd seen that seemed to me neither here… neither here nor there…*

1, 75, 2302-14 *just… well, I suppose… I suppose… 'cause, for me, the tragedy of suicide is that, like it's a solution to a problem?… or it's seen as a solution to a problem… and it's not… it's just an end… it stops the possibility of… anything changing, or happening… it's just an end… I mean… because I don't have a spiritual faith… I believe in it being an absolute end…*

Subordinate Theme #1.7: "He hadn't used our service": distancing self from responsibility

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Transcript Ref:	Quote:
1, 3, 73-80	*erm, to my knowledge, no one that I have seen has committed suicide, and actually acted… but someone I saw when I worked at (second higher education employer)… I saw for an assessment… went on about six months later to kill himself…*
1, 3, 86-92	*I mean, in truth, at (current higher education employer)… I think, since I've been here… I've been here seven years… erm… we've had two members of staff commit suicide, and one student… whereas at (second higher education employer)… and none of them were users of the service here… and at (second higher education employer), we would have one or two suicides a… a year…*
1, 12, 345-49	*and there have been a couple of incidents in the papers… and, certainly, there was, I think, a Chinese lad, who threw himself off the… one of car parks in (name of town)… he wasn't a… err… a client of ours… he hadn't used our service, but… there was… it got into the papers…*

Superordinate Theme #2: "It's unethical to kind of do it half-way": Responding to client suicidality

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Subordinate Theme #2.1: "Not neat": accepting the attachment difficulties of suicidal clients

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Transcript Ref:	Quote:
1, 33, 1000	*and suicidal clients are not neat… it doesn't work that way…*
1, 33, 1008-12	*not neat… no… no, absolutely not… ha ha… 'cause they're in a must, a muddle, and a mess…*
1, 34, 1019-39	*erm… I experience it as very human… it's like the human condition, isn't it?… it's kind of… we… we all struggle, I feel… I… my personal belief is… we all struggle with the… kind of, to make meaning out of life, which often is chaotic and random, and to make an accommodation with the fact that we die, and that it's finite… and that in that muddle, a suicidal person is… is faced with those same set of dilemmas, and making relationships… making meaning of… what I believe to be, kind of, a bit of an accident, really… life's a bit of an accident… ha ha ha… (laughter)… I don't think there is any inherent meaning particularly…*
1, 54, 1664-66	*when things happened, and they didn't have to be big things, he… became very distressed, and… would disappear…*
1, 55, 1682-86	*erm, but anyway, he was booked-in with an assessment with me… erm, and at that assessment… it was quite clear, he was in a lot of difficulty... he couldn't speak really… so, actually, we just sat quietly together…*

1, 57, 1730-35	*erm… the police had taken him to the hospital, and they'd done an assessment… erm… err, a psychiatric assessment… and so, he came the next week, and said I can't speak, but handed this to me… and… clearly had been unable to speak to the psychia… to the psychiatrist… and err, the psychiatrist had said, he was 'uncooperative'…*
1, 57, 1738-39	*I think he really hadn't… he just couldn't… didn't know what to say…*
1, 57, 1739-41	*and the crisis team were involved, but they… he was out when they came… so they didn't come again…*
1, 81, 2479-80	*erm… and she was sucking her thumb… she was clearly in a state of great distress…*
1, 85, 2595	*and then, she didn't come the first morning back…*
1, 86, 2652	*yeah… and she was quite confused when I saw her…*

Subordinate Theme #2.2: "Being with": providing a secure connection with a view to avoiding outcomes of suicide

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Transcript Ref:	Quote:
1, 34-35, 1043-56	*I think the core thing is to… for me, is to… (pause)… is to stay… (pause)… present… to stay, I think… because, I think, an element of suicidal kind of ideation is that sense of… not being connected… not being… not being, umm… it's a very lonely place… very existential aloneness, I think… so, for me, one of the things that I try really hard to do is to provide a sense of connection… a sense of being with…*
1, 35, 1060-61	*yeah, in relationship… because I think… I believe that that is, erm… helpfulness in its own right…*
1, 35-36, 1074-79	*erm… I might do some work around taking a transitional object… if this feels like a safe place… taking something from this room with them… that kind of symbolic…*
1, 36, 1091-99	*erm… making sure that they… there's… they never leave without another appointment… erm, trying to box… 'cause often, particularly for students… because weekend just lacks… sometimes lacks structure… and can be very empty… so, to… to make a Monday appointment… so there's… so there's… so there's some practical kind of things…*
1, 58, 1760-66	*I met him at nine o'clock, Monday morning… every week for a year… and he… he'd come at two minutes to nine, and just walk straight in…*
1, 84, 2572-74	*I… I made an appointment for her… for her… for my first working day back…*

Subordinate Theme #2.3: "Staying safe": fostering client capacities to manage risk with a view to avoiding outcomes of suicide

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Transcript Ref:	Quote:
1, 35, 1065-66	*erm… and I do… do some work around staying safe…*
1, 36, 1103-04	*and talking about… safety, and… and… stuff, but not letting that dominate…*
1, 46, 1411-12	*make it feel… work a lot on safety… safety in the room… safety in the relationship, which is kind of…*
1, 80, 2439-40	*so… so in the end… I mean, we talked about safekeeping…*

Subordinate *Theme #2.4: "Don't want to stand on any landmines": holding back in the therapeutic encounter to avoid outcomes of suicide*

Transcript Ref:	Quote:
1, 44-45, 1354-69	*I think I'm… I think I'm less freewheeling… ha ha… you know, kind of, I won't just take a punt on something in the same way… I'm more… I work more carefully… take fewer chances… you know, I might just chance something to see… to see… that kind of works with somebody… does that seem to strike a chord?… whereas I'm more careful with them…*
1, 45, 1373-82	*yeah… yeah… don't want to upset… don't want to set anything off… that I will… don't want to stand on any landmines, I suppose… or don't want the client to either…*
1, 45-46, 1386-1411	*erm… so, tend to slow down… I'm aware my voice becomes… slightly quieter… slightly slower… erm… and I'm aware that my body tends to mirror more… my eye contact might change slightly… just really kind of slow… trying to slow everything down… take time…*
1, 82, 2507-12	*erm… and I was aware I was working really hard to stay very calm… very steady…*

Subordinate Theme #2.5: "I ended up seeing him all year": accommodating to client needs with a view to avoiding outcomes of suicide

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Transcript Ref:	Quote:
1, 53, 1634	*erm, who I ended up seeing all year…*
1, 55, 1670-71	*and I ended up… seeing him all year…*

1, 55, 1686-87	*I said, 'are you comfortable?'… 'if it's good, we don't have to speak'… 'let's sit together', 'we don't have to do anything'…*
1, 55, 1689-95	*erm, but there was a bit of a row, because, of course, because he had been silent, I hadn't been able to write any assessment notes, because he hadn't been able to speak…*
1, 58, 1759-75	*so… and it was very… (pause)… strange work… I met him at nine o'clock, Monday morning… every week for a year… and he… he'd come at two minutes to nine, and just walk straight in… he didn't go to the reception… he wouldn't engage with that at all, and that was another row, because he was supposed to go and sign himself in, and sit in the waiting area, and he just wouldn't do it… so, he just walked up the stairs, and into the room… and we'd just sit, largely in silence, but he stopped wanting to jump off bridges…*
1, 61, 1851-56	*but it felt necessary, 'cause he didn't have any money at all, and he wasn't eating, so… and that again, in terms of suicide… you just think, 'well…'*
1, 67, 2058-62	*and I said, 'well, he's not engaged with the mental health team... he's supposed to see (name of mental health team member), and he doesn't go and see her… erm, and… he's actively suicidal, and he does engage with me, so it does seem like there isn't another easy place for him to go'…*
1, 68, 2075	*'because of how he is, it's unethical to kind of do it half-way'…*
1, 69, 2109-14	*'no, but it is ridiculous'… it's kind of… I'm any port in a storm… this is a ridiculous way of thinking…*
1, 82, 2512-22	*I had this client immediately afterwards, and I was thinking, 'right, I'll have to actually go out, and… ask… our reception people to phone and actually stop them coming, because this might take longer'…*

Subordinate Theme #2.6: "It was pulling me out of my role": discomforted by accommodating to the needs of suicidal clients

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Transcript Ref:	Quote:
1, 59-60, 1819-33	*but again, around Christmas… erm, that was very tricky, because he was estranged from his family… and the other thing practically, which is difficult… but, I felt, uncomfortable… 'cause it felt like it was pulling me out of my role… but he completely ran out of money, because he was… estranged from his family, but his family were wealthy… erm… so he wasn't getting any of the top-up for the loan… and there was a big shortfall…*
1, 60-61, 1841-51	*so in the end, I just sent him off to Student Advice, who… sorted him out, and gave him an emergency loan, and… and then, intervened on his behalf with, err, Student Finance England, so… but that felt difficult, 'cause… I didn't… I don't like that…*
1, 61, 1861-70	*yeah, saying 'I think you should' doesn't sit very well… but I don't think… it's not going to improve his… his state of mind.…*

1, 81, 2484-87	*erm… and… so, it was just, 'oh, ahh, not on my last day of work'… (laughter)… was my first thought… 'ahh, no'… 'poor… poor me'… 'cause it is all about me… but, no, no, kind of 'oh, God'… anyway… erm… and then…*
1, 81, 2491-92	*yeah… just, I'm knackered… it's the week before Christmas… please don't do this to me…*
1, 81-82, 2497-2501	*yes… (laughter)… yes, not now… (laughter)…*

Superordinate Theme #3: "Noisy, but unhelpful": encountering the institutional expectations and anxieties occasioned by client suicidality

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Subordinate Theme #3.1: "There's anxiety rattling around": experiencing noisy reactions to client suicidality within the organisation

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Transcript Ref:	Quote:
1, 25, 754-70	*it just … just feels… depends on the quality of your manager… quality of your manager's manager… whether the Vice-Chancellor sees something in the newspaper… erm… (pause)… whether the person you see happens to be, erm, the PA to the Head of HR… erm… erm, you know, it just all… it just all seems… I don't know… noisy…*
1, 27, 814-21	*and I'm aware, you know, that… I'm not working in private practice… there's a lot of stuff that's good about working at a university… I'm aware of all of that, but the… I do find the noise a big downside…*
1, 49, 1493-94	*erm… and (manager's name), because she's the closest, is the loudest…*
1, 54-55, 1666-70	*and they'd had the police… and he was known to other people, and the mental health team here, and so on… they had the police out, erm, several times looking for him, and they found him on the bridge over the M1, wondering whether to jump off, so… so there was a lot of concern…*
1, 56, 1724-26	*and it turned out he'd… the police of the… the time that they'd found him on the bridge… the… the last time… the last event… it had happened three or four times…*
1, 62, 1903-09	*umm… I think, from time to time, I was aware… of quite a lot of noise, because he did have a couple of episodes… and his pattern would've be to disappear…*
1, 63, 1939-43	*and I thought… so there's a noise… there's… there's anxiety rattling around…*

Subordinate Theme #3.2: "It's like a boundary dispute": organisational anxieties as occasioning intrusion from outside the service

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Transcript Ref:	Quote:
1, 12, 358-63	*erm… and that came from the Vice-Chancellor's Office… because it had caught his eye, and he… I think he was worried about reputational damage…*
1, 25, 754-65	*it just … just feels… depends on the quality of your manager… quality of your manager's manager… whether the Vice-Chancellor sees something in the newspaper… erm… (pause)… whether the person you see happens to be, erm, the PA to the Head of HR…*
1, 29, 876-81	*so, for instance… the GP will phone… say they're concerned about somebody…*
1, 29-30, 886-96	*and the GP will come, and… and then, it will be a kind of a fuss, because the GP's being unreasonable, and they're panicking that we're not doing the job… the job of the NHS, and… you know, they should be providing this person with CBT and IAPT, and dadidadidadidadida… so, a very noisy, defensive reaction, and actually… GP's worried… and they're right to be worried…*
1, 30-31, 901-927	*and I… I do understand it's resources… I know that our GP… because we've got a GP on campus… that they know that they've got a long wait for the IAPT service… and that they believe that the students are paying £9,000 plus a year, and they shouldn't have to wait twelve weeks for counselling if they are in need, and I know…. my boss, and there is some justification for this as well, says, 'well, we are not the NHS'… that's… you know, they have that… access to that budget… they have access to IAPT… so, it's like a boundary dispute…*
1, 55, 1676-82	*so, Dr (doctor's name) from the medical practice had phoned… because she was worried about him… and he'd told her that he was coming to counselling, and was on the waiting list… and she'd said that he needed to be seen immediately… so (manager's name) was very cross about that, and saying that she was just panicking, and it was none of her business, and how dare she tell us what… who to see, and dadidadida…*
1, 56, 1698-99	*and the GP was phoning again…*
1, 63, 1917-22	*yeah… yeah… so, I'd get a phone call… (name of HoSS) once popped in, and he said, 'would you just let me know… 'cause you… you see (client's name)'… he said, (client's name)'s surname… he said, 'every Monday at nine, don't you?'… I said, 'yes'… he said, 'would you just let me know if he doesn't turn up, 'cause there's some anxiety about where he might be'…*
1, 63, 1931-33	*erm… I like (name of HoSS), and I think he's very competent, but I just thought, 'he's squeezed', because this has gone up to the Chief Operating Officer, 'cause (client's name) said that it had…*
1, 63, 1934-35	*and also, the GP had been on the phone to (name of HoSS), 'cause she'd escalated her anxieties…*

1, 89, 2732-39	*I think it's just really having the chance to focus on just what the institution… what bits of the institution… (pause)… erm, intrude… and what... what I can tolerate reasonably well, and what really… makes me cross…*

Subordinate Theme #3.3: "Blame will be flying around": experiencing organisational anxieties around accountability for client suicide

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Transcript Ref:	Quote:
1, 8, 230-37	*erm… at (second higher education employer)… when the client who I assessed went on to commit suicide, we had a temporary manager who, erm… went into my… I wasn't… it happened on a day I wasn't working… went into my filing cabinet… and took and copied my notes…*
1, 9, 270-73	*also, it was like, 'is that your first thought?'… this man has died, and your first thought is, 'let me look at the notes… to check that we're not going to get into trouble', you know…*
1, 10, 281-84	*yeah, who was, you know… who was… who was responsible?… were we responsible?... were we… had we been at fault, I suppose... and that just seemed to me to be an extraordinary response…*
1, 10-11, 297-311	*I think there's a huge institutional fear… and I think my current manager feels that… erm, that there might be blame… and the blame will be flying around… and, as long as none attaches to her, it doesn't really matter where else it is…*
1, 11-12, 339-63	*sometimes, it feels like I don't know how real it is… how… how real the threat is… it seems like a lot of anxiety that somehow someone will point the finger… and there have been a couple of incidents in the papers… and, certainly, there was, I think, a Chinese lad, who threw himself off the… one of the car parks in (name of town)… he wasn't a… err… a client of ours… he hadn't used our service, but… there was… it got into the papers… and there was a huge… flurry… of, kind of, 'did he access the service?', 'what you know… did he have to wait?'… dadidadida… erm… and that came from the Vice-Chancellor's Office… because it had caught his eye, and he… I think he was worried about reputational damage…*
1, 48-49, 1481-85	*erm, and I think the Head of Operations… who is Chief Operating Officer… COO he's called, (name of COO)… his fairly explicit expectation is that (current higher education employer) isn't in the papers… as having had somebody die while they were on the waiting-list…*
1, 51, 1553-55	*yes… erm… and there's a sense, I think, with both the COO and (manager's name) is that if blame was flying around, their first instinct would be to make sure it didn't land on them…*
1, 51-52, 1574-87	*yeah, that you could be thrown under the wheels of the car… erm… but I do feel that there is… it's kind of… I could appeal to (senior manager's name) and (name of HoSS), and that I'd get a fair hearing, so… so that steadies me up…*

Subordinate Theme #3.4: "Keep it short": organisational anxieties as occasioning pressure towards systemic throughput

Transcript Ref:	Quote:
1, 5, 128-30	*erm, the questions that, particularly my manager, who comes from a very different background, might be asking about why I'm seeing someone for the length of time I am…*
1, 15, 438-63	*'we've got three 'at risk' people on the waiting-list, one of them's been waiting three weeks'… can I afford to let this person… go without an appointment?… or, putting the appointment for three weeks' time… and get that other person in… or… whereas actually, if I was working in private practice, I'd be saying, 'well, that's really great, and we'll just see each other next week'… erm… that would not be on my sort of radar…*
1, 17, 520-21	*I think the institution can kind of push the client… push you… (hand gesture indicating being pushed)…*
1, 18, 535-40	*so, (manager's name)'s supposed to see five clients a week… and we will sit, and she… I know she has two clients… ha ha… and she'll sit and say, somebody needs to pick up… there's an 'at risk' on the waiting-list and somebody needs… and… someone needs to pick them up… and, err… somebody in the team will always crack, and say, 'well, I think I might have a space', and…*
1, 21, 624-25	*erm… and last week, we were told to… err, that there won't be any more resources, so we need to come up with solutions…*
1, 25, 753-54	*you know, I feel that in supervision, we hold the client in mind… erm… and the client is central… but… but the institution, it doesn't…*
1, 32, 957-58	*yeah… so then my boss'll troddle down, and say, '(counsellor's name), they mustn't get dependent on you'…*
1, 32-33, 984-96	*oh yeah… yeah, keep it short… keep it short… keep it short… keep it neat…*
1, 47, 1440-46	*I think (manager's name)'s very clear thing is about throughput… she came from an EAP… it's about throughput… it's about seeing people for the shortest length of time we can…*
1, 48, 1462-66	*yeah… and it's about… avoiding dependence, because that takes longer…*
1, 48-49, 1481-85	*erm, and I think the Head of Operations… who is Chief Operating Officer… COO he's called, (name of COO)… his fairly explicit expectation is that (current higher education employer) isn't in the papers… as having had somebody die while they were on the waiting-list…*
1, 55-56, 1688-98	*erm, and then he said he'd come back again the next week, which he did… erm, but, there was a bit of a row, because, of course, because he had been silent, I hadn't been able to write any assessment notes, because he hadn't been able to speak… erm… so*

	(manager's name) was cross about that, and saying, 'well, we can't do anything with him if he's not going to be prepared to talk and engage, and dadidadida'…
1, 66, 2014-16	*yes… what I find more difficult is actually… at one point (manager's name) came, and said, 'I notice you've seen him for a long time'…*
1, 67, 2048-54	*yeah… oh, it was like (manager's name) came trundling down, and said, 'you know, you're working with him rather a long time'… and I said, 'well, he is suicidal'… and she said, 'well, is this the right place for him?'…*
1, 67, 2062-64	*and she said, 'well, just because there isn't an easy place for him, we don't want him to get dependent'… the big 'dependent' word again…*
1, 71, 2163-76	*and that somehow that was being called into question in a therapeutic way… when actually, it was a management issue… but it was masquerading as a therapeutic… that I'm encouraging dependence…*
1, 71, 2185	*yeah… and that, actually, that was about a management…*
1, 72, 2204-14	*this is about me having seen him for fifteen sessions… erm… this isn't about me and him… this is about (manager's name)'s issue…*
1, 83, 2531-39	*yeah… and then, a sense of relief that (manager's name) was on leave, so I didn't… she was out of the picture… I didn't have to go talk… or she couldn't give me a lecture on boundaries… (laughter)… or, kind of, whatever she would do… so, it was a sense of relief that I…*

Subordinate Theme #3.5: "The third chair in the room": organisational expectations and anxieties as intruding into the clinical work

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Transcript Ref:	Quote:
1, 5, 134-40	*erm… so, it… so, it… it feels like the institution is in the third chair in the room sometimes, and that… can be quite hard to shut that off… erm, and it… feels like an additional pressure…*
1, 6, 161-73	*and I've worked in different institutions… and I've experienced that third chair… sometimes it's out in the corridor, and the door's shut, and it's just me and the client… erm, and other times, it's kind of parked in the doorway… ha ha… (laughter)… and other times, it's kind of… as… as close as… in the room as… I allow it…*
1, 7, 200	*yes, that it is… sometimes feels intrusive…*
1, 22-23, 667-80	*yes… erm, as an individual, kind of, really, and I think… I think, working with suicide, it… you always do hold stuff… 'cause it's an individual relationship, isn't it… but there's that sense felt of holding the institution's stuff as well…*
1, 64, 1947-51	*and now it's come tumbling down to me… erm, and I'm supposed to hold it, really…*

Subordinate Theme #3.6: "The demands are so much greater than my resource": torn between competing priorities

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Transcript Ref:	Quote:
1, 4, 106-24	*it's sometimes difficult, because… and I think we'll probably talk about this more… because of the pressure on the service… erm, we work in a time-aware way… we don't at the moment have a rationed number of sessions… which… is very positive overall… but it does mean that it comes down much more to your judgement in a way… there's nowhere to hide… erm, and you're balancing… the risk… that… that you think the individual is at against the knowledge of the length of the waiting-list…*
1, 6, 155-61	*because it's hard enough to hold the client without having to hold… erm… a lack of understanding by my immediate manager… erm… and that's… that is… difficult… it is difficult…*
1, 15, 433-44	*erm… (pause)… it's another factor in the mix… (pause)… I'm aware, for instance, erm, if I'm sitting with someone, and they were actively suicidal a couple of weeks ago… they're a bit better... things seem to have settled down a bit… erm… then I'm aware that… I've been in a meeting, say, in the morning… and… so part of me is with the client, but the other part is thinking, 'we've got three 'at risk' people on the waiting-list, one of them's been waiting three weeks'… can I afford to let this person… go without an appointment?…*
1, 16-17, 489-94	*so, and that… and that's part of the mix in a way that it just wouldn't be if the waiting-list wasn't there…*
1, 20-21, 604-19	*erm… (long pause)… stressed and overwhelmed, really… yeah… and a knowledge that, if I'm in that headspace for too long, I'll burn out… and that's always kind of at the back of my mind… that… is not a good place to feel that the demands are so much greater than my resource…*
1, 46-47, 1420-40	*I think they're implicit… there aren't explicit expectations… but there are implicit ones… and I think… they're in tension… so, I think… I think they're in tension…*
1,49, 1489-1508	*so, I think there are different… yeah, competing pressures… erm… and (manager's name), because she's the closest, is the loudest, but there's a sense that if… (pause)… if something actually happened… that the other voices would be the loudest… so it is competing… which is why the irritability with the noise… (laughter)… yeah… yeah… because they all want different things…*

Subordinate Theme #3.7: "Sound and fury, signifying nothing": impatience with inauthentic organisational noise as distracting from client needs

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Transcript Ref:	Quote:
1, 23-24, 694-711	*sometimes, that feels like the easiest bit… because the client is the client… they just come, and you're kind of… doing the best together with what you both bring, and that feels… (pause)… (sigh)… well, it can feel connected… it can feel not connected… it depends on*

	how the client is… but it feels authentic and real, and the rest feels like noise and stupidity… it just feels stupid… (raucous laughter)… whereas, actually, the work with a client never… never feels stupid… (laughter)… but the institution frequently feels stupid…
1, 24, 715-26	*erm… and so, in a way, even if the work is really difficult, and I feel very anxious and very worried about the client… erm… (pause)… it feels authentic, I suppose… it feels real… whereas, I think, quite a lot of the institutional dynamics feel a bit concocted, or a bit… (pause)… a bit about other stuff…*
1, 25, 743-70	*and my work with my supervisor feels real as well…(pause)… and that's… that… you know, I feel that in supervision, we hold the client in mind… erm… and the client is central… but… but the institution, it doesn't… it just… just feels… depends on the quality of your manager… quality of your manager's manager… whether the Vice-Chancellor sees something in the newspaper… erm… (pause)… whether the person you see happens to be, erm, the PA to the Head of HR… erm… erm, you know, it just all… it just all seems… I don't know… noisy… noisy, but unhelpful, and not… often very real…*
1, 26, 784	*I think, erm… I feel impatient with it…*
1, 26, 790-92	*and… isn't there a poem?... isn't there… noise… noise and something… signifying nothing…*
1, 28, 842-47	*well, it just makes a difficult job more difficult, I suppose… I think that's the… that's the unhelpfulness…*
1, 28-29, 851-67	*erm… (long pause)… it takes away the focus… again, it's a… a kind of… (pause)… that sense of, instead of it being, 'what does this human being need… from all of us, as an institution, and as a community to be as safe as they can be… and to recover from this distress or despair?'… erm… (pause)… it feels like that's not kind of the centre of it… as far as the institution's concerned…*
1, 30, 896-97	*and could we not just all put the client in the middle, and say, 'what can we all do to help this person?'…*
1, 31, 935-44	*unhelpful… just unhelpful really… because it's not about where the client sits… it's about what the client needs…*
1, 32, 967-79	*but, it's not my most central thought in my head is, 'don't let them become dependent on me, because we're a short-term service, and… if they really are going to get dependent, they should go to the NHS, because they've got the set-up'… you know, it's like, it's just not… that's not the way I am thinking when I'm with the client…*
1, 65, 1980-88	*erm… but I did think, before… whilst I was waiting for (client's name)… it would be really easy for me to say, 'oh, I'm quite relieved to see you'… ha ha… or something… which would not be appropriate in terms of what we're doing, because that's bringing a whole other…*

Subordinate Theme #3.8: "A lack of understanding": feeling unsupported by the organisation, and subject to unreasonable expectations

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Transcript Ref:	Quote:
1, 6, 155-61	*because it's hard enough to hold the client without having to hold… erm… a lack of understanding by my immediate manager… erm… and that's… that is… difficult… it is difficult…*
1, 21, 619-34	*erm… and the institution talks about supporting students, so… but… and mind, there is no money… erm… and last week, we were told to… err, that there won't be any more resources, so we need to come up with solutions… and that makes me angry, I think because… don't make this about me, and about the team… it's kind of… there isn't a solution… it's denying that it's complicated, and…*
1, 25, 748-65	*you know, I feel that in supervision, we hold the client in mind… erm… and the client is central… but… but the institution, it doesn't… it just… just feels… depends on the quality of your manager… quality of your manager's manager… whether the Vice-Chancellor sees something in the newspaper… erm… (pause)… whether the person you see happens to be, erm, the PA to the Head of HR…*
1, 27, 819-29	*there's a lot of stuff that's good about working at a university… I'm aware of all of that, but the… I do find the noise a big downside… yeah… and lack of understanding, I suppose…*
1, 50, 1517-28	*erm… well, I just… I just feel that (senior manager's name) and (name of HoSS) are the only grown-ups in the room… I think the COO and (manager's name) are both unreasonable… erm… which is why I asked about confidentiality before we started talking… but I think they're both unrealistic about what can be done actually…*
1, 68, 2082-83	*because, I think… 'cause, I thought, there's a fantasy that… that I can leave, and he'll be fine… there's a fan… there's some fantasy that I can do something that I can't do…*

Subordinate Theme #3.9: "It doesn't matter about my notes": disbelief at prioritisation of organisational interests in the wake of suicide

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Transcript Ref:	Quote:
1, 8, 230-41	*erm… at (second higher education employer)… when the client who I assessed went on to commit suicide, we had a temporary manager who, erm… went into my… I wasn't… it happened on a day I wasn't working… went into my filing cabinet… and took and copied my notes… erm, and I came in to hearing about the death, and then she'd sent me an e-mail, saying, 'I've… I've looked over your notes, and they're exemplary'… and I remember just being furious, and thinking, 'well, the client's dead… ha ha… it doesn't matter about my notes'…*
1, 9, 259-73	*well… (long pause)… I think I was very angry… not particularly that she wanted to see my notes… although I kind of, as I say, you know, the… the client was dead… ha… and the fact that I'd said that if his relationship broke down, or if his studies were compromised*

	in any way, that I felt he… he would be very seriously at risk very quickly… and that was what had happened… his relationship had broken-up, and he'd killed himself… so, the fact that I'd seen that seemed to me neither here… neither here nor there… also, it was like, 'is that your first thought?'… this man has died, and your first thought is, 'let me look at the notes… to check that we're not going to get into trouble', you know…
1, 10, 281-84	*yeah, who was, you know… who was… who was responsible?... were we responsible?... were we… had we been at fault, I suppose... and that just seemed to me to be an extraordinary response…*
1, 13, 371-85	*yeah… and actually, I think the bit that I experience is that the client gets lost… it's like, this was a person… and… somehow, they are lost in the institutional response… that's very much how it felt…*
1, 13-14, 393-403	*it's seen… yes, it's not seen as a… the… the kind of tragedy it is, really… that it's just seen as something that's a prob… a problem for the institution…*

Superordinate Theme #4: "Difficult conversations": responding to institutional expectations and anxieties occasioned by client suicidality

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Subordinate Theme #4.1: "Thrown under the wheels of the car": anxiety about being held accountable in the event of client suicide

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Transcript Ref:	Quote:
1, 4, 117-24	*but it does mean that it comes down much more to your judgement in a way… there's nowhere to hide… erm, and you're balancing… the risk… that… that you think the individual is at against the knowledge of the length of the waiting-list…*
1, 5, 145-46	*erm… (pause)… I think it feels… it makes me anxious… makes me anxious…*
1, 10-11, 306-11	*and the blame will be flying around… and, as long as none attaches to her, it doesn't really matter where else it is…*
1, 11-12, 339-45	*sometimes, it feels like I don't know how real it is… how… how real the threat is… it seems like a lot of anxiety that somehow someone will point the finger…*
1, 51, 1553-55	*yes… erm… and there's a sense, I think, with both the COO and (manager's name) is that if blame was flying around, their first instinct would be to make sure it didn't land on them…*
1, 51-52, 1574-87	*yeah, that you could be thrown under the wheels of the car… erm… but I do feel that there is… it's kind of… I could appeal to (senior manager's name) and (name of HoSS), and that I'd get a fair hearing, so… so that steadies me up…*

Subordinate Theme #4.2: "It rocked me": destabilised by organisational pressure to favour systemic throughput

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Transcript Ref:	Quote:
1, 49, 1493-94	*erm… and (manager's name), because she's the closest, is the loudest…*
1, 67-68, 2062-68	*and she said, 'well, just because there isn't an easy place for him, we don't want him to get dependent'… the big 'dependent' word again… and I found that more unsettling…*
1, 68, 2082-83	*but that made me more unsettled… because I think… 'cause I thought, there's a fantasy that… that I can leave, and he'll be fine…*
1, 69, 2100-14	*and I found that more unsettling… erm… because then I started to think, 'well, maybe there is something'… 'maybe it is dependence'… 'no, but it is ridiculous'… it's kind of… I'm any port in a storm… this is a ridiculous way of thinking… but it rocked me at the time…*
1, 72, 2197-2200	*well… well, to start with, I was a bit floored… and I did kind of examine my conscience, and think, 'well, maybe he is getting dependent?', and 'is that a bad thing?', and 'is that… is that going to cause, umm…?'… and so, it did wobble me…*

Subordinate Theme #4.3: "Rage against helplessness": anger at the demands and limitations of an unsympathetic organisational context

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Transcript Ref:	Quote:
1, 5-6, 151-61	*erm… and it also makes me angry, because it's hard enough to hold the client without having to hold… erm… a lack of understanding by my immediate manager… erm… and that's… that is… difficult… it is difficult…*
1, 8, 230-41	*erm… at (second higher education employer)… when the client who I assessed went on to commit suicide, we had a temporary manager who, erm… went into my… I wasn't… it happened on a day I wasn't working… went into my filing cabinet… erm, and I came in to hearing about the death, and then she'd sent me an e-mail, saying, 'I've… I've looked over your notes, and they're exemplary'… and I remember just being furious, and thinking, 'well, the client's dead… ha ha… it doesn't matter about my notes'…*
1, 9, 247-48	*and I don't think our working relationship ever actually really recovered from that…*
1, 9, 259-61	*well… (long pause)… I think I was very angry… not particularly that she wanted to see my notes… although I kind of, as I say, you know, the… the client was dead… ha…*
1, 18, 530-31	*yeah… and also, I'm aware… I think, what it does, is it makes me short tempered…*

1, 18-19, 535-66	*so, (manager's name)'s supposed to see five clients a week… and we will sit, and she… I know she has two clients… ha ha… and she'll sit and say, somebody needs to pick up… there's an 'at risk' on the waiting-list and somebody needs… and… someone needs to pick them up… and, err… somebody in the team will always crack, and say, 'well, I think I might have a space', and… and then… and what is never said, is, 'well, could you not pick them up?'… ha ha… and sometimes, it's… it's that kind of irritability… erm… with that kind of… (pause)… manage… there's a sense that… that she's not pulling her weight… and that that makes me really angry when I'm having these difficult conversations in my head… erm, and she's slacking, I suppose… so that makes me irritable and bad tempered… erm… so I think what happens is she gets a lot of my… rage against helplessness, I suppose…*
1, 20, 589-90	*and then, she's almost like the lightening conductor…*
1, 20, 595-99	*it's very… (pause)… difficult… sometimes I'm better… I think… I think it's difficult when I'm tired…*
1, 21, 624-34	*erm… and last week, we were told to… err, that there won't be any more resources, so we need to come up with solutions… and that makes me angry, I think, because… don't make this about me, and about the team… it's kind of… there isn't a solution… it's denying that it's complicated, and…*
1, 26, 784	*I think, erm… I feel impatient with it…*
1, 26-27, 796-802	*I work quite hard just to screen it out… (pause)… 'cause I'm aware of just being impatient, feeling impatient about it… I think… probably, if I have to settle on a word, it's 'impatient'…*
1, 63, 1927	*(sigh)… I just thought, 'oh, for God's sake'…*
1, 64, 1961-74	*yeah… yeah… that it kind of… I was a bit frustrated, but I also thought, 'well, I suppose that's his job to… to be the squishy bit between the coalface and the Chief Operating Officer'…*
1, 71, 2163-64	*yeah… and that somehow that was being called into question in a therapeutic way…*
1, 72, 2214-18	*and then, I thought, hang on a minute… this is about me having seen him for fifteen sessions… erm… this isn't about me and him… this is about (manager's name)'s issue…and then I just got really cross… ha ha… (laughter)… 'piss off'… (laughter)…*
1, 73, 2222-25	*yes… (laughter)… so… so that was… yeah… so that was that really… ha ha ha… this has turned into a long moan about my manager… but, yeah… yeah… in the end, I just got really cross… ahh, dear…*
1, 89, 2732-39	*I think it's just really having the chance to focus on just what the institution… what bits of the institution… (pause)… erm, intrude… and what... what I can tolerate reasonably well, and what really… makes me cross…*

Subordinate Theme #4.4: "That stays outside of the door": resisting organisational intrusion into the clinical work, sometimes occasioning conflict

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Transcript Ref:	Quote:
1, 6, 168-78	*and other times, it's kind of… as… as close as… in the room as I allow it… so sometimes I have to work quite hard to say, 'no, you're not… this isn't appropriate… you need to go to the other side of the door, and be shut'…*
1, 26, 796-98	*so, I… I suppose… I work quite hard just to screen it out… (pause)… 'cause I'm aware of just being impatient, feeling impatient about it…*
1, 55-56, 1688-98	*erm, and then he said he'd come back again the next week, which he did… erm, but, there was a bit of a row, because, of course, because he had been silent, I hadn't been able to write any assessment notes, because he hadn't been able to speak… erm… so (manager's name) was cross about that, and saying, 'well, we can't do anything with him if he's not going to be prepared to talk and engage, and dadidadida'…*
1, 56, 1698-1715	*and he had given me permission to liaise, so… and the GP was phoning again, so she… so, in the end, I spoke to the Head of Mental Health, who was somebody called (name of HoMH)… erm, because he had met this… my client… over the summer, when he was coming back to return to study… erm… and I spoke to (name of HoMH), and said, would you mind… I can't be trying to referee between (manager's name)… a row between (manager's name) and the GP… would you mind just stepping in… he's on your books as well… and picking up the liaison with the GP, and dealing with that… you're a manager… you go, and… would you just manage these people?… ha ha ha…*
1, 58, 1766-69	*he didn't go to the reception… he wouldn't engage with that at all, and that was another row, because he was supposed to go and sign himself in, and sit in the waiting area, and he just wouldn't do it…*
1, 65, 1980	*I'm quite good at compartmentalizing… generally…*
1, 65, 1988-90	*and, it just… I'm just aware of having to really think, 'right, that… that… that stays outside of the door'…*
1, 67, 2048-62	*yeah… oh, it was like (manager's name) came trundling down, and said, 'you know, you're working with him rather a long time'… and I said, 'well, he is suicidal'… and she said, 'well, is this the right place for him?'… and I said, 'well, he's not engaged with the mental health team... he's supposed to see (name of mental health team member), and he doesn't go and see her… erm, and… he's actively suicidal, and he does engage with me, so it does seem like there isn't another easy place for him to go'…*
1, 68, 2068-78	*but, fortunately, when there was a fuss right at the beginning, I'd sent an e-mail, and said, 'I'll either see him, but it might be all year… or I will be not prepared to see him at all… because of how he is, it's unethical to kind of do it half-way'… and she'd said, 'yes, that's fine'… so, I said, 'well, this feels like it's different now from the e-mail, and bases of…'... so, I was able to kind of head it off…*

1, 72, 2204-14	*and then, I thought, hang on a minute… this is about me having seen him for fifteen sessions… erm… this isn't about me and him… this is about (manager's name)'s issue… and then I just got really cross… ha ha…*

Subordinate Theme #4.5: "Well, you've done what you can": disenchantment with the organisation's level of investment in mitigating suicide risk

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Transcript Ref:	Quote:
1, 36-37, 1098-17	*so there's… so there's… so there's some practical kind of things… and talking about… safety, and… and… stuff, but not letting that… dominate, because I think… you can do what you can do, but… it's actually the… trying to work with the distress or the despair… that is what's going to change how that person is… if change is possible…*
1, 38, 1146-64	*I think, err… hmm… (pause)… and this is where notes are interesting, because the thing that… certainly, the experience of having my notes read was that I'd asked about a client, I'd discussed safety, I'd given out the Samaritans number, and that I'd recorded it… so, that was the institution's agenda… I know that… you know, in terms of just basic good practice… sort of, almost like hygiene… ha… that hygiene factor is… that's kind of something that you just do… but to me is not… it's not really about that…*
1, 38-39, 1164-79	*erm… and, I guess, what… what I… feel is I could give you a lot of words about how I gauge risk… and there are certain things I do… like I talk about a plan… I'll check for previous attempts… erm… (pause)… suicide in the family… erm, that kind of…*
1, 40-41, 1223-57	*well, I believe in it… I do think… I do think… that having the Samaritans number, and knowing where the emergency walk-in centre is… could well come in handy… you know, at two in the morning… so, I do believe in it… but it feels like… all that the institution will be bothered about is that I've done it, and I've recorded it… and I actually think that misses the point of kind of… risk, I suppose… what the risk actually is…*
1, 42, 1272	*no… no, I think it's… it's a thing…*
1, 42-43, 1281-1306	*so, I wouldn't go and talk to (manager's name)… but I would talk to someone else in the team if I was bothered… and we're a very close and supportive team, so… erm… because (manager's name) would be constant… 'have you told them about the Samaritans?'… 'oh, well that's alright then'…'have you got permission to liaise… liaise?'… 'oh well, they've refused that'… 'well, you've done what you can'… but actually, if I really wanted to talk about the client, I would talk to a member of the team…*

Subordinate Theme #4.6: "That steadies me up": supportive others as modulating organisational intrusion and containing anxieties

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Sub-Theme #4.6.1: Managerial staff

Transcript Ref:	Quote:
1, 6-7, 178-87	*since my immediate manager has got a much better manager, who was a counsellor, and, in fact, was my supervisor for many years… she came from (first higher education employer)… (senior manager's name)… I've been less anxious, because I have some sense that, even if my immediate manager is… doesn't get it… that (senior manager's name) actually does…*
1, 7-8, 211-26	*in (first higher education employer), it wasn't a feature at all… erm… and interestingly, I worked there as a sessional… as a placement counsellor, and as a sessional counsellor…and I saw at least two people there who… (pause)… had well worked-up plans… and were clearly at risk, and I never… never felt any of that anxiety… I felt the anxiety that I felt about… the client, and the safety of the client… (pause)… but nothing with the institution, because that was held very well at (first higher education employer)…*
1, 9, 248-53	*and then, we got a new permanent manager, who was much more containing… and, err, the Head of Student Services did actually come and talk to me… and she… 'cause she dealt with all the student deaths, which are quite a lot at (second higher education employer) one way and another… erm, and she was unusually containing…*
1, 11, 311-18	*whereas, as I say, since (senior manager's name)'s come… err, it feels like (senior manager's name) is much more able to hold… that's (manager's name)'s manager… hold the fact that people die, and no one's to blame…*
1, 11, 332-38	*yeah… yes, and actually, erm, the Head of Student Services at (second higher education employer) was really good… she just said, 'these things happen'… erm… (pause)… and she kind of… she was very… (pause)… sensible about it…*
1, 48, 1470-77	*yeah… erm, and I would say, (senior manager's name), and (name of HoSS), who is the Head of Student Services… their implicit expectations are that we… work given the constraints on the resources we have… to meet the need… the need, and mitigate the risk…*
1, 49, 1493-99	*erm… and (manager's name), because she's the closest, is the loudest… but there's a sense that if… (pause)… if something actually happened… that the other voices would be the loudest…*
1, 50, 1517-43	*erm… well, I just… I just feel that (senior manager's name) and (name of HoSS) are the only grown-ups in the room… I think the COO and (manager's name) are both unreasonable… erm… which is why I asked about confidentiality before we started talking… but I think they're both unrealistic about what can be done actually… whereas I have some faith that (name of HoSS) and (senior manager's name) are quite grown-up in their expectations, and quite reasonable in their expectations… erm… and that's… that's the bit that feels quite steady institutionally for me…*

1, 51, 1553-61	*and there's a sense, I think, with both the COO and (manager's name) is that if blame was flying around, their first instinct would be to make sure it didn't land on them, whereas with (senior manager's name) and (name of HoSS), I don't have that sense at all… I have considerable respect for them…*
1, 52, 1578-91	*erm… but I do feel that there is… it's kind of… I could appeal to (senior manager's name) and (name of HoSS)… and that I'd get a fair hearing… so… so that steadies me up… just… while there are some people, it's not a completely…*
1, 52, 1596	*yeah… yeah… to be reasonable…*
1, 56, 1706-17	*erm… and I spoke to (name of HoMH), and said, would you mind… I can't be trying to referee between (manager's name)… a row between (manager's name) and the GP… would you mind just stepping in… he's on your books as well… and picking up the liaison with the GP, and dealing with that… you're a manager… you go, and… would you just manage these people?… ha ha ha… (laughter)… and, bless him, he said, 'yes… yes, of course I'll do that'… is there anything else you need?', and I said, 'no, I don't'… (laughter)…*
1, 56, 1721-24	*yes… (laughter)… and bless him, he did… and he was… he was very… he went and poured oil over everybody… (laughter)… and actually that just then created the space, and then (client's name) came back*
1, 83, 2547-53	*so (name of HoSS) was the only one in, so he was covering… so, I thought, 'well, that's okay, because if there's a problem, and can go and talk to him, and he's sensible… erm, so there was quite a sense of relief…*

Sub-Theme #4.6.2: Supervisor

Transcript Ref:	Quote:
1, 17, 498-516	*erm… I suppose it makes me much more reliant on my supervision… I think I use my supervision a lot… to hold that tension… erm… because it's almost like I need another voice… to… and another conversation… a conversation which isn't… which puts the client back in the middle… back to that… back to the client being in the middle…*
1, 25, 743-53	*and my work with my supervisor feels real as well… (pause)… and that's… that… you know, I feel that in supervision, we hold the client in mind… erm… and the client is central…*

Sub-Theme #4.6.3: Colleagues

Transcript Ref:	Quote:
1, 42-43, 1276-1315	*I guess, what I find enormously helpful is the other members of our team, so I wouldn't go and talk to (manager's name)… but I would talk to someone else in the team if I was bothered… and we're a very close and supportive team, so… erm… because (manager's*

	name) would be constant… 'have you told them about the Samaritans?'… 'oh, well that's alright then'… you know… 'have you got permission to liaise… liaise?'… 'oh well, they've refused that'… 'well, you've done what you can '… but actually, if I really wanted to talk about the client, I would talk to a member of the team, and they are really… erm… we are supportive of each other… people would always make time… so, I feel supported in that way…
1, 43-44, 1320-36	*yeah… so I might knock on someone's door, and say, 'look, can I just have five minutes… I saw someone, and… the CORE scores are very low, and they didn't seem… but I'm just… been left feeling really bothered… and I'm seeing them next week, but can I just have… 'cause I don't know what it's about, but I feel really bothered'… and people will always make time for that, so…*

Subordinate Theme #4.7: "That's all I can do really": accepting relative lack of control in no longer struggling against limitations

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Transcript Ref:	Quote:
1, 19-20, 570-89	*but actually, I am quite helpless… I can… I can only do what I can do… and I can't always meet the demands that are made… I mean, we can't as a team always meet the demands that are made on us… because our... our demand on the service has gone up over 30% in two years, so we just can't…*
1, 23, 694-704	*sometimes, that feels like the easiest bit… because the client is the client… they just come, and you're kind of… doing the best together with what you both bring, and that feels… (pause)… (sigh)… well, it can feel connected… it can feel not connected… it depends on how the client is…*
1, 32, 957-74	*yeah… so then my boss'll troddle down, and say, '(counsellor's name), they mustn't get dependent on you'… I've been working with this suicidal client actually… I can do what I can… but it's not my most central thought in my head is, 'don't let them become dependent on me, because we're a short-term service, and if they really are going to get dependent, they should go to the NHS, because they've got the set-up'…*
1, 34, 1019-39	*erm… I experience it as very human… it's like the human condition, isn't it?… it's kind of… we… we all struggle, I feel… I… my personal belief is… we all struggle with the… kind of, to make meaning out of life, which often is chaotic and random, and to make an accommodation with the fact that we die, and that it's finite… and that in that muddle, a suicidal person is… is faced with those same set of dilemmas, and making relationships… making meaning of… what I believe to be, kind of, a bit of an accident, really… life's a bit of an accident… ha ha ha… (laughter)… I don't think there is any inherent meaning particularly…*
1, 36-37, 1098-1117	*so there's… so there's… so there's some practical kind of things… and talking about… safety, and… and… stuff, but not letting that dominate, because, I think, you can do what you can do, but… it's actually the… trying to work with the distress or the despair… that is what's going to change… how that person is… if change is possible…*
1, 39-40, 1197-1204	*and on paper, you'll be thinking, 'why am I seeing this person when his CORE scores are like that?'… and 'why are they not telling me the truth?'… and 'why should they?'... 'they don't know me'… 'they don't… they might feel very ambivalent about trusting me…*

1, 64, 1961-74 *I was a bit frustrated, but I also thought, 'well, I suppose that's his job to… to be the squishy bit between the coalface and the Chief Operating Officer'…*

1, 81, 2491-93 *yeah… just, I'm knackered… it's the week before Christmas… please don't do this to me… but it… it is the time… it's like the Friday afternoon… it is the time when these things happen…*

1, 86, 2622-25 *erm, so… but then there wouldn't necessarily be if she'd killed herself off… and wasn't on campus… erm, so I was aware of feeling uneasy… I thought, 'well, I'll just write a calm e-mail, and that's all I can do really'…*

Table of Master Themes

Superordinate Theme #1: "Stirred up": emotionally unsettled by encounters with client suicidality

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Subordinate Theme #1.1: "You're on high alert inside": experiencing anxiety about possible client suicide

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Subordinate Theme #1.2: "Absolutely on the edge": troubled to witness despairing clients walk the "tightrope" between life and death

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Subordinate Theme #1.3: "There's always doubt": living with uncertainty and lack of control in relation to client choices

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Subordinate Theme #1.4: "I felt so helpless": experiencing a powerlessness to help in relation to suicidal clients

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Subordinate Theme #1.5: "I do carry a weight around all the time": experiencing work with suicidal clients as burdensome and challenging

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Subordinate Theme #1.6: "Everything in me doesn't want them to die": invested in keeping suicidal clients alive

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Superordinate Theme #2: "Goldilocks and the Three Bears": experiencing risk management as either 'too much', 'not enough', or 'just right'

Subordinate Theme #2.1: "This is not gonna happen in five or six sessions": concerned by insufficient investment in mitigating suicide risk

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Subordinate Theme #2.2: "Don't want to stand on any landmines": erring on the side of caution in taking the threat of client suicidality seriously

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Subordinate Theme #2.3: "Keeping them in the wider organisational mind": flagging up suicidal clients to facilitate support from colleagues

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Subordinate Theme #2.4: "Does everyone know?": linking in suicidal clients with external professionals in the interests of minimizing risk

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Subordinate Theme #2.5: "Being pulled off course": experiencing risk management obligations as compromising the therapeutic relationship

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Subordinate Theme #2.6: "Going through the motions": experiencing risk management as an empty gesture, unlikely to protect client well-being

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Superordinate Theme #3: "It's good to ask for help": experiencing both isolation and organisational support when working with client suicidality

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Subordinate Theme #3.1: "Handcuffed": struggling with the restrictions on disclosure of suicidality imposed by confidentiality requirements

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Subordinate Theme #3.2: "Everybody's head goes underneath the water": feeling isolated and unsupported in the process of managing risk

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Subordinate Theme #3.3: "That steadies me up": appreciative of empathetic managerial support when working with suicidal clients

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Subordinate Theme #3.4: "Being able to offload": appreciative of supervisory containment and reassurance in relation to suicidal clients

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Subordinate Theme #3.5: "It's like a sort of basket, holding you": experiencing relief in sharing the burden of responsibility with others

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Subordinate Theme #3.6: "Being affected, but not infected": engaging in self-protective boundary-setting in the interests of self-care

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Superordinate Theme #4: "Noisy, but unhelpful": grappling with the institutional expectations and anxieties occasioned by client suicidality

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Subordinate Theme #4.1: "The third chair in the room": organisational expectations and anxieties as intruding into the clinical work

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Subordinate Theme #4.2: "Sound and fury, signifying nothing": impatience with inauthentic organisational noise as distracting from client needs

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Subordinate Theme #4.3: "Thrown under the wheels of the car": fearful of being blamed in the event of client suicide

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Subordinate Theme #4.4: "It can be a bit knee-jerky": experiencing the vulnerability occasioned by reactive organisational politics

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Subordinate Theme #4.5: "It's a no-win situation": forced to make difficult choices about competing priorities when overloaded with clients

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Subordinate Theme #4.6: "Rage against helplessness": angered by confrontation with the limitations and demands of an unsympathetic system

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Detailed Table of Themes

Superordinate Theme #1: "Stirred up": emotionally unsettled by encounters with client suicidality

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Subordinate Theme #1.1: "You're on high alert inside": experiencing anxiety about possible client suicide

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Transcript Ref:	Quote:
1, 3, 80-1	*erm… and… (pause)… it feels a big responsibility…*
1, 4, 112-18	*erm, we work in a time-aware way… we don't at the moment have a rationed number of sessions… which… is very positive overall… but it does mean that it comes down much more to your judgement in a way…*
1, 5, 146-47	*and, I think, I'm anxious anyway if I think somebody is… suicidal… I hold… I hold that anxiety…*
1, 22, 671-72	*and I think… I think, working with suicide, it… you always do hold stuff… 'cause it's an individual relationship, isn't it?…*
1, 58, 1775-84	*and I was worried, because… 'cause he did so much climbing, I was worried that he was desensitized to… to the fear factor…*
1, 81, 2473-79	*and it was my last day of work before Christmas… and I was thinking, 'this is going to be, but there's nobody around'…*
1, 82, 2505-07	*and then, as the tale unfolded, I was thinking, this is really… potentially… there are not many breaks here… I can't see any easy…*
1, 86, 2625-30	*and I was aware of a huge sense of relief that… when she came back, and said, 'no, no, I'm…'*
1, 86, 2639	*yeah… she kind of popped into my head a couple of times…*
2, 27, 749-62	*it might speed-up the amount of help that student gets from the GP, and…and in getting a referral into an NHS psychiatric assessment… so, things that I might not have thought about, possibly in my anxiety… because it stirs up such anxiety… especially if it's quite acute, and the student is… is threatening to commit suicide imminently… that anxiety that gets stirred up in… in me can… prevent me being able to think clearly…*

2, 30-31, 857-80	*I mean, in… in this… at this particular time, I am aware that resources are tight in all senses of external support, but… and… and that is stirring up a lot of anxiety, I think, in the student counsellors at the moment… there is a feeling that… resources are limited… and if I refer the student to the GP, how long is it going to be before he's actually able to get help?... hopefully… I mean, if he's in acute crisis, it will be dealt with, but if he's one of the many who feels suicidal from time to time… erm… or has ideas, but isn't… isn't going to act them out… but still needs a lot of help… that level of suicidal feeling is… I think, in a way, stirs up more anxiety…*
2, 32, 893-909	*yes… he could be assessed… he could have a psychiatric assessment… yes, this student, you know, is 'at… is 'at risk'… but because he might not be the highest level of risk, he'll be… go to the back of a… a long waiting-list, and that… that stirs up anxiety… also, because he… our resources are limited… we therefore can't always offer him what he needs… he needs money in order to pay for private counselling to get what he needs… he might not have that money… so, he falls into that gap between, you know, ongoing private support and limited NHS support…*
2, 32-33, 914-20	*yes… yes… which might of course be his experience with his own parents of needing more support, and falling… it falls short of what he needs… so that stirs up a lot of anxiety…*
2, 38, 1065-88	*yes, it's more anxiety-provoking, because one can never relax with that student… I never know what will… you know, in theory, I never know what will have happened to that student when I go home after one week's session before next week's session… I may be… I may be informed during the week, or when I come back in, that that student has got drunk, and made a suicidal attempt… erm… so, although I can switch off, and I do switch off between sessions, that student will come into my mind periodically during the week at odd times at home… so external to the organisation… for sure…*
2, 39-40, 1102-1119	*yeah… yeah… even now, my mind… my head feels quite sort of spinning… as if I'm… there's a level of anxiety in talking about this… and about those students that… that…*
2, 40-41, 1142-69	*yes… yes… I've got one here in note form… so, I've got one in this room that does stir up… you know, that… that e-mailed me at twenty minutes to New Year, and I got that e-mail during the Christmas break, after New Year… erm, which brought him into my home… you know, and… into… into my thinking, and level of concern…*
2, 56, 1587-94	*so he… he… unlike some students who I might feel quite rejecting of at a personal level… this one, I feel very close to, and very attached to, and very, yeah, very maternal towards… so it stirs up a huge amount of concern in me…*
2, 58, 1641-54	*he finds it hard to think about the danger that he puts himself in when he gets drunk, so my role is to say, you know, every time you get drunk, you might have an accident… you might kill yourself without even realizing that you're doing it… that's really worrying… so, we need to think about that worry… we need to think how you can keep yourself safe… and you clearly are drinking, and putting yourself in dangerous situations when you're not with me, so we need to think about this… how can we keep you safe?... I'm not going to let this drop, and pretend that you're going to be okay when you leave this room until next week, 'cause I don't know if you'll be here next week… so, let's think about this… let's…*

2, 60, 1697-1712	*so… you know, breaks… yes… yes… and of course, breaks, as you're probably aware, are when… when they don't feel held in mind, so it can be… stir up an increased concern… both in me, 'cause I'm now not going to be there for four weeks, and… and in him…*
2, 62, 1769-74	*you know, there are students who say, 'no, please don't tell my parents', and that in itself stirs up a lot of anxiety…*
2, 63, 1803-05	*absolutely… and it's what the parent normally wants to be informed of, but if the student says 'no', that stirs up a lot of difficult feelings, I think, for…*
2, 68, 1948-49	*and a bit worrying at night, or on your own, about the safety of a student…*
2, 84-85, 2403-18	*if I know the student is in their room, on their own, all the time between seeing me and the next session… you know, so… not in relationship with… even with themselves enough to feed themselves, you know… so that, of course, is… stirs up a lot of concern in the… in all of us…*
2, 94, 2676-95	*yeah… yeah… and then, when I left the service, I could feel that she was still being held by them… which was quite a nice feeling for me, 'cause there's always that anxiety… yeah, there's always anxiety… that's the other thing, at the end of university counselling work, it's going to come to an end… they've then got to leave the university… another transitional time, when those feelings are going to get stirred up again…*
2, 95, 2708-14	*and, you know, I can refer them to external or low-cost counselling… and will always do that if that's what they'd like, but that's where it ends… it's hard to manage that helplessness…*
2, 99, 2835-45	*erm, but… but because it's all about managing… risk and death, which inevitably stirs up a lot of anxiety in myself and the student, that ability to remain able to think is what it's all about… only then can I… can I help them…*
3, 6, 157	*I find it quite anxiety-provoking…*
3, 8, 206-08	*it is difficult… I certainly feel more stressed… in fact, I'm feeling a bit anxious even talking about it, which is interesting… so, I'm sort of getting in touch with that anxiety…*
3, 9, 235-36	*now, I didn't feel it was up to me to say, 'we have to complete this', because that's really about my anxiety…*
3, 9, 242-49	*erm… but, I suppose, I'm thinking, well, I have done what I have learned to do… in… both in my initial training, and also in CPD… erm… and, at the end of the day, if somebody kills themselves… I suppose I always think in terms of… 'if there was any sort of investigation, can I say what I did, when?'… 'yes, I can'…*
3, 10, 269-76	*we only… we can only trust that our clients are okay between now and next week… now sometimes, I might see them on campus… erm, but mostly I don't, even though… even though it is a small campus here… erm… and I think it is… there is a lot of anxiety about that…*

3, 11, 289	*well, I think, in some ways, it's very worrying…*
3, 11, 306-07	*so, I may be feeling anxious…*
3, 12, 325-34	*because I could worry… I could… I could stay awake all night worrying every night until I came back to meet with my client, but actually, it's not… it's gonna be quite harmful to me, and it's not making any difference whatsoever… and sometimes, of course, that's easier, erm, you know, said than done…*
3, 22, 623-32	*I think that's… I think that is true… I think so… I suppose, for me, there's also a fear… erm… that… that they will kill themselves…*
3, 33, 950-52	*erm… but the fact that somebody was feeling drawn to the sea, and we… we're close to the sea… I suppose that that felt more worrying…*
3, 35-36, 1001-13	*but, I suppose, my… my role is different… I generally work very much on my own… erm… and I can't share information because I feel anxious… you know, the ethical guidelines… that's another thing, of course, is the ethical guidelines… a very important part of decision-making… erm… but I can't share information because I feel anxious… I have to manage my anxiety…*
3, 51, 1468-70	*umm, hmm… erm… this is a client that I'm actually working with… erm… this is the second academic year… erm… and last year, she disappeared on me, which was quite difficult…*
3, 53, 1524-25	*but I knew that this student was suicidal, so that was really quite… quite worrying for me…*
3, 54, 1536-38	*and then, it was difficult, because I didn't know whether she was on campus… I didn't know whether she was okay…*
3, 55, 1559-65	*now, it's not written down anywhere that they should let me know… erm… but, I'm thinking, 'well, they… they knew that she was gone, and I didn't, and I had all that anxiety, and had they let me know, I needn't have had that anxiety'…*
3, 58, 1644-49	*erm… but, I suppose, I find it more worrying that somebody's suicidal and not particularly articulate, and not very clear-headed…*
3, 59-60, 1688-1700	*yeah… which is difficult for me to manage… it is difficult… erm… and I suppose… I… I have worked with people in the past who've been suicidal, and have come every week… ha ha… that was easier… ha ha ha… you know, the being suicidal, and… and the not coming… and not knowing whether you're okay or not is hard…*
3, 63, 1796-99	*now, when she didn't turn up in that last appointment… erm… I'm thinking, 'we're now gonna have a two-week break'… 'she's not turned up'… 'I've no idea whether she's alright or not'…*
3, 79, 2257-60	*and I sat… she was my last client in the morning… and I sat then, in the room… in the surgery, on my own… I tried to get hold of my supervisor, and I couldn't… and I thought, 'she is at risk'… 'far as I know, apart from her making an appointment, she's going to go and kill herself'…*

3, 84, 2399-2402	*so, there was me with all that anxiety for all those hours, and it was easily forgotten about by someone else… but I suppose that's it, that I hold the majority of the responsibility…*
3, 92, 2626-27	*I think, certainly at the beginning, it was an 'ahhhh'… (gesture indicating falling)…*
3, 92, 2631-39	*erm… and I think it's… I… I think, also, you know… we… we… we always… we know that people who talk about suicide, there's less chance… but I think, when I first started, although I knew that intellectually, I don't know that I really believed it, and I think there was that fear of, 'if we talk about it, is that going to make them do it?'…*
3, 95-96, 2736-54	*it… it is particularly difficult for me to work with suicidal clients… I can't imagine anybody would welcome a client coming in and telling them that they're thinking about ending their life… erm… and I suppose that kind of validates, having talked for an hour and a half about it, it is difficult… it's difficult because it's difficult… and that's not going to change… ha… erm… and that it's okay for it to be difficult for me, and it's okay that it's anxiety-provoking… and that I can live with that anxiety… and I suppose, if I couldn't, I wouldn't do this…*
4, 2-3, 51-59	*erm, and the university as a whole, we've had a recent number of suicides… so that is really hard… so, we hear about these suicides, and, in fact, we had one quite recently… erm… and she was seeing someone here… but then, she intermitted and left… and she actually killed herself at home… err, which caused a lot of, err, angst and worry here…*
4, 5, 116-19	*well, just… erm… sitting between sessions… 'are they gonna come back next week?'... 'will they kill themselves over the weekend?'... 'is it gonna turn from ideation into an actual plan?'... erm… yeah…*
4, 6, 144-58	*yeah… yeah… or just that they have more concrete… there's either been a past of an attempt… or they have more concrete plans… so, you know, I have a client who's already written his will, and already knows how he's gonna do it… and, he's already said, 'if this doesn't happen, then, I'm gonna end my life'… and that's quite concrete, I think… so, sitting with that, as time goes by, and his so-called deadlines approach, I'm nervous… yeah…*
4, 7, 198-99	*(sigh)… it's very diff… it's… well… well, I worry, of course… I worry about him…*
4, 8, 210-21	*and in the therapeutic relationship, if he's not willing to address anything, because it's very black-and-white… I either get this, or I don't… and he's finding it really hard to consider any kind of alternative… it's me or death… ha ha… so, it does feel… so, I'm really concerned…*
4, 19-20, 544-54	*erm… but… yeah, I have to say, I don't… well, it doesn't… yeah… I have gone home on the weekends going… (big sigh)… 'just please let them be okay by next week'… yeah… yeah…*
4, 22, 614-24	*so, I… I know clinically… like, I know, I've done my job… I've written the notes… I've flagged it… I spoke to my line manager… she knows… but essentially, the feedback is, 'well, you've done everything you're supposed to do'… but I keep thinking, 'well, is there more'…*

4, 28, 784-800	*and often, with suicide, it's often the people who are not making a fuss who tend to kill themselves, you know… I don't know if… it's been my experience… often, students who are making the biggest fuss, and demanding all the attention, tend not… not to… there's no correlation… (chuckling)… I'm just saying, from what I've realized… so, it's those students who are kind of really hiding that… that worry me…*
4, 31-32, 894-921	*yeah… and, of course, it's down to the students… so, I know of a student who is very vocal… is very able to get resources… who's able to identify how they're feeling… who's worried they might do something, or act on their thoughts… would… would… would get help, but one or two people who I know, wouldn't… that's what worries me… I guess it's for those students in those situations… I know they wouldn't tell someone that they're feeling suicidal… and, they have thought about plans over time… so those plans are there… so, they could carry them out…*
4, 40, 1129-41	*(pause)… well, it feels, I guess… I'm very aware that I feel uncomfortable with it… I feel… I start to get more worried… yeah… that feels a lot more worried… and, I think, the taking more responsibility kicks in, and having to maybe manage or controls sticks… sticks… you know, my… I guess, my own anxiety…*
4, 64, 1844-45	*and I guess it's the same way with the suicidal thing… there's a flare of concern…*
4, 71, 2029-41	*yes, because of the increased numbers… yeah… yeah… so, I guess, when you, or when… or, when you… when I am sitting opposite a client who presents with a very complex psychological history… erm… automatically, I know from the first session, this is not gonna be one session, or two or three… it's gonna be more than that… yeah… and, I guess, that raises my worry or anxiety…*
4, 75-76, 2160-95	*yeah… yeah… it is… I think it's hard… because, yeah… you do… you're touched by the struggle in front of you, and, I guess, you don't want them to die… ha… you don't want them to kill themselves… and, I guess, the… it is… the suicides in the universities are high… Bristol University's been through really a tough time… and they're cutting services… I think it's the East London University?… I can't remember which university… they're cutting the counselling services… so we're very privileged to have what we have, I think… erm… so, it is very worrying… and I guess… touch wood… I've never lost someone, and I guess part of me thinks, 'it's… it's gonna happen', and I guess that's what gets triggered for me when I think it's close… 'is this gonna be the one?'…*
4, 77, 2199-2208	*yeah… yeah… I guess maybe that's the underlying fear that one of my… the students that I'm seeing… might take their life…*
4, 84, 2400-12	*you know… whereas his again, it's planned… he doesn't do anything on like a whim… he's not self-harming… she is so much more impulsive… so, I think, if she… she could just decide one day, 'right, I'm doing it now', and, I think, that's what makes it harder for me to sit with between the weeks… I worry about her with that…*
4, 94-95, 2703-30	*(sigh)… yes, in my private practice, but not here… not here… I guess, here to the extent where it's just holding the 'what if?'… you know, where something has not been so clear, but you know you've done everything you can… 'it will be fine'… and then, you're holding it, kind of, on the weekend… I do… yeah… especially sometimes…*

4, 95-96, 2740-51 *yes… but you're still left with that, 'it could be, right?'… and then you go home… and it's the weekend… and it's family time… and everything's going on normal… but you know, at the back of your mind, you're thinking, 'ohh, this is what I left today'…*

4, 97, 2789-93 *yeah… it is… it's unease… it's discomfort… and, I think, it's having to sit with the discomfort the whole weekend… yeah… yeah… I mean, it comes and goes… obviously, I don't sit there worrying the whole weekend… it's not like that… but I think it's just there… it's just always there in your mind…*

4, 121, 3471-79 *(long pause)… I think there is a lot of anxiety in the light of the fact that they happen at the university… and I think there is a lot of worry about us trying to make sure that we cover all our bases, and everything is documented, everything is reported, and everything is talked about… but I think there is a lot of anxiety about that here…*

6, 8-9, 223-42 *erm… he was… he… came to this crisis point very often, and didn't want to be there, and… and didn't, as a kind of an… on an ongoing level… want to… to kill himself, or to die… but he would be caught up in the moment of crisis… and so, it was possible to, kind of, engage with him on that level about it… but he was also very aware, because he knew that he got caught up in this moment of crisis… he was aware of all of the services available to him… the, sort of, duty psychiatrist at A&E… and the crisis team… and was in contact with them… so, in… in a lot of ways, he was safeguarding himself, which was… whi… wh… which was helpful… I suppose it left me with an anxiety about… I think, it… it… it… on some level, it was just, 'what is the long-term effect on your health of these constant overdoses?… even if each individual one doesn't kill you… what are you… what are you doing to yourself in the long run?'… and… and the notion of that as being an… an… an ongoing kind of self-harm…*

6, 34, 957-59 *so, I think the difficulty for me sometimes is, erm… when someone says something that on… you know, on paper… activates all of the kind of alarm signals…*

6, 51, 1454-61 *it probably introduces that little frisson of anxiety if someone sort of says… you know, when someone starts saying things like, 'well, you know, sometimes I just wish that… (pause)… eh, you know, I weren't here anymore'… or, 'I think the world would be better off without me'… and you start, sort of, going down, and asking about that, and sort of probing those feelings, and, you know, I sort of think, 'okay, right'… it's like there's a little bell going on…*

6, 60, 1716-18 *it's, erm… (pause)… so it was a… it was a strange thing, in that, on… on one level… what was the risk?… there was a constant ongoing risk…*

6, 60-61, 1728-48 *yeah… yeah… and so, it… it was a tricky one, because it was… it was clearly… it was clearly risky… but it was being done in such a way that it had become completely normalised… pause)… and I suppose my kind of long-term worry for him was, I thought, 'well, you are… you are killing yourself slowly by taking lots and lots and lots and lots of Paracetamol… like, a lot at a time… when you already have, you know, quite significant health problems'… erm… 'whether any one overdose sort of succeeds, you're still causing yourself a lot of damage'… erm… 'and all it takes is one day for you not to, kind of… not to get to them at all'…*

6, 61-62, 1752-66 *yeah… yeah… but I think there have been so many services involved… and so many people doing their bit for the, umm… you know, sort of… alerting everyone else, and de de de de… it's kind of like a telephone tree or something… (chuckling)… and… and I think,*

everyone had… y… you know, become very comfortable with the idea that nothing… you know, he doesn't… eh… he… he isn't gonna do it… and I think that… there's something about that dynamic which is… a bit scary as well, because you just sort of think…

6, 62, 1770-86 *yeah... or, they… they… you know, they sort of take it seriously… but he's not died yet, and he's done this many, many times, so this is maybe just part of his thing… but then you think, 'I don't know if you can feel like that… I don't know if you can feel like you want to die… constantly, for years and years and years, without eventually succeeding'… I don't know… I mean…*

6, 65-66, 1860-80 *but I think… yeah… it is a different sort of risk… it is a different… erm… well, it's funny… it… it depends on, kind of… how you talk about risk… like, is the risk… when you talk about risk, are we talking about risk of one… person killing themselves… on one occasion, or are we talking about someone killing themselves sort of slowly over a long period of time… you know, what… what counts as self-harm… what counts as risk… erm… and in what sen…*

6, 66-67, 1902-13 *yeah… well, and particularly if it… if it's… if it's a sort of, you know, series of… of damaging attempts at terminal… ha… harm… erm… but I think there… I think if enough people become involved, and there's enough of a kind of… eh… network there, you can lose sight of the actual risk maybe, or you can, eh… erm… because, if we're saying that previous attempts are an indicator of future success… this guy's getting closer and closer to success every week… ha… umm… you know, if you… if you look at it that way…*

6, 85, 2450-52 *yeah, the… eh… eh… I suppose, erm… (sucking gums)… yeah, I suppose in the… in the latter case, I was very much left holding the anxiety…*

6, 86-87, 2462-88 *'you can't share it was anyone'… 'I've ju… no, I was just saying that… I didn't mean it'… and then… and so… I was stuck, sort of going… 'well, but… uh… uh… uh… uh… uh'… 'but technically, I mean… eh'…(sigh)… you don't want to split hairs… you know, you don't want into… to go into, sort of, technicalities on this, but you just sort of think, 'but you did… you did s… you did say, and I have the feeling that you're saying now this, because you don't want me to contact your GP'… and, you know, and you can talk about all of that, but at the end of the day, it… it kind of left me with this feeling of, 'so, what do I do?', and, you know, I talked it through with my supervisor, and…(sniffing in air)… erm… eh… the feeling we had was that there was not an active risk, and I… I ag… I agree with that, but I still feel very anxious with that client… eh… erm… and I feel like I'm sort of holding that anxiety… (beeping noise)… and I think… I think that is a dynamic that he brings into a lot of his relationships, as well…*

8, 3, 64-78 *I… I think I live… I… well, on the one hand, it's, like, normal… on the other hand, I live in… I live… I… I think… I… I… this is what I say, 'I live in fear every day that someone is gonna kill… a client's gonna kill themselves'… it hasn't happened yet on… eh, in terms of one of my clients… or someone that I was, kind of, responsible for, if you know what I mean… that's not happened… but, yeah, I live in fear of it every day… yeah…*

8, 4, 100-15 *I think… k… k, as long as it doesn't happen… (chuckling)… it's okay, but I… I worry about how I would cope if one of my clients killed themselves, and I was… it was on my watch, if you know what I mean… and they've now gone to a different service, or… that's different… if I feel like it was under my… I was… it was… the… the… they were on my caseload at that time, I don't know how I'd man… I don't really know how I'd cope with that… (intake of breath)…*

8, 9-10, 243-69	*yeah… and I'd miss somebody, or I'd… like, I suppose my fear would be… someone doesn't turn up for an appointment… I need to contact them… I don't contact them, because if you've got space, then s… you just get asked to do something else… several other things would take over… and then it's… you know, you… you're… you're tired… it's the end of ter… and you'd think… and you didn't contact that person, and then they'd do… they'd do something to hurt themselves, or… and then you'll be blamed for not contacting them… that kind of… that's my… that was my fear mainly…*
8, 40, 1140-52	*umm… (sucking gums)… cau… ve… I just do it very… err on the side of caution… and I just try and… you know… eh… eh, just build… I suppose… b… eh… I don't… you know, I don't want to… I might be very concerned, but I don't want to show the client that I'm… anxious, or…*
8, 88, 2525-32	*(drawing in and letting out air)… I think, I feel… I always feel a bit like this is a… like a, kinda… it's a high… what's the word?… you're on high alert inside, but… what was I gonna say?… I've forgotten what I was gonna say… erm… (sucking gums)…*
8, 94, 2697-2705	*yes, it's anxiety-provoking… yeah… yeah… it's a gamble, I think…*
8, 125-26, 3588-3605	*yeah, she… she doesn't understa… she doesn't really understand why she… (sucking gums)… did it, so that's… (sucking gums)… that's… I wor… I am worried about her, so I've made…*
8, 126, 3611-24	*yeah, but she knows that she can come here, and 'Open Door'… I've given her 'The Sanctuary' phone number, and… but, yeah, it feels rea… it feels scary… feels a bit worrying, yeah…*
8, 127, 3631-39	*so that it causes anxiety…*
8, 130, 3733-44	*yeah… yeah… yeah… yeah… but, yeah… availability in the relationship… but I think that's what I rely on, and you're right… so that's why I'm anxious if I'm away and she's away… I'm, kind of thinking, 'oh, I suppose I've got to trust that she will… you know, contact one of my colleagues, or…'*

Subordinate Theme #1.2: "Absolutely on the edge": troubled to witness despairing clients walk the "tightrope" between life and death

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Transcript Ref:	Quote:
1, 3, 81-2	*and… (pause)… I think there's something about them being young as well…*
1, 4, 96-106	*and there is something about the death of a young person… which I think is particularly… it has a particular kind of… emotional punch to it, I suppose…*

1, 73, 2231-38 *yeah, I think… I mean, there's… there's… there's the guy who then went on to die… erm, to kill himself… and I… that… that assessment, although I only met him once… erm, really stayed with me… just the sense of him being absolutely on the edge… absolutely on the edge…*

1, 73, 2242-50 *troubling… (pause)… troubling to see somebody… on… the tightrope… that one step…*

1, 73-74, 2250-60 *and I saw somebody just before Christmas as well… who I'm seeing tomorrow… and again, that really troubling sense… when you get a final year chemist saying, 'well, I've been researching how to get arsenic on the internet', and you're thinking, 'yeah, you have the plan', 'you have been thinking about the means'… and just, 'you are in a very troubled place… a very despairing place'… and that leaves me troubled…*

1, 74, 2264 *troubled, more than anxious, I think…*

1, 74-75, 2272-89 *well, I suppose my anxious is, 'have I done all I can?', whereas the troubled is… to be with somebody in… in a place of such despair... leaves me troubled that somebody could be in that place, and again, often because they are so young, there's an element of…*

1, 75, 2302-14 *just… well, I suppose… I suppose… 'cause, for me, the tragedy of suicide is that, like it's a solution to a problem?… or it's seen as a solution to a problem… and it's not… it's just an end… it stops the possibility of… anything changing, or happening… it's just an end… I mean… because I don't have a spiritual faith… I believe in it being an absolute end…*

1, 76, 2318-34 *erm… and to see people who are young, for whom life might change, and for whom there's potential change and growth… they've not been grinding around their core therapeutic issues for fifty years… (laughter)… you know… (laughter)… again, there's a potential… erm… and a life… that might have a lot of joy… and… and meaning… and creativity… just to feel none of that… just to feel… to be so lost…*

1, 76, 2343 *and to be so lost, so young, I think…*

1, 77-78, 2356-84 *yeah, not… I mean, that's not to… (pause)… that's not to play down an older person… but… but it might be that there's more of a story… that I can make more intellectual sense… and I suppose, because I use intellect… well, it's my most… intellectualizing is… is my most cherished defence… ha ha… erm, it allows me to make more sense of it for myself at an intellectual level maybe, whereas with the young, it just… I can't use that particular defence, so that leaves me exposed to the awfulness of it…*

2, 9-10, 254-72 *yeah… I think it has a very slow… a slow impact that is building up all the time on me, and my colleagues… we occasionally give voice to… well, quite often give voice to… that it is… it's now a normal part of our daily work… and what does that mean to us… that… that somebody saying that they feel suicidal… which, when you think about it, is a really traumatic, you know, awful feeling to have… that we are now encountering that on a daily basis?…*

2, 11, 290-300 *I am being confronted with death on a daily basis… and that's going to have an impact… it, sort of, slowly filters into you, I think…*

2, 12, 324-25	*but I must also be aware that it is going to be a pressure, and it's not possible to process everything that I am internalizing…*
2, 15, 411-15	*well, there's no doubt that initially, when a student says, 'yes, I… I… I do feel suicidal', or, 'I have felt suicidal'… and, bearing in mind, the anyone who has felt suicidal, can always feel suicidal again… I mean… erm… when they first say that, there is always, for me, a feeling of… despair…*
2, 15-16, 420-33	*but there's no doubt that there is a deathly part to the work that stirs up some despair in me… and… and a difficulty that now this is in the room, it's… there's something now between us in this work that is… we're going to be struggling with death, as well as life… so, my work will focus on encouraging the student to think about the part of them that is engaged with life, and that is here at university, and does want to live…*
2, 16, 438-44	*and so, that in itself… the presence of that deathly part in the room is inevitably going to have an impact on both of us… it's going to dampen our… well, my… my mood… 'cause it's always got to be kept in the room…*
2, 17, 468-82	*but, of course, in sharing that experience with the student, and really understanding and empathizing with the student, I come into touch… I bring myself in touch with… what it feels like to feel that hopelessness… so, I can have those feelings, which I then need to process at the end of the session, or in supervision… erm… you know, there's a part of me that will be resisting being brought into that feeling myself… but, of course, I have to bring myself into it in order to empathize fully… and it can feel very sad… I can feel very hopeless… so, you know, in the countertransference… I will have those feelings of hopelessness…*
2, 19, 517-25	*you know, there'll be the student that you almost know why they feel suicidal, because what gets stirred up in me is a feeling that I don't really want to be in the room with you… and that's that student's experience perhaps with all the important people in their lives that they're attached to… which is so awful for him to bear…*
2, 19, 537-38	*so, you know, it… that again depends on that person, and their… the way they relate to other people will get stirred up in me…*
2, 33, 919-45	*it falls short of what he needs… so that stirs up a lot of anxiety… and general sort of feelings of… sometimes, I think, of despair in myself and my colleagues, but… so… that we're… we're constantly hovering between the despair and the, actually, you know, 'never mind'… a more depressive feeling that… 'we're doing what we can'… and that, you know… 'better that we're doing what we can, than nothing', but it… we hover between that, I think, and despair… and again, that is the student's experience… yeah… yeah… yeah… yeah… it's so much what the student's experience is…*
2, 56, 1587-1601	*so he… he… unlike some students who I might feel quite rejecting of at a personal level…*
2, 67, 1906-18	*yes, because if I was holding it by myself… and say I had ten students I was holding by myself, I wouldn't last very long, I don't think, in… in the work, and I would quickly become depleted by it, and would begin to feel very deprived myself… and then I would not be in a position to help the student, because I'd be too preoccupied with my own feelings…*
2, 67, 1925	*I think I've come close to it…*

2, 80-81, 2287-3311	*I think it's possibly one of the hardest emotions to sit with, because the work is there in order to find the more hopeful part of the student that's engaged with life… and when there is despair, I feel that that part of the student becomes extremely small… that… that part that is engaged with life… and I think that despair can be projected into me, and, it can feel quite hopeless… sometimes that can last for… it hasn't with this student… but, it can last for several sessions, and I think, it's the hardest…*
2, 81, 2316-25	*yes… and in yourself… finding it hard in yourself to find any hope in continuing the work, you know…*
3, 2, 48-54	*err, I've worked with one or two suicidal clients each year… erm… I find it very difficult, to be perfectly honest… erm, and I would be surp… well… (intake of breath)… I would be surprised if any counsellor said they didn't find suicidal ideation to be difficult…*
3, 3-4, 87-102	*it's not so hard, I don't think, with other issues, because with self-harm, for example, often it's a maladaptive way of, erm… in a way, looking after themselves… erm, and although I know that people can go on to self-harm… from self-harm, and it becomes more severe, and they can kill themselves… erm, it feels quite different to me in that, they may be able to manage their difficulties and their emotional pain by harming themselves, but there's something very different about working with a client who wants to end their lives… when it could be terminal…*
3, 4, 108-09	*and he… he intends to kill himself, erm, in a year… and she is utterly accepting of that, and I suppose, I find that quite hard…*
3, 6, 153	*I think, it's, kind… it's hard…*
3, 6, 158-60	*I have never had a client who's completed suicide, and I think it must be extremely difficult…*
3, 7, 182	*erm… (pause)… it… it… it is very difficult…*
3, 8, 206	*it is difficult… I certainly feel more stressed…*
3, 10, 261-70	*erm, but I do find it difficult… and I do find… and I… and I certainly take clients with suicidal ideation to supervision frequently… and, erm… I suppose the best that I can do is make an appointment for next week, and hope that they come… and I think that's difficult, 'cause we don't know… we can only trust that our clients are okay between now and next week…*
3, 12, 322	*erm… so, the not knowing is… is a hard part…*
3, 14, 376-404	*we'll also look at the difficulties in life, and what they would like to change… and, it depends, because sometimes, when they're so suicidal, and so… sort of, in that… they can't really see beyond that… but, if it seems appropriate, I will sometimes ask clients how they see themselves, say, in five years, or a year's time, couple of years, five years, and again… that can sometimes help clients to see an alternative if things were to improve… but, if… if they're in such a difficult place, then they can't… erm… one thing I'm really careful of is not sticking entirely with the suicidal ideation, because, erm, I think it's like… it's like any issue… that, they may… they may have suicidal feelings, but that's not all they're bringing to counselling, so, I suppose, I'm careful to let them lead the conversation… erm… and not get stuck on that, because, you know, you could kinda go down a… erm, a sinkhole, I think… ha ha ha… erm…*

3, 15, 409-14	*erm, maybe it's more a feeling that that's where it could go than actually… I'm trying to think if that has ever really happened… erm, I don't know that it has, to be honest…*
3, 15, 418-21	*umm, I'm trying to think whether I've ever had to really redirect the con… you know… I'm saying, have to really redirect the conversation… I don't think so… maybe it's more of a feeling that it… we might just go to that, and…*
3, 17, 482-83	*erm… I think it's a very difficult subject…*
3, 18, 508-12	*'cause, you… I mean, it's a kind of odd thing, 'cause you can have a client saying that they want to end their lives… everything's so dreadful… but then, they'll be talking about something that they're planning to do in quite a light-hearted way… so, again, there's that kind of inconsistency, I feel…*
3, 18-19, 516-42	*very much so… ah, ha… yeah… so, sometimes when clients are really very depressed, and… and thinking about suicide a lot… erm… it's almost astonishing if they can come to a session here… because, they're not… they're not eating… or they're not going to the canteen… they're not socializing… they're not going to classes… they're not doing their academic work… erm… they're just kind of existing… erm… but other times, clients can feel quite suicidal, and yet, they're going to all their classes, working very hard, doing very well, and… to some level they've got plans for the future, with what they're going to do when they graduate, and how they're spending their time when they're not busy with their academic work, so… it's… (chuckling)…*
3, 21, 601-04	*and if they're bringing issues of relationship difficulties, or procrastination, or… you know, nothing that's terribly kinda full-on and heavy… erm… then… or a mixture of issues… then I think it's easier…*
3, 23-24, 661-86	*exactly… and, I think, that's different, because generally, I think, we work with our clients… you know, with the…. it's about change, isn't it?… it's about identifying difficulties in living at the moment, and… and change that clients would like to make… and, I think, in some ways, it's about exploring that… and, to some extent, facilitating that… seeing what's possible, what's not, and how they might do that… so suicide, to me, is a little bit different, particularly if… if that's what a client is kind of intent on… erm… and if they're really focused on that, rather than on…*
3, 25, 695-99	*but, that… it does feel a bit different from other issues…*
3, 40, 1136-37	*it's quite hard… I mean, I think it's quite hard in general, actually, to be a lone counsellor…*
3, 44, 1243-56	*erm… (pause)… what is it like?... I don't find it so anxiety-provoking as people who're, erm… suicidal… erm… it feels different… erm… and obviously, people can change also from being suicidal… they can move from feeling suicidal to… to not being suicidal, but it feels as if there's more likelihood of them changing their behaviour… and, I suppose, in saying that, I'm saying, ag… 'I would like them to change that behaviour'…*

3, 45, 1273-78	*erm… I think now, because I've worked now for so many years with so many clients who are self-harming, err, I suppose I'm much more matter of fact about it… I'm much more able to ask them about it… erm… I will ask them how they… what they use?... how they do it?... how frequently?...*
3, 46, 1301-19	*I suppose, it feels like… (sigh)… almost like a decision that they've made… this doesn't actually make sense… I mean, I'm thinking and talking at the same time… I'm thinking, it's a decision they've made, and it's much less likely to be open to change… but why would that be when other things are less open to change?… d'you know the image I'm getting in my head at this moment is of something which comes down like a… like a funnel, but it doesn't have a hole at the bottom… but it's like something that's funnel-shaped, and… and, maybe it's glass, and it's see-through, and it's like the… the suicidal thought sits in that, kind of stuck…. erm… and that it's much more difficult to move from that position…*
3, 47, 1331-32	*yeah… stuck in at the bottom there… you almost need to give it a little shake… ha ha…*
3, 47, 1336-41	*it feels different from that… yeah, it does… it feels more fluid, somehow… erm… which is really quite interesting…*
3, 47-48, 1347-67	*yeah, it's quite interesting… 'cause, I find with… erm… with self-harm, that… often, it is something people want to change, and, yeah, this is maybe the difference… very frequently, it's something they want to change… and, sometimes, they will have gone… a bit… a bit like an… an… an alcoholic, which has not drunk for a while… they'll say, you know, 'it's been a month, or whatever… since I last self-harmed'… and then, they come in, and they tell me they've self-harmed, and… and we'll explore that, and they have a lot of guilt about it, and they'll talk about what led up to it, and how helpful it was, and often, they'll say, 'it didn't really help… you know, I thought it was going to, and its only lasts for such a short period of time, and then, I'm annoyed at myself'… erm… but it seems to me that most people, though not all, who are self-harming… they want to change it, and they also see that it's not a particularly effective way… and they worry about… some of them… not all of them… some of them will worry about the marks that they make, and the scars they incurred, and… and other people seeing them…*
3, 48, 1374	*but it does feel as if there's something different…*
3, 48-49, 1384-86	*but, I think, what's interesting is that there is something different in my perception of a client coming… with suicidal ideation…*
3, 51, 1451-58	*I think there is that… and I've wondered about that, because… (sigh)… I… I… I wonder what else you have… if you don't have hope, what else do you have?... if you don't have hope, then you'd be as well just to kill yourself, I think…*
3, 68, 1937-40	*erm… I think she got a bit of a fright, 'cause she had to go to A&E, and she's not had to do that before… so, I think she'd cut deeper… erm… and, sometimes, I've found that sometimes that actually can change behaviour…*
3, 68, 1953-54	*erm… I think… I think, being honest, when a client tells me that they're suicidal, there's a part of me goes, 'ohhh'… ha…*

3, 59-60, 1688-1700	*yeah… which is difficult for me to manage… it is difficult… erm… and I suppose… I… I have worked with people in the past who've been suicidal, and have come every week… ha ha… that was easier… ha ha ha… you know, the being suicidal, and… and the not coming… and not knowing whether you're okay or not is hard…*
3, 69, 1967-71	*erm… so, there's that kind of mixture of my heart sinking, and also, kind of… a… a lightness almost… a pleasure… pleasure's not the right word… erm… a relief, perhaps, that… that we are able to talk about this…*
3, 70, 2000-02	*err, that's quite an interesting question… erm… it must do… I think it must be different from working with a client who's not shared that with me…*
3, 79, 2248-50	*and… and I had to end a session, when she was still… 'cause I knew that I had another client, you know, in ten minutes… it was incredibly difficult to keep the time boundary…*
3, 92, 2626-27	*I think, certainly at the beginning, it was an 'ahhhh'… (gesture indicating falling)…*
3, 95-96, 2736-45	*it… it is particularly difficult for me to work with suicidal clients… I can't imagine anybody would welcome a client coming in and telling them that they're thinking about ending their life… erm… and I suppose that kind of validates, having talked for an hour and a half about it, it is difficult… it's difficult because it's difficult… and that's not going to change… ha… erm… and that it's okay for it to be difficult for me…*
4, 4, 90-112	*erm… I find it slightly easier than in private practice, because I felt that was really difficult… you know, I really carried it alone… whereas here, there is… there is levels of management, which is great… so I felt reassured that after… at the end of the day, I could got to say to my line manager, this is what's happening… she'd make sure everything's okay… that I've done all the things that I needed to…… and, in a sense, although I still worried, I've felt I've done… I'm covered… I've done what I need to do… erm, but it has been extremely uncomfortable… yeah, very uncomfortable…*
4, 7-8, 198-202	*(sigh)… it's very diff… it's… well… well, I worry, of course… I worry about him… and also, it's very difficult in the session to have that, because it feels, erm, very… I don't know if the word's 'deskilling'… but it feels like you're up with death… you're up against death…*
4, 14-15, 391-413	*erm… (long pause)… (sigh)… well, I don't know… it's strange… I guess, on the one hand, I think, 'am I exaggerate?'… 'am I being over-emotional in my response to the client's stuff?', or, erm… so, I guess, I hold that on the one hand, and then, on the other hand, I think, 'no, I'm not'… 'it is serious'… so, I… there's a… there's always a tension… there's always a tension of… I feel really worried about something… and then I get told, 'don't worry', 'it's fine'… erm… it just… it just feels very… I just feel a bit all over the place sometimes…*
4, 21, 591-605	*well, it is… it's both… yes… well, that's how it is… it is… it's both… and, I guess, that's where I switch between thinking, 'am I being over-dramatic?', and then I feel a bit… not ashamed… but a bit like, 'oh, you're fussing again'… 'you're worrying too much'…'you, err… I don't know what it is'…*

4, 30, 841-49 *yeah, I don't like it… ha… I don't like it… yeah…*

4, 30, 853-54 *exactly… I think that's what it… and also, I guess, it is the, erm… the… I guess it is because you care about these young people…*

4, 40, 1129-30 *(pause)… well, it feels, I guess… I'm very aware that I feel uncomfortable with it…*

4, 61-62, 1754-78 *(sigh)… yeah… I don't like it… I don't like it… it doesn't… it's, erm… I go home, and I find it hard to shift it… I find it really hard to shift, so, I guess…'cause I'm new, and, I guess, I don't… I kind of know my line manager, but not 100% yet… I kind of feel a bit… it… I do… I guess I feel like my emotions get the better of me in those moments, and I'm a bit dramatic, and… but that's my, kind of, irrational side… so, I'm very rational, I think… I know I'm being very clear clinically… but it just feels a bit… I guess, it's the… I don't know if it's the transference, or it's just the client feels very... overwhelms me… and, I guess, then, I feel a bit like, 'oh God'… erm… 'this is serious'… you know… and, I think, when she says to me, 'you've done everything you can'… 'don't worry'… and then I think, 'and now what do I do?'… (noise, indicative of ongoing emotional overwhelm)…*

4, 63-64, 1815-31 *so, someone will present to me with a serious borderline personality disorder… err, eating disorder… erm, really difficult relational issues… and they're currently quite seriously self-harming, and suicidal ideation is daily… and so, when I assess that as a clinician, I think… (sharp intake of breath)… 'oh my God'… 'this is not gonna happen in five or six sessions'… 'what is the… what is the point?'… and then I move between, 'well, what is the point?'... 'well, they can get some help with something'…'but then, as we know, does that help?'... 'and if there's attachment issues, is this helpful?'… and then, I guess, I feel overwhelmed by that…*

4, 65, 1864-67 *(chuckling)… yes, eh, it is… it's true… and, I guess, that's where the silliness comes in… I think, 'oh my God'… 'am I being silly?'… 'am I not holding…?', 'why can't I hold… hold that for myself?'… erm…*

4, 75, 2160-66 *yeah… yeah… it is… I think it's hard… because, yeah… you do… you're touched by the struggle in front of you, and, I guess, you don't want them to die… ha… you don't want them to kill themselves…*

4, 97, 2780-93 *it's difficult… (chuckling)… Adam, it's difficult… it's… it's… err… holding the frustration… and… yeah… it is… it's unease… it's discomfort… and, I think, it's having to sit with the discomfort the whole weekend… yeah… yeah… I mean, it comes and goes… obviously, I don't sit there worrying the whole weekend… it's not like that… but I think it's just there… it's just always there in your mind…*

4, 101-02, 2906-30 *well, I think what happened was she felt shamed in the session, where a supervisor actually openly said, 'I'm disappointed'… 'you're not doing as well as you should'… err… this… err… (gasp of indignation)… just… I want just to kill some of the tutors… (chuckling)… erm… not the tutors, the supervisors… and just, I think it was the… the exposure… and she is very aware of how she looks, and how people see her, and that was just too big a trigger, whereas before, it's… it's been kind of just in her mind and her thoughts… no one has said anything… and this was very… she felt very ashamed… and it was too much… she couldn't cope with this…*

4, 111-12, 3208-11 *so, she was restricting her food… she was self-harming… she had suicidal thoughts… she was buying detergent… and there was… noth… no one was intervening… so I felt so helpless, and so isolated with her…*

6, 10, 264	*I think it was… it was, sort of, fairly hopeless, in a way…*
6, 23, 635-37	*frustrating and anxiety-provoking… erm… and sometimes a bit… (sucking gums)… not angering, but kind of despairing… (chuckling)…*
6, 67-68, 1926-35	*yeah… yeah… and, also a feeling of… of… having to fight against giving up hope… giving up hope that he will feel better… if you see what I mean…*
6, 68-69, 1939-65	*yeah, well, I… I… yeah… that… that… that if it becomes… such a kind of fact of someone's life that every couple of weeks they try to kill themselves, and they activate this whole kind of, you know, chain of people who sit with them, and… and talk them through the same things that always bring them to this point of wanting to kill themselves… that… how do you keep yourself engaged with that… and keep trying to find different ways of approaching it… so… in the hope that something might change… yeah…*
6, 69, 1969-70	*umm… yeah… it's, erm… it's frustrating… and sometimes, kind of, demotivating…*
6, 69, 1975-88	*(sigh)… well, or… it… we… because you sort of think… 'are we helping?'… 'are we…?'… you… you know… I mean, I'm sure we… I'm sure we are on some level… but it… but it's, erm… we're helping… we're all there… we're all giving support, and we're being there… and we're offering our presence, but he's not any happier for it… I mean… erm… he might be happier than if we weren't all there, but… he's still suffering a lot…*
6, 70-71, 2011-23	*yeah… well, and it's interesting actually, 'cause I… 'cause I… I pi… I picked him to talk about now… and actually, hardly spoke about him at all in supervision, now that I think about it… erm… you know, I mention… I mentioned, you know, risk…'yep, it's this person'… 'yep, we've seen him before'… 'yep'… and… erm…*
6, 71, 2027-34	*(sucking gums)… (blowing out air in a dispirited way)… well, it's quite depressing in a way, isn't it?… err… I guess, because… because his presentation had not changed so much over so many years that he's been familiar with the service, that people were like, 'oh, yeah'… ha…*
6, 75, 2180-83	*(sucking gums)… oh, I don't know… I guess… I guess it's just, err… (long pause)… well, I guess you can't… you know, you can't be in a high state of alarm with someone all the time, can you?… err… it's not helpful for them…*
6, 75-76, 2187-2200	*in a high state of alarm with someone all the time, can you?… and it's not helpful for them, and it's not helpful for… for… for you… but, I guess, it's just the sort of… I guess, it's the dismay… God, I'm sounding really burnt out, aren't I?… (chuckling)… but it's the dismay of, kind of… erm… the normalisation of… of such high levels of distress, I think, with some people… umm…*
6, 77, 2212-18	*just quite sad… I mean, I think you… you… (sniffing in air)… eh… go into this profession with a hope of… (intake of breath)… well, I didn't go in… err… I mean… eh… eh… knowing that you're gonna come up against some really difficult, intractable sort of psychological problems, but… you don't spend a lot of time thinking about the intractability of them, and how some of them just can't be fixed… ha… so… so I think it's that, that sometimes is… is hard…*

7, 3-4, 70-97 *well, actually, prior to that, I had also done fifteen years with the Samaritans, and I was the Branch Director a few years before I left the Samaritans to do… to do counselling training, etcetera… so I was quite comfortable about talking about suicide anyway… well, as comfortable as one can be… erm… I certainly saw it as… as necessary and… and important… erm… so, err… yeah, erm… I mean, it… it… it's like sitting on edge with somebody… erm… just… just being there, and that holding, and the intensity sometime… yeah, I can just… whe… when they're really feeling like…*

7, 7, 177-98 *yeah… and… and those… and… and I think, particularly with… with, erm, students in university… erm… that there's more ambivalence about… about it… when they're feeling suicidal…'well… why not?', sort of, thing… it's almost… erm… (pause)… sometimes, they haven't really grasped the concept of time healing or changing things… sometimes, they're quite young, or… erm… inexperienced in dealing with, erm… major events or difficulties, so that might be part of it…*

7, 11, 296-309 *I suppose it… it… because it's so serious… erm… so, it… it's almost… maybe, I'm just, sort of, feeling that they can be… it's like they're looking over the edge, and I am… sit… with them… at that… so that, sort of, holding… that, sort of… (pause)… getting alongside… erm… sounds a bit… bit, 'ahhh'… but… but that's… that is how it feels… yeah, that is how it feels…*

7, 11, 317-18 *yeah… as if you're looking over a cliff… you know, that actually… there could… this could be an end…*

7, 12, 322-41 *yeah… yeah… yeah… I… I've never thought of it in that terms before… it's just when you were asking me, 'how do you experience it?'… something about that… that intensity… that… that real… ehh… eh, eh, almost as if everything else disappears, and we are together… erm…*

7, 13, 363-67 *sad… erm… yeah… very, very sad… erm…*

7, 13-14, 371-79 *because it's so heavy… what… you know, what… what… what… you know, what they're… erm… going through… erm… so, I… I think that's… I think what I'm saying is that I'm… at that… what… you know, my immediate respon… that… that sadness is empathy… that isn't me… erm… for my own… erm… I don't… erm…*

7, 14, 383-97 *yeah… I think, that… that sadness… isn't… isn't just my s… sadness… that sadness is… well, it is, isn't it?… that… that's because I'm… I'm… I am sad for their situation… I am feeling sad… because it… it's awful… it's that awful… so, erm… so, that's…*

7, 19-20, 545-60 *yeah, I suppose that, very often… if a student is… yeah… if a student is feeling like… you know, erm… 'what's the point?'… 'I, you know… wha…?'… err… they're not usually… shouting and… erm… crying abou… well, they might be weeping… it's not like…*

7, 22, 622-31 *and she had been in hospital, because, erm… she'd been in hospital for a couple of months actually, after a very, very, erm, serious suicide attempt, and she was very distressed at not… you know, that she'd survived… and she'd caused some physical damage to herself as a result, as well… so it was really serious… and, erm…*

7, 37-38, 1056-77 *I think, what… maybe… maybe that, erm… that kind of ambivalence about, 'well… you know…'… it… it does seem… you know, I remember, it was something that, erm… s… erm… did (name of Head of another Counselling Service)… erm… (name of Head of*

another Counselling Service)… was he talking to me…?… (noise of aeroplane passing overhead)… saying something about, 'it's almost as if, erm… they don't really think that they won't be able to just to come back tom… to life tomorrow', kind of thing… I… I kind of thought, 'yeah, there is something about that… there is something about the permanence of it… that… that maybe… they… that it's something about this age… you know, where they haven't really…'

7, 38-39, 1081-1105 *yeah… possibly… possibly there's some of that… yeah… erm… because it is… eh, you know, it is… it… it's not usually, you know, something that they've been thinking about for a long time, although those feelings may have been coming and going… and they might be feeling like, 'oh, you know, I've had enough of this'… continually low… you know, it's… it's awful feeling… erm…*

7, 74, 2113-22 *yeah, it was…'cause it was… because it was imminent, and, erm… yeah… just… just a little bit more unusual… erm… 'cause normally, I guess, we… umm… I mean, if somebody's turned up for counselling, then usually it's because they do want… there's part of them that is trusting that there will be some help, or something can be done…*

7, 74-75, 2126-41 *yeah, because… because, eh, where there have been deaths by suicide… erm, they haven't been people that have accessed the service, and I think that's not unusual in other universities as well… erm… so, yeah, where we get these, err, student deaths, I think… erm… almost always they… they have not s… accessed, erm, support services…*

7, 79, 2253-59 *but I kind of… you know, I did remember her coming in and sitting, and that kind of, 'oh my God', you know… eh… my hopelessness maybe, about, you know, 'will this…'… erm…*

7, 81, 2317-24 *yes… yeah… that's right… erm… and they weren't going… they said, 'well, you know, she's got to go to A&E'… erm… err… 'that she… that… you know… that… that's what she's taken, and that's bad', you know…*

7, 98, 2817-27 *yeah… I mean, you know, sometimes, yeah, I will… I can feel very concerned, because sometimes, I will really think, 'I'm really not sure that this person, you know, is going to be able to keep going, and…'… erm…*

7, 127, 3638-61 *erm… but, err… I suppose… yeah… because when… when there's a live person in the room in front of me who is feeling… and that's… that's the sadness, I guess… that… yeah… that it's… that it… it's so awful… and that is… that's bad… you know… that feels… erm… yeah… but that is… and that's my… my response… it's that sadness… that, erm…*

7, 128-29, 3670-3707 *oh, I think that… that probably it's all too long ago for me to recall that… the, erm… yeah, but maybe some people, you would just get that connection with anyway, even on the phone, so it would be very sad… or, you know, I remember one old lady telling me, 'I just can't enjoy things anymore… you know, I'm… I used to be able to do all these things… now, I can't do anything… I can't leave the house… I don't see anybody all day… I'm resenting my daughter and her fam… you know, I'm…'… and I'm just thinking, 'yeah… how… how… that's… that's awful… I can understand that it would make you feel that bad'… erm… but, erm… is it… is it different applying for a young person?… yeah, I guess so… I guess that's the other thing… we're talking about young people… I mean, these students have got huge potential, as any young person has really, but… erm…*

7, 129, 3715-20 *yeah… they're… they're clever enough to be here… they're… you know, I just wish they could believe it…*

7, 129, 3720-25	*I mean, I'm more concerned about the pressure that… that they're under these days… so, yeah… this need to be perfect, and all this rubbish…*
7, 130-31, 3747-68	*yeah, I think it… it probably does… is… is… I'm saying tha… I gue… 'cause, eh… prob… I hadn't really processed that thought, but I imagine it is, you know… like, I… I used to work in a doc… GP surgeries… and meet a lot of older people as well… erm… so, it always mattered… but maybe there is something… you know… I've got kids, so I know… you know, I… wh… what… err… how… how much I would want them to… to feel okay, and to manage… erm, things, and, err…*

Subordinate Theme #1.3: "There's always doubt": living with uncertainty and lack of control in relation to client choices

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Transcript Ref:	Quote:
1, 44, 1331-32	*'cause I don't know what it's about, but I feel really bothered'…*
1, 44, 1340-44	*yeah… and try and… work out what it was that left me feeling uneasy…*
1, 65, 1980-88	*erm… but I did think, before… whilst I was waiting for (client's name)… it would be really easy for me to say, 'oh, I'm quite relieved to see you'… ha ha… or something… which would not be appropriate in terms of what we're doing, because that's bringing a whole other…*
1, 84, 2578-83	*erm… and I did think, 'I wonder if I'll see you'… 'actually, I wonder if you're going to make it'…*
1, 85, 2609-14	*well, the Sunday night, I looked at my list for Monday, and thought… umm… I remember this… I wonder… and I was aware of feeling uneasy on Sunday night…*
1, 85-86, 2615-24	*and then, when I came in, and she didn't come, I thought, 'well… that's… I've not heard anything… there's not been a message… from (name of COO), who's our Chief Operating Officer, saying there's been a student death'… erm, so… but then there wouldn't necessarily be if she'd killed herself off… and wasn't on campus… erm, so I was aware of feeling uneasy…*
3, 6, 157-58	*I also know, and that, it is entirely up to the client… I do believe that…*
3, 6, 160-61	*but, erm… I do believe, certainly, at one level, that it's entirely up to clients how they live their lives…*
3, 10, 263-75	*and, erm… I suppose the best that I can do is make an appointment for next week, and hope that they come… and I think that's difficult, 'cause we don't know… we only… we can only trust that our clients are okay between now and next week… now sometimes, I might see them on campus… erm, but mostly I don't, even though… even though it is a small campus here…*
3, 12, 319-22	*erm… I think, for me, and, I think, this is true for a lot of people that, the thing is the not knowing… that, for me, whatever happens, however tragic it is, then you can act, and you can get on with something… erm… so, the not knowing is… is a hard part…*

3, 12, 325-29 *because I could worry… I could… I could stay awake all night worrying every night until I came back to meet with my client, but actually, it's not… it's gonna be quite harmful to me, and it's not making any difference whatsoever…*

3, 20, 551-57 *however, I think when people are planning things, and there's more in their lives, there's… there's more to work with, and there is more… there is more hope…*

3, 33, 948-50 *erm… well, I suppose anybody could walk into water anyway, couldn't they… anywhere?...*

3, 37, 1058-68 *sad, as I know, it worked well… he would phone occasionally… because I also had a role at that time for, erm, Business Learning students… and he would phone from time to time… erm… so I know, actually, that he was getting on very well… umm, hmm…*

3, 38, 1073-77 *it was very nice, actually…*

3, 51-52, 1468-75 *umm, hmm… erm… this is a client that I'm actually working with… erm… this is the second academic year… erm… and last year, she disappeared on me, which was quite difficult, and I actually feel a bit angry about that, because… erm…*

3, 52, 1479-90 *yes… now, what I didn't know, and what I now know, is that, actually… erm… it was agreed with other members of staff that she would leave the college, and that she would take some time out… erm… what I knew was that she had missed, erm, her appointment… and I didn't actually know whether she was here…*

3, 53-55, 1525-80 *erm… and, I actually copied in… 'cause I susp… beginning to suspect that she might not be on campus… for another reason, which was that she was… she's a group of four friends, and if I did see them on campus together, you would usually see the four of them together… and I'd see the three of them together, which made me think, she maybe wasn't here… but I also, in that final e-mail… erm… I also copied in her, err, personal e-mail address, not just her college e-mail address… and then, it was difficult, because I didn't know whether she was on campus… I didn't know whether she was okay… as time went on… erm… I can assume that she's alive, because if a student was dead, I'm likely to hear… well, I'm definitely gonna hear… so, that made me think she was alive… but the reason I was angry… and I wasn't… I wasn't angry then… I think I eventually must have heard that she wasn't on campus… erm… but what actually made me a bit angry, and I don't know… well, I was going to say, I don't know whether I'm entitled to be angry or not… it dun't matter whether you're angry… you're angry… but, it… it's… she came back… erm… in the second semester this year… which would be at the beginning of February… and, shortly after she was back… a few weeks after she was back… erm… she got in touch to say that she is back on campus… she's on, erm, antidepressants, but she would like some help with her anxiety… and, it's emerged in our work together that her personal academic tutor and Student Services co-ordinator met with her, and it was a planned, erm, exit last year… erm… and it was also a planned return… so that she would… basically, she would miss… she'd completed the first semester, so she'd just left, I think, around Easter-time, and then, that she would return… and, I suppose, my anger about that was that both of those members of staff knew that she was coming to counselling, and they didn't let me know… now, it's not written down anywhere that they should let me know… erm… but, I'm thinking, 'well, they… they knew that she was gone, and I didn't, and I had all that anxiety, and, had they let me know, I needn't have had that anxiety'… erm, I remember taking it to supervision, and agreeing in supervision that I would contact her one more time after she'd gone… so, this is additional to the, you know, 'I'll assume'… and I think, what I said to her… and it actually sounds a bit… it's interesting… it sounds slightly pathetic from my point-of-view… but, I think, what*

I wrote to her was that 'it would be helpful if she could let me know, erm, because, because of confidentiality… I… I wouldn't hear from anyone else'… now, that was absolutely my need for reassurance… and when I'm telling you about it now, I'm thinking, 'why did I need that?'… but I do need it… erm… and, in supervision, we decided that it would be okay to do that…

3, 56, 1603-06 *erm… but, when... when she came back, and… she didn't come to… so, she got in touch, and said, she would like to come to counselling again… and then I offered her an appointment, and she didn't come…*

3, 57, 1622-24 *erm… but we are working together… erm… and she didn't turn up for her last appointment before Easter…*

3, 59-60, 1688-1700 *yeah… which is difficult for me to manage… it is difficult… erm… and I suppose… I… I have worked with people in the past who've been suicidal, and have come every week… ha ha… that was easier… ha ha ha… you know, the being suicidal, and… and the not coming… and not knowing whether you're okay or not is hard…*

3, 60-61, 1721-40 *there's also the fact that it would be a lot easier if I know… ha ha… and, if you let me know that you're not coming, then at least you're in touch, and I know that you're alive, and you're not coming… ha ha… the not… the not knowing… and the sitting here wondering, and I can't get on with anything else, because you might just come to the door… 'cause she has done that… sometimes come quite… quite late into sessions as well… erm… and, in fact, I've just remembered, that when she wanted to come, and then, I offered her an appointment… she didn't come…*

3, 63, 1796-99 *now, when she didn't turn up in that last appointment… erm… I'm thinking, 'we're now gonna have a two-week break'… 'she's not turned up'… 'I've no idea whether she's alright or not'…*

3, 66, 1878-84 *so, I e-mailed back to say, erm, 'I have actually let Student Services know that you… you didn't, erm, come to your session today'… so, that I would be completely transparent… I'm not entirely comfortable about it, but I actually think… I think I reflected on it, and I think it was an okay decision… and I think that it was about caring for my client… erm… there was an element of reducing my anxiety, as well…*

3, 79, 2251-58 *but, you know, I… I said to her that her time was up… erm… and, you know, she… she pulled herself together, and stopped crying, and, erm, I said, 'would you like to make an appointment for next week?'… and that was my one area of hope, was that she said, 'yes… would it be at the same time?'… erm… but I didn't know that she wasn't going to go out to kill herself…*

3, 80, 2286-2300 *erm… and I suppose I quite often think of that when I think about holding… holding confidentiality… I'm thinking, 'well, what… what difference will it make if I share this information?'… and otherwise, do I just wait for them coming to see if they come next week?...*

3, 92, 2631-40 *erm… and I think it's… I… I think, also, you know… we… we… we always… we know that people who talk about suicide, there's less chance… but I think, when I first started, although I knew that intellectually, I don't know that I really believed it, and I think there was that fear of, 'if we talk about it, is that going to make them do it?'… whereas I really, really know now that there's less chance… they might still do it, anyway…*

4, 5, 116-134	*well, just… erm… sitting between sessions… 'are they gonna come back next week?'... 'will they kill themselves over the weekend?'... 'is it gonna turn from ideation into an actual plan?'... erm… yeah… so, it… it has been quite hard, and some people… I think, I guess, from experience… some people, even though they express it, I kind of know it's gonna be fine, but with others, I don't know… and it's with the ones that I don't know that I find the hardest, to… to be honest…*
4, 6, 146-58	*so, you know, I have a client who's already written his will, and already knows how he's gonna do it… and, he's already said, 'if this doesn't happen, then, I'm gonna end my life'… and that's quite concrete, I think… so, sitting with that, as time goes by, and his so-called deadlines approach, I'm nervous… yeah…*
4, 6-7, 163-79	*yes… exactly… and also, I guess, with the higher education, he's coming to the end of his degree, so it's very much like, 'well, where does the responsibility lie then?'… if he finishes in a few weeks, he's no longer a student… the university doesn't have responsibility any more… he doesn't come here, doesn't get the paid sessions, but he still has to go on… so it's… it's really tricky…*
4, 7, 184-94	*exactly… so, 'where does he go to after this?'... err, 'who's he gonna have?'... 'who will support him after this?'... and 'will he carry on his plan?', I guess... yeah… essentially…*
4, 7-8, 198-206	*(sigh)… it's very diff… it's… well… well, I worry, of course… I worry about him… and also, it's very difficult in the session to have that, because it feels, erm, very… I don't know if the word's 'deskilling'… but it feels like you're up with death… you're up against death, and someone can choose to do that or not…*
4, 19-20, 544-54	*erm… but… yeah, I have to say, I don't… well, it doesn't… yeah… I have gone home on the weekends going… (big sigh)… 'just please let them be okay by next week'… yeah… yeah…*
4, 22, 614-24	*so, I… I know clinically… like, I know, I've done my job… I've written the notes… I've flagged it… I spoke to my line manager… she knows… but essentially, the feedback is, 'well, you've done everything you're supposed to do'… but I keep thinking, 'well, is there more'…*
4, 27-28, 780-93	*and they're isolating in their rooms, and they're on their own, and they're not asking for help… and often, with suicide, it's often the people who are not making a fuss who tend to kill themselves, you know… I don't know if… it's been my experience…*
4, 29, 818-37	*exactly… and that's a fine line of do… is this warrant enough for a breach of confidentiality, or not?... and… and I think… I guess that's where you have to really assess in the session… where that client is… and, we know it can change, right, overnight to the next day, so…*
4, 31-32, 894-907	*yeah… and, of course, it's down to the students… so, I know of a student who is very vocal… is very able to get resources… who's able to identify how they're feeling… who's worried they might do something, or act on their thoughts… would… would… would get help, but one or two people who I know, wouldn't… that's what worries me…*

4, 34, 966-72	*yes, it is… it's like… I've got the means… I've thought about it… it's there… and when I feel I can do it, or… I don't know… it could just happen… yeah…*
4, 46, 1303-18	*erm… I'm just trying to think whether there've been one or two guys… yeah… one guy, who just… had tried in December… he tried to hang himself from a ceiling fan, but it… he, kind of, was standing on the edge of the bed, and teetering, and then stepped down, so didn't actually go through with it… I don't know what would have happened… and I've seen him quite regularly… and he's alw… it's always there… there's always a… a… playing… and it is… it's really tricky just to know…*
4, 58, 1653-67	*yeah… yeah… it's neutral, yeah… I do… but I don't know if that advantage outweighs the… ha… disadvantages of not being able to say anything, especially when the students are very unwell… because they are… and they teeter on the border of suicidal ideation to suicide…*
4, 76, 2181-95	*erm… so, it is very worrying… and I guess… touch wood… I've never lost someone, and I guess part of me thinks, 'it's… it's gonna happen', and I guess that's what gets triggered for me when I think it's close… 'is this gonna be the one?'…*
4, 83-84, 2391-2412	*so, I take that very seriously… and she's quite impulsive, so I worry about that, you know… whereas, his again, it's planned… he doesn't do anything on like a whim… he's not self-harming… she is so much more impulsive… so, I think, if she… she could just decide one day, 'right, I'm doing it now', and, I think, that's what makes it harder for me to sit with between the weeks… I worry about her with that…*
4, 94-95, 2703-30	*(sigh)… yes, in my private practice, but not here… not here… I guess, here to the extent where it's just holding the 'what if?'… you know, where something has not been so clear, but you know you've done everything you can… 'it will be fine'… and then, you're holding it, kind of, on the weekend… I do… yeah… especially sometimes…*
4, 95-96, 2740-61	*yes… but you're still left with that, 'it could be, right?'… and then you go home… and it's the weekend… and it's family time… and everything's going on normal… but you know, at the back of your mind, you're thinking, 'ohh, this is what I left today'… and there is… there are days where I do… I… I actually, honestly, go, 'just please let them be okay this weekend'… I've actually said that to myself… I'm very conscious of saying that, yeah… 'just let them be okay'… just hopefully they'll stick… hang in there, and we'll see each other next week, and, of course, that's what happens… (chuckling)… but I don't think it's a guaranteed thing… I think it's just that…*
4, 96, 2678-75	*of course… yeah… because I don't think we have that knowledge… I don't think we can ever be 100% sure, which is, I guess, why they happen, don't they?… if we could prevent them, it would be… I guess, they happen because we don't always know…*
4, 97, 2789-93	*yeah… it is… it's unease… it's discomfort… and, I think, it's having to sit with the discomfort the whole weekend… yeah… yeah… I mean, it comes and goes… obviously, I don't sit there worrying the whole weekend… it's not like that… but I think it's just there… it's just always there in your mind…*
4, 109-10, 3135-55	*erm, I'd referred her to… we run groups here… and I'd referred her to the bereavement group here… and she was assessed at the pre-grouping, and the counsellor here said she couldn't join, because of the… that, actually, if you're currently suicidal, you can't join*

	the group… you're too unwell… and she hasn't come back to me… and that was really hard… well, I'm in that at the minute… so, following this assessment, she… 'cause we had a break… she hasn't come back for us to, kind of, start ending, and that's really awkward… so, I don't know what's going on with her… I don't know where she is…
4, 110-11, 3173-84	*exactly… exactly… so that I haven't seen her for a few weeks… I haven't assessed her… I don't know where… I happ… I happened to catch a glimpse of her, and I thought, 'she's alive'… (noise, suggestive of relief)… that was my thought… erm… but the truth is that I… I… I…*
4, 111, 3188-89	*yes… 'cause I could see her from afar… I thought, 'oh my God, she's alive'… 'thank God'…*
4, 114, 3269-95	*just… I didn't expect it… yeah… I didn't expect it… I thought she would have come back for a few sessions… and, in fact, to be honest with you, I actually would have found a way to manage her 'til the end of the term…'cause she is very vulnerable… I would have found a way… I would have just done it, and, erm, but she didn't come back, and it was… it's very sad, and it is worrying, 'cause I don't know how she's surviving right now, but maybe in the same way she did… I don't know how actively suicidal she is… I don't know…*
4, 118-19, 3408-27	*so, yeah, it's an abrupt… brupt break with someone who's constantly in suicidal ideation… ha ha… and, err, is not coming back, and choosing not to come back, so… yeah, and, I guess, there is, 'did I do something?'…'was she not happy with me?'… 'with me escalating a concern?'… I guess, that's… the analogy I was using was the tortoise in the shell… was she like, 'okay, this therapist is getting a bit too pushy'… (chuckling)… or 'she was go…' I don't know…'it's too much, so I'm gonna retreat'… I don't know what happened…*
4, 120, 3444-45	*I don't know… I don't know… it could be all of that… it could be none of that… it could be something else… yeah… ha ha…*
4, 123, 3545-50	*but then, last term, we had a… a new PhD student, never been to (name of university) before, arrive, and within three weeks, had killed himself… so, and that was even, kind of, harder… whereas this other case, we kind of knew what was going on… she was being seen by the mental health adviser here… and new students…*
4, 124, 3554-60	*yes… she'd been here before… they knew her… we knew the tutor… every… everything was known… this other student was just… no one had an idea… it was just completely random…*
5, 46, 1302-14	*yeah… and, I think, erm, that, in itself… when the dialogue comes, and the student actually says, 'well, yes, I am suicidal'… then, I feel that that's the point that you can work with someone… erm… and, eh, in a sense, I suppose, there's a sense of relief when they've said it, because then you know you can work… it's… I find that the difficulty, especially, and maybe this is from my past experience, but… as an RMN… it's the people that don't say it, and you have this real gut about it, and you kn… think there's something not right, and you're… they're not saying it… the… that really worries me…*
5, 46, 1319	*and they're not saying it…*
5, 47, 1330-38	*but, I suppose, for me personally… as a counsellor, my anxiety is the people that don't say it… yeah… and, it has happened a couple of times… err… like the… the boy that actually committed suicide… I still didn't know he was suicidal…*

5, 47, 1342-46 *yeah… didn't know… didn't know…*

5, 48, 1354-70 *and it were… it was a real weird, 'cause I heard through… three month later, through a total different source… somebody who didn't know I was his counsellor… and actually, talking about him… saying that his girlfriend had jilted him twenty-four hours beforehand… and, you know… that was just… I think that was what the issue was… but that's not the point… I never picked up the highest level of anxiety that that young man felt, or that it could be internalized… and that's the kind of thing that worries me, that, through the process that we go… this pre-assessment process… then, when you get in the counselling room, if you miss that…*

5, 52, 1478-95 *but, you know, the… the young man had actually… you know, thanked me for his work… you know, he'd come to a conclusion… he had decided to leave the university… erm… and, erm… you know, he was… eh, there was… he… he… he was at peace with himself at… at that decision… but, I suppose, there was just that… you know, you never know… in these situations… in these situations… I think, as a counsellor, having experienced that, there's always doubt that you… you…*

5, 53, 1503-18 *yeah… yeah… but, I think, you… we have to keep it in perspective, as well… you know, it's… people will only… share what they want to, as well… but it's a case of… you know… at… at the time when he finished, his girlfriend hadn't jilted him… (chuckling)… so… who knows… how… who… what had effect?...*

5, 54, 1539-47 *umm… but then… yeah… and… and… who knows?...*

6, 16-18, 458-501 *erm… I think the times when it's been extra anxiety-provoking, in some senses, has been whe… you know, if there's someone who… I worked with someone recently who, erm… presented very differently in all the different encounters we had…so, in his pre-counselling form, he said he'd… previously suffered from mild depression… and then… erm… when he turned up for… eh, sort of, in person, it was clear that he was very profoundly depressed, and in a very, very, very bad way… but was, sort of, understating it, and that was part of his, sort of, general presentation… but then, talked a lot about quite active suicidality… and when I started talking to him about the fact that, you know, we would… we would like his permission to contact his GP, backed off, refused permission to contact his GP, and said, 'actually, no… no, I'm not gonna… no… no, I'm not gonna… I'm not gonna to kill myself'… and that was a very tricky one, because… (clearing throat)… I felt like, erm… I… I wanted to keep the… erm… keep the conversation open to… to being able to discuss his… his suicidal ideation… but not in a way that would, sort of, threaten him, with the… you know, he… he… he was worried he would be sectioned… he was worried about all of these sorts of things… and, of course, I couldn't give him any guarantees about what would happen after we'd alerted his GP… erm… and so, that had the effect of kind of shutting down a lot of… mmm, potential, sort of, therapeutic interventions… and after that, he… you know, he kept insisting, 'no, no, no, no, no, no, no, no, no… I don't… I don't wanna kill myself… I'm not gonna kill myself… I'm not gonna kill myself'… and I… I wasn't sure I believed him… erm…*

6, 19-20, 529-66 *(sucking gums)… it was very frustrating, because again, it brings in the third party of the organisation… I mean, it brings in, sort of, like, 'well, you… you know, he has said', and… and 'what does it mean… what does it mean, erm, then if he does do something?'… 'what if he does harm himself?... and I've tried to discuss this with him, and… erm… you know, in the… in the way that we're trained to do, and we're asked to do… and he backed off, and, sort of, denied it, and… and I… I wasn't then able to, kind of, follow it up… and what if something really did happen?… and… what would my part in that be?... and how do you claw that back without, erm… without impinging on someone's autonomy?… how do you protect and also respect their boundaries?… and what are you supposed to say if*

someone says, 'no, I… I don't', you know… 'I was just… I was just speaking… it was just a figure of speech… I don't actually want to kill myself'?… what part of what they say do you believe, and what part do you not, essentially?…

6, 40, 1147-51 *I actually anticipate I would… I would have a lot less support, so I… so I'm grateful in… in a way for a Staff Handbook, and for a variety of people who I can, sort of, consult, and talk it through with, but… wouldn't it be great if they gave me really clear, 'right' answers… (laughter)… so… (clearing throat)…*

6, 41, 1156-63 *well, I feel everyone does their best, but… eh, you know… everyone does their best… and I guess that's the thing with… with suicide, is that… (pause)… sometimes your best isn't good enough, and… and the consequences of that can be awful…*

6, 66-67, 1002-18 *yeah… well, and particularly if it… if it's… if it's a sort of, you know, series of… of damaging attempts at terminal… ha… harm… erm… but I think there… I think if enough people become involved, and there's enough of a kind of… eh… network there, you can lose sight of the actual risk maybe, or you can, eh… erm… because, if we're saying that previous attempts are an indicator of future success… this guy's getting closer and closer to success every week… ha… umm… you know, if you… if you look at it that way, and that's the thing… it's like, what can you predict, and what can you not… eh… erm…*

6, 85, 2450-52 *yeah, the… eh… eh… I suppose, erm… (sucking gums)… yeah, I suppose in the… in the latter case, I was very much left holding the anxiety…*

6, 86-87, 2462-88 *'you can't share it was anyone'… 'I've ju… no, I was just saying that… I didn't mean it'… and then… and so… I was stuck, sort of going… 'well, but… uh… uh… uh… uh… uh'… 'but technically, I mean… eh'…(sigh)… you don't want to split hairs… you know, you don't want into… to go into, sort of, technicalities on this, but you just sort of think, 'but you did… you did s… you did say, and I have the feeling that you're saying now this, because you don't want me to contact your GP'… and, you know, and you can talk about all of that, but at the end of the day, it… it kind of left me with this feeling of, 'so, what do I do?', and, you know, I talked it through with my supervisor, and…(sniffing in air)… erm… eh… the feeling we had was that there was not an active risk, and I… I ag… I agree with that, but I still feel very anxious with that client… eh… erm… and I feel like I'm sort of holding that anxiety… (beeping noise)… and I think… I think that is a dynamic that he brings into a lot of his relationships, as well…*

6, 88-89, 2533-59 *yeah… and he… he's the one that on his sort of pre-counselling form, said, 'oh, I think I've got some mild depression, and a bit of work block', and when he turned up, he was like through the floor with misery... I mean, this was someone who was really, really quite profoundly depressed… so it's hard to… you know, all you have to work on is how they seem to you, and what they say about their experience, and when those things are very different, it's hard to know what… what activates the risk… so, yeah…*

6, 90, 2582-95 *there's a… yeah… there's a… yeah… erm… and that's helpful… and that's he… he… yeah, and I guess that's helpful from a, kind of, an organisational perspective, that I sort of think, 'well, I'm… you know, I'm… I'm doing the right thing by the organisation'… erm… but I still have my own conscience, and if something were to happen, and I ha… and I had misjudged it…*

7, 90-91, 2572-2606 *but the other thing is… that I haven't actually experienced anybody… any of my clients ever actually taking their life… and that… and that's scary, 'cause, I think, 'yeah, after all… it's only a matter of time, surely'… and… and I've often thought that would be… I mean, I*

	thought that when I'd been doing it for two years or three years… (chuckling)… ha ha… so, now… and I'm so grateful… and, of course, that would have impacted as well, won't it?… if I had experienced one of my clients taking their life, then I'm sure that would affect me differently… maybe… maybe it would change someone… how I work… erm…
7, 119, 3409-16	*erm… we… we… erm… so she gave us a num… her boyfriend's number, who we kept in contact as well… (noise of aeroplane passing overhead)… until they met up at (local hospital)… erm… so, and we just kept in phone contact… neglected to mention that she…*
7, 119-20, 3420-48	*yeah… yeah… yeah… that's right… yeah… err, we actually put her in the taxi, and made sure that she was well enough to travel… erm, but that was just really by… what… you know, as best we could judge it… erm… and so, that was… yeah, that was one of the… the… the worst things, I suppose, you know, doing that, because… erm… because it was a little bit like, 'well, let's just hope it all works out now, and that she gets what she needs, and sorts things out'…*
7, 120-21, 3464-73	*yeah… that was hard… so it was good that we were able to maintain contact to be able to check what happened…*
7, 125, 3586-3601	*umm… erm… I suppose it's been… it has been over a long time, so I suppose it has… changed… erm… it might of changed, because, erm… I'm sitting in the room with somebody… erm… which makes it easier in some ways, more difficult in others… you know, easier than the phone…*
7, 125-26, 3605-10	*you know, erm… and people had the choice about whether they gave you information about where they were, for example… so if they were really determined, then…*
8, 4, 100-06	*I think… k… k, as long as it doesn't happen… (chuckling)… it's okay, but I… I worry about how I would cope if one of my clients killed themselves, and I was… it was on my watch, if you know what I mean…*
8, 43-44, 1228-42	*well, almost like, you know, if there's… (sigh)… if it's a Friday, it's worse, isn't it?… but like, if it's a… (chuckling)… if it's a Tuesday, you can… you can assess whether they're… they feel safe today, 'cause they can come back tomorrow, and w… we can do a further… you know…*
8, 88, 2525-32	*(drawing in and letting out air)… I think, I feel… I always feel a bit like this is a… like a, kinda… it's a high… what's the word?… you're on high alert inside, but… what was I gonna say?… I've forgotten what I was gonna say… erm… (sucking gums)…*
8, 90, 2565-78	*yes, this per… that I need to make sure this p… that… I need to assess what stage of risk they're at… is it a kind of A&E?… is it a…?… can they…?… are they going to agree to go to the doctors?… do we trust that they're gonna go?… erm… can… we… we can check… we can… 'can I phone your GP afterwards, or can I phone you afterwards?'… and just get a sense of whether that feels okay or not…*
8, 93, 2662-66	*oh, awful… awful…*
8, 94, 2697-2705	*yes, it's anxiety-provoking… yeah… yeah… it's a gamble, I think…*

8, 95, 2709-27 *just the relief the next… just the relief the next day… but it's the same with… (pause)… eh… (pause)… eh, I think it's the same with a lot of suicidal… it's quite a common feeling… I mean, not that… not someone… but ev… (sucking gums)… oh, what am I tryna say?… like, that, say, someone'll come and talk to me here, and say, 'we've done this, this, and this'… or (name of Mental Health Advisor), who's the Mental Health… Health Advisor… if my Manager isn't in, she does a handover to me… so she only works Monday to Thursday, and in term-time… so on a Thursday night, evening, she'll handover these people to me… and I kind of… (blowing out air)… eh… you know, that's risky… so, like…*

8, 95-96, 2731-41 *yeah, I might not… might of not… might not have met, and… and it's kind of like… that feels risky… it feels a bit like… well, I don't know these people… what's happening?… you have to ask what's happening, and…*

8, 96, 2745-49 *yeah, and then… so I might say… 'so, you haven't even heard from so-and-so… 'd'you want me to call her?', and (name of Mental Health Advisor) will say, 'yeah'… so I'll call her on the Friday… there's no answer… it's like, what… what do we do now?… do we trust that this client's… this student's alive?… (blowing out air)…*

8, 96, 2754-66 *not always… not always… yeah… yeah… yeah, exactly, and then… so, I might go through the notes… and think, 'well, when was the last time we had any contact with the GP, and do they know?… and is this case… is this situation serious enough for us to call the GP now, and say, 'look, we've lost contact with this person… we're concerned'…*

8, 107-08, 3073-89 *because it's easier, and we don't have to think about how they're gonna get to A&E… do we trust that they're gonna get to A&E?… so, here, we can call a taxi… at (former higher education employer), we weren't allowed to call a taxi… we had to call… we either had… had to entrust that they're gonna get there, or could call an ambulance, depending on how ill they are… and both of those are risk… risky…*

8, 109, 3121-31 *yeah, and A&E's a night… you know, they might be waiting for hours, depending on what day it is, and… it's not a str… it's not a pleasant environment, and lots of them will leave with… lots of them will leave without being seen…*

8, 123-124, 3522-75 *yeah… yeah… like, I've got a client who… she was ref… she was referred… sort of a weird… so… (sucking gums)… some students… her flatmates… had gone to their tutor, and their tutor had contacted us, and said… we often get this… and said… (sucking gums)… this g… this g… this girl is s… s… erm, self-harming… tried to hang herself… suicidal… they're in a private house… I mean, 'what…?'… you know, basically, 'do something!'… and you're kind of like, 'well… you know… if they're … if they're not in university accommodation, it's… we're quite limited'… I mean, we can… if it's… gets to… ratcheted up to (name of DoSS), who's my… who's the Director of Student Services… if it goes to that level, then, yeah, probably we can get the ph… the student's phone number, and phone them, even though it's just gonna be a call out of the blue… I mean, you just have to handle that… 'this is a call out of the blue… you're not gonna be expecting to hear from me… we've just had s…'… you know… and then you're thinking, 'oh God… is this gonna…?'… you know, if the flatmates don't want her to know that they've told us, then how do you handle that, and… anyway… but, eh… I… uh… I've got a relationship with her now… I'm seeing her… the… the girl that tried to hang herself… so she's… I worry about her… and then… so she's on holiday this week, and I'm on holiday next week… so I am worried… she's on my mind… I'm worried about her… erm… 'cause she can go… she can be like, fine, fine, fine… like, fine… like, coping… keeps busy to cope, and then… she hung… she attempted to hang herself after she'd finished all her exams, and everything was fine, and she attempted to hang herself the next day…*

	almost like she can't… it's almost like a bit of a chasm… like, work, work, work… exams, xams, xams… finish… (sound suggestive of explosion)… you know…
8, 125, 3579-83	*yeah… and I've… I've got nothing to focus on…*
8, 125-26, 3588-3605	*y… yeah, she… she doesn't understa… she doesn't really understand why she… (sucking gums)… did it, so that's… (sucking gums)… that's… I wor… I am worried about her, so I've made…*
8, 126, 3611-24	*yeah, but she knows that she can come here, and 'Open Door'… I've given her 'The Sanctuary' phone number, and… but, yeah, it feels rea… it feels scary… feels a bit worrying, yeah…*
8, 127, 3631-39	*so that it causes anxiety…*
8, 130, 3733-44	*yeah… yeah… yeah… yeah… but, yeah… availability in the relationship… but I think that's what I rely on, and you're right… so that's why I'm anxious if I'm away and she's away… I'm, kind of thinking, 'oh, I suppose I've got to trust that she will… you know, contact one of my colleagues, or…'*

Subordinate Theme #1.4: "I felt so helpless": experiencing a powerlessness to help in relation to suicidal clients

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Transcript Ref:	Quote:
2, 42, 1191-1200	*well, there's no doubt that a part of me can feel irritated and angry… I don't want that… I certainly don't want it…*
2, 54, 1547-50	*so, he's a student who finds it very difficult to bring the aggressive, erm, sort of murderous part of him to me… he keeps it away from me, because he's ashamed of it…*
2, 55, 1561-78	*a lot of… a lot of aggression, and… yeah… very… very difficult feelings come out… and then I will meet up with him, and he'll talk about it, but he will appear to be managing… so, that stirs up in me, quite a lot of helplessness, because I… and… and… and the need to keep in the room those feelings that he hasn't brought to me, and to explore with him why he can't tell me what he feels about me, what he feel… which I think is what he feels about his father… you know, a lot of anger and rejection, and difficult feelings, that he can't express, so he… he acts them out on himself… he tries to murder himself, rather than the person he really wants to murder… which is his father, and possibly his mother…*
2, 57, 1623-29	*erm… in quite a sort of… he's… he's able to talk about it in a very… you know, a subdued and sad, but… but part of the conversation way… yeah… he's… he's sometimes will be a bit downcast, and… and find it hard to make eye contact me… with me when he's… normally he can, but when he's talking about that… so there is a level of shame… erm… and he's… and it's a quieter way of talking when he talks about it…*

2, 70, 1995-2017 *there… there can be… there can be negative feelings, as well as feelings of… erm… concern, and wanting to help… there can be irritation… there can be impatience… there can be, why aren't… what I give you… why isn't it enough to keep you alive?... why did you not tell me that you were feeling like this?... why did you go and do it quietly by yourself, and get to this point of crisis?... why didn't you let me help you?... but, of course, that's all part of his difficulties… is… is feeling so awful about his feelings that he can't bring them… erm… but that stirs up great feelings of helplessness in me… powerlessness… failure… err, all sorts of feelings of… of why?... and… and wanting to get to the point where he's feeling better…*

2, 72, 2047-56 *he is very angry… he cannot express that… he's very likeable, smiley, erm… erm… wanting me to only… wanting to be a good student, who can tell me how he feels in the room, but what he's not accessing is his more aggressive feelings… and I think those get projected into me sometimes, and I… I will find myself feeling very powerless and helpless and angry…*

2, 82, 2329-35 *it's when the student is quietly withdrawing, and doesn't come… that, in a way, can be more… can be the hardest thing to work with…*

2, 95, 2708-14 *and, you know, I can refer them to external or low-cost counselling… and will always do that if that's what they'd like, but that's where it ends… it's hard to manage that helplessness…*

3, 7, 184-201 *erm… but, I was working previously with a client, and she said that she was suicidal… erm… and when I asked her if she had a plan, she said, 'yes', but she didn't want to tell me about it… and it's interesting… I took that to supervision… and my supervisor said, 'that's quite a kinda push-pull, isn't it?'… erm… sort of, sharing… admitting… the suicidal ideation, and I'm not going to tell you any more about it… and, in some ways, I could totally understand that, because… why would she tell me about it?… if she's sort of keeping it as something she might do, it does make sense for her, in some ways, not to tell me… and it's also, I think, interesting, that she did tell me, and I suppose, I wonder what that's about…*

3, 8, 228-35 *but what happened with her was, she said, 'no', she didn't want to complete it… and with somebody else, he completed it, but he said, 'no', he didn't want to take it with him… ha ha ha ha…*

3, 29, 825-26 *erm… I suggested that he went to see his GP, and he wasn't entirely sure whether he would do that or not…*

3, 41, 1170-72 *erm… but if… if somebody's suicidal, and they're adamant that they're not going to go to their doctor… erm… then, there's a situation…*

3, 42-43, 1214-24 *and, I said to him, 'I… I think that you should, erm, mention the not eating to you doctor, 'cause I'm concerned that you're underweight… I'm concerned that you're… you're malnourished'… and he said that that wasn't something he could mention to his doctor, which I found quite extraordinary, actually… I'm still finding it surprising telling you today… because he had discussed the fact that he felt suicidal with his doctor…*

3, 55,1566-86 *erm, I remember taking it to supervision, and agreeing in supervision that I would contact her one more time after she'd gone… so, this is additional to the, you know, 'I'll assume'… and, I think, what I said to her… and it actually sounds a bit… it's interesting… it sounds slightly pathetic from my point-of-view… but, I think, what I wrote to her was that 'it would be helpful if she could let me know, erm, because, because of confidentiality… I… I wouldn't hear from anyone else'… now, that was absolutely my need for reassurance… and*

when I'm telling you about it now, I'm thinking, 'why did I need that?'… but I do need it… erm… and, in supervision, we decided that it would be okay to do that… she didn't get in touch, and I haven't asked her whether she got that e-mail… she must have done, actually, 'cause, as far as I know, her e-mail address hasn't changed…

3, 56, 1593-95 *erm… so, we're working together, erm, again… erm… and she is suicidal… this is the one that won't tell me, erm, how she would harm herself…*

3, 56, 1599-1610 *this is the push-pull… because, in the first… so, she got in touch… and, of course, this is… this is the thing which I also find difficult… if I'm working with someone, I want them to come to sessions, and I know that for some people, it's really, really difficult… erm… but, when... when she came back, and… she didn't come to… so, she got in touch, and said, she would like to come to counselling again… and then, I offered her an appointment, and she didn't come… so, then, I e-mail her, and I say, erm, 'we had an appointment'… erm… 'd'you want an appointment at the same time next week?'… erm… and I don't know whether it was the second time or the third time, she got in touch to say, she hadn't… I think there had been a problem with her college e-mail…*

3, 57, 1615-19 *but, I suppose, my need is… I want… I want communication… so, if you're not gonna come, then let me know… and I've had to work through a whole thing of it being about disrespect to me… I know… I know now that it isn't, but it still feels a bit like that…*

3, 57, 1622-24 *erm… but we are working together… erm… and she didn't turn up for her last appointment before Easter…*

3, 58, 1658-65 *erm… but my preference would certainly be that she would come every week as arranged… but then, how can you do that if your life's very difficult?... and sometimes, she goes to classes… and sometimes, it's really, really difficult for her to go to classes… erm… (intake of breath)…*

3, 59, 1671-79 *it's a bit periodic, yeah… yeah… yeah, there's definitely a bit of mirroring there, isn't there…*

3, 60-62, 1714-75 *so, the contract is that you come every week, and if you're not able to come, you let me know… so, there is that part… erm… you know, it is actually… we have contracted to do that… but there's also the fact that it would be a lot easier if I know… ha ha… and, if you let me know that you're not coming, then at least you're in touch, and I know that you're alive, and you're not coming… ha ha… the not… the not knowing… and the sitting here wondering, and, I can't get on with anything else, because you might just come to the door… 'cause, she has done that… sometimes come quite… quite late into sessions as well… erm… and, in fact, I've just remembered, that when she wanted to come, and then, I offered her an appointment… she didn't come… erm… and then… erm… she turned up apparently… we didn't have an appointment… but apparently she came… she told me, she'd come to the door… but we didn't have an appointment that day, 'cause she hadn't been in touch, but she came to the door on the off-chance… and actually, I was unwell, and not able to work, and, I remember thinking, 'you've been to counselling before'… 'it doesn't work like that'… 'you can't just pop in, and see if (counsellor's name)'s available', so I suppose, there's something about… despite the contracting, and that despite, you know, our appointments lasting one hour, and being at a specific time… for her, there must be something about not really quite having that understanding of that… you know, that she would like to just pop in when she feels like seeing me… or not… or not pop in…*

3, 64, 1836-42	*yeah… now, as it happened, I put the phone down, and there was an e-mail from the student… the devil (whispered)… ha ha ha ha… however… and she said that she'd been ill all week…*
3, 66, 1874-78	*anyway, I… erm… the student did contact me, just, I think, right at the end of the session, or even after our time would have been up… by e-mail, to say that actually, she'd been ill… erm… and she'd completely forgotten about our session… that she'd intended to let me know, but… but she hadn't…*
3, 67, 1917-22	*erm… well, I… I… this was the client that I asked to complete the, err… so, this is the client that won't tell me about her plan… she wouldn't fill out the form…*
3, 82-83, 2362-68	*I also decided to phone his mother… erm… and I said to her, 'you know, I'm… I'm breaking… I'm breaching confidentiality, but I'm very concerned… and I've spoken to his GP, and I am of the opinion, and they are of the opinion, that he needs an urgent psychiatric referral'… not just because of this, but because of other things… and the mother, interestingly, said that he was absolutely fine…*
3, 83, 2380-86	*erm… and it was at a later date that I spoke with his mum, who said that he was absolutely fine, and he wasn't… and the GP, in fact, at home, unusually got back in touch with me, and said, err, 'he's been to see me… erm… but, erm, he won't have a… he won't be referred to… for psychiatric referral… he says he's absolutely fine'… and I said, 'well, that seems to be the general opinion, that he's absolutely fine'…*
4, 19-20, 544-54	*erm… but… yeah, I have to say, I don't… well, it doesn't… yeah… I have gone home on the weekends going… (big sigh)… 'just please let them be okay by next week'… yeah… yeah…*
4, 27-28, 765-800	*yes, I guess…. yes… I guess, in some ways, so that they're aware… because we have students who, err, the tutors don't even know that they've come to us… and some of the tutors don't even know how vulnerable they are, and they're isolating in their rooms, and they're on their own, and they're not asking for help… and often, with suicide, it's often the people who are not making a fuss who tend to kill themselves, you know… I don't know if… it's been my experience… often, students who are making the biggest fuss, and demanding all the attention, tend not… not to… there's no correlation… (chuckling)… I'm just saying, from what I've realized… so, it's those students who are kind of really hiding that… that worry me…*
4, 31-32, 894-912	*yeah… and, of course, it's down to the students… so, I know of a student who is very vocal… is very able to get resources… who's able to identify how they're feeling… who's worried they might do something, or act on their thoughts… would… would… would get help, but one or two people who I know, wouldn't… that's what worries me… I guess it's for those students in those situations… I know they wouldn't tell someone that they're feeling suicidal…*
4, 33, 939-48	*yeah… and no one knows how she is… the tutors are completely unaware that she's struggling that much…*
4, 34, 966-72	*yes, it is… it's like… I've got the means… I've thought about it… it's there… and when I feel I can do it, or… I don't know… it could just happen… yeah… and I know she wouldn't alert anyone…*

4, 35, 984-88 *yeah… well, I guess, for her, erm, this kind of got uncovered… erm… eh, she's not very forthcoming, so she would never say… like, I have other client who's very clear about what he's done, or what he's planned… for her, it kind of seeps into the sessions, and… it does…*

4, 35, 998-1004 *yeah… yeah… yeah, that's what I feel, because, erm… especially with her, she'll have… she'll say something… but then, it's made in a, kind of… it's no… it's no really big deal…*

4, 35-36, 1009-20 *exactly… and I think that's what it is… it's really reflecting the seriousness of it… or that I take this seriously… because I don't think she is… yeah… and I don't think she's telling people around her how serious it is… yeah…*

4, 37, 1045-49 *well, yeah… just the fact that I'm now naming it, and that I'm really concerned, and that something needs to be done… that actually, I think, that's what she's been avoiding… anything being done… (chuckling)… she wants to kind of hide with it, and get on with what she's doing...*

4, 44, 1259-66 *if it is imminent, as in, the stu… I… I didn't feel safe to let the student go… I would keep them after the session if I was… so far, it hasn't happened… so, I've never had to do this… touch wood…*

4, 47-48, 1356-66 *yes… yeah… yeah… because often, if they're very, very depressed, they're isolating, and they're not speaking to anyone… and it's our biggest difficulty… then no one knows that this is going on…*

4, 76, 2181-82 *erm… so, it is very worrying… and I guess… touch wood… I've never lost someone…*

4, 95-96, 2740-60 *yes… but you're still left with that, 'it could be, right?'… and then you go home… and it's the weekend… and it's family time… and everything's going on normal… but you know, at the back of your mind, you're thinking, 'ohh, this is what I left today'… and there is… there are days where I do… I… I actually, honestly, go, 'just please let them be okay this weekend'… I've actually said that to myself… I'm very conscious of saying that, yeah… 'just let them be okay'… just hopefully they'll stick… hang in there, and we'll see each other next week, and, of course, that's what happens… (chuckling)…*

4, 107-08, 3086-3111 *erm… yes, I guess, it's this other one that I was telling you about with the detergent, and that… who's very under… so, erm… she has no contact with the tutors, and only my line… line manager knows about her… and, eh, she's very under the radar… and she came to me because of a bereavement issue, and she was never very open about everything else that was going on, so we… we spoke a lot about bereavement… and she was really struggling to adjust to university… but only after like the seventh or eighth session did it come out that she was actually quite… she had suicidal ideation every day, and that she was… erm… (pause)… she'd started to self-harm… she did when choosing high school… it started up again… she also had quite a serious disordered eating… but none of that was obvious… because, she wasn't very… even in our… even in my assessment, that didn't really come up, funnily enough… she didn't… so, erm…*

4, 108-09, 3115-29 *yeah… so she talked about her dad, and we spoke a lot, and she'd lost her dad, and we focused on all this bereavement… and, of course, in college… I mean, obviously, you know, she… we're only allowed six sessions here… and we were coming to the end, and*

my sup… my manager said, 'well, see her for a bit longer'… so, it went to nine… and then, she was like, 'well, you've got to start ending'… and, erm, as the last couple of sessions came… all the stuff just came to the fold… and it's… it's because I hadn't asked her specifically about self-harm, 'cause it was never in the presentation in the begin with… she wasn't presenting as depressed… so she really took… we took a long time…

4, 109, 3135-50 *erm, I'd referred her to… we run groups here… and I'd referred her to the bereavement group here… and she was assessed at the pre-grouping, and the counsellor here said she couldn't join, because of the… that, actually, if you're currently suicidal, you can't join the group… you're too unwell… and she hasn't come back to me… and that was really hard… well, I'm in that at the minute… so, following this assessment, she… 'cause we had a break… she hasn't come back for us to, kind of, start ending, and that's really awkward…*

4, 111-12, 3188-3216 *yes… 'cause I could see her from afar… I thought, 'oh my God, she's alive'… 'thank God'… but the truth is that I feel very sad, because we actually had a really good relationship… we were working really well… and she was… when I told you about becoming more assertive, it was with her… that I was really starting to worry about her… and I was upping my, 'I'm really concerned about you'… 'cause she wasn't talking to anyone… so, each week, I'd say, 'have you spoken to the nurse?'… 'have you gone to the chaplain?'… 'have you spoken to your tutor?'… 'do you speak to your mother?'… 'no', 'no', 'no', 'no'… it was all 'no'… so, she was restricting her food… she was self-harming… she had suicidal thoughts… she was buying detergent… and there was… noth… no one was intervening… so I felt so helpless, and so isolated with her… that she wasn't speaking to friends about what was going on… and, erm… and… and…*

4, 112-13, 3231-42 *yes… yeah… because she wasn't… she just wasn't acting at all… she was doing nothing to help herself… nothing… so it felt like this was deteriorating in front of me, and again, thinking, she's someone who would very much go into doing something without anybody knowing…*

4, 113, 3250-60 *so when I came back, she was on the list for this group… she was assessed by my colleague… and then my colleague told me that, eh, she wasn't gonna take her into the group… so I literally wrote back, and I got the feedback…'really disappointed you didn't come'… blah blah blah… 'let's make a time for a next session'… I never heard a thing, because she came every week… she never missed a session… she never missed a session…*

4, 114, 3269-88 *just… I didn't expect it… yeah… I didn't expect it… I thought she would have come back for a few sessions… and, in fact, to be honest with you, I actually would have found a way to manage her 'til the end of the term…'cause she is very vulnerable… I would have found a way… I would have just done it, and, erm, but she didn't come back, and it was… it's very sad…*

4, 117, 3359-61 *it's really tricky, that… and especially with her… and I think this is a good example where something can go under the… just, seep away…*

4, 117-18, 3369-90 *no… (chuckling)… no… no… because I know, at some point, I'm gonna have to write back, and say… that bog standard e-mail of, 'well, I haven't heard from you, so I assume you no longer wish to pursue counselling at this time, but please feel free to contact us*

again', and… I have to do that, and yet it just seems so sad, because we really did very intimate, personal work with her, and, I guess, there's been no ending, or not even… I don't know…

4, 118, 3402-10 *exactly… not even like, 'what's next?'... there's been no, 'what next?'… so, I don't know… yeah… and, I guess, that's hard, because with most of the clients I get, there's an ending… so, yeah, it's an abrupt… brupt break with someone who's constantly in suicidal ideation… ha ha… and, err, is not coming back…*

6, 16, 439-54 *yeah… I think… (pause)… I mean, he's the only one I can think of where the… where the… (pause)… hmm… (pause)… I think… I think, with that client, we'd aler… everyone had been alerted who could possibly be alerted… I mean, and… and he was very responsible for that himself as well, and very co-operative in kind of allowing us to sort of be in touch with people… erm… but I think it did mean that we all were encompassed by his own sense of helplessness in some sort of way…*

6, 69, 1975-88 *(sigh)… well, or… it… we… because you sort of think… 'are we helping?'… 'are we…?'… you… you know… I mean, I'm sure we… I'm sure we are on some level… but it… but it's, erm… we're helping… we're all there… we're all giving support, and we're being there… and we're offering our presence, but he's not any happier for it… I mean… erm… he might be happier than if we weren't all there, but… he's still suffering a lot…*

7, 100-01, 2873-2909 *yeah… yeah… so, I guess that, yes, I'm very experienced, and the majority of time, I kind of know what I'm doing… every day is different… it's… it's challenging… it's stressful… but it's within my competence… and I'm secure… but then there'll be other times where I'll feel, 'ahhhh… (intake of breath)… what?… (letting out air)… and… and I think that actually, then, eh… erm… I… y… you know… I mean, I'm… I… I'm a Christian… erm… I do have faith, and I have belief, and I…*

7, 103-04, 2970-78 *and I did occasionally… I remember… I used to really find myself praying as I'd be walking in to… to take up the… the duty, and thinking, 'right, over to you… 'cause I don't know what… I don't know what to do or say'… erm… and I think that at times like that, I might think, 'come on… ha ha ha… help!'… yeah… so I would then be seeking…*

7, 104, 2982-91 *yeah… yeah… yeah… yeah… 'come on', you know, to… take care of… of this, you know, because, erm…*

7, 116-17, 3345-62 *yeah… and so far, it's worked… when I've said, 'help!'… you know, I really… ha ha… I'm… I'm… I just want, erm… you know… you know… I can… allow to myself to be, eh, worked with it, or used… but I just don't know… I… this… this needs more than… more than me, maybe… you know, I'm… I suppose, I'm… what am I doing?… I'm praying for them, in a sense… not in a… erm… you know, not that I'm reeling off a prayer… but I am calling on…*

7, 117-18, 3366-97 *yeah… yeah… yeah… and I think there is that… I think it is… don't know… you know, I guess that… that you can see it in various different ways… whether it's spiritual healing, or, erm… eh… whe… you know, I… I think that there is… eh… eh… that goes back to that experience with that, erm, young person that I met in Samaritans, who said, 'this… this… you know, I just feel human for the first time'… it's like, 'wha… what?'… you know… and, I think, that's what… what happened… I think that there was something, erm, that happened there, and… and that's maybe what happens when all else… ha ha… seems… erm… because somehow, we do get to the end of… of a session… we do get through it…*

Subordinate Theme #1.5: "I do carry a weight around all the time": experiencing work with suicidal clients as burdensome and challenging

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Transcript Ref:	Quote:
1, 59-60, 1819-33	*but again, around Christmas… erm, that was very tricky, because he was estranged from his family… and the other thing practically, which is difficult… but, I felt, uncomfortable… 'cause it felt like it was pulling me out of my role… but he completely ran out of money, because he was… estranged from his family, but his family were wealthy… erm… so he wasn't getting any of the top-up for the loan… and there was a big shortfall…*
1, 60-61, 1841-51	*so in the end, I just sent him off to Student Advice, who… sorted him out, and gave him an emergency loan, and… and then, intervened on his behalf with, err, Student Finance England, so… but that felt difficult, 'cause… I didn't… I don't like that…*
1, 61, 1861-70	*yeah, saying 'I think you should' doesn't sit very well… but I don't think… it's not going to improve his… his state of mind.…*
1, 81, 2484-87	*erm… and… so, it was just, 'oh, ahh, not on my last day of work'… (laughter)… was my first thought… 'ahh, no'… 'poor… poor me'… 'cause it is all about me… but, no, no, kind of 'oh, God'… anyway… erm… and then…*
1, 81, 2491-92	*yeah… just, I'm knackered… it's the week before Christmas… please don't do this to me…*
1, 81-82, 2497-2501	*yes… (laughter)… yes, not now… (laughter)…*
2, 9-10, 254-72	*yeah… I think it has a very slow… a slow impact that is building up all the time on me, and my colleagues… we occasionally give voice to… well, quite often give voice to… that it is… it's now a normal part of our daily work… and what does that mean to us… that… that somebody saying that they feel suicidal… which, when you think about it, is a really traumatic, you know, awful feeling to have… that we are now encountering that on a daily basis?…*
2, 11, 290-300	*I am being confronted with death on a daily basis… and that's going to have an impact… it, sort of, slowly filters into you, I think…*
2, 12, 324-25	*but I must also be aware that it is going to be a pressure, and it's not possible to process everything that I am internalizing…*
2, 13, 360-65	*err, I also really enjoy the work… but it has changed over the last seven years dramatically because of the high level of risk… so, I…*
2, 17, 482-84	*and it can feel very sad… I can feel very hopeless… so, you know, in the countertransference… I will have those feelings of hopelessness…*
2, 18, 500-13	*yes… being affected, but not infected, is the… phrase that, you know, I'm sure you've heard, which is… is so important… but it is a struggle, especially if you have a strong attachment to the student…*

2, 25, 712-17	*that, you know, one… I… I could have felt in the past… that it was my job to keep this student alive so that he could stay on at the university… and not to take into the count that he had pre-diagnosed mental health difficulties… he's felt suicidal long before he came to university… lots has got stirred up by coming to university…*
2, 28-29, 802-25	*I think, as a trainee counsellor, you can fear that you ought to be able to manage this on your own, and I think that… some of that is the countertransference from the student, who is feeling alone in his suicidal feelings, and feeling that he should manage alone… and then that can get, you know, transferred into me as the counsellor, feeling I should manage him on my own...*
2, 38, 1085-88	*erm… so, although I can switch off, and I do switch off between sessions, that student will come into my mind periodically during the week at odd times at home… so external to the organisation… for sure…*
2, 40, 1119-28	*it's reminding me, actually, of… if I were not doing this work, or if I were to leave the university, some great weight would be shifted from me… so, I think I do carry a weight around all the time… I think we all do…*
2, 40-42, 1142-85	*yes… yes… I've got one here in note form… so, I've got one in this room… that does stir up… you know, that… that e-mailed me at twenty minutes to New Year… and I got that e-mail during the Christmas break, after New Year… erm, which brought him into my home… you know, and… into… into my thinking, and level of concern, and meant that I then got in touch with the organisation, and… erm… you know, one doesn't want that, but it's inevitable… partly because we do… I do check in on my organisational e-mails during the week… so, it brings the suicide into my personal life… I… I choose to do that… but actually, I have to do that really… I couldn't function just… on…*
2, 42, 1191-01	*well, there's no doubt that a part of me can feel irritated and angry… I don't want that… I certainly don't want it… I understand that it's part of the work, and I am…*
2, 51-52, 1461-83	*so, you could have a caseload of fifteen students, and twelve of them, you'd like to bring to supervision, but there's only time to bring one or two… so, those other ten… yes, so then you have to be quite responsible to think, if there's another, in… in those ten that I couldn't bring… if there's somebody that I know need… I need to discuss… I need to find that time to talk about that with Head of Counselling, or with someone else in the team… to be responsible for that… not to think, 'oh, I'll just leave it for another two weeks'…*
2, 54-55, 1547-52	*so, he's a student who finds it very difficult to bring the aggressive, erm, sort of murderous part of him to me… he keeps it away from me, because he's ashamed of it… so it all gets acted out when he's not with me… and then I hear about it when I come in… or I get an e-mail during the week…*
2, 56, 1586-87	*he's the one that e-mailed twenty minutes before the New Year…*
2, 59, 1680-93	*and at that point, he seemed to feel so alone, that he actually e-mailed me to say, 'can I see you in the week before term starts, 'cause I think I do need help?'… so, he became aware of an unsafety in himself and in his situation, so he made contact to remind himself that, I might not… I might be busy now, but can you make sure that you do still hold me in your mind, and that you will see me…*

2, 62, 1769-79 *you know, there are students who say, 'no, please don't tell my parents', and that in itself stirs up a lot of anxiety, because it increases my burden… I've now got to manage without the parents… and it's…*

2, 69, 1975-81 *erm… awareness of… or anger with the father and mother, which, of course, is unprofessional, because they have their own experiences and issues which have caused them to be unable to perhaps help their son, or… or… or… but it definitely does stir up some feelings about the parents finding it difficult to empathize with him and… and be non-judgemental of him…*

2, 72, 2043-56 *yeah… which might a lot be to do with his anger, which is being projected into me… he is very angry… he cannot express that… he's very likeable, smiley, erm… erm… wanting me to only… wanting to be a good student, who can tell me how he feels in the room, but what he's not accessing is his more aggressive feelings… and I think those get projected into me sometimes, and I… I will find myself feeling very powerless and helpless and angry…*

2, 72-73, 2061-74 *well, it's helpful… it's… you know, I could… I could feel, umm, at an instant level, ashamed of having those feelings… as if that's not a helpful thing to feel when I'm with him… but, after that, comes an awareness that, actually, it's helpful, because that then helps me to think about how he might be feeling… and to monitor how much of it is my feelings, and how much of it is… is him…*

2, 80, 2272-79 *yeah, I think, shock… and… and noting that shock, and noting the absence of shock in him… you know, that got put into me… I'll… I'll be the one to be worried about that… he can just carry on at uni… and just wants me to know, that actually, erm…*

2, 80-81, 2298-2311 *and I think that despair can be projected into me, and it can feel quite hopeless… sometimes that can last for… it hasn't with this student… but it can last for several sessions, and I think it's the hardest…*

2, 81-82, 2316-29 *yes… and in yourself… finding it hard in yourself to find any hope in continuing the work, you know… and the level of worry goes up… but the fact that the student comes each week, I suppose…*

2, 83, 2367-76 *yes… yes… and… and then, the feeling of responsibility that I might be the only person that that student is… seeing, or talking to… feels quite onerous…*

2, 84, 2394-2413 *yes, because I can feel the only link between life and death for that student… it might not be the case, but that's how it can feel… if I know the student is in their room, on their own, all the time between seeing me and the next session… you know, so… not in relationship with… even with themselves enough to feed themselves, you know…*

2, 85-86, 2434-46 *vigilant… the more suicidal… the more… the higher the risk… and that, in itself, is tiring… so, I think… yeah, that's it…*

2, 89-90, 2383-74 *but actually, just reminding them that you won't be there to see your parents learn their lesson… is enough for them to think of the reality of what they were actually about to do, and just how real, and close they came, can frighten them, and then, they feel that shock that I had felt, and, I think, it gives it back to them, and in doing that, I felt better, and more able to think again… 'cause I was overwhelmed with shock, and when you get that shock, you become unable to think for a minute… the horror… and I gave it back to her… now, I can think, and she's now got the horror… and that's what I want… because I want her to, err, begin to think about that…*

	and in doing that, she began… she made one more half-hearted attempt, and then she became much better, and able to join a therapeutic group at (former higher education employer), and stayed in it, and, you know, that was quite a turning point in handing that back to her, and, I think, that in itself is why it's stayed in mind as a… a memorable piece of work, actually…
2, 90-91, 2578-90	*my intervention, and my use of her feelings that got into me on the countertransference was… was really helpful… her feelings were helpful, and my acknowledging them was helpful… yeah…*
2, 91, 2595-2600	*yes… yes… yeah… the trauma that flooded me, and at times, she told me, erm, was what had flooded her… yeah…*
3, 20-21, 566-78	*(pause)… is my experience different?... I suppose, it less… it feels perhaps… less… 'exhausting' is the word that comes to mind… I think, with working with suicidal clients, it's really quite exhausting for me… and last academic year… erm… I was working with two clients who were… erm… quite… I'm never quite sure what 'actively' means, to be honest, in this stage, 'cause 'actively' would say to me that, when they're sitting here, they're actually in the process of killing themselves… (chuckling)… and I know it doesn't mean that…*
3, 21-22, 592-617	*erm… and I… as I say, I only do one day a week… erm… most of that time, I think, I… I wasn't working at full capacity, in that I wasn't seeing five clients… but then, I am on some committees, and I do have other work to do… and, I think, I struggle a bit with, should I always be working to full capacity… other people are seeing five clients a day, and I'm not doing that… but, I think, what I discussed in supervision was the fact that actually… (chuckling)… three was really quite enough… (chuckling)… erm… because it obviously does make a difference… the issues that your client's are bringing… and if they're bringing issues of relationship difficulties, or procrastination, or… you know, nothing that's terribly kinda full-on and heavy… erm… then… or a mixture of issues… then I think it's easier… but actually, if your whole day, one day a week, is clients, you know, who really are really quite depressed, then I find that quite exhausting, and I go home tired, and I don't have much energy…*
3, 68, 1953-54	*erm… I think… I think, being honest, when a client tells me that they're suicidal, there's a part of me goes, 'ohhh'… ha…*
3, 69, 1967-71	*erm… so, there's that kind of mixture of my heart sinking, and also, kind of… a… a lightness almost… a pleasure… pleasure's not the right word… erm… a relief, perhaps, that… that we are able to talk about this…*
4, 2, 51-52	*erm, and the university as a whole, we've had a recent number of suicides… so that is really hard…*
4, 8, 210-22	*and in the therapeutic relationship, if he's not willing to address anything, because it's very black-and-white… I either get this, or I don't… and he's finding it really hard to consider any kind of alternative… it's me or death… ha ha… so, it does feel… so, I'm really concerned, but at the same time, therapeutically, it's really hard to shift it…*
4, 9, 243	*yeah… yeah… so, it has been… it has been a difficult journey…*
4, 30, 841-49	*yeah, I don't like it… ha… I don't like it… yeah…*
4, 30, 853-54	*exactly… I think that's what it… and also, I guess, it is the, erm… the… I guess it is because you care about these young people…*

4, 75-76, 2160-71	*yeah… yeah… it is… I think it's hard… because, yeah… you do… you're touched by the struggle in front of you, and, I guess, you don't want them to die… ha… you don't want them to kill themselves… and, I guess, the… it is… the suicides in the universities are high… Bristol University's been through really a tough time…*
4, 77, 2199-2208	*yeah… yeah… I guess maybe that's the underlying fear that one of my… the students that I'm seeing… might take their life… yeah… and that's really hard…*
4, 77, 2212-22	*no… no… no… I'd find it very hard… yeah… I think any therapist would find it really hard… but I guess… yeah, I don't know… yeah, I'd find it really hard… yeah…*
4, 97, 2780-85	*it's difficult… (chuckling)… Adam, it's difficult… it's… it's… err… holding the frustration… and…*
4, 103-04, 2965-86	*(nodding)… yes… and it's not that she's failing… she's just there, and, err… she fails to see the… that she's actually done really well considering her mental health, so… that's hard… that's really, really hard…*
4, 121, 3471-72	*(long pause)… I think there is a lot of anxiety in the light of the fact that they happen at the university…*
4, 122, 3504-16	*yes… yeah… so when it happens out there, it effects the students who come in here… then it triggers their own suicidal stuff… and… eh… (blowing out air)… there's so many different layers, yeah… but it does create a… a reaction in the education system here, which is about mental health… and, I think, they're trying to lay it… really tryna raise awareness…*
4, 124, 3564-70	*so, it's… it's really hard… the suicides effect the students… and then, students talk about it in here… and then, it triggers their own stuff, so…*
4, 132, 3790-91	*erm… I'm just tryna think what else I can say… (pause)… yeah, I know… I think it's a really difficult area…*
7, 13-14, 371-79	*because it's so heavy… what… you know, what… what… what… you know, what they're… erm… going through… erm… so, I… I think that's… I think what I'm saying is that I'm… at that… what… you know, my immediate respon… that… that sadness is empathy… that isn't me… erm… for my own… erm… I don't… erm…*
7, 14, 383-97	*yeah… I think, that… that sadness… isn't… isn't just my s… sadness… that sadness is… well, it is, isn't it?… that… that's because I'm… I'm… I am sad for their situation… I am feeling sad… because it… it's awful… it's that awful… so, erm… so, that's…*
7, 99, 2835-40	*yeah… erm… so sometimes, I guess I can sit and feel… erm… inadequate… erm… and maybe, for me… erm… maybe… ahhh…*
7, 99, 2844-56	*like, it's about… like, eh, oh… oh my goodness… you know… I really… this person is… eh… eh… in so much, you know, pain… erm… that, eh, eh, I'm feeling at a loss… (noise of aeroplane passing overhead)… I'm feeling… I don't… I think they would be feeling overwhelmed… I think I would be feeling… erm… yeah, inadequate… erm, and… and that…*

7, 100, 2860-65 *yeah, that… it's too… too much… or I'm… erm… I don't… you know… I don't know what… what to do or say…*

7, 100-01, 2873-99 *yeah… yeah… so, I guess that, yes, I'm very experienced, and the majority of time, I kind of know what I'm doing… every day is different… it's… it's challenging… it's stressful… but it's within my competence… and I'm secure… but then there'll be other times where I'll feel, 'ahhhh… (intake of breath)… what?… (letting out air)…*

7, 103, 2970-73 *and I did occasionally… I remember… I used to really find myself praying as I'd be walking in to… to take up the… the duty, and thinking, 'right, over to you… 'cause I don't know what… I don't know what to do or say'…*

7, 104, 2982-3000 *yeah… yeah… yeah… yeah… 'come on', you know, to… take care of… of this, you know, because, erm… so… so, yeah… I suppose that… that most of the time, I just do it, because that's what I do… but sometimes, I remember that actually… ha ha… you know…*

7, 105-06, 3004-33 *yeah… yeah… yeah… this is… this is much, much too much for… this is, erm… this is somebody with immense pain and difficulty… and I really, really don't know what to do or say to help them… and…*

7, 106-07, 3050-68 *yeah… so what would they be?… erm… not… not really… I've got a sense of it, 'cause it's something that's… that happens occasionally… so it would be that… it'd be very intense, I guess… and very… erm…*

7, 107-08, 3072-94 *probably the… the feeling… the… the despair… erm… that… that hopelessness, as I say… the… the de… and maybe the whole situation, you know, like… some people do seem to have so much more of their share of pain… you know, that it might not just be one horrendous thing, but several, that, eh… that s… that someone is dealing with, and, erm…*

7, 109, 3122-42 *and… and kind of getting that… you know, like I was saying, sometimes, that having… gone into the experience with them, I will then kind of step back, and draw them out again by opening up, you know… eh, a bigger picture if you like… but where that really just seems impossible, because there is nothing… nothing that I can say… I can't mend this with them…*

7, 109-10, 3146-59 *no… yeah… yeah… yeah… where it just feels like it really is as bad as it can be… you know, the worst is happening… this is awful, and…*

7, 110-11, 3173-94 *yeah… yeah… and it's… and it would be… it would be insensitive… it would be… it wouldn't be, and, eh… to… to… eh, to offer… you know, because…*

7, 112, 3224-34 *erm… so, eh, eh… so, eh, eh, eh, but it… it would feel like there's nothing… there isn't a solution… there isn't a… there isn't, erm… something that… that I ca… I can't… I don't know what to say, sort of, to help…*

7, 113, 3239-52 *yeah… yeah, to a… to an extent… or at least with the despair, I would say, more than the hopelessness… erm… I probably don't completely lose hope… but I would feel less hopeful, I suppose…*

7, 114-15, 3276-94	*yeah… but, what… what would be helpful?… what would be…?… what… you know, what can I offer?… sometimes, I might feel like I just don't know… I just don't know what to say… I don't know what to offer this per… I… they really are s… in the pits, and… erm…*
7, 116, 3323-29	*and I think… I don't think it's… I think it is to do with the, err, magnitude of… of it all, you know… erm… because… and it would be a case of, 'yeah, of course you feel like that… it is so bad'… erm…*
7, 116-17, 3345-56	*yeah… and so far, it's worked… when I've said, 'help!'… you know, I really… ha ha… I'm… I'm… I just want, erm… you know… you know… I can… allow to myself to be, eh, worked with it, or used… but I just don't know… I… this… this needs more than… more than me, maybe…*

Subordinate Theme #1.6: "Everything in me doesn't want them to die": invested in keeping suicidal clients alive

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Transcript Ref:	Quote:
2, 14, 382-88	*I am helping students to keep themselves safe who feel suicidal… I think there is always that desire to keep the student safe in the work…*
2, 18, 500-13	*yes… being affected, but not infected, is the… phrase that, you know, I'm sure you've heard, which is… is so important… but it is a struggle, especially if you have a strong attachment to the student…*
2, 19, 517-33	*you know, there'll be the student that you almost know why they feel suicidal, because what gets stirred up in me is a feeling that I don't really want to be in the room with you… and that's that student's experience perhaps with all the important people in their lives that they're attached to… which is so awful for him to bear… but the ones that I… are very loveable… that I really feel strongly attached to, and… and… and more consciously concerned about… that's quite hard to bear sometimes, the feeling that they want to kill themselves, because everything in me doesn't want them to die…*
2, 56, 1584-86	*this student, I feel… I feel very maternal feelings about… I'm very… I attach to him... I feel very concerned about him… he's a lovely student, and I feel very…*
2, 56, 1587-1601	*so he… he… unlike some students who I might feel quite rejecting of at a personal level… this one, I feel very close to, and very attached to, and very, yeah, very maternal towards… so it stirs up a huge amount of concern in me… you know, if I were to hear that he had committed suicide, I think I would find that really difficult… I still wouldn't feel responsible for it, but I would feel enormous amount of loss and sadness… that, you know, that I feel his… his mother would feel…*
2, 56-57, 1605-09	*a care… because he's a very loveable, sweet boy… yeah…*
2, 70, 1996-97	*as well as feelings of… erm… concern, and wanting to help…*

2, 71, 2016-17	*and… and wanting to get to the point where he's feeling better…*
3, 3, 66-87	*I suppose, for me, what's difficult is that… I accept my clients as they are, and, in the first few sessions, of course, we establish the therapeutic alliance, the core conditions… and when… and I do an assessment in… in the… the initial meeting, and, I think, my difficulty always is that I have a duty of care to my clients… I want them to live… erm… I also want to accept fully how they're feeling, and find out more about that… erm… I… I think, in all of my client work, I'm learning all the time… it's an ongoing process… but, I think that I don't feel yet fully comfortable, erm… in… in that, which feels a bit… it… it feels almost like a… an… an inconsistency that my client may want… to die, to kill themselves, and yet, I want to be fully accepting of them, and understanding their world, and yet, there's a part of me… a strong part of me… that would like them to live… and, I think that… to me, that makes it a bit different from other issues that clients bring…*
3, 4, 108-09	*and he… he intends to kill himself, erm, in a year… and she is utterly accepting of that, and I suppose, I find that quite hard…*
3, 4-5, 115-22	*but, I think, for me… erm… I remember a previous supervisor talking to me about… he was very, very person-centred… and saying that 'you can accept your client, and you can go with them, but you don't actually climb onto the bridge, and jump off with them'… (chuckling)… 'you're not that person-centred'… and I… I… that stayed with me… and it's… I still haven't really worked out… erm… how exactly you stay with them, but you don't get up on the bridge with them…*
3, 6, 153-57	*I think, it's, kind… it's hard… I find it quite anxiety-provoking…*
3, 15, 418-20	*umm, I'm trying to think whether I've ever had to really redirect the con… you know… I'm saying, have to really redirect the conversation… I don't think so…*
3, 16-17, 461-79	*he… he hung on to that… that it was… had been so difficult, he knew, for this family… and that he knew it would be so difficult for his parents, and… and his siblings… and… and I said to him that I was pleased to hear that, because I think that it's… I think it's okay, as… as a counsellor, to be honest, that I would like the person not to die… that I have hope that things… I don't know, for certainty, but I have hope that their life might improve, if they don't die… and if they die, they won't know what might have happened… so, that's usually what I will say to people… if it feels appropriate to say it… but when I was talking to this counsellor, she was saying she wouldn't use the bit about, erm, family and friends, because there's guilt around that… and she wouldn't want to increase their feelings of guilt… which, I hadn't really thought about like that before… and, I suppose, in other situations… (chuckling)… we wouldn't want to increase the guilt of our clients, but maybe it feels slightly different… (chuckling)… with suicidal clients…*
3, 22-23, 631-50	*I suppose, for me, there's also a fear… erm… that… that they will kill themselves… I don't want them to kill themselves, however much I am accepting how terrible they feel, and that the best option for them feels, if they were to end their lives… if they were to be dead and not go on… I don't want them to kill themselves… I suppose, I would like them to wait and see…*
3, 28, 802-03	*what are the expectations?... erm… I think it would be fair to say, we don't want anybody to kill themselves…*
3, 44, 1251-56	*it feels as if there's more likelihood of them changing their behaviour… and, I suppose, in saying that, I'm saying, ag… 'I would like them to change that behaviour'…*

3, 44, 1266-67 *erm… there might be a coping mechanism which is not as harmful…*

3, 45, 1273-94 *erm… I think now, because I've worked now for so many years with so many clients who are self-harming, err, I suppose I'm much more matter of fact about it… I'm much more able to ask them about it… erm… I will ask them how they… what they use?... how they do it?... how frequently?... erm… and I'll ask them if it's something they want to change?… erm… and I'm just thinking as I'm saying this, I'm not sure when I've got a client who's suicidal if I ask them if it's... it's something that they want to change, which is quite interesting… I don't know why I don't, but I don't… I don't think I ask that question… 'so, you're feeling suicidal at the moment… is that something you would like to change?'…*

3, 46, 1299-1319 *(pause)… I don't know… 'cause it's actually pretty obvious, actually, isn't it?... ha ha ha… considering counselling is about change… I suppose, it feels like… (sigh)… almost like a decision that they've made… this doesn't actually make sense… I mean, I'm thinking and talking at the same time… I'm thinking, it's a decision they've made, and it's much less likely to be open to change… but why would that be when other things are less open to change?… d'you know the image I'm getting in my head at this moment is of something which comes down like a… like a funnel, but it doesn't have a hole at the bottom… but it's like something that's funnel-shaped, and… and, maybe it's glass, and it's see-through, and it's like the… the suicidal thought sits in that, kind of stuck…. erm… and that it's much more difficult to move from that position…*

3, 47, 1331-32 *yeah… stuck in at the bottom there… you almost need to give it a little shake… ha ha…*

3, 47, 1345-47 *exactly… yeah… (chuckling)… I hadn't thought of that… yeah… like you'd create a hole at the bottom for it to run down, or something… into something else…*

3, 48-49, 1384-96 *but, I think, what's interesting is that there is something different in my perception of a client coming… with suicidal ideation… and I've not really asked… not explored change as much as I would with self-harming, and with other iss… with other issues… (pause)… and I don't quite know how I'm gonna frame that… but it's certainly food for thought…*

3, 50-51, 1415-46 *yes, I think that fits… ah, ha… because there's… I'm thinking… in a… in a way, I'm not really agreeing with my client, because they're in a place where they're considering suicide… and I'm not really wanting them to do that… so I'm not really agreeing… and so, actually, that kind of prevents our conversation about, 'well, would you like to move from that?'… because, if I say that… I mean, and I've already said… perhaps said to them… 'well, I would hope that if you wouldn't kill yourself, and that you would remain alive'… 'you know, you won't know what happens, and there might be better things ahead'… 'there might be worse things, of course, but…' erm… it's almost like we're not discussing that, because I kind of don't want to admit that I don't agree with you… you know, almost like the accepting of it, in a way, gets in the way of discussing the change, so I think I need to work on a way of accepting where my client is, and also discussing the possibility of change… which, in a way, I'm doing, but there's something kind of different… I think it will need to settle a bit before I really understand what it is…*

3, 93, 2661-79 *absolutely… yeah… yeah… and for all… they're not going to be judged by me… d'you know, for all I'm saying there's that tension… that conflict... that inconsistency… about me wanting to accept it… I accept where they are… I'm not judging them in any way*

	whatsoever…it's just that, in addition to them being suicidal, I would like to generate some hope, so that they will see that there might be some purpose to their lives…
3, 94, 2683-88	*absolutely… umm, hmm… and… and perhaps… and… and, you know, finding a way through that struggle… because life can be extremely difficult… but there is an alternative to ending your life… you might be able to find a way to struggle through… and, also, of course, that people often find strength in the most difficult things… that that's where resilience is born, isn't it?… in the difficult things…*
3, 94, 2694-95	*exactly… well, that seems to be what I'm doing… and I imagine it's what most… I imagine it's what most counsellors are doing… (chuckling)…*
3, 97, 2789-90	*and whether or not they kill themselves, I suppose I still feel… and, you know, let's hope that won't ever happen…*
4, 30-31, 853-78	*exactly… I think that's what it… and also, I guess, it is the, erm… the… I guess it is because you care about these young people, and, erm, even though I know I'm not 100% responsible for them… because they are young adults… but, some of them are still bordering on, kind of, adolescence, and I think they're really caught in a really difficult patch of… erm, they're not adults in their 30s or 40s, and they might not be children, but they're in this little group, where I think, still… some of them could be… some of them are emotionally young, you can see, and you kind of think… they need someone to take that responsibility still in a sense, I guess…*
4, 31, 882-86	*I know… me!… I don't know… well, it just… yeah, I do… I do… I do…*
4, 31-32, 894-912	*yeah… and, of course, it's down to the students… so, I know of a student who is very vocal… is very able to get resources… who's able to identify how they're feeling… who's worried they might do something, or act on their thoughts… would… would… would get help, but one or two people who I know, wouldn't… that's what worries me… I guess it's for those students in those situations… I know they wouldn't tell someone that they're feeling suicidal…*
4, 35, 988-94	*I've been a lot more directive with… 'I'm really concerned about you now, today'…'we need to do something to address this, today'… whereas I would never really say things like that…*
4, 35, 998-1005	*yeah… yeah… yeah, that's what I feel, because, erm… especially with her, she'll have… she'll say something… but then, it's made in a, kind of… it's no… it's no really big deal… and I feel like, because she's not taking it seriously, I feel like I have to reflect…*
4, 35, 1009-11	*exactly… and I think that's what it is… it's really reflecting the seriousness of it… or that I take this seriously… because I don't think she is…*
4, 36, 1025-30	*(sigh)… eh… erm… I don't really like it, because, erm… I feel like it's… not forceful… but it's a different stance, I guess, and…*
4, 36, 1034-41	*well, I might say, but not so asser… not so assertively with her, because it felt more urgent… erm… but, I think, because she's been so timid and so self-conscious, and so shy, I'm wondering if that kind of pushed her back into a shell… like a tortoise… you know…*

4, 37, 1045-60	*well, yeah… just the fact that I'm now naming it, and that I'm really concerned, and that something needs to be done… that actually, I think, that's what she's been avoiding… anything being done… (chuckling)…she wants to kind of hide with it, and get on with what she's doing... and, I think, me kind of naming it in the room, and talking about what we need to do… it felt to me like her head was going back in the shell… like, as in, I shouldn've told you these things… (chuckling)… or maybe I shouldn've… I mean, she didn't say that… that's just in my mind…*
4, 40-41, 1138-59	*yeah… that feels a lot more worried… and, I think, the taking more responsibility kicks in, and having to maybe manage or controls sticks… sticks… you know, my… I guess, my own anxiety… 'what do I do with this now?'… this… 'we can't end the session', or 'they can't just leave like this'… and I'm conscious of time… 'cause you've got a next session, right… and, err… so all of those elements come in… and I think that's what happens when I then… am more assertive, in like, 'well, what are we gonna do today?'... and 'what's gonna be the plan now?'... 'we've got ten minutes left of the session'… 'you're leaving'… 'what are we gonna do?'... and I think that's kinda what kicks in for me…*
4, 41, 1171-85	*yeah… yeah… yeah, that's true… yeah… whereas I feel with suicidal ideation, we can sit with it for much longer… next week… next session… now, we do talk at the end of the session about, 'well, you know, if this shifts into a plan'…*
4, 42, 1202-06	*so, who… who would you call this weekend if you needed help?... 'okay, I'll do this'… err… and then, we go through numbers… and we go through people… and we go through strategies… and we do the same with… with suicide, but… the suicidal plans…*
4, 44, 1259-71	*if it is imminent, as in, the stu… I… I didn't feel safe to let the student go… I would keep them after the session if I was… so far, it hasn't happened… so, I've never had to do this… touch wood… so far, I haven't had to do that… erm, but we would kind of hold them here until…*
4, 45, 1279-85	*yes… if they were very distressed in the session… if they had this plan… if I knew they were serious… erm… we would hold… I think, we would keep them here…*
4, 46-47, 1328-48	*yes… yeah, which isn't really… it's really difficult here to do that… because we're very busy… very, very busy… so, erm… if that's… is the case, I would offer a second session, yeah, to see if they… or a check in… so, for example, erm… if the week feels too long, and there's a weekend in-between, I might say, 'well, I'll just check in with you by e-mail on Monday morning when I come in'… and usually they e-mail back… 'I'm okay'…*
4, 111, 3188-3204	*yes… 'cause I could see her from afar… I thought, 'oh my God, she's alive'… 'thank God'… but the truth is that I feel very sad, because we actually had a really good relationship… we were working really well… and she was… when I told you about becoming more assertive, it was with her… that I was really starting to worry about her… and I was upping my, 'I'm really concerned about you'… 'cause she wasn't talking to anyone… so, each week, I'd say, 'have you spoken to the nurse?'… 'have you gone to the chaplain?'… 'have you spoken to your tutor?'… 'do you speak to your mother?'… 'no', 'no', 'no', 'no'… it was all 'no'…*
4, 112, 3224-27	*exactly… and I… I felt like each week I could see physically almost a deterioration… erm… she spent a lot of time crying in the session, and… I guess, with her each desperation each week, I was getting more, 'we have to do something'… 'you have to somehow…'*

4, 118-19, 3408-27 *so, yeah, it's an abrupt… brupt break with someone who's constantly in suicidal ideation… ha ha… and, err, is not coming back, and choosing not to come back, so… yeah, and, I guess, there is, 'did I do something?'…'was she not happy with me?'… 'with me escalating a concern?'… I guess, that's… the analogy I was using was the tortoise in the shell… was she like, 'okay, this therapist is getting a bit too pushy'… (chuckling)… or 'she was go…' I don't know… 'it's too much, so I'm gonna retreat'… I don't know what happened…*

7, 16, 439-62 *well, there… there's two levels… there's… I suppose that there's, first of all, here-and-now, me with the client, and the sort of things that… that I, as the counsellor… as the… supporter… what… you know… eh… erm… and… and wanting to take care of the client, or my… erm… my responsibility as a human to this person… there… there's that, kind of… what… you know, what… what needs to happen…*

7, 29-30, 832-68 *absolutely… it does… yes… yeah… yeah… yeah… yeah… I don't feel that I need to start, you know, getting… getting… you know, action stations, right… I suppose that if it was very urgent, then I would… erm… in fact, at Easter, I was, erm… in a local pub… ha… and a woman came over, and said to me, 'oh, you know… you're a counsellor from (name of university)'… and I said, 'yeah'… and she said, erm, that… how m… how many years?… it was six or eight years ago… that she used to come to see me… I didn't recognise her, but she said she was a few stone heavier, and she had been diagnosed with what we then called borderline personality disorder, and, erm… (sucking gums)… she said that she used to come and see me… and she… she remembered one particular day where she came in, and said, 'I've just taken sixty whatever'… and, I said, 'umm, you know, we… we'll have to do something here'… (chuckling)… and she said she remembers me phoning, and doing something, but, erm…*

7, 31-32, 872-912 *yeah, sometimes think, 'well, actually… umm'… or I did have a student recently where I've been called in, erm… by one of the other… by a counsellor, who was seeing a student who had also, erm, taken an overdose… and they had been to the Health Centre, who couldn't do anything, and said, 'oh, no, she'll have to go to A&E', and so… yeah… that was quite interesting… so I went in, erm, to support the counsellor, and just to, sort of, check with the student, 'well, what are we gonna do now?'… and I'm looking out the window, and it's snowing really heavily… (chuckling)… it was when we had all the snow… and, I'm thinking, 'right… you know, are we gonna have to get an ambulance?… are we gonna get a taxi?… what's gonna?… erm… and talking to the student about these options… asking her to… to get a friend to go with her, or who might go with her… no, she didn't want anybody… she didn't want to tell any of her friends, or anything like that… and, err, she said, 'oh, I'm really tired… I just wanna go back to my room'… (chuckling)… I said, 'no… ha… no, don't think we can let you do that just yet'…*

7, 32-33, 916-29 *so sometimes… yeah… sometimes, eh… 'no, actually that isn't one of the options… you know, we've got a few options here… that's not one… you're not leaving'… (chuckling)… erm…*

7, 33, 933-46 *ahhh, yeah… we can't… yeah… exactly… so, erm… and, you know, in the end, her boyfriend was gonna meet her at the hospital, and we put her in a taxi, and she got there okay, but…*

7, 35, 1002-07 *erm… well, I think… I mean, if somebody has already hurt themselves so badly, or they've taken something…*

7, 36-37, 1028-43 *no… no… and… and I guess that keeping them alive is my… erm… my preference… you know, I mean, that's… that's what I would want to do… erm… and… yeah, so that… that's the priority, I suppose, conveying that…: that I care… that… erm…*

7, 49-52, 1387-1479 *having said that, erm… I'm… eh, I'm also, at the moment, erm, presenting an argument to say that maybe our counsellors could be trained in DBT to run groups, so we can have some training to… to do that… because maybe, actually, we do need to be addressing some of these things… erm… because those with this… emotionally un… containable, unstable, erm… personalities are not just, erm… not just struggling themselves, but they are causing chaos around them in the departments… in the… you know, their residences, whether it's houses, or… or halls… erm… y… you know, students sh… other students shipping them off to A&E in the middle of the night… ha… taking knives off them… hiding… you know, looking after their medication… losing sleep… having them sleep in their rooms, you know… eh, eh, there's security… there… diff… you know… eh, eh, eh… th… they kind of, erm… eh, and all the support, so… you know… so maybe, actually, eh… we… we could be doing something more for some of these people that are more likely to be… are very likely to be suicidal as well… certainly self-harming… very badly, but… but, often suicidal, so… maybe there's an increase in the number… I don't know, but… but I think that's something… erm… that I would like to address more… umm… so, I guess that's a bit of the organisational head… ha ha… sort of… (chuckling)… you know, being aware that, 'oh… eh, you know, maybe I need to persuade this organisation that we do have, erm, some responsibility to do more for the student population…*

7, 56, 1590-95 *I don't… I don't know if I'm necessarily just being with… with what they're bringing…*

7, 75-76, 2154-70 *I think, probably, in that situation… erm… my colleague had already… erm… been, eh, eh, in that very supportive and caring role… I think I was being a little bit more… 'right'… parental… I'm coming in here now… and I'm going to… let you make some choices, but they are limited… and you're not just going to… to come in, and tell us that you've taken an overdose, and then wander off out the service again'… so… so that… yeah… so that was…*

7, 77-79, 2204-53 *yeah… yeah, that somebody is actually… I suppose, a little bit like the parents with the toddler… you know, that actually, the parent is now saying… you know, 'because I said so'… ha ha…'that's enough'… 'no more negotiating'… 'no more…'… you know, actually… you know, I… I do know… yeah… becau… because they might feel uncontained, or… I don't know… whatever… and it's all too scary, and that… you know… (noise of aeroplane passing overhead)… and actually, sometimes they just need to know somebody does know where the boundaries are, and what… what's going on… you know… what's gonna happen… so… so, I don't… so, yeah, it is a slightly different role, in a way… erm… but that was because the situation was more immin… maybe I'd be doing that… a little bit like that woman… that remembered me… erm… you know… getting on the phone… well, of course, I didn't remember that… you know…*

7, 82-83, 2353-94 *yeah… yeah… and, w… what were the… you know, because in my head, I'm thinking of lots of options really… but I decided it wasn't appropriate to… for us to take her, for example… erm… but… but it wasn't like my head didn't, kind of, come up with lots of ideas… but I was making choices immedia… and then… presenting them… but I think that in… but, also… particularly if I'm with the student in the room, then it is… it is working… with, you know, eh… erm… it… it's not like I'm s… I'm going to say, 'right, you know…'… not… I usually won't say, 'well, you know, actually, this is it'… eh, I mean, I've done it before… I remember even working in a GP surgery once, where somebody had come in, and said how bad they were feeling, and I said, 'look, I'm sorry… I'm not going to… I cannot let you leave like this… I need you to see the doctor'… erm… you know… and we talked about that, and then we would talk about, 'well, would it help if I said something to the doctor first, or do you want to… to do it?'… lalalalala… how to make it better?… erm… and I think that that's… that's what I would be doing with… with a suicidal student… you know, it's kind of, 'well, what… what can we do then?'…*

7, 84-85, 2398-2443	*it's… it's… it's… yeah… yeah… yeah… and helping them… if they g… you know… so… so it might be that… that we're exploring options together… maybe they need to open up some… y… you know, maybe they didn't see any options… or maybe they did… but, 'okay, what are we going to do?'…'do you need to go home?', for example… you know, that might be one of them… 'would it help, you know, going home for the weekend?'…'or going…?'… erm… 'and would it help for me to talk to somebody?'… 'would…?'… you know… especially if… if, on top of everything else, they're… worrying about work, or something… 'would you like us to…?'…*
7, 95-96, 2735-60	*yeah… yeah, she just… just gave me the next question, so I just knew what to say next… and then, once I had got started, it was okay… but, yeah, so it was kind of hit the ground running, I suppose… and, erm… I think we called an ambulance… (chuckling)… ha ha ha…*
7, 119-20, 3420-36	*yeah… yeah… yeah… that's right… yeah… err, we actually put her in the taxi, and made sure that she was well enough to travel…*
7, 126, 3614-34	*yeah… so, the way that we used to… to deal with a situation like that was that if they did give us information about where they were, then… erm… we would… if, for example, they lost consciousness… we would assume that if we'd continued, we would have been able to persuade them to let us call an ambulance… and so, we'd call an ambulance… if they've told us where they are, we can't… we don't have to… just, you know… we can… they can be angry and alive… I guess, that's… that's part of the bottom-line as well, you know… let's have somebody angry and alive, rather than it's too late to do anything…*
7, 130-31, 3747-58	*yeah, I think it… it probably does… is… is… I'm saying tha… I gue… 'cause, eh… prob… I hadn't really processed that thought, but I imagine it is, you know… like, I… I used to work in a doc… GP surgeries… and meet a lot of older people as well… erm… so, it always mattered…*
8, 135, 3871-76	*I think, I… I know… eh… I know some counsellors that do treat it more like a… and this probably much more healthy… it's a job, and we can't… obviously, we can't prevent anyone… everyone from killing themselves that… if they've got that intention… but I think I'm more on the… I'm not… I wouldn't sort of overstep boundaries… eh, but I really want to try and prevent… and I tr… I really…*
8, 95-96, 2731-41	*yeah, I might not… might of not… might not have met, and… and it's kind of like… that feels risky… it feels a bit like… well, I don't know these people… what's happening?… you have to ask what's happening, and…*
8, 96, 2745-48	*yeah, and then… so I might say… 'so, you haven't even heard from so-and-so… 'd'you want me to call her?', and (name of Mental Health Advisor) will say, 'yeah'… so I'll call her on the Friday… there's no answer…*
8, 96-97, 2754-84	*not always… not always… yeah… yeah… yeah, exactly, and then… so, I might go through the notes… and think, 'well, when was the last time we had any contact with the GP, and do they know?… and is this case… is this situation serious enough for us to call the GP now, and say, 'look, we've lost contact with this person… we're concerned'… erm… or… you know, I like contacting the student… often, that will bring people out of the woodwork… (sucking gums)… you know, 'I've been trying to contact you… I'm really concerned… erm, please do get in touch with me… if I don't hear from you by, whatever, I will need to update your GP'… often, like that… (snapping fingers)… produces a phone call… (chuckling)… you know, that kind of thing… just all loads of stages in… I think, what some…*

8, 135, 3871-76	*I think, I… I know… eh… I know some counsellors that do treat it more like a… and this probably much more healthy… it's a job, and we can't… obviously, we can't prevent anyone… everyone from killing themselves that… if they've got that intention… but I think I'm more on the… I'm not… I wouldn't sort of overstep boundaries… eh, but I really want to try and prevent… and I tr… I really…*

Superordinate Theme #2: "Goldilocks and the Three Bears": experiencing risk management as either 'too much', 'not enough', or 'just right'

Subordinate Theme #2.1: "This is not gonna happen in five or six sessions": concerned by insufficient investment in mitigating suicide risk

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Transcript Ref:	Quote:
1, 5, 128-30	*erm, the questions that, particularly my manager, who comes from a very different background, might be asking about why I'm seeing someone for the length of time I am…*
1, 17, 520-21	*I think the institution can kind of push the client… push you… (hand gesture indicating being pushed)…*
1, 21, 624-25	*erm… and last week, we were told to… err, that there won't be any more resources, so we need to come up with solutions…*
1, 25, 753-54	*you know, I feel that in supervision, we hold the client in mind… erm… and the client is central… but… but the institution, it doesn't…*
1, 32, 957-58	*yeah… so then my boss'll troddle down, and say, '(counsellor's name), they mustn't get dependent on you'…*
1, 32-33, 984-96	*oh yeah… yeah, keep it short… keep it short… keep it short… keep it neat…*
1, 38, 1147-65	*I think, err… hmm… (pause)… and this is where notes are interesting, because the thing that… certainly, the experience of having my notes read was that I'd asked about a client, I'd discussed safety, I'd given out the Samaritans number, and that I'd recorded it… so, that was the institution's agenda… I know that… you know, in terms of just basic good practice… sort of, almost like hygiene… ha… that hygiene factor is… that's kind of something that you just do… but to me is not… it's not really about that…*
1, 40-41, 1223-57	*well, I believe in it… I do think… I do think… that having the Samaritans number, and knowing where the emergency walk-in centre is… could well come in handy… you know, at two in the morning… so, I do believe in it… but it feels like… all that the institution will be bothered about is that I've done it, and I've recorded it… and I actually think that misses the point of kind of… risk, I suppose… what the risk actually is…*
1, 42, 1272	*no… no, I think it's… it's a thing…*

1, 42-43, 1281-1306	*so, I wouldn't go and talk to (manager's name)… but I would talk to someone else in the team if I was bothered… and we're a very close and supportive team, so… erm… because (manager's name) would be constant… 'have you told them about the Samaritans?'… 'oh, well that's alright then'…'have you got permission to liaise… liaise?'… 'oh well, they've refused that'… 'well, you've done what you can'… but actually, if I really wanted to talk about the client, I would talk to a member of the team…*
1, 47, 1440-46	*I think (manager's name)'s very clear thing is about throughput… she came from an EAP… it's about throughput… it's about seeing people for the shortest length of time we can…*
1, 48, 1462-66	*yeah… and it's about… avoiding dependence, because that takes longer…*
1, 55-56, 1688-98	*erm, and then he said he'd come back again the next week, which he did… erm, but, there was a bit of a row, because, of course, because he had been silent, I hadn't been able to write any assessment notes, because he hadn't been able to speak… erm… so (manager's name) was cross about that, and saying, 'well, we can't do anything with him if he's not going to be prepared to talk and engage, and dadidadida'…*
1, 66, 2014-16	*yes… what I find more difficult is actually… at one point (manager's name) came, and said, 'I notice you've seen him for a long time'…*
1, 67, 2048-54	*yeah… oh, it was like (manager's name) came trundling down, and said, 'you know, you're working with him rather a long time'… and I said, 'well, he is suicidal'… and she said, 'well, is this the right place for him?'…*
1, 67, 2062-64	*and she said, 'well, just because there isn't an easy place for him, we don't want him to get dependent'… the big 'dependent' word again…*
1, 71, 2163-76	*and that somehow that was being called into question in a therapeutic way… when actually, it was a management issue… but it was masquerading as a therapeutic… that I'm encouraging dependence…*
1, 71, 2185	*yeah… and that, actually, that was about a management…*
1, 72, 2204-14	*this is about me having seen him for fifteen sessions… erm… this isn't about me and him… this is about (manager's name)'s issue…*
1, 83, 2531-39	*yeah… and then, a sense of relief that (manager's name) was on leave, so I didn't… she was out of the picture… I didn't have to go talk… or she couldn't give me a lecture on boundaries… (laughter)… or, kind of, whatever she would do… so, it was a sense of relief that I…*
4, 3, 68-71	*so, erm, for me, in here, it has… I mean, I've come from private practice work, so, I've come here… and, I think, the context really changes the way that you work with suicide and suicidal ideation, and how you manage it…*

4, 9, 243-52 *yeah… yeah… so, it has been… it has been a difficult journey, and, I think, coming back to the context, I think… our own assessment in the session with the student in terms of… is this ideation, or possible suicide… is very relative and subjective, and, erm, I think I've… since I've been here, I've been struggling with… what my idea of serious is, and possible suicide risk, and the organisation…*

4, 10, 269-70 *well… well, that's what I was battling with… and, I think, I've been tryna figure that out with my line manager about, well…*

4, 10-11, 282-89 *so, if there's a client you're concerned about, you can flag it, but… even just flagging was… when do you flag?... what's serious enough?... and, my understanding was, suicidal ide… ideation is not flag-able…*

4, 12, 301-21 *yeah… no… exactly… what's flag-able is if they have an active plan… yeah, or if there's been… well, I thought, if there's been previous suicide attempts, that's… should be flag… you should be able to flag… well, I… so, I guess what I'm saying is, it's not 100% clear… so, there's a system of flags so that everyone knows… but actually, I think what that flag means is different for everybody…*

4, 12, 330-42 *exactly… exactly… so, when I first started working, I was really concerned about a student… my line manager might say, 'but they're not actively suicidal'… and I'd say, 'no'… she'd say, 'well, that's okay'… not that it's okay that the student is feeling that way, but that, erm, you don't need to flag them… keep working…*

4, 13, 355-73 *well, I… err… I don't know… so, I don't tend to flag that often... but, when I… but… but… I've often felt I've wanted to, I guess… I've often felt I wanted to flag more than I do, but, erm, whenever I've checked it out, it seems like I shouldn't be, and, that's kind of the message I've got, so I don't…*

4, 14, 377-86 *yes, I guess… I guess that's what I'm saying… I'd probably flag more frequently than I do if I was going along with my own…*

4, 14-15, 391-413 *erm… (long pause)… (sigh)… well, I don't know… it's strange… I guess, on the one hand, I think, 'am I exaggerate?'… 'am I being over-emotional in my response to the client's stuff?', or, erm… so, I guess, I hold that on the one hand, and then, on the other hand, I think, 'no, I'm not'… 'it is serious'… so, I… there's a… there's always a tension… there's always a tension of… I feel really worried about something… and then I get told, 'don't worry', 'it's fine'… erm… it just… it just feels very… I just feel a bit all over the place sometimes…*

4, 15, 423-31 *yes, I guess… yeah… not in all cases, but just now and again…*

4, 18-19, 519-40 *I don't know… yeah… I don't know… it's a thing… that's… I guess, that's what I sit with… but then, I guess, I come back to what we said at the beginning, which is that a lot of the students are expressing suicidal ide… ideation, so I'm thinking if I lowered… if we lowered the threshold, I guess, at which we flagged, we would flag all the time… (chuckling)… does that make sense?… so, it's almost like the flag… the flag that we do put up are for the real serious cases…*

4, 21-22, 591-620 *well, it is… it's both… yes… well, that's how it is… it is… it's both… and, I guess, that's where I switch between thinking, 'am I being over-dramatic?', and then I feel a bit… not ashamed… but a bit like, 'oh, you're fussing again'… 'you're worrying too much'…'you, err… I don't know what it is'… and then, on the other hand, I move into… 'that's my clinical judgement'… 'that's my assessment'… 'that's*

what I think about'… even if… my line manager says, 'don't worry'… 'everything's fine'… so, I do… I move in-between those two… and it's really difficult sometimes to find where I can sit… so, I… I know clinically… like, I know, I've done my job… I've written the notes… I've flagged it… I spoke to my line manager… she knows… but essentially, the feedback is, 'well, you've done everything you're supposed to do'…

4, 59, 1685-90 *yeah… yeah… I do… I find that really difficult… and, I guess, in private practice, I'd err… always err on the side of caution, and I would…*

4, 60, 1710-33 *yeah, it's true… yeah, it's true… because, I guess, if it was down to me, I'd probably flag more often… or, err… yes… yeah… probably… but I guess that's… yeah… being on your own, I guess, in private practice, I had to be very… I felt like I had to just… you have all that responsibility, so you have to just be sure… I guess, I was more careful… I'm more careful… but I was probably more… inclined to flag there than I would here… that's, I guess, what I… what I've had to…. I've had to shift that a bit… you only flag when it's very serious…*

4, 62, 1767-78 *so, I'm very rational, I think… I know I'm being very clear clinically… but it just feels a bit… I guess, it's the… I don't know if it's the transference, or it's just the client feels very... overwhelms me… and, I guess, then, I feel a bit like, 'oh God'… erm… 'this is serious'… you know… and, I think, when she says to me, 'you've done everything you can'… 'don't worry'… and then I think, 'and now what do I do?'… (noise, indicative of ongoing emotional overwhelm)…*

4, 62-63, 1788-1802 *yeah… I think what the… I think, the context of it is… maybe if I put it into context… the context of that is, we get some really serious cases here… and the university's not equipped to really deal with it, in the sense that… err, not that as therapists, we can't… but we don't have the time… so, it's a brief service…*

4, 63, 1806-07 *yes… and, err, we get some really, really difficult, complex cases…*

4, 63-64, 1815-31 *so, someone will present to me with a serious borderline personality disorder… err, eating disorder… erm, really difficult relational issues… and they're currently quite seriously self-harming, and suicidal ideation is daily… and so, when I assess that as a clinician, I think… (sharp intake of breath)… 'oh my God'… 'this is not gonna happen in five or six sessions'… 'what is the… what is the point?'… and then I move between, 'well, what is the point?'... 'well, they can get some help with something'…'but then, as we know, does that help?'... 'and if there's attachment issues, is this helpful?'… and then, I guess, I feel overwhelmed by that…*

4, 65-66, 1872-83 *yes, for sure… yeah, I find that really… yeah, I guess that's really difficult… I guess, in being… that's been my readjustment here… yeah… is going from long-term work, or, if it's short-term CBT, it's still three months… these are numbers of sessions… and that's really… really, really hard…*

4, 66-67, 1893-1921 *yeah… I don't like it… it's really hard… well, I think, because it… what… it's something I'm struggling with still, because I feel like it… it goes against what's clinically… what we've been trained to do… and then, there's a whole… there's a whole another discussion around… it's a Counselling Service… I'm a Counselling Psychologist… and actually, is there a difference?... between Psychology and Counselling… and I don't know if… so, yeah, it's a struggle…*

4, 67-68, 1934-58	*yes… yeah… and how we fit in in services like these… I don't know… yeah… yeah… which is a huge, bigger issue… I don't know if that relates to your topic, but, it's like, erm… but it is, because I guess it's how we then work with someone with whom we're presented… so if you do… if you have to see someone who's presenting with what I told you, that's longer-term work… yeah… so…*
4, 70, 1996-2009	*so, I guess, when you, erm… I think what they've found in the universities… and, I think, this is probably true to most… is that the acuity level of the students has gone up in terms of mental health… so, the students are not presenting with just, 'I broke-up with my boyfriend, and I'm really sad'… students are presenting with serious mental health problems, but the demand, err, is so great, that we're having to offer a reduced number of sessions…*
4, 71, 2029-41	*yes, because of the increased numbers… yeah… yeah… so, I guess, when you, or when… or, when you… when I am sitting opposite a client who presents with a very complex psychological history… erm… automatically, I know from the first session, this is not gonna be one session, or two or three… it's gonna be more than that… yeah… and, I guess, that raises my worry or anxiety…*
4, 71-72, 2046-59	*yes… so what's very common is that you might see someone fortnightly, so when someone comes into my room who is suicidal, and I'm left with a full diary, I find a space for the week later… (chuckling)… because I cannot not see them… my… my sense… I can… my clinical judgement is… in my private… again, private practice, I'd be seeing that person either twice a week, or, definitely, once every week, with a check in…*
4, 88, 2532-44	*of course… and even bypass me… because, erm, I got one client who was ridiculous… err, just… a… a young guy… serious eating disorder… and he came here for CBT… and when I told him we would only have about five… six sessions, he went mad… and, I think, the tutor was upset… so, the tutor didn't speak to me… she went straight to our Head of Service…*
4, 89, 2548-54	*yes…'is that true?'… 'is that not happen?'…'can he not get more time?'… and the truth is, he does need more time… six sessions is not enough for him…*
4, 89, 2564-69	*it was terrible… ha ha… it was one of my usual… I… I mean, I'm sitting in an assessment… he leaves… and afterwards, I'm like… (slapping hands together for effect)… (sigh)… 'what am I gonna do with this?'… 'how am I gonna manage this?'… 'how am I gonna help him in six sessions?'… I went straight to my manager… 'I don't think it's an appropriate referral'…*
5, 2, 36-48	*it's… it's drastically changed over the last ten years from where I was when I started to… as a qualified counsellor… to now… erm… first of all, when, erm, the manager that was of this service, it was very secretive… erm, if you had a… a… a… a c… c… suicidal person come in, or… erm, you were at all concerned, you would, erm, state the name to the pers… to your senior manager at the time, and he would put it in a locked cabinet, and that was how it was kept… nobody, eh, knew… that was it… so, if he wasn't on, and I wasn't on, and the person came in, nobody would know…*
5, 2-3, 52-60	*the name of the person… to suggest that this person was at risk, and should be seen…*

5, 11, 314-19 *err… it's interesting, because I feel that… erm… on one hand, it is really good, because there's more pro… more people out there to support you… there's more… as a counsellor… there's more support… there's a structure in place… we have done our level best to help that student… erm… but, on the other hand, I still feel there's more work to be done…*

5, 13-14, 362-78 *and also, obviously, what happened the second time it happened, we had to get another new manager in place, who had never had anything to do with Student Support… she was managerial hat… not even from a Student Support Service… and, when it landed on our doorstep, she didn't want to take anything… any advice… any prev… previous experiences from any of the counsellors… she went off, and did whatever she did… and, it was really not beneficial, because what I was hearing was students were saying that they discovered… the… the teachers… the tut… the lecturers were saying, 'where's Joe Bloggs?'… and, they would say, 'ohh, he committed suicide', in the middle of a lecture theatre… and it was just like, well…and so, there was no notification given out to staff… there was no… they just ignored everything… it went into 'secret mode'… we didn't know… erm… we just heard something had happened to him… but yet, we were to put on the place where students were coming in to us… and they're telling in graphic detail… the ones that had found him… what happened…*

5, 14-15, 378-407 *and, erm, we were f… we were at… at the edge of having… erm… a cluster scenario… there was a group of them… there was about six of them… and it was… erm… again, there was a worry… having done a lot of reading about this… there's, erm… that… this… this suicide had actually happened in the first three months of his first year… err, you know, up until Christmas… so, he was a first year… and that was 'high risk', then… erm… it's been discovered that it's 'high risk' territory… but there was also… the fact was that these other students found him… they hadn't been normalised… and I ended up with something like thr… three out of six… I… I think… four in total, actually… whereby, over the period of the following three months, they came in… and what I discovered I was doing was doing normalisation work with them… which, we had… I had suggested that they should have maybe done that with the students at the time, but, they said, 'no, no, let's just wait until they come'… but actually, what happened was… it's taken them over two years to actually, erm, come to terms with things, whereas the first time it happened, it seemed a lot more… erm… because it was more reactive… it was more counsellor-led… it… the peace seemed to be, within the students, a lot quicker…*

5, 16, 448-57 *yeah… yeah… he… he actually committed suicide… as I said earlier, that he was in the first three months of his first year…*

5, 33-34, 942-69 *umm… we have, erm, a form… a pre-assessment form, which… again, has been changed over the years, so for… erm… but, at the moment, we've got a pre-assessment form whereby we kind of go through it… and, erm… well, we don't go through it… I'll have to take you right back to this… okay… sorry… start again… we used to have a pre-assessment form whereby we would actually fill in the form, complete it, and then we would be able to assess through the c… assessment process whether we thought the person was at risk… okay… but now… this is where it gets really bad… where the… the… the… the managerial systems are absolute rubbish… because the person will put it into the Hub… a Joe Bloggs admin worker looks at it, and if they haven't ticked the box saying that they're suicidal, then they get put as low priority… but the actual form might suggest they haven't eaten, they haven't slept, they have no connection with people, they, erm… erm… ha… have no self-respect, whatever… but that's not counted…*

5, 34, 977 *one box…*

5, 35, 981-83	*so therefore, there is now, in my opinion, a higher risk factor going on at the university than prior, because it's not been totally and correctly assessed properly, so…*
5, 35, 992-1007	*yes… well… well, it… not just interpreted… it's interpreted by the wrong person… because if I've had time, I've gone through the forms, and looked again, and I've changed the priority, and I've written to my manager, saying, 'look, this is not right… I… I've changed the priority… this person needs to be seen'… but now, it does…*
5, 36, 1011-19	*well, the clin… the manager's not involved in it… yeah… it's a… it's… it's an admin worker… it's a… just… diff… somebody…*
5, 36-37, 1027-39	*yeah… there's no interpretation there… so, even though we've got a pre-assessment form, to be honest, it's a total waste of effort… because, if they don't tick that box, they're not going to get prioritised… so, it… it… it's… it's something that the counsellors are banging on about… but, at the moment, we're being not heard…*
5, 37-38, 1045-69	*that's right… yeah… or… or somebody with that experience… a mental health adviser… somebody… but not an admin worker looking for the boxes… so, it's literally two boxes, and it's like… you know, what's that from a…a… you… you get seen as high priority if you say you're going to leave the university, or if you say you're suicidal… the rest of it means nothing to anybody…*
5, 38-39, 1093-1106	*erm, but, you know, it's… and, I think, she's finding it very difficult… erm… because, a.), I'd say, there's not enough time given… and b.), just what I've said… that she looks at these forms, and she'll think, when she's seeing somebody who was supposedly low priority, they're turning out to be nearly… eh… just about high, and on the 'cause for concern' list… and so, there's something within the process… they're ticking the boxes theoretically, but they've not got the understanding, or the correct people in place, to assess it correctly… so, therefore, the risk now, I believe, is higher than what it was before… because of a system…*
5, 39-40, 1115-27	*interpreted… umm, hmm… by the wrong people, you know…*
5, 40-41, 1135-57	*yeah… umm, hmm… and the other thing is, is that… you know, I keep saying that we need to have something… if you… if… if… if… they have this box, saying, 'do you feel suicidal?'… and, when you've interviewed them, erm, people will say, 'ah, yes, I… I was suicidal ten years ago, but not now'… but, you've had that ticked on the box… so, there's something about the actual form, which we keep saying as counsellors, we need to readdress… now, as counsellors, we would readdress it, and develop it… but our managers' structure… and again, here's your managerial… they feel the need to do these things, when they can't actually know the… they haven't got the knowledge base on knowing how to do it, so it gets left…*
5, 41-42, 1172-88	*yeah… yeah… because they've read it… they may have felt… well, invariably, what I find is that you get, erm, students that have come from school… they've maybe being self-harming… and they'll say, 'oh, I was suicidal, 'cause I used to cut myself when I was twelve'… and, 'but are you suicidal now?'… 'no'… 'no, I don't'… 'no'… 'but I was', and that's what the box says, so… erm… it's…*
5, 42-43, 1197-1213	*yeah, and then the people that are being missed are the ones where they've got eight… eight… eight or nine questions which are really low, or negative… so negative about themselves… but because they haven't ticked that box saying 'suicidal', they… they get missed… and they're the ones that worry me… yeah…*

5, 43, 1218-32	*oh, horrendous… I… I… brought it up and up and up… and at every counselling meeting, I'm bringing it up, because, err, eh, you know… eh… although we're trying to… make a system… less vulnerable, if you like, 'cause it… it… wherever… wherever you are, there's going to be this risk… it doesn't matter what university… but, actually, I see that as a gaping hole… and, as someone who… err… as an RMN, who has been interviewed by the police, hav… having been in court, if they go through the processes, that's a huge process that's just not right… I keep saying, this is a process problem… this isn't a counselling problem… it's a…absolute process… get the right person involved, who should be looking…*
5, 43-44, 1237-42	*eh, yeah… absolutely… if… if I was sitting… and I was a judge, and sitting in a court…*
5, 104, 2983-91	*it was just a name to your manager, and just put it in an envelope, and that's what I did… yeah…*
5, 104-05, 2996-3004	*yeah… (chuckling)… I didn't know what the purpose of it was, but… (clapping hands together)…*
5, 109-10, 3134-56	*yeah… but I think it is… though, saying that, although the procedures are actually improved, which they are, when there's a glaring hole in it, who is going to listen to that glaring hole?… because I'm afraid that there will be another suicide because of it… because of that lack of…*
5, 110, 3164-69	*yeah… and I… and… and I do feel that that worries me… that's my concern…*
6, 8-9, 223-36	*erm… he was… he… came to this crisis point very often, and didn't want to be there, and… and didn't, as a kind of an… on an ongoing level… want to… to kill himself, or to die… but he would be caught up in the moment of crisis… and so, it was possible to, kind of, engage with him on that level about it… but he was also very aware, because he knew that he got caught up in this moment of crisis… he was aware of all of the services available to him… the, sort of, duty psychiatrist at A&E… and the crisis team… and was in contact with them… so, in… in a lot of ways, he was safeguarding himself, which was… whi… wh… which was helpful…*
6, 16, 439-52	*yeah… I think… (pause)… I mean, he's the only one I can think of where the… where the… (pause)… hmm… (pause)… I think… I think, with that client, we'd aler… everyone had been alerted who could possibly be alerted… I mean, and… and he was very responsible for that himself as well, and very co-operative in kind of allowing us to sort of be in touch with people…*
6, 33, 934-48	*oh… well… and I… I think, actually, the ones that… the ones that… kind of raise my anxiety even a bit more, though, is… is for someone who talks ab… in a way that I find alarming about, sort of, suicide… erm… and, err… not alarming… but, you know, someone who will say, 'yes, I've thought about this… this is what I would do… I would electrocute myself in the bath'… and I think, 'that's pretty specific'… 'okay… that sounds… that sounds like something, you… you know, we really need to, kind of, go into, erm… and start thinking about risk management'… and I think, sometimes, the worry is when, erm… a supervisor or line manager will, sort of, say, 'yes, but I wonder if that's, you know, part of… part of this person's general presentation'…*
6, 34, 957-72	*so, I think the difficulty for me sometimes is, erm… when someone says something that on… you know, on paper… activates all of the kind of alarm signals… underneath it, there is a sense that, you know, maybe this is part of a, sort of, an ongoing dynamic of, sort of, drama… but at the same time… I don't want to mi… you… I don't want to miss anything… and so I… so, it's… so, it's difficult to take*

supervision that says, 'well, maybe sit with this for a minute, and sort of… before going in guns blazing'… I don't go in guns blazing, but… you know, before you…

6, 37, 1054-63 *yeah… I mean, and… eh, you know, in an ideal world, I would manage to strike some sort of balance… (chuckling)… where I wasn't just, kind of, going through the motions… but, err… you know, and I… and I would try to do that… but I think I do get a bit… I suppose, I do get a bit jumpy in any situation where my instinct is… does… is not aligned… my instinct for risk management is not aligned with, sort of, an organisational… you… you know, my supervisor's going, 'ahh, you know, I don't know… what do… what do you think… what do you think about that really?'… and I sort of go, 'I don't know… I don't know what I think'… erm…*

6, 38, 1068-81 *yeah… not… perhaps it's not aligned, but I guess that, erm… (sniffing in air)… (pause)… I'm lucky to work with some very, very experienced supervisors, who have worked in, sort of, personality disorder clinics, and things like this… and who have worked with people with some pretty severe presentations and complex presentations… and sometimes I think… and… and possibly it's a, kind of, product of my own, sort of, lack of experience, but… I get a bit more… more jumpy that… they… they can be sanguine about things, and… and… and, possibly, sort of, suggest working more therapeutically, or… or working in a more nuanced way with… eh… erm…*

6, 52-53, 1500-11 *(sigh)… well, that's the really tricky one… I mean, I think it's… I think it's just a, erm… (sucking gums)… it's a mixture of how they present, and what their history is… erm… (pause)… and then, a feeling of… (pause)… needing to bel… you know, believe them… to… to… to take what they say at face value… you know, that, eh, erm… and I suppose that is part... that is part of… you know, that's part of the anxiety when someone says, 'well, maybe this is just part of their presentation'…*

6, 58-59, 1662-76 *I think… I think I'll share the one who was probably most concerning… err… and he's the one who I mentioned before, who… who… who overdoses sort of every couple of weeks… who's known to our service… who's known to most of the services around…*

6, 59, 1681-95 *erm… and… from… from really adolescence, he had been, erm, self-harming, and, erm, sort of, overdosing… and some of his overdoses were not… he overdoses a lot on Paracetamol… he goes around as a matter of… just as a matter of, like, as part of his weekly routine, he goes around to all different pharmacies, and sort of stocks up, and then, erm… sees how long he can last without doing it, and then something will trigger him, and he will just, sort of, go and… (clicking fingers)… take a whole bunch of them, and then sit there for a whole hour, and then take himself to A&E… erm… where… he is, fortunately, kind of, you know, treated with compassion… you can imagine a situation where he wouldn't be, because he's in there a lot… erm… he goes a lot to, erm… there's a… a thing called 'The Sanctuary', which is a, kind of, mental health crisis team… drop-in centre… erm… sort of, overnight… and he, sort of, goes there quite a bit…*

6, 60, 1716-23 *it's, erm… (pause)… so it was a… it was a strange thing, in that, on… on one level… what was the risk?… there was a constant ongoing risk… but he was managing it himself… you know… he would call… you know, he had the mental health crisis team on speed dial on his phone… (pause)… and…*

6, 60-61, 1728-38 *yeah… yeah… and so, it… it was a tricky one, because it was… it was clearly… it was clearly risky… but it was being done in such a way that it had become completely normalised…*

6, 61-62, 1752-66 *yeah… yeah… but I think there have been so many services involved… and so many people doing their bit for the, umm… you know, sort of… alerting everyone else, and de de de de… it's kind of like a telephone tree or something… (chuckling)… and… and I think, everyone had… y… you know, become very comfortable with the idea that nothing… you know, he doesn't… eh… he… he isn't gonna do it… and I think that… there's something about that dynamic which is… a bit scary as well, because you just sort of think…*

6, 62, 1770-79 *yeah... or, they… they… you know, they sort of take it seriously… but he's not died yet, and he's done this many, many times, so this is maybe just part of his thing…*

6, 63, 1790-1803 *it does… it does… yeah… yeah… but a network of care that also prevents him from seeking out any kind of, you know, intimacy… in real life… eh… with other people who… who aren't caregivers, so…*

6, 64-65, 1835-56 *yeah… eh… yeah… well, I mean… it… I guess, it's… erm… I suppose it's a sort of thing, and I, eh… erm… I wonder whether I'm also influenced by the fact that he's… you know, he's got an autism diagnosis, and I know that, very often… people will say, 'oh, yeah, people who are autistic… yeah… they… you… you know, there's… there's a lot of suicidal ideation… it's just… just normal for autism… you know, that's just part of it'… as… as though that's kind of acceptable and okay, and sort of like… erm… you know, an alright way for someone to live… erm…*

6, 66-67, 1902-10 *yeah… well, and particularly if it… if it's… if it's a sort of, you know, series of… of damaging attempts at terminal… ha… harm… erm… but I think there… I think if enough people become involved, and there's enough of a kind of… eh… network there, you can lose sight of the actual risk maybe, or you can, eh… erm…*

6, 68, 1939-55 *yeah, well, I… I… yeah… that… that… that if it becomes... such a kind of fact of someone's life that every couple of weeks they try to kill themselves, and they activate this whole kind of, you know, chain of people who sit with them, and… and talk them through the same things that always bring them this point of wanting to kill themselves…*

6, 70, 2011-17 *yeah… well, and it's interesting actually, 'cause I… 'cause I… I pi… I picked him to talk about now… and actually, hardly spoke about him at all in supervision, now that I think about it…*

6, 71, 2027-45 *(sucking gums)… (blowing out air in a dispirited way)… well, it's quite depressing in a way, isn't it?… err… I guess, because… because his presentation had not changed so much over so many years that he's been familiar with the service, that people were like, 'oh, yeah'… ha… yeah… I mean… (sniffing in air)… you know, not… not in that tone of voice, but it… but… but there was a sort of, 'yes, we're familiar with this'… 'yes, he's aware of all the things'… 'yes, he's good at looking after himself'… 'yeah, it's fine'… so it's…*

6, 72, 2064-72 *yeah… but for someone else… you know… if another client, who we didn't have that kind of understanding of, or knowledge of, sort of came in and said, you know, 'I was in A&E last week, because I'd… you know, taken a massive overdose', there'd be… there… you know, there would be a… a higher level of alarm, I think…*

6, 73-74, 2099-2115 *yeah… y… yeah… and I… you know, I think it's… it's… erm… it was different with him, because I was just, sort of, the latest in a long line of practitioners to, sort of, work with him, so… risk had been covered pretty comprehensively… you know, over the years… erm… but that didn't mean he wasn't still, you know, in some senses, quite risky…*

6, 74, 2120-34 *I guess… I guess, what's coming up for me… as we talk about this is the difference between… levels of alarm… ha… at what someone's telling you, and, sort of, what… what you… what you do to protect that person… and actually…*

6, 75, 2138-42 *erm… well, that there's a lot being done to protect this person, but there's not a lot of alarm about his situation… but there are some people who we… you know, if it's the first time you meet them, and they come in, and… they're presenting with high levels of suicidal ideation, you might be, sort of, quite alarmed… erm…*

6, 78, 2223-45 *just talking to him, eh, a lot about… 'you know, so whatta you do?'… 'what trick…?'… you know… he was very familiar with the situations that would, sort of, bring it on… (sniffing in air)… he was very familiar with… you… you know, he had all sorts of things that he would try to keep this feeling at bay, and then, after a certain point, he said, 'the thing is, I just… I know what I should be doing, but at the moment, something just takes over, and I can't think clearly'… erm… (clearing throat)… and, that's when he would act out… and then, after a little while, he would begin to calm down, and that's when he would reel it back in… and so, you know, we talked a lot, and quite frankly, about, sort of, what was going on for him, and how that affected his relationships with other people, because other people, you know, inevitably ended up sort of embroiled in… erm, in these sorts of attempts, and he felt horrible about that… erm… (long pause)… and he did, and I believe that he earnestly did want things to change, and want the pattern to stop…*

6, 81-82, 2326-45 *(sucking gums)… yeah, I mean, I remember saying… and I remember feeling, as I said it, like a… a bit of an automaton… sort of going, 'okay, so, you know, you… you've told me that you took an overdose on… ha ha… on Saturday… erm… and… and, what happened?'… and 'okay, you called A&E'… 'is your GP…?'… 'you… you know… we've spoken about confidentiality, and the limits of confidentiality, and, erm, you know, I'd… I would like permission to, sort of, speak to your GP'… 'oh, no… my GP already knows'… (chuckling)… and, erm… and he was basically able to, kind of, recite the service protocol back to me… I mean, he, sort of, said, 'yeah… no… I know… no, I know… and I'm… and I'm in touch with these people and these people and these people… and I do this and this and this and this, and… erm…*

6, 82-83, 2362-78 *yeah… I guess, it's kind of… it was… it was, sort of, tough… I mean, on… on… on one level, I was grateful that he wasn't alarmed by any of it… I was grateful that he knew what support was available… I was grateful that he didn't feel like I was sort of imposing, or, you know, taking away his power or anything… erm… but it did feel like making something quite serious, quite humdrum…*

6, 105-06, 3013-31 *exactly… that… yeah… and it was, kind of like, referral… and if anyone was at all complex, refer, refer, refer, refer, refer… get them off your books…whereas… whereas, you… you know, I think what feels nice about having, erm, you know, a policy that we all are aware of, and is written down, and we revisit, and… an, eh, eh… and… and that is, sort of, enforced here, is that actually, having that containment, eh, contains the clinicians, and allows you to feel… eh… eh… a little bit freer, I suppose, to work with the clients… and I suppose, actually, this goes back to what I was saying about, sometimes, you know, with my supervisors, who are very experienced, sort of saying, 'well, you know, do you think that's really a risk?… well, let's see where else we can go with that'…*

8, 5, 130-37	*yeah, it is something different… obviously, and that has… ha… happened… erm… and obviously, I was… you know, I was upset about that… I'm not… I'm not kind of saying I wouldn't have any feelings about it, or saying…*
8, 10, 277-84	*yeah… that's per… I know other people make diff… they've made… (drawing in and letting out air)… they've… eh… colleagues, I suppose, if they've had suicides, they've made decisions… considered decisions… and then the client has killed themselves…*
8, 12-13, 342-66	*like, for example, I'm quite new here… but I've got a… I'm like the deputy manager, and I've got quite strong views on things like contacting clients after they've missed appointments, and… bit of a… a battle, but… 'cause some clien… some counsellors here are like, 'well, it's their choice… they didn't come'… I'm like, 'you… you always need to…' (chuckling)… you know… maybe not first ass… assessments, where we've never met them, but if we've got any information on them at all, we need to contact them…'cause that's what I've learned from pre… from inquests in the past… we've been told, you need to contact… (drawing in and letting out air)…*
8, 14-15, 374-412	*(sucking gums)… I think that's what we've been told… that's… you know… so, say there's been an inquest into a suicide at (former higher education employer) Uni… and then the learning from the inquest has come out… I mean, I think I've just, obviously, taken that onboard, you know… like, there was… there was, erm, a client over there who I saw… eh… eh… the previous year, and, erm, it was still when we had paper notes… (sucking gums)… and he had quite significant mental health problems… and I'd done an assessment… and I'd… he was being picked up by the NHS… (sucking gums)… erm… and so we kind of… like, he was going to be treated on the NHS… we kind of left it… but obviously, he cou… he could come back to the service if he wanted to… then fast-forward about a year, or some… or I can't even remember what… but it was quite a significant amount of time… I saw his name in the diary, booked-in as an initial assessment with another counsellor… so I b… got… I found the notes, and I gave it to… gave them to her… and I said, 'oh, this guy is coming in… I've seen him'… you know, like… 'cause, I remem… he had a very distinctive name, and I remembered he had quite a significant mental health problem… so I gave her the notes… he didn't come to that initial assessment appointment with her, and she didn't contact him, and he killed himself shortly after…*
8, 15-16, 424-44	*yeah… not just 'cause, eh, I'll ge… I'll get criticized, but I agr… I agree… I don't understand this, 'oh well, it's their choice'… I think, 'we're not… we're not living in that world… it's not that world… people have mental health problem… they don't come for all sorts of reasons… they could be struggling… you just need to contact them… I don't understand why… (chuckling)… please, can you tell me'… (drawing in and letting out air)…*
8, 17, 472-82	*and I just think, how… how would you feel as a client if you had an appointment, and then you missed it, and the counsellor didn't say, 'ooh, we had an appointment… are you okay?… d'you want to make another one?'… I… I just find it odd…*
8, 17-18, 486-99	*it's not… yeah… it's not a hairdressing appointment… d'you know what I mean?… ha… I don't understand why people think, 'oh, well'… (sucking gums)… (intake of breath)… so, yeah…*
8, 18-19, 507-24	*oh, God… yeah… awf… I felt really upset for hi… yeah… and I remem… eh, remembered him… felt really upset that he'd… it was a missed opportunity, 'cause apparently he'd… he was on a roof, eh, drinking somewhere, and the police intervened, and didn't pick up that he was psychotic, and, erm… so there was missed… you know, there was those, kind of, missed opportunities in there… yeah…*

8, 46-47, 1318-53 *because the GP has statutory responsibility, so… and it's our… so it's our limit of confidentiality… it's the go-to person… and it could be like the Mental Health Liaison Team if you can get… it's harder to get the client to go to A&E than to get them to go to their own GP, 'cause they've been… they've probably been before… and it's a… it's a more… it's a lower-key thing for them to do… but if you've passed on concerns, then the GP could engage the… you know, Mental Health Home Treatment themselves, or… they could do a medication review… you know, they… there's lots of things… but it's joined-up… and that's what's been highlighted in… some of the Coroner's… err… some of the inquests here… is that, wh… why haven't you linked more in with the G…?… and I think (former higher education employer)'s better at doing that than here… why haven't you linked with th… in with the GP more?… why dun't the GP know about this, and…?…*

8, 52, 1474-94 *but again, I've thou… thou… thought… I've asked for… erm… (sucking gums)… risk to be put as a heading in… 'counselling session notes'… so, say in an 'initial assessment notes', the template that we have… eh, there'll be a section on 'risk'… but then, the 'counselling session' temp… template no… for notes doesn't have a 'risk', and I just think, you should have a 'risk'… you should ask… you should be aware of the… about risk every session, so I've asked that to be put in, and it has… erm… because I think that's bonkers… to think that if someone's stable now, they're gonna be fine for the entire therapy contract… (chuckling)… erm…*

8, 53, 1504-13 *a template on the system… so, like when clients… when counsellors write-up their notes, there'll be a section on… whatever… 'focus'… dedededе… 'action'… now there's a foc… there's a te… a heading, 'risk'…*

8, 54, 1530-48 *I think so, but whether that's true or not, I don't know, 'cause I've not even been here that long… I just thought, 'why haven't we got a 'risk' heading for 'ongoing session notes'?'… I think that's a bit… like, 'why?'…*

8, 54, 1554 *I suppose, to just to flag it up that we need to be…*

8, 55-56, 1573-1600 *yeah… and then, once someone's in counselling, they don't have risk… that's almost like it seem… what it seemed like it implied to me, and I kind of think, 'well, that's not right to say… that's…'… and over there, we had, erm… the… the couns… the clients did a CORE-10 every session… at the beginning of every session… so obviously, there's one risk question on that, and that flags risk… we don't have that here… so, how are you gonna be alert to… someone that, eh… whose… whose mood or risk is, kind of, deteriorating or increasing?… eh… you know, just to put it in their… err… in c… in the minds of the counsellors just a bit more…*

8, 56-57, 1607-31 *I wondered about… yeah… I don't know if that, err, is actually the case, but I wondered that, yeah, because, obviously, if someone fills in a CORE-34 here at… eh… in… when they come for 'Open Door', or they come for initial assessment… and then they don't fill in anything, or a lot of counsellors don't give them another one part-way through, or… I just, eh… I just… worry about that kind of thing… yeah… ha ha…*

8, 110, 3142-52 *yeah… I mean, the… the… the guy that ki… that killed himself that I'd seen a few months previously, who was booked-in with my colleague at (former higher education employer)… eh… that really impacted… that was really upsetting…*

8, 110-11, 3165-77 *so, even though he… I wasn't seeing him, I do remember him, and I did… I di… di… I think there was a kind of… I suppose there was a bit of a disappointment, or a… sadness in me that I'd spotted his name, given the notes to my colleague, said this person's coming*

	in, read the notes, and then she didn't contact him when he didn't come… I think there was a bit of a… not that I'm blaming… I don't mean I'm blaming her… I think there's a bit of a kind of… almost like, I kind of tr… I remembered him… I tried… to do something… to… to…
8, 111, 3181-93	*yeah, kind of like a joined-up bit of… 'oh, I remember him… oh, and…'… 'cause we did that quite a lot over there… talk about… in informal ways… but just sharing with… you know… bit of informal supervision… and I kind of… I thought, 'oh, you didn't contact him… why not?'… but not in a blame way… I don't… not in a blame way… just in a sor… I don't know…*
8, 112, 3218-22	*yeah…'you had the notes… why didn't you?'…*
8, 134-35, 3839-67	*yeah… yeah… I feel a… I feel… that's what makes me feel really strongly about certain things… like, and I will say… I don't… I don't… in a way, I don't care what my manager thinks… if I'm in a… if I'm leading a team meeting here… my manager's not here… I'm saying, 'we need to contact people who DNA… that's that'… and they're, 'oh, well, eh…'… and I'm like, 'well that's my… feeling', because wh… I mean, what… like, you… you know… I just feel really strongly, having… you know, experienced, eh… ex… eh… results of inquests in the past, and… yeah… I mean, not even… not my clients… but just… this is what we get told that we should do…*

Subordinate *Theme #2.2: "Don't want to stand on any landmines": erring on the side of caution in taking the threat of client suicidality seriously*

Transcript Ref:	Quote:
1, 44-45, 1354-69	*I think I'm… I think I'm less freewheeling… ha ha… you know, kind of, I won't just take a punt on something in the same way… I'm more… I work more carefully… take fewer chances… you know, I might just chance something to see… to see… that kind of works with somebody… does that seem to strike a chord?… whereas I'm more careful with them…*
1, 45-46, 1373-1411	*yeah… yeah… don't want to upset… don't want to set anything off… that I will… don't want to stand on any landmines, I suppose… or don't want the client to either… erm… so, tend to slow down… I'm aware my voice becomes… slightly quieter… slightly slower… erm… and I'm aware that my body tends to mirror more… my eye contact might change slightly… just really kind of slow… trying to slow everything down… take time…*
1, 82, 2507-12	*erm… and I was aware I was working really hard to stay very calm… very steady…*
2, 34, 960-61	*I will… I will let that go for now… I'll be listening out in future sessions for signs of… erm, risk…*
2, 46, 1310-11	*but the trust is that, if at any time I feel there is risk, I… I will communicate that…*
2, 46, 1318-19	*erm… so, yes, the expectation is that I will regularly monitor and communicate that…*

2, 77, 2201-06	*sometimes, if a student… if they're obviously… it's more of a neurotic, erm, presentation… or they've come because they're not getting on with their music tutor, or something, and… they don't appear to be depressed… although, I will at some point always ask about suicide ideation and self-harming, it might not happen in the initial session…*
2, 78, 2214-25	*but it's… there's something in that student's presentation and narrative that will have triggered in me an… an… an alert that suicide is… is in the room, and I suppose some of that is just… comes from… it…it… it's sometimes hard to… it might just be that one picks that up in experience… but trying to analyse what it is that makes one think that… will be, yes, either the narrative, or the affect, or the presentation, or the referral to a third person that immediately alerts you, or the…*
2, 79, 2243-64	*he has a level of autism… I'm not sure to what level… he's a… a very high-functioning if he has… but he has been diagnosed autistic, and it meant that in his presentation… it isn't always the case, but… there was almost a normality about him saying it, as if he's… it's just part of his normal presentation… as if he's said it many times before, you know… and I had to be very aware of that normalisation… that, actually, it's not normal… and it's extraordinary that you've just told me you've tried to commit suicide six times, almost as if it's an… an… almost then, move on to something else… so, to be aware of that normalisation is, in itself, an alert to a… a level of risk, because it's not normal, but you're telling me it is… erm…*
2, 80, 2268-73	*so, shock… yeah, I think, shock… and… and noting that shock, and noting the absence of shock in him…*
2, 84-85, 2403-30	*if I know the student is in their room, on their own, all the time between seeing me and the next session… you know, so… not in relationship with… even with themselves enough to feed themselves, you know… so that, of course, is… stirs up a lot of concern in the… in all of us… erm… (pause)… so, vigilance is… is another strong word, I think, that needs to be…*
2, 85, 2434-38	*vigilant… the more suicidal… the more… the higher the risk…*
3, 6, 160-63	*but, erm… I do believe, certainly, at one level, that it's entirely up to clients how they live their lives… erm, and there are times when I have shared information with other people… erm… in order to… to keep someone safe…*
3, 41, 1170-78	*erm… but if… if somebody's suicidal, and they're adamant that they're not going to go to their doctor… erm… then, there's a situation… well, am I going to… am I going to share this with somebody?... and, of course, it's not… it doesn't always feel necessary, but there are times when... when it does…*
3, 63, 1796-1813	*now, when she didn't turn up in that last appointment… erm… I'm thinking, 'we're now gonna have a two-week break'… 'she's not turned up'… 'I've no idea whether she's alright or not'… and I did something I've never done before… I phoned Student Services, and I said, 'do you know of anyone who's seeing me for counselling?'… and she said, 'yes, I know… I know one or two'… erm… and I said, 'this is kind of new for me, but somebody's not turned up… erm… and I'm concerned that we're now going to have a break', and she immediately said, 'well, I know that so-and-so's coming to see you'… and I said, 'okay, that's all I need to know'… I said, 'well, in that case', I said, 'I'm going to let you know that that person has not turned up for their appointment, and I'm going to let her know in an e-mail that I have let you know'… erm… and that's actually a bit of a break for me…*

3, 66, 1878-83 *so, I e-mailed back to say, erm, 'I have actually let Student Services know that you… you didn't, erm, come to your session today'… so, that I would be completely transparent… I'm not entirely comfortable about it, but I actually think… I think I reflected on it, and I think it was an okay decision… and I think that it was about caring for my client…*

3, 79, 2257-71 *and I sat… she was my last client in the morning… and I sat then, in the room… in the surgery, on my own… I tried to get hold of my supervisor, and I couldn't… and, I thought, 'she is at risk'… 'far as I know, apart from her making an appointment, she's going to go and kill herself'… 'so, do I share information?'... she'd been referred by the GP… and I thought, 'I think I have to go and share that information with the GP', and I think… I think I have to do that now, and not wait until I see my supervisor, because then the GPs might have gone home… so I went… the GP was sitting… it was lunchtime… she was sitting with her door open, and I said, 'can I have a word with you?'… and I… I told her…*

3, 82-83, 2357-67 *I phoned the surgery here… and, I talked to, erm, the GP… now, he was… he was visiting… he would see both the GP here, and his GP at home… so, I talked to the GP about it here… and, erm, he said that, erm… he said, well, if he's gone home, it's really the responsibility of his GP at home… and I phoned, and managed to get hold of his GP, and, erm, I also decided to phone his mother… erm… and I said to her, 'you know, I'm… I'm breaking… I'm breaching confidentiality, but I'm very concerned… and I've spoken to his GP, and I am of the opinion, and they are of the opinion, that he needs an urgent psychiatric referral'… not just because of this, but because of other things…*

3, 83, 2381-85 *and, the GP, in fact, at home, unusually got back in touch with me, and said, err, 'he's been to see me… erm… but, erm, he won't have a… he won't be referred to… for psychiatric referral… he says he's absolutely fine'…*

4, 81, 8322-30 *erm… I think she's very serious… and I think she has, erm… she's been depressed for very long… it was diag… undiagnosed… and I think the attempts would be serious… I would take her very seriously if she said to me that this was what she was gonna plan to do… yeah… I would… I'd take her very seriously…*

4, 81-82, 2334-66 *yes… yes… well, I… yes, because I truly believe she is unhappy… and I truly believe she wants to die… whereas I have another guy, who… this other guy who's written his will, and planned it all… he doesn't wanna die… you know, he just feels he's running out of options… he's an international student… who wants to stay in the UK, and he can't… he doesn't want to go home… he doesn't have a good family life… has really struggled, and he's really been happy here, so the death for him is just… it's not a last resort… it's not a hopelessness… it's just, if I can't be here, I don't wanna be there, so it's not that I don't take his seriously, but, erm, I know he doesn't want to, and I think he's still tryna search for options…*

4, 82-83, 2370-79 *he wants to be here… he wants to be alive… whereas, I know, for her, it's very much… tied, and just…*

4, 83, 2383-87 *yes… yeah… tied-in with all this pain…*

4, 83-84, 2391-2412 *no possibility… yeah… yeah… so, I take that very seriously… and she's quite impulsive, so I worry about that, you know… whereas, his again, it's planned… he doesn't do anything on like a whim… he's not self-harming… she is so much more impulsive… so, I think,*

if she… she could just decide one day, 'right, I'm doing it now', and, I think, that's what makes it harder for me to sit with between the weeks… I worry about her with that…

4, 104-05, 3006-24 *yes… yeah… yeah… yeah… yeah… she would… she would be… I guess, she would be on our more, err, serious… yes… yeah… yeah… she would be… yeah, I think she would be… yeah, she would be moving into our more serious side… yeah…*

4, 108-09, 3115-31 *yeah… so she talked about her dad, and we spoke a lot, and she'd lost her dad, and we focused on all this bereavement… and, of course, in college… I mean, obviously, you know, she… we're only allowed six sessions here… and we were coming to the end, and my sup… my manager said, 'well, see her for a bit longer'… so, it went to nine… and then, she was like, 'well, you've got to start ending'… and, erm, as the last couple of sessions came… all the stuff just came to the fold… and it's… it's because I hadn't asked her specifically about self-harm, 'cause it was never in the presentation in the begin with… she wasn't presenting as depressed… so she really took… we took a long time… and this is where, I guess, the relationship kind of unravelled all of this stuff, and then, suddenly, I was stuck with… it's actually quite serious… (noise, suggestive of ruefulness)…*

5, 43-44, 1237-49 *eh, yeah… absolutely… if… if I was sitting… and I was a judge, and sitting in a court… and… and that's how I feel about c… counselling a bit now, that… you have to cover yourself, and make sure that you legally have done the most ethical… you… ethical position… but it's also something about covering yourself as well… erm…*

5, 47, 1342-53 *yeah… didn't know… didn't know… and, erm… I genuinely… I've gone through it in my head… and time and time and time and again… I went to supervision… increased supervision… I've… done… and there was, seriously, not a jot… I looked through my notes… we talked… err… and, you know, I… I… that… that… that was the k… the… the thing that… when… it's those people that you miss… and, if you miss them, you know… he was a miss for me, and, I suppose, that's why I'm very much… erm…*

5, 48, 1354-76 *and it were… it was a real weird, 'cause I heard through… three month later, through a total different source… somebody who didn't know I was his counsellor… and actually, talking about him… saying that his girlfriend had jilted him twenty-four hours beforehand… and, you know… that was just… I think that was what the issue was… but that's not the point… I never picked up the highest level of anxiety that that young man felt, or that it could be internalized… and that's the kind of thing that worries me, that, through the process that we go… this pre-assessment process… then, when you get in the counselling room, if you miss that… erm… and, I… I don't think we should take it personally… there says me, saying you… it's me… but it…it… it's this… it is that high anxiety level, you know…*

5, 49-51, 1399-1446 *no… not at all… but what bothers me about it is when you go on these CPD courses and things… I had gone to… ohh, I've forgotten his name now… erm… he used to work here… err… Professor (surname of ex-colleague)… erm… d'you know him?... erm… ahh… God, it's going round a bit… erm… he's working over at University of (name of another regional university) now, and he does… he does… his whole work is round suicide… and one of the things that he had acknowledged in one of his presentations that I went to was the high level of anxiety in a student should really be clocked, and really be taken very seriously from the perspective that it could have… it coul… that there's… I can't remember the percentage, but… there could be an inclination more towards the suicide because of the anxiety levels… and that young man was extremely anxious… but he came in with anxiety over whether he should stay, or try something different… and he was on a course for something different… and he was in the process of trying to work it out… but the anxiety levels was quite high… but it… it never clocked with me, err, or I never… I never checked in… you know, I didn't say to him,*

'are you feeling…?'… you know, I never checked in with that, and I don't know if it would have been right to either… but it does leave you in that reflection… you know, if I have somebody with high anxiety now… umm, you know, I do sit down a bit more, and think about that… umm… learning…

5, 51-52, 1457-78 *yeah… for me, personally, as a counsellor… I would… as I say… in a student population, I suppose, you see anxiety all the time… it's… it's just… with exams… it's this, that, and the other… but, I suppose, the significance of the anxiety now has been heightened through that episode for me… that incident… erm… and, having… listening to, you know, Professor (surname of ex-colleague), I thought, 'woorr, I maybe should have listened further'…*

5, 53, 1503-24 *yeah… yeah… but, I think, you… we have to keep it in perspective, as well… you know, it's… people will only… share what they want to, as well… but it's a case of… you know… at… at the time when he finished, his girlfriend hadn't jilted him… (chuckling)… so… who knows… how… who… what had effect?… was it high anxiety was that caused it?… but it does make you reflect and reflect about it…*

5, 54-55, 1539-67 *umm… but then… yeah… and… and… who knows?... but it did… I think… if… if you take a learning curve from anything, whether it be… you know, for… for whatever reason, the learning curve for me was… sit back and listen to anxiety with more respect maybe, and not just assume that every student that comes through the door is going to be anxious… and maybe that's what I've learned through that… yeah…*

5, 75, 2148-56 *erm… (long pause)… (sigh)… I think what it probably does is make you think very much in terms of your own legalities, and where you stand… I contact my… my insurance company and BACP quite frequently… I make sure that I am in a legal standing, and I'm ethically still correct…*

5, 76, 2171-80 *yeah… yeah, but actually, when you go to the legal… erm, go to the insurance companies… they've got more definition, and more… and more understanding legality of it…*

5, 76-77, 2188-93 *yes… and… and… and I… I… I…I've… I've been grateful to the insurance companies…*

5, 78, 2223-51 *yeah… and… and that, funnily enough, was one of the ones with the suicide… because I didn't know… I was… I… I was… eh… eh… you know… felt a wee bit put out to dry, 'cause nobody could help me on it… but… but I didn't actually say, erm… I didn't know whether, when I was asked by the Procurator Fiscal, whether I should be handing in my notice or not… I didn't know… there had been mixed messages about it… and, erm, I contacted… erm… BACP, who weren't actually very useful about it… 'oh, we don't have any dealings with anything like that'… 'you'll have to go to your, err, legal department… you know… erm… in the institution'… well, our legal department is rubbish, because they… our… our university won't actually… erm… err… even pay for insurance for counsellors… erm, so, then, it was left again…'what do I do to make sure that I'm ethically correct?'…*

5, 79, 2255-64 *so, then, you have to… I… I went to, erm, my… my insurance company, and they talked me through it, and they actually wrote the letter, and they did everything for me… they were brilliant…*

5, 82, 2345-50	*I… I think it's because people haven't got a framework that they understand… they don't understand the counselling framework… I think BACP are too worried in case we quote BACP at them… erm… and, erm… then, also… err… the only people that are willing to support you are actually the legal people, 'cause they actually are legal… they do know about it…*
6, 3-4, 72-109	*I think the main issue for me is, erm, you… you know, when you talk about risk management, and organisational risk management, is that you're… you're dealing with your exp… or, I'm dealing with my experience of the client… but, also… and, my duty to the client… but, also, my duty to the organisation, and, erm… so, for example, I always in my supervision will prioritize any issues of risk… erm… and I tend to be quite conservative about that, and I tend… and, I think, that's possibly 'cause I worked in IAPT for a long time, and there was, erm, such a culture of, sort of, being defensive against poten… potential litigation, and things like that… so, erm… so, anyone who mentions suicide at all, I will tend to, sort of, bring that up in… in supervision… and sometimes it can feel like I'm doing that for bureaucratic reasons… you know, to sort of, pu… just to make sure that I've, sort of, covered my back, and covered the organisation's back… erm… even if I don't feel that a client is, sort of, actively suicidal, but, I feel that it needs to go on the record… erm… and I think the trouble that I sometimes have with that is that you get… or I get in… so much into the habit of, sort of, saying, 'this person has mentioned suicide… erm… eh… you know, they have no plan… they have… blah, blah, blah… but, eh… eh… but I feel like I need to just, kind of, share this, and… and have this… erm… have this out there somewhere'… (sniffing in air)…*
6, 7-8, 179-204	*yeah, I mean, I suppose… erm… in terms of risk management, I think… you know, for someone who mentions it… you know, 'I some… I sometimes think about it, but I have no plans, and I wouldn't want to do that to my family, as such'… someone who doesn't have an active, kind of, plan… or… or actually, really, a kind of… an entire desire to, erm… to harm themselves… then, I think I will discuss it in supervision, and, sort of… I… lay out my reasons why I don't think we need to write to their GP, for example… erm… but, you know, make a record that I'm gonna keep that conversation open with the client… and I do sort of check back in with the client…*
6, 10, 264-87	*I think it was… it was, sort of, fairly hopeless, in a way… and it… and, I guess, where the… where the organisational aspect of that came into it for me was thinking, 'well, at least… at least, I can check with all of these people', and say, 'is there anything else we can be doing?'… 'what are we doing?'… 'what are we doing?'… but, on some level, there's always the worry that that feels like what you're seeking is validation… like, 'well, we've done everything, right?'…'we've done everything, right?'… erm… 'what more can we do?'… so, it can almost feel, sort of, like a giving up… (beeping noise)… I don't know if that makes sense, but… it's on the one hand comforting to be able to… to… (pause)… to have sort of proof-readers, in a way… to have people you can go out to, and say, 'have I done ev… ev… ev…?'… you know, 'we got this covered?'… 'are we…?'… 'are we…?'…*
6, 12, 321-41	*well, no… it's… well... it… well, it… well… well, it's… it… yeah… it's sort of ticking… ticking boxes, but also, sort of saying… (pause)… kind of like, handing over the situation to a protocol… sort of going, 'well, okay… so, we've done this… we've done this… we've done this… we've done this… we've done…'… like having a fire drill, or something, you know… we've taken attendance… everyone's, kind of, exited the building in an orderly fashion…*
6, 23-24, 658-68	*well, and also, and, I guess, the despair… the hopelessness is a sense of that… (intake of breath)… on a particularly jaded day, you think, 'well, I'm gonna tell his GP… what's the GP gonna do with it?… you know… it's gonna sit in a file… it's gonna be, sort of, on record… it's gonna be a paper-trail, and… and… where…'… you know… it can feel like, you… you're just, so that the buck doesn't have to stop anywhere…*

6, 24, 672-81	*an evasion of something, or a, kind of, a… a sharing out of, sort of, culpability or… or responsibility… erm… so that everyone's part gets diluted… so that… erm…*
6, 25, 694-703	*(sucking gums)… errgh… err… I mean… it's funny, because, on the one hand, and of course, this is, you know, partially my, sort of, background in IAPT speaking, but, you know, you… you… you have a sense, in this day and age, in a counselling organisation, of incredible organisational vulnerability anyway, because budgets are being cut… and so, you know, you do feel that you have to do your part to make sure that we're… eh… you know… (pause)… not 'looking after ourselves', because that does make it sound, sort of, sinister in some way… not, sort of, 'watching our backs', but, erm… (pause)…*
6, 33-34, 934-66	*oh… well… and I… I think, actually, the ones that… the ones that… kind of raise my anxiety even a bit more, though, is… is for someone who talks ab… in a way that I find alarming about, sort of, suicide… erm… and, err… not alarming… but, you know, someone who will say, 'yes, I've thought about this… this is what I would do… I would electrocute myself in the bath'… and I think, 'that's pretty specific'… 'okay… that sounds… that sounds like something, you… you know, we really need to, kind of, go into, erm… and start thinking about risk management'… and I think, sometimes, the worry is when, erm… a supervisor or line manager will, sort of, say, 'yes, but I wonder if that's, you know, part of… part of this person's general presentation'… I'll sort of go… (pause)… 'yeah, but also, eh, you know, if… if they're generally presenting in a way that they want to, kind of, electrocute themselves in the bath, then I think we… we… we, kind of, owe it to them… whether or not they say that to everyone to… to try to… eh… to take that seriously… we have to take some of this on face value… so, I think the difficulty for me sometimes is, erm… when someone says something that on… you know, on paper… activates all of the kind of alarm signals… underneath it, there is a sense that, you know, maybe this is part of a, sort of, an ongoing dynamic of, sort of, drama… but at the same time… I don't want to mi… you… I don't want to miss anything…*
6, 35-36, 991-1025	*yeah, or… I… I… I don't know… maybe it's… erm… I mean, I've never, to my knowledge, had a client kill themselves… erm… and… I suppose, I… I… I don't know how I would cope if it was someone who had said, 'I'm planning to electrocute myself in the bath', and they had said this a million times before, or whatever… or they were… eh… eh… eh… erm… and… (pause)… and I had taken it with a grain of salt, and then they did it… I'd just… so… so then, my own, sort of, personal anxiety comes in there, as well… so that sometimes, something that… that could very well be just, s… you know, another part of someone's interpersonal style… erm… (pause)… and then, I guess, the worry that… that I have ab… about the impact of that therapeutically is, then, if that is part of that person's therapeutic sty… or, sort of, interpersonal style… then, I am being drawn into that dynamic, and we are replaying everything that… eh, goes on in all of their other relationships… so, they'll sort of say, 'I'm gonna kill myself', and I'll go, 'urrrgghhhh', and… and there we go again, and we're not changing anything in the way that person sort of interacts with others and the world…*
6, 36-37, 1034-45	*yeah… but I suppose… I'd rather take a risk of… of doing some lacklustre therapy that didn't really move things on very much than… than take a risk of… not… not doing all I could if someone was, you… you know, really gonna kill themselves…*
6, 37, 1054-57	*yeah… I mean, and… eh, you know, in an ideal world, I would manage to strike some sort of balance… (chuckling)… where I wasn't just, kind of, going through the motions… but, err… you know, and I… and I would try to do that…*
6, 37, 1060-63	*you… you know, my supervisor's going, 'ahh, you know, I don't know… what do… what do you think… what do you think about that really?'… and I sort of go, 'I don't know… I don't know what I think'… erm…*

6, 38, 1072-78 *I'm lucky to work with some very, very experienced supervisors, who have worked in, sort of, personality disorder clinics, and things like this… and who have worked with people with some pretty severe presentations and complex presentations… and sometimes I think… and… and possibly it's a, kind of, product of my own, sort of, lack of experience, but… I get a bit more… more jumpy that…*

6, 38-39, 1093-1108 *yeah… and I think part of that is organisational, and wanting to… wanting to be a good employee, as well as a good therapist… erm… and wanting to make sure that I do the right things, and I have the… eh… eh… erm… and to show the client that I care… but then, I can just end up, sort of, re-enacting all sorts of stuff…*

6, 39-40, 1113-43 *I guess that means, sort of… I guess, erm… following the rules… I guess, erm… following the rules… you know, making sure that I'm, sort of, doing what is in our Staff Handbook about risk management… erm… and I think, you… you know, there are all sorts of things that are in the Staff Handbook that you can fudge a bit… diary management… things like that… (chuckling)… you know, sort of, who fills up the water filter… erm… but the… the… the big things… erm… you don't want to be on the wrong side of that if something goes wrong… erm… so I suppose that becomes a tension for me, is, erm… and I don't know how that would feel differently in private practice, for example… erm… you know, how I would feel about that on my own behalf if I was making the rules, and I was making the, sort of, protocols… well, you know, and my… you know, UKCP, or the BACP, but, erm…*

6, 42, 1196-1207 *so, it's, if you have any concerns… about a client's, erm, suicidal ideation… and they have a… a, sort of, a… a list of things that constitute risk… so, sort of, prior attempts… suicide of family members… erm… self-harm, past or present… erm… then, y… you speak to your supervisor… erm… you, obviously, speak to the client about… y… you know, in greater detail…'so, what are…?'… 'have you thought…?… 'have you made a plan?'…'what are your thoughts?'…'what are the protective factors?'… 'what are…?…*

6, 51, 1454-61 *it probably introduces that little frisson of anxiety if someone sort of says… you know, when someone starts saying things like, 'well, you know, sometimes I just wish that… (pause)… eh, you know, I weren't here anymore'… or, 'I think the world would be better off without me'… and you start, sort of, going down, and asking about that, and sort of probing those feelings, and, you know, I sort of think, 'okay, right'… it's like there's a little bell going on… going, 'alright, look… you know, what do we do now?'…*

6, 52-53, 1500-24 *(sigh)… well, that's the really tricky one… I mean, I think it's… I think it's just a, erm… (sucking gums)… it's a mixture of how they present, and what their history is… erm… (pause)… and then, a feeling of… (pause)… needing to bel… you know, believe them… to… to… to take what they say at face value… you know, that, eh, erm… and I suppose that is part... that is part of… you know, that's part of the anxiety when someone says, 'well, maybe this is just part of their presentation'… I sort of go, 'yeah, but also… it's… it's possibly part of their presentation, because they need someone to take that seriously, and, you know, you… okay, sure, you could be entering a dynamic where you become really alarmist, and step in to rescue them, but you could also enter a dynamic… you know, it could be part of their dynamic with people that people see them as a 'drama queen'… they don't take them seriously… so you can be the person to take them seriously'… so then, all of the second guessing about what is this person's natural style… what response are they, kind of, invoking in other people, and, eh… erm…*

6, 54-55, 1547-69 *yeah… and I don't know… I guess, at some level, I kind of think, 'well, maybe… you know, it's not really the worst outcome in the world if I end up being played a bit, is it, really, considering the alternative?'… erm… sure, it… (gulping in air)… you know, might… as we've*

said, it might… might not, kind of, further their personal development a great deal, but, eh… you know, I guess I think it is important to, kind of, pay that attention… (sniffing in air)…

6, 55-56, 1586-1615 *yeah… yeah… err, yeah… yeah… to some extent… yeah, exactly… I… I mean… yeah… yeah… well, because I… 'cause I also wouldn't want to fall into, err… if the dynamic is the opposite… that… that someone presents in this very, kind of, emotive, high drama way… and everyone brushes them off… everyone says, 'ah, you know… you know, that's what they're like'… you know, it can be potentially really transformative to… to be able to be someone who gets past that feeling of 'you're manipulating me'… and sort of goes, 'well, sounds like you're really hurting'… 'can we talk about this?'… 'can we look at this?'… you know… 'I'm gonna take this seriously'…'I don't want this to happen', and… I'm not, 'I don't want this to happen', but, you know, it dep… (sigh)… umm… in a way, to preserve the other person's autonomy… you know, like, eh… 'I want to help you not to suffer like this'… 'what can we do to… to protect…?'…*

6, 63, 1790-1803 *it does… it does… yeah… yeah… but a network of care that also prevents him from seeking out any, kind of, you know, intimacy… in real life… eh… with other people who… who aren't caregivers, so…*

6, 71, 2027-55 *(sucking gums)… (blowing out air in a dispirited way)… well, it's quite depressing in a way, isn't it?… err… I guess, because… because his presentation had not changed so much over so many years that he's been familiar with the service, that people were like, 'oh, yeah'… ha… yeah… I mean… (sniffing in air)… you know, not… not in that tone of voice, but it… but… but there was a sort of, 'yes, we're familiar with this'… 'yes, he's aware of all the things'… 'yes, he's good at looking after himself'… 'yeah, it's fine'… so it's… I… I mean, in that sense, I guess, you know, risk management protocols were working, because everyone was aware of him… and everyone was aware that he was aware of all of the… resources… erm…*

6, 88, 2521-22 *that… that… he'll say, 'I feel like this'… and I'll say, 'well, let's look at that, and let's take that seriously'…*

6, 90, 2582-93 *there's a… yeah… there's a… yeah… erm… and that's helpful… and that's he… he… yeah, and I guess that's helpful from a, kind of, an organisational perspective, that I sort of think, 'well, I'm… you know, I'm… I'm doing the right thing by the organisation'…*

6, 102-03, 2937-69 *yes… yes… and also… and also, that I think, erm… I think, all avenues should be exhausted before anyone gets just, sort of, left to it… ha ha… I think… erm… yeah… so… so, I suppo… I… you know, I'm… I'm very grateful for… risk protocols and procedures… I'm… I'm grateful for the clarity with which they're spelled out here… and this is a very safety-conscious service… you know, it's… it's rea… they're… they're very, very serious about lone worker policies… they're very serious about, you know, sort of, safety alarms and things like this, and that actually feels… very containing in lots of ways for… for the… for the clients… you know, for… for me with my clients, as well as, sort of, for us… erm, in a way that I think… I think risk management protocols felt v… very different in the NHS… and felt very defensive, and very, erm… they weren't spelled out very clearly…*

6, 105-06, 3013-33 *exactly… that… yeah… and it was, kind of like, referral… and if anyone was at all complex, refer, refer, refer, refer, refer… get them off your books…whereas… whereas, you… you know, I think what feels nice about having, erm, you know, a policy that we all are aware of, and is written down, and we revisit, and… an, eh, eh… and… and that is, sort of, enforced here, is that actually, having that containment, eh, contains the clinicians, and allows you to feel… eh… eh… a little bit freer, I suppose, to work with the clients… and I suppose, actually, this goes back to what I was saying about, sometimes, you know, with my supervisors, who are very experienced,*

	sort of saying, 'well, you know, do you think that's really a risk?... well, let's see where else we can go with that', and... and maybe it's my anxiety held over from the NHS, that I think, 'eww, is that good enough?'...
7, 2, 36-52	*erm... (pause)... well, erm, I mean, it's twenty years of working in higher education... so, erm... so, I've obviously come across a lot of students who have been experiencing suicidal feelings... I mean, it... you know, it's... err... it's part of the experience... you know, normal, I suppose, to... to counselling... erm... so, I don't know how to talk about generally... it's... it's just something that I... I feel is being alw... consistently monitored...*
7, 14-15, 392-410	*I am sad for their situation... I am feeling sad... because it... it's awful... it's that awful... so, erm... so, that's... I don't... I don't get... I... there's also a kind of stillne... I don't... I don't get anx... alarmed or anxious, so... erm... although... although, there's also... I suppose it's separating the head from the... the heart, or the... you know, I... I know that there are... theories of... of, erm, other thoughts that need to be checked out... you know, that there are... erm... some practicalities that will have to be addressed...*
7, 16-17, 439-83	*well, there... there's two levels... there's... I suppose that there's, first of all, here-and-now, me with the client, and the sort of things that... that I, as the counsellor... as the... supporter... what... you know... eh... erm... and... and wanting to take care of the client... or my... erm... my responsibility as a human to this person... there... there's that, kind of... what... you know, what... what needs to happen... and then, there's... behind that, the... the organisation... erm... I ca... I call it, requirement... but, erm... it's... it's about safety, I guess, you know... (noise of aeroplane passing overhead)... I... yeah... my concern is more about the safety of the client than the reputation of the university... erm... so... so, we do have, eh, protocols... you know, we have, erm... eh... eh... we will identify students who we consider to be at risk, so that they will be seen promptly if ever they want to come to the Student Counselling Service... and we would monitor them much more carefully, so that if they didn't show up, we would be checking that things were okay much more than we would with other students...*
7, 21-22, 603-08	*so, I'm... so, before... I know that there is a series of actions for whatever, or questions, or things to be done...*
7, 64, 1820-26	*so, it's really... so... and so... we kind of feel... and I meet with the supervising counsellors every week... so we kind of contain that... we... and... and I will be monitoring, erm, anyone that we consider to be high risk...*
8, 10, 277- 86	*yeah... that's per... I know other people make diff... they've made... (drawing in and letting out air)... they've... eh... colleagues, I suppose, if they've had suicides, they've made decisions... considered decisions... and then the client has killed themselves... I think my fear would not be that... it would be... 'cause I'd always err on the side of caution...*
8, 11-13, 315-53	*yeah... and that you... 'well, why didn't you contact them after they missed the session?'...'you knew they were... you had some risk... why didn't you do that?'... and it's kind of like... 'I know... I need to do that... it's...'... this hasn't actually happened... it's just a con... it was just a constant fear, and other people have been criticized for that... you know, 'why didn't you contact her... you know, after the... she missed the session, and...?'... and I feel very strongly about things like that, because of these experiences over the years... so I feel very s... like, for example, I'm quite new here... but I've got a... I'm like the deputy manager, and I've got quite strong views on things like contacting clients after they've missed appointments, and... bit of a... a battle, but... 'cause some clien... some counsellors here are like, 'well, it's their choice... they didn't come'... I'm like, 'you... you always need to...' (chuckling)... you know...*

	maybe not first ass… assessments, where we've never met them, but if we've got any information on them at all, we need to contact them…
8, 15-16, 424-39	*yeah… not just 'cause, eh, I'll ge… I'll get criticized, but I agr… I agree… I don't understand this, 'oh well, it's their choice'… I think, 'we're not… we're not living in that world… it's not that world… people have mental health problem… they don't come for all sorts of reasons… they could be struggling… you just need to contact them… I don't understand why… (chuckling)…*
8, 16, 453	*hold the frame…*
8, 16, 457	*yeah… hold the…*
8, 17, 461-82	*well, hold the fra… and hold the frame, I suppose… from a… is that like a psychodynamic way of putting it… like, we have an appointment… I was here… I'm acknowledging we had an appointment… you know, that kind of… and I just think, how… how would you feel as a client if you had an appointment, and then you missed it, and the counsellor didn't say, 'ooh, we had an appointment… are you okay?… d'you want to make another one?'… I… I just find it odd…*
8, 17-18, 486-99	*it's not… yeah… it's not a hairdressing appointment… d'you know what I mean?… ha… I don't understand why people think, 'oh, well'… (sucking gums)… (intake of breath)… so, yeah…*
8, 21-22, 597-618	*yeah… yeah, and again, before… it was… it was a suicide before my time… but, just like, we were… eh… you… you know, there's a, kinda… I, kinda, felt, eh, here, that… that it's a little bit… bit more behind the, (former higher education employer), in terms of how hot… (former higher education employer) was so hot on risk… k… (sucking gums)… and so hot on… obviously, the media… how people are gonna be represented… what's gonna happen in Coroner's Court… and it's… it… it's less so here, and I think that's… (sigh)… I felt a bit like… (gesture suggestive of heaviness)… about that… like, a bit, just, sort of… I feel the weight of that, I suppose…*
8, 22, 622-26	*(blowing out air)… oh, it's massive… yeah…*
8, 22-23, 631-39	*yeah, it's huge… that's a huge issue here, yeah…*
8, 24-25, 683-95	*(pause)… even though you get more… you get more blame over there, or wherever we are to over there… (sucking gums)… erm… I felt safer, because… I think, the protocols were more in place… for example… well, it's a differ… it's a diff… a different sort of system, so… we… it was a bit of a stepped care model…*
8, 36, 1024	*over there…*
8, 36-37, 1030-46	*it's weird, because I… I think, that… they just have… they have suicides… (sucking gums)… so it's not, eh… it's not like it's… (blowing out air)… I think… umm… I think there were more experienced counsellors, basically, over there… that were used to dealing with risk, and didn't have this system whereby they just handed it over, or…*

8, 37-38, 1066-70 *yeah… experienced, yeah…*

8, 39-40, 1123-35 *yeah… yeah… so, not in a, kind of, like, intrusive way, but just like, 'oh, how many… how many did you take?'… 'and did you… (sucking gums)… did you seek me…?'… y… you know, if… if they say, 'oh, I went to hospital'… 'how did that happen?… did you call somebody?… did someone else find you?'… all these things are like really important to assess risk for the next… currently, or for the next time, or…*

8, 40-41, 1140-56 *umm… (sucking gums)… cau… ve… I just do it very… err on the side of caution… and I just try and… you know… eh… eh, just build… I suppose… b… eh… I don't… you know, I don't want to… I might be very concerned, but I don't want to show the client that I'm… anxious, or… so, I want to f… feel that I'm containing, but I… I can say, 'I'm very concerned', if I need to…*

8, 50, 1428-29 *well, it can… in terms of like safety first… yeah… that becomes like the priori… priority, yeah…*

8, 50-51, 1433-42 *yeah… yeah, and again, it's different here than at… (sucking gums)… at… when I was working at (former higher education employer)… so, say I was working with somebody… it's different… it's a completely different set-up here… so, here, it's more traditional, I think… we have a waiting-list… peop… clients get assigned different therapies… you can see them weekly…*

8, 53, 1517-25 *yeah, that's what we did at (former higher education employer)… yeah… err…*

8, 54-55, 1554-56 *I suppose, to just to flag it up that we need to be… you know, I've come from a service that it's just hot… like, it's just rea… eh… risk is just… hot… like, you… you're aware and alert to it all the time…*

8, 56, 1586-1600 *and over there, we had, erm… the… the couns… the clients did a CORE-10 every session… at the beginning of every session… so obviously, there's one risk question on that, and that flags risk… we don't have that here… so, how are you gonna be alert to… someone that, eh… whose… whose mood or risk is, kind of, deteriorating or increasing?… eh… you know, just to put it in their… err… in c… in the minds of the counsellors just a bit more…*

8, 75-76, 2148-64 *well, it just feels like… (sucking gums)… eh… like it's all a bit of a loose cannon… eh… especially here… I mean, it wasn't like this at (former higher education employer)… like, a bit like everyone's just going off… (chuckling)… shooting from the hip, instead of there being like a… the Pr… Press Office needs… erm… (sucking gums)… well, there used to be a protocol…*

8, 76, 2170-78 *yeah, it's more contained… yeah…*

8, 78, 2222-31 *because… erm… it just felt more structured… more experienced counsellors… yeah…*

8, 88, 2525-32 *(drawing in and letting out air)… I think, I feel… I always feel a bit like this is a… like a, kinda… it's a high… what's the word?… you're on high alert inside, but… what was I gonna say?… I've forgotten what I was gonna say… erm… (sucking gums)…*

8, 97-98, 2790-2803 *or they think, 'I didn't realise… sorry, I didn't realise you were so concerned'… 'oh, right, I'm causing this level of concern'… you know, because some clients, they're like… erm… they'll… they'll… they'll… you know, they'll drink bleach, or something, and then be quite shocked that people are concern… you know, this kind of… they're just a bit cut off from it… erm…*

8, 98, 2812-20 *yeah… yeah, we're taking this seriously… you know, they might have had a… a… a history of… sort of being overlooked and n… neglected by their parents… so the fact that someone's noticing that they're taking ten Paracetamol every week, or whatever… you know, in small overdoses… they think, 'well, that's nothing… I was fine'…*

8, 99, 2824-46 *it's like… well, it's like… you know, 'this is of concern'… and they're like, 'really… but I was fine'… 'no, no… but this behaviour is of…'… it's modelling something, I suppose, as well, isn't it?… it's not just covering your back, or… it's modelling that, you know… con… like, appropriate concern, I suppose, and that they mat… and then… eh, that they matter, and, you know, how you treat your body matters, and… if you go off track, and you've told us that you were suicidal two weeks ago… (sucking gums)… and you… and you don't contact us, then we're gonna be concerned…*

8, 123-24, 3522-48 *yeah… yeah… like, I've got a client who… she was ref… she was referred… sort of a weird… so… (sucking gums)… some students… her flatmates… had gone to their tutor, and their tutor had contacted us, and said… we often get this… and said… (sucking gums)… this g… this g… this girl is s… s… erm, self-harming… tried to hang herself… suicidal… they're in a private house… I mean, 'what…?'… you know, basically, 'do something!'… and you're kind of like, 'well… you know… if they're … if they're not in university accommodation, it's… we're quite limited'… I mean, we can… if it's… gets to… ratcheted up to (name of DoSS), who's my… who's the Director of Student Services… if it goes to that level, then, yeah, probably we can get the ph… the student's phone number, and phone them, even though it's just gonna be a call out of the blue… I mean, you just have to handle that… 'this is a call out of the blue… you're not gonna be expecting to hear from me… we've just had s…'… you know…*

8, 129, 3697-3707 *(intake of breath)… well, you… you can't a… eh… in a way, you can't offer a client appropriate care, or the care that you would like to have done… 'c… 'cause you know what it's like… like… ke… often risk is really grey, and when you see them, they're not saying, 'I'm gonna… I'm gonna go and kill myself right now', or… you… they might be saying, 'I haven't got plans'… but you know that there's risk… they're vulnerable, and there's risk there, and…*

8, 134-35, 3839-67 *yeah… yeah… I feel a… I feel… that's what makes me feel really strongly about certain things… like, and I will say… I don't… I don't… in a way, I don't care what my manager thinks… if I'm in a… if I'm leading a team meeting here… my manager's not here… I'm saying, 'we need to contact people who DNA… that's that'… and they're, 'oh, well, eh…'… and I'm like, 'well that's my… feeling', because wh… I mean, what… like, you… you know… I just feel really strongly, having… you know, experienced, eh… ex… eh… results of inquests in the past, and… yeah… I mean, not even… not my clients… but just… this is what we get told that we should do…*

Subordinate Theme #2.3: "Keeping them in the wider organisational mind": flagging up suicidal clients to facilitate support from colleagues

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Transcript Ref:	Quote:
2, 23-24, 647-66	*that, I guess, very much make sure that they're linked in with their GP… and there's often a lot of resistance to that… because there's a lot of shame attached to having these feelings… so, I would write, usually write to a GP, because GPs tend to be fairly overworked, and often don't respond, in my experience, to phone calls… or it's very difficult to find times when they're available, and I'm available… so, I write to a GP... encourage the GP to e-mail me back… let the student know that I'm going to, not only contact the GP, but I'm also going to contact the wider Student Affairs, which is our Student Services body… we call it Student Affairs… contact that body, to make sure that there's a feeling of linked… joined-up-ness between me and other sort of parents in the student's life… and that we are all supporting the student… making sure that, between our sessions, when the student can often feel a lot worse than they're letting me know in the room, that they can contact… who they can contact… erm… crisis centres… Student Night-Line… Samaritans… Maytree… various, you know, crisis and acute services… so, letting the student know that although we only have this one session per week, there is actually support available at times of crisis… erm…*
2, 29-30, 825-32	*actually, the more people that are brought in to support… erm… the… obviously, the better… and… and helps the student to feel that he's held in lots of people's minds, not just mine…*
2, 34-35, 975-86	*they will be entered on our waiting-list as 'risk one' if they are acutely 'at risk', and 'risk two' if they are… if there is an ongoing risk, but they're felt to be safe with themselves…*
2, 36, 1008-31	*and we have an 'at risk' register, so they'll be entered on that 'at risk' register, which means they will be discussed at a 'Students of Concern' meeting on a weekly basis, and I will update that, erm, every week, to let the service… the Head of Counselling, and the Student… those members of Student Affairs who are concerned, who go to the 'Students of Concern' meeting… each week, that 'at risk' register will be updated… do I still feel that this student needs to be discussed?... erm… so, there is a weekly monitoring of the 'Students of Concern'… sometimes, I will feel that actually, 'okay, the risk is fairly low at the moment, and it's being managed'… other times, I will feel that the wider team need to know again… and need to be aware that in-between the sessions, when I'm not there, that student may well present into the service, and they need to be aware where we're at… and my notes on that student will be available to them, so they can see where we're at in the counselling… and so, I… I will constantly be updating the wider team, sort of…*
2, 37, 1037-46	*absolutely… absolutely… it's keeping them in… in the wider organisational mind, as well as mine…*
2, 41, 1159-70	*and I got that e-mail during the Christmas break, after New Year… erm, which brought him into my home… you know, and… into… into my thinking, and level of concern, and meant that I then got in touch with the organisation, and…*
2, 46, 1302-11	*well, to… to communicate frequently in supervision, and with Head of Counselling, and the Head of Student Affairs, regarding the… the… the situation each week with the student… I mean, if I… if… there is a level of trust that if I feel that the student is not of concern*

	at the moment, I don't need to constantly communicate, but the trust is that, if at any time I feel there is risk, I… I will communicate that…
2, 46, 1318-20	*erm… so, yes, the expectation is that I will regularly monitor and communicate that, and make sure that… keep… keep good notes, and make sure that those notes are always available to others…*
2, 51-52, 1461-83	*so, you could have a caseload of fifteen students, and twelve of them, you'd like to bring to supervision, but there's only time to bring one or two… so, those other ten… yes, so then you have to be quite responsible to think, if there's another, in… in those ten that I couldn't bring… if there's somebody that I know need… I need to discuss… I need to find that time to talk about that with Head of Counselling, or with someone else in the team… to be responsible for that… not to think, 'oh, I'll just leave it for another two weeks'…*
2, 57, 1632-36	*so, my role is to keep that concern in the room, and to say, you might not feel concerned, but I feel very concerned about you… and… and that's why I get his GP involved, and the Student Affairs… that he knows we all feel very concerned…*
2, 60-61, 1718-47	*well, there will be people there throughout the break, apart from the actual Bank Holiday… so, the students are made aware of that… I'm aware of that… I'm aware that the student… that I can tell the student that, if at any time, they feel the need to talk to someone, and that it might feel hard that I'm not available, they're to come into Student Affairs, and talk to the Head of Student Affairs, or the Mental Health and Well-Being Adviser… so there is somebody who will be there… erm… that… that's how the organisation… is, I think, the, in… the most supportive… by being there as a link between myself and the student at times of my absence… and with a good list of, you know, emergency services, and people to contact… and awareness of how to manage a suicidal student… not let them be alone… make sure that somebody goes with them to A&E… so all that kind of protocol is all in place, and the student knows that, so…*
2, 64, 1818-26	*yes… we have counsellor business meetings every two weeks, which are not clinical, so they're not to discuss clients, but we do make ten or fifteen minutes at the beginning of each meeting if anybody has something urgent about a client they want to mention… so, I did mention this student at the last one…*
2, 65, 1844-55	*I then got in touch with the psychiatrist, and I'm going to have a phone session with him, erm, next week… so, although he can't see him ongoing, he can… I can then take his assessment… written assessment… and give it to the student's GP to speed-up the GP referral to IAPT services that we've also got in place…*
2, 82, 2355-56	*I have to work hard to maintain contact… bring other people in the organisation into it… into the help…*
2, 92-93, 2635-70	*I then talked with my clinical lead about her… so that I could just think about any… any… any other ways that she could be helped… but we established that, actually, I think, we… that was… what was done was safe enough… but also, the service was now aware of her, so if she came-in in the week between our sessions, they would be aware of her… it's a slightly different service at (former higher education employer)… different people… different… different roles within the team, but all… everyone I felt that she might contact, knew that she… about her now… and we had a central system, where I'd written… entered all the notes, so they could access those notes, and then I… then I got in touch with the group therapist, in time… and introduced her to the idea of a group… so that when our work finished, our one-to-one work, which is quite time-limited at (former higher education employer), she could then be moved safely*

into a group… and then, she could stay in that group the whole of her time at (former higher education employer)… which was great… and she's still in it, so that's good…

2, 94, 2676-81 *yeah… yeah… and then, when I left the service, I could feel that she was still being held by them, which was quite a nice feeling for me…*

3, 62-63, 1775-1813 *exactly… yeah… umm, hmm… but, erm… (pause)… Student Services have spoken to me about her… had said that she was back… and, asked if I would be willing to help with a… erm… learning support plan… erm… and, that attending counselling should be part of that… now, for whatever reason, that never happened… I wasn't actually asked to be part of the learning support plan… and I've not seen it… erm… but I was aware that Student Services were going to suggest it… so, although the client contacted me herself… erm… I was fairly certain that Student Services would know she was doing that… and, when she was here, I said to her, 'I think it would be helpful if you let Student Services know that you're coming to counselling'… erm… and, she said that she would do that… now, when she didn't turn up in that last appointment… erm… I'm thinking, 'we're now gonna have a two-week break'… 'she's not turned up'… 'I've no idea whether she's alright or not'… and I did something I've never done before… I phoned Student Services, and I said, 'do you know of anyone who's seeing me for counselling?'… and she said, 'yes, I know… I know one or two'… erm… and I said, 'this is kind of new for me, but somebody's not turned up… erm… and I'm concerned that we're now going to have a break', and she immediately said, 'well, I know that so-and-so's coming to see you'… and I said, 'okay, that's all I need to know'… I said, 'well, in that case', I said, 'I'm going to let you know that that person has not turned up for their appointment, and I'm going to let her know in an e-mail that I have let you know'… erm… and that's actually a bit of a break for me…*

3, 64-65, 1842-70 *'cause actually, when I spoke to Student Services… she said she'd been concerned about this person, because, erm, I think she had intended meeting with her, and, actually, she hadn't seen her around, and she hadn't turned up… erm, and, what I said, was, as a Student Service, you can do more… you know, in counselling, it's… it's… (bangs table)… it's an arranged appointment, once a week… you don't have contact with your clients in-between time… well, I don't… erm… but, having previously been counsellor and Student Services… when I was Student Services, I could find out whether a student had gone to class… I could phone up… up academic staff… I could ask, erm, the Residences staff… I could even go to the… it's quite different… it's quite different… ah, ha… and, it could be for all sorts of reasons… erm… so, I felt that I was… well, my… my reason was, I'm saying to… to Student Services… it's not the end of term yet, 'cause it was the Wednesday… there's still another couple of days… there's a two-week break… you'll be able to find out whether she's alive and okay… it's up… it's over to you…*

3, 66, 1878-96 *so, I e-mailed back to say, erm, 'I have actually let Student Services know that you… you didn't, erm, come to your session today'… so, that I would be completely transparent… I'm not entirely comfortable about it, but I actually think… I think I reflected on it, and I think it was an okay decision… and I think that it was about caring for my client… erm… there was an element of reducing my anxiety, as well… not holding it all, but saying to Student Services, 'well…' erm… and I think we've still got to work that out between counselling and Student Services, because, when I did both, and I wore these different hats, and I did have dual and multi-relationships… erm… I could do more than I can do now in my role as…*

3, 68, 1940-45 *erm… but other risk management?... well, Student Services is aware of her, so that's part of the risk management, as well…*

4, 4, 90-104	*erm… I find it slightly easier than in private practice, because I felt that was really difficult… you know, I really carried it alone… whereas here, there is… there is levels of management, which is great… so I felt reassured that after… at the end of the day, I could got to say to my line manager, this is what's happening… she'd make sure everything's okay… that I've done all the things that I needed to…… and, in a sense, although I still worried, I've felt I've done… I'm covered… I've done what I need to do…*
4, 10, 270-83	*so, for example, the system here is… if… erm… we're a paperless organisation, so everything's done on computer, and we have a computer programmes… now, if you're concerned about a client, you can flag the client, so, there's a red flag that comes up, so everyone has access to the… everyone here has access… so, if there's a client you're concerned about, you can flag it, but…*
4, 12, 319-20	*well, I… so, I guess what I'm saying is, it's not 100% clear… so, there's a system of flags so that everyone knows…*
4, 16, 445-61	*erm… well, I guess, especially in here, I guess, by flagging, I've alerted the whole team… so if anybody accesses our system… I mean, within the team… they would see that… I feel like it's covering your back… yeah… you've covered your back… you've made this flag, which means you've been concerned, and you've brought it to… everyone's attention…*
4, 17, 473-84	*exactly… yeah… so, what… for example, if I'm on holiday or away, and the student, err… a tutor calls into the service… and a student's flagged… the management will respond very quickly… they'll know, and they'll be able to… to handle the situation quite quickly…*
4, 22, 614-19	*so, I… I know clinically… like, I know, I've done my job… I've written the notes… I've flagged it… I spoke to my line manager… she knows…*
4, 24-25, 675-702	*and it was great, because obviously, we were in a medical setting, and confidentiality was there in the sense of, err, we didn't discuss with the nurses and doctors the content of what we were saying in our one-to-ones… but, I could very well go back to the nurse after, and say, 'there are… there is a lot of suicidal ideation today, or even self-harm, thoughts, whatever'… you know, 'I just wanted to hand that over, keep that in mind'… you can't do that here… you can't phone a tutor, and say, 'look, I just want you to be mindful that I saw so-and-so today… they are expressing suicidal thoughts, but I think we're just at a thought level'… so you can't do that… so, err, there's no… err… 'cause that would be breaching confidentiality… we're not allowed to do that… so, I guess, that's where I felt there's a safety net in a hospital…*
4, 45, 1279-92	*yes… if they were very distressed in the session… if they had this plan… if I knew they were serious… erm… we would hold… I think, we would keep them here… and we would, err, then, let their GP know… and we would let their tutor know… and we would alert the college… and it would be taken over from there… I haven't had that experience so far… yeah… no, I haven't had that…*
4, 46, 1316-19	*and I've seen him quite regularly… and he's alw… it's always there… there's always a… a… playing… and it is… it's really tricky, just to know… erm… so… well, putting in… in… things in place…*
4, 47, 1348-52	*erm… I'm trying to think what else we do… erm… yeah, so, I guess… the… err… thinking of the client, and where they are, I try and think of everything that can be mobilised… so, it's about widening their support network… and trying to see if we can access… kind of access… all of those… erm… before they need…*

4, 48-49, 1370-1406 *and what we also try and do is… I mean, it's not a pressure… but we do try and get them to consent to us talking to their tutor… so we might say, you know, 'would it be helpful if we got in touch with your tutor?'… and usually, I have to say, they're not really against… not often against it… unless they really don't get along with their tutor… but they… they often say, 'that's fine'… 'you can let them know'… and then, usually, once we've done all those things… we also have a college nurse… the nurses all have… err, the colleges all have a nurse, and they're often in touch with the nurses every day, which helps a lot… they go and just touch base, and there's… kind of, chats a little bit… we've also got, err, college chaplains, who play an incredible role really… they're there always for the students to speak to... so, we try and generate all of this, kind of, support network around them… their parents… err, trying to get them to make contact with all of these people before the next week… yeah…*

4, 52, 1475-89 *exactly… and the tutor's key… because the tutors are responsible for student welfare… so, welfare being mental health well-being… so, the tutor is quite a key person, because if they're alerted to the student struggling in a college, they can… they have communication with the faculties… they can support the student academically… they can, erm… they often, some of the colleges, have funding for long-term therapy… things can be mobilised when there's an awareness…*

4, 52-53, 1494-1506 *yes… that I don't have always access to… or that I can't always initiate… yeah… because that's essentially where the student's going… back to college… that's where the student lives… in their little college… so, the tutor who's responsible for their welfare, when they're alerted, it's a big deal for us…*

4, 56, 1600-08 *because we work a lot with students who are intermitting, and there's a lot of tension in the tutorial teams when the students don't like what the tutors are saying… erm… and I got involved in all of this with one student, who was very depressed, and… kind of, quite suicidal… erm… but because he'd given me consent, I was able… we were able to have discussions…*

4, 85, 2442-55 *erm… so, very similarly to what I said before… just about, erm… so… well, first of all, I talk about obviously all of this in supervision… erm… so that's my go-to-place to just be able to air stuff out… erm… and then, eh, she was referred by the mental health adviser, so I speak to the mental health adviser… so, there's a possibility that when a client… deteriorates, they could go back to her, and stop seeing me, because they have…*

4, 86, 2464-73 *exactly… so, that's what I do… so, I'm in touch with our mental health adviser… and I speak to her, and there might be appro… time when she goes back to her, and she's held by her more than me… erm… and we, erm…*

4, 94-95, 2703-21 *(sigh)… yes, in my private practice, but not here… not here… I guess, here to the extent where it's just holding the 'what if?'… you know, where something has not been so clear, but you know you've done everything you can… 'it will be fine'…*

4, 109, 3135-36 *erm, I'd referred her to… we run groups here… and I'd referred her to the bereavement group here…*

4, 115, 3299-3301 *yeah… yeah… and again, so I've been to line management… (chuckling)… I've told them what I've done… everything's documented…*

4, 121, 3471-79	*(long pause)… I think there is a lot of anxiety in the light of the fact that they happen at the university… and I think there is a lot of worry about us trying to make sure that we cover all our bases, and everything is documented, everything is reported, and everything is talked about… but I think there is a lot of anxiety about that here…*
5, 4, 106-14	*yeah… so, a 'cause for concern' register is whereby… it's like… erm… only you counsellors, and the manager of the service, and the Head of Support, have got access… and, if they're… erm… we can monitor the care of what we think's happening with a suicidal patient… err, eh, eh, student… so, if, for instance, we feel that they need, erm, a mental health adviser, or if we feel… we have documented and logged that we have contacted these people… erm, so that there's a follow-up of high risk, eh, with these students…*
5, 11, 314-18	*err… it's interesting, because I feel that… erm… on one hand, it is really good, because there's more pro… more people out there to support you… there's more… as a counsellor… there's more support… there's a structure in place… we have done our level best to help that student…*
5, 56-57, 1605-20	*well, at the moment we have, erm, a new ca… case management system, whereby if… if somebody was suici… even ha… having suicidal ideation… err… but not with intent… we would still put them on the… we have a… a… a little… we put them on a form, erm, on a computer, basically, which says, err, 'could be risk of harm', and just to acknowledge that, if anybody looks in there from Student Support, that… they don't know anything about this person, but there could be a risk of harm… erm…*
5, 57,1624-28	*well, it's only if they come into the Hub, and if they're asking for help…*
5, 57-58, 1636-65	*no, well, if they flag themselves… if they come in, and say, 'I'm not feeling well'… they can go and see what help there is… and then, they might have been coming to counselling, obviously, if I've put it up… but the fact there's a risk of harm, they would then maybe, erm, fast-track 'em into different areas… so there's an acknowledgement there, without knowing all the ins and outs of it, and still maintaining pa… privacy and confidentiality within Student Support, that there is a problem, and there could be a problem here, so, fast track them… yeah…*
5, 62-63, 1765-96	*well, there was… there was an example I can give was that I… I had to take it to my supervisor, 'cause my student was at risk, and from a home situation of… eh, basically, physical abuse at home… wa… wasn't affecting the university as such, but it could become an issue for the university… and I was told by my supervisor, 'you should really put them on the 'cause for concern', 'cause there's a major risk there'… and obviously, I was trying to get her linked in with 'Woman's Aid', and all the rest, but at that point of time, there was a risk that she could come in, and she needed accommodation from us… yeah… so they were saying, 'what kind of risk is she at?'… and, you know, I wasn't to say… I was just to say, 'well, she's at risk… but it's… it's… it's… you know'… erm… 'oh, does she self-harm?'… 'does she…?'… and… and… and it's like, 'no, I… I can't say, but she's at risk, and may need accommodation… you know, and that's why I've put her on'… so that was okay to say…*
5, 85, 2435-41	*(pause)… ohhh… it's a difficult one, because… as being part of an institution, and part of this very structured 'cause for concern'… they discuss it once a week, so it…*

5, 85, 2445-52 *yeah… ah, ha… err, we meet as a group once a week… and because of that, if somebody is at risk, erm, there's, erm… there's a… by putting someone on that register, there's an acknowledgement that this person is at real risk…*

5, 87-88, 2506-13 *so… so after I've done the 'normal', in brackets, counselling work, I would then go back to them at the end, and say, 'let's review what you feel about this session'… and they would come up with whatever… but if they're still feeling very much at risk, I would then set up a plan with them to see if we can carry them to the following week… if not, phone numbers, GP, you know, take it further up the line, or whatever… you know, whatever we need to do…*

7, 31, 872-87 *yeah, sometimes think, 'well, actually… umm'… or I did have a student recently where I've been called in, erm… by one of the other… by a counsellor, who was seeing a student who had also, erm, taken an overdose… and they had been to the Health Centre, who couldn't do anything, and said, 'oh, no, she'll have to go to A&E'…*

7, 64-65, 1820-59 *so it's really… so… and so… we kind of feel… and I meet with the supervising counsellors every week… so we kind of contain that… we… and… and I will be monitoring, erm, anyone that we consider to be high risk… and I also attend a meeting, erm… with the Head of, erm… eh, Student Advisory and Well-Being Services… with the… and the, erm… who… who oversees Well-Being… so, also the… the Well-Being Advisors and Mental Health Adv… somebody from Disability… erm… so, we meet to talk about any students of concern generally… sometimes it might be disciplinaries that are happening, or other things… security have made a report about something… so… but a lot of the students that are discussed in that meeting will also be students that we might have concern about… erm… but the… we can kind of keep the confidentiality restricted, because usually it's them that bring them up, and I may, or may not, depending on how, erm… usually, I would say, 'yes', but… you know, we do know that it…*

7, 66-67, 1896-1913 *yeah… yeah, so I would… eh, sometimes it's me bringing… bringing the… the student to the meeting, just because, erm, it might be a student who's likely to cause concern elsewhere, where there'll be some disruption…*

7, 68, 1935-46 *erm… well, usually it would only be because they are the ones that are often on call… so that if Security are concerned about a student, or… then they might be… so, in… in fairness to them… you know, it would sometimes be worth saying, it's possible that this person…*

7, 68, 1950-60 *yeah… yeah… out-of-hours, it could be… erm… so… so, really… it's just if… if… to help… you know, to make them aware that, actually, if… if this student does come up, then there probably is some, erm, concern…*

7, 69, 1964-85 *a little… yeah… yeah… yeah… yeah… yeah… seems to just work, without much… you know, there doesn't… there doesn't seem to be any, err… real problems with that…*

7, 80, 2294-2301 *umm… I think… I mean, in… in th… the situation where I went in with my colleague, she had already gone with the student… they had already sought support from the Health Service… erm… and that hadn't worked out… so they'd already come back from that… so…*

7, 81, 2317-36 *yes… yeah… that's right… erm… and they weren't going… they said, 'well, you know, she's got to go to A&E'… erm… err… 'that she… that… you know… that… that's what she's taken, and that's bad', you know… but they weren't prepared to take the responsibility to take the student, and deal with it, which… is… is a bit concerning… and being worked on now… ha ha ha… no, it was… well… how*

these things should be done… it was a time when there wouldn't have been a problem with that, but anyway… erm… (sucking gums)… so…

7, 85-86, 2434-55 *erm… 'and would it help for me to talk to somebody?'… 'would…?'… you know… especially if… if, on top of everything else, they're… worrying about work, or something… 'would you like us to…?'… normally, in that situation, I would, erm, ask them if… you know, if we could involve a Well-Being Advisor, who would liaise with the department about the… the work aspects, and then I don't have to talk to the department about anything… erm… and just… you know… focus on the em… emotional stuff with them…*

8, 14-15, 389-407 *like, there was… there was, erm, a client over there who I saw… eh… eh… the previous year, and, erm, it was still when we had paper notes… (sucking gums)… and he had quite significant mental health problems… and I'd done an assessment… and I'd… he was being picked up by the NHS… (sucking gums)… erm… and so we kind of… like, he was going to be treated on the NHS… we kind of left it… but obviously, he cou… he could come back to the service if he wanted to… then fast-forward about a year, or some… or I can't even remember what… but it was quite a significant amount of time… I saw his name in the diary, booked-in as an initial assessment with another counsellor… so I b… got… I found the notes, and I gave it to… gave them to her… and I said, 'oh, this guy is coming in… I've seen him'… you know, like… 'cause, I remem… he had a very distinctive name, and I remembered he had quite a significant mental health problem… so I gave her the notes…*

8, 25, 697-705 *there was a Visiting Psychiatrist and a Mental Health Advisor there, as well as here… erm… but you… you just were used to phoning the GP, writing to the GP, doing risk management on your… on your own… I mean, you could go and talk to somebody…*

8, 28-29, 803-29 *erm… but, yeah… so last Friday, one of my colleagues, a counsellor, had… he's not worked in HE very long… or just here actually… he worked in a private GP practice, and he hasn't had that much experience of managing risk… so, we have 'Open Door', which is like a drop-in… so this guy came and drop-in… so the counsellor came to see me… said, 'this… this student has plans to end his life'… erm, you know… so we talked it through, and I said, 'is he registered with the GP?', 'cause that's another… if the students aren't registered with the GPs, we're really, really stuck, because unless they're like… (sucking gums)… you know, immediately at risk, and we can call an ambulance, and send them to A&E, we're, you know… but if they've got a GP, that… so I said, 'try and talk to the client about getting his permission to contact the GP, contact the GP, make an urgent appointment'…(sucking gums)… erm… and then, the counsellor came back… 'no, eh, he won't… he won't let me'… so then I go in, talk to the client, and then eventually get his agreement to contact the GP, and, erm, get an urgent appointment for him… and then get another appointment with someone in the… his department… 'cause he's worried about his academic work…*

8, 31-32, 889-904 *yeah, not… (clearing throat)… not be completely on their own with it, but like… be… fe… just feel more able to build that rapport, and y… you know… because what… you know, what happens if they… they are… in the sit… I mean, they can always go and talk to a colleague, obviously…*

8, 36-37, 1030-48 *it's weird, because I… I think, that… they just have… they have suicides… (sucking gums)… so it's not, eh… it's not like it's… (blowing out air)… I think… umm… I think there were more experienced counsellors, basically, over there… that were used to dealing with risk, and didn't have this system whereby they just handed it over, or… I mean, here, there's more support, because you have to go and talk to somebody… so, over there, it was a kind of… yeah, you can do, and…*

8, 44-45, 1265-86 *yeah, you need to do a safety plan, and there's a form… erm… you need to talk… here, you need to talk to someone about it, like the manager, me, or b… or refer them to (name of Mental Health Advisor), if she's in… I mean that is one good thing about… when we have 'Open Door' between one and two, everybody's free, so that's goo… that's… as in, unless they're seeing an 'Open Door' client, everyone's free… erm…*

8, 45-46, 1290-1302 *yeah, I can go… go into (name of Mental Health Advisor)'s room, and say, '(name of Mental Health Advisor), I've got a client here… de, de, de… you've… I can see that you've got a space at two… please can you see her'… (chuckling)… or that… that kind of… you know, for a further assessment… so, more… erm… if you… you know, for more time… erm…*

8, 51, 1442-52 *so, if… eh… so, if somebody… eh… was deteriorating during a contract like that, then… erm… I don't know… it's a bit… 'cause of my position, I don't know… if I was a th… if I was a counsellor here, I might… I don't know if I'd stop the work, and refer them to (name of Mental Health Advisor)… to manage the risk a bit more, or… or to see the Psychiatrist, and stop the phone call…*

8, 51, 1462-64 *temp… or even temporarily, like… like to sta… stabilise… you know, if they're kind of… if there's… if they had a crisis, to kind of… help them stabilise… but I don't know…*

8, 51-52, 1467-70 *normally, someone comes in, in crisis, they get seen by (name of Mental Health Advisor), our Mental Health Advisor, or (name of Psychiatrist), the Psychiatrist, and then… and then, they're, sort of, stabilised, and then, they're like ready for therapy… like that…*

8, 81-82, 2326-46 *so, it was another colleague that had seen him, and then I… I was asked to come in, and… (sucking gums)… talk to the client… and then, I tried to… eh… use what he was saying to help him see a different side… so, 'I help other people'… and I was saying, 'so… so it sounds…'… he's saying, 'hi… hi… his job in Tesco'… he had a part-time job… he said, 'oh, everybody knows me… everybody finds me helpful'… so I said, 'so you're valued, then… sounds like you're really valued'… so I tried to… (chuckling)… tried to reframe… help him to see that… 'it sounds like you're important to a lot of people, and it sounds like you're valued, and… (sucking gums)… and it isn't the end of the world… we can phone… look, you've got evidence from your GP… we can phone up the Student Support Officer, and get an appointment with her this afternoon…*

8, 82, 2355-63 *yeah, so then we'd… then… so my co… I got his permission, so my colleague could phone the GP, and got a GP appointment that day… (sucking gums)… I asked my colleague to tell the receptionist why we wanted the urgent appointment… erm… and… I agree… and we booked we in with the Student Support Officer…*

8, 103-04, 2950-88 *yeah… it… it… it's internal resources, and then external… so, say it's a day when our Ps… Psychiatrist's in, and he's got a space… (blowing out air)… well, if we can get the client to see him, that's good… erm… or if (name of Mental Health Advisor), the Mental Health Advisor's in, and she's got a space… it just extends the time… the… the action might be the same, but… it just extends the kinda… th… the time that the client's got with us, and… and build the relationship with us, and, erm… share… it is nice… you… you know, it is nice to share risk with someone… ha… erm… (sucking gums)… (intake of breath)… and also, if two people are saying… 'cause sometimes, I'll come in, or like, (name of Mental Health Advisor) might come in… if two people are saying the same thing, it's harder… it is harder for the client to say 'no', I think… (chuckling)… sounds awful, but…*

8, 111, 3181-91	*yeah, kind of like a joined-up bit of… 'oh, I remember him… oh, and…'… 'cause we did that quite a lot over there… talk about… in informal ways… but just sharing with… you know… bit of informal supervision…*
8, 126, 3611-15	*yeah, but she knows that she can come here, and 'Open Door'…*
8, 130, 3733-44	*yeah… yeah… yeah… yeah… but, yeah… availability in the relationship… but I think that's what I rely on, and you're right… so that's why I'm anxious if I'm away and she's away… I'm, kind of thinking, 'oh, I suppose I've got to trust that she will… you know, contact one of my colleagues, or…'*

Subordinate Theme #2.4: "Does everyone know?": linking in suicidal clients with external professionals in the interests of minimizing risk

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Transcript Ref:	Quote:
1, 40-41, 1224-37	*well, I believe in it… I do think… I do think… that having the Samaritans number, and knowing where the emergency walk-in centre is… could well come in handy… you know, at two in the morning… so, I do believe in it…*
2, 23-24, 647-66	*that, I guess, very much make sure that they're linked in with their GP… and there's often a lot of resistance to that… because there's a lot of shame attached to having these feelings… so, I would write, usually write to a GP, because GPs tend to be fairly overworked, and often don't respond, in my experience, to phone calls… or it's very difficult to find times when they're available, and I'm available… so, I write to a GP... encourage the GP to e-mail me back… let the student know that I'm going to, not only contact the GP, but I'm also going to contact the wider Student Affairs, which is our Student Services body… we call it Student Affairs… contact that body, to make sure that there's a feeling of linked… joined-up-ness between me and other sort of parents in the student's life… and that we are all supporting the student… making sure that, between our sessions, when the student can often feel a lot worse than they're letting me know in the room, that they can contact… who they can contact… erm… crisis centres… Student Night-Line… Samaritans… Maytree… various, you know, crisis and acute services… so, letting the student know that although we only have this one session per week, there is actually support available at times of crisis… erm…*
2, 25, 698-705	*it's so much more helpful for the student, but also for myself, to share the load… to be able to talk with colleagues… to talk in supervision… to, erm, receive other viewpoints on how this student might best be managed… erm… and to link in with NHS support…*
2, 31, 873	*hopefully… I mean, if he's in acute crisis, it will be dealt with…*
2, 57, 1632-36	*so, my role is to keep that concern in the room, and to say, you might not feel concerned, but I feel very concerned about you… and… and that's why I get his GP involved, and the Student Affairs… that he knows we all feel very concerned…*
2, 62, 1754-69	*absolutely, and the link with the student's parents… I mean, obviously, at the student's… with the student's consent… that the organisation will act as a link between the student and the parent… and acknowledge the university's… the boundary around the university's responsibility… that the… that it's also the parental responsibility… or, even though the student's over eighteen, that there*

	will be… (pause)… there… there is the parental… umm… link if the student wants it, and if the parents want it… it's an additional person to be in touch with...
2, 62-63, 1779-91	*and it's… it's nice to be able to say, 'here's your child', 'you deal with it'… in… in so many ways… not in such a sort of cold term, but, you know, 'let's bring you in, and let's think together about this student, and whether the best support is at home, with the local services, or whether it's here'… but at least bring the stu… parent in… erm…*
2, 63, 1795-1804	*yeah, absolutely… absolutely… and it's what the parent normally wants to be informed of…*
2, 65, 1844-55	*I then got in touch with the psychiatrist, and I'm going to have a phone session with him, erm, next week… so, although he can't see him ongoing, he can… I can then take his assessment… written assessment… and give it to the student's GP to speed-up the GP referral to IAPT services that we've also got in place…*
2, 92, 2625-33	*I… I gave her another couple of numbers to ring… she was able to say that she would ring Samaritans… she was able to tell me a friend that she would call… so, she felt… that she could manage her own safety… and then I talked with her about contacting her GP, and that I would contact them, and that she should also contact them now…. you know, after the session…*
2, 95, 2708-09	*and, you know, I can refer them to external or low-cost counselling… and will always do that if that's what they'd like…*
3, 6, 167	*erm… I certainly would encourage them to go to their doctor…*
3, 7, 182-84	*and I… I… I make sure, of course, that… that people have numbers for Samaritans, Breathing Space…*
3, 8, 208-09	*and, I suppose, what I do is that, when I'm working with a client who's suicidal… as… as I say, I make sure that they've got numbers…*
3, 8, 210-28	*but this particular client, erm, I… I use, err… erm, there's something on 'Students against Depression'… there's a… a suicide… well, it's for stu… clients who are feeling suicidal… that, you… you can go through the plan with them… and there are numbers for Samaritans, and… err, well, I know that… I think Breathing Space is actually a (regional), erm, helpline, so I don't think that's on it, but there's… there'll be other ones… erm, and… so, they fill in, erm, maybe parents, friends, that they would contact… erm, but again, if somebody wants to be in a position where they want to be able to kill themselves, they're not… they're not actually going to… well, they might complete it with you…*
3, 9, 253-54	*erm… and, I have advised people to go to the doctor and discuss it, and sometimes people have done that…*
3, 29, 825-31	*erm… I suggested that he went to see his GP, and he wasn't entirely sure whether he would do that or not… and I said to him, 'would you like me to make you an appointment?'… because sometimes, that can encourage people to go… erm… and… and he… he… I was actually a bit surprised, but he said, 'yes, would I do that?'… so, I picked up the phone when he was there, and made an appointment…*

3, 40-41, 1156-57	*I… I would suggest to a client that they contact their GP…*
3, 41, 1162-69	*I mean, I'm… I'm saying to them, 'I think that you should go and tell your GP that you're feeling… feeling suicidal'… and part of that might be that they don't have a diagnosis of depression, for example…*
3, 42, 1188-90	*I mean, I had a client, and he was suicidal, and interestingly, he told his GP that… erm… and he was on antidepressants…*
3, 42-43, 1212-33	*and interestingly, he… he was attending the doctor regularly, because he was on antidepressants… erm… and, I said to him, 'I… I think that you should, erm, mention the not eating to you doctor, 'cause I'm concerned that you're underweight… I'm concerned that you're… you're malnourished'… and he said that that wasn't something he could mention to his doctor, which I found quite extraordinary, actually… I'm still finding it surprising, telling you today… because he had discussed the fact that he felt suicidal with his doctor… erm… and I asked him if he… he would like me to do that… and if… if he would give me permission to do that… erm… and then, of course, said, 'is there anything else that you would like me to say?'… 'is there anything specifically that you don't want me to say?'… erm… and it turned out, actually, he wasn't underweight… but, I think, also, that his eating actually changed after that…*
3, 67-68, 1926-32	*and… and, I asked her, erm, if she would contact anybody if she felt suicidal… and interestingly, she said that she would, but I think that's changed… I think, last year, she said 'no', and this year, she said, 'she would'...*
3, 68, 1945-47	*erm… and she is attending a doctor, and she does go to her appointments… I check that with her… erm…*
3, 75, 2147-55	*erm… but then, I suppose, I would encourage somebody to go to their GP… and, they can still get an appointment with a GP fairly quickly here, though it's not as good as it used to be… used to be, you could get an appointment on the same day… that's not always the case…*
3, 83, 2365-67	*'I am of the opinion, and they are of the opinion, that he needs an urgent psychiatric referral'… not just because of this, but because of other things…*
3, 83, 2381-85	*and, the GP, in fact, at home, unusually got back in touch with me, and said, err, 'he's been to see me… erm… but, erm, he won't have a… he won't be referred to… for psychiatric referral… he says he's absolutely fine'…*
4, 45, 1279-92	*yes… if they were very distressed in the session… if they had this plan… if I knew they were serious… erm… we would hold… I think, we would keep them here… and we would, err, then, let their GP know… and we would let their tutor know… and we would alert the college… and it would be taken over from there… I haven't had that experience so far… yeah… no, I haven't had that…*
4, 46, 1316-19	*and I've seen him quite regularly… and he's alw… it's always there… there's always a… a… playing… and it is… it's really tricky, just to know… erm… so… well, putting in… in… things in place…*

4, 47, 1348-52	*erm… I'm trying to think what else we do… erm… yeah, so, I guess… the… err… thinking of the client, and where they are, I try and think of everything that can be mobilised… so, it's about widening their support network… and trying to see if we can access… kind of access… all of those… erm… before they need…*
6, 8, 204-08	*for someone who is, erm… sort of actively overdosing a lot, or, erm… you know, has a serious history of self-harm… err… eh… (clearing throat)… it's… it's a matter of, sort of, looking into who they're in touch with already… who already knows?… are they talking to their GP?…*
6, 8-9, 223-31	*erm… he was… he… came to this crisis point very often, and didn't want to be there, and… and didn't, as a kind of an… on an ongoing level… want to… to kill himself, or to die… but he would be caught up in the moment of crisis… and so, it was possible to, kind of, engage with him on that level about it… but he was also very aware, because he knew that he got caught up in this moment of crisis… he was aware of all of the services available to him… the, sort of, duty psychiatrist at A&E… and the crisis team… and was in contact with them…*
6, 9, 242-43	*I don't think I'm really answering your question… erm… but, I suppose, in… in that sense, his GP was aware…*
6, 14, 384-92	*no… no… and… and, I guess, it makes you realise that… that part of what risk management is about is about an attempt to control… when you haven't been able to change… you know what I mean… it's… it's sort of, erm… what can we do to alert as many different people to the fact that there's a danger here… erm…*
6, 14-15, 397-418	*yeah, if… if… if… if you haven't, in your eight to ten sessions, been able to help this person get to a point where they don't want to kill themselves, then everything else is just kind of… erm… (sucking gums)… partly for the benefit of the organisation… partly for the benefit of your own peace of mind… partly for, sort of… erm… 'does everyone know?'… 'maybe someone else has something they can do?'… erm… yeah…*
6, 16, 439-42	*yeah… I think… (pause)… I mean, he's the only one I can think of where the… where the… (pause)… hmm… (pause)… I think… I think, with that client, we'd aler… everyone had been alerted who could possibly be alerted…*
6, 43, 1221-27	*and… you know, obviously, you… you make sure that they know about the mental health crisis team… you make sure they know about duty psychiatrist at A&E… erm… you know, you offer to get them a taxi there if you think they're going to do it, sort of, right then… you get… you… you make sure that they have access to all the… all the things, but… erm…*
6, 45, 1270-89	*yeah, well, I think it's… err… eh… you know… erm… (sucking gums)… (sigh)… or w… you know, ringing the GP… erm… and in fact, I haven't done it in this job… I've done it in IAPT before… erm… and what would happen is, you would sort of write a letter, and you would sort of call them and say, 'a letter is arriving… we're concerned about your patient'… and they would go, 'okay'… (chuckling)… I remember saying, erm, 'we'd really… you know, we would suggest that you undertake a… you know… invite them in for an appointment, undertake a medication review… we are… we are, eh, concerned about…'*

6, 46, 1298-1303 *and, I'm sure that there are lots of… I mean, you know, I worked in IAPT in London, and I'm… I… I… I'm sure… people talk really nicely about their GPs here… I have clients whose… whose GPs sound fantastic, so it's possible it's very different here… erm… and I really would hope that it… that it is…*

6, 47, 1336-44 *yeah… so, you could write to the surgery… (sucking gums)… yeah…*

6, 48, 1363-76 *yeah… I don't… I don't feel like… we're… we're… you know, it might be, but it… it… it feels like a pretty lacklustre somehow response… erm… and we do have a whole lot of other resources… you know, we do have a whole lot of… you know, we can refer people to… depending on what sort of their issues… we can refer them to alcohol services, and drug and… you know, we have this huge… really, really helpful… really exhaustive, sort of, list of resources… that we kind of talk people through… and we can refer people to, and… erm… you know, Rape Crisis, and Women's Aid, and all of these sorts of things, and… and… erm…*

6, 48-49, 1381-86 *yeah… well, and I think… I think they… I think they are useful… I think… eh....*

6, 61, 1752-55 *yeah… yeah… but I think there have been so many services involved… and so many people doing their bit for the, umm… you know, sort of… alerting everyone else, and de de de de… it's kind of like a telephone tree or something… (chuckling)…*

6, 71, 2027-55 *(sucking gums)… (blowing out air in a dispirited way)… well, it's quite depressing in a way, isn't it?… err… I guess, because… because his presentation had not changed so much over so many years that he's been familiar with the service, that people were like, 'oh, yeah'… ha… yeah… I mean… (sniffing in air)… you know, not… not in that tone of voice, but it… but… but there was a sort of, 'yes, we're familiar with this'… 'yes, he's aware of all the things'… 'yes, he's good at looking after himself'… 'yeah, it's fine'… so it's… I… I mean, in that sense, I guess, you know, risk management protocols were working, because everyone was aware of him… and everyone was aware that he was aware of all of the… resources… erm…*

6, 81, 2326-30 *(sucking gums)… yeah, I mean, I remember saying… and I remember feeling, as I said it, like a… a bit of an automaton… sort of going, 'okay, so, you know, you… you've told me that you took an overdose on… ha ha… on Saturday… erm… and… and, what happened?'… and 'okay, you called A&E'… 'is your GP…?'…*

6, 107, 3070-83 *exactly… it's the organisational culture around it, and… and, I think it's also like… eh… you know, here… we revisit all of the resources that we've, sort of, can refer people to annually… and, we sort of go and lo… and look… and, you know, make sure we've got the right weblinks for, you know, Rape Crisis, and, you… you know, sort of, suicide/bereavement things, and… you know, make sure that we're clear about… about what they offer people, and make sure that we know what else is available… and, I think, that feels like… you know, good risk management, and… eh, and, good, sort of, containment for ourselves, and our clients as well… so…*

7, 48, 1360-67 *erm… I… I think that maybe there's more of this stepped… you know, that okay, so somebody who's got a diagnosis like that… shou… what else shou…?… you know, where's the treatment that they ought to be having?… that, you know…*

8, 14, 389-96 *like, there was… there was, erm, a client over there who I saw… eh… eh… the previous year, and, erm, it was still when we had paper notes… (sucking gums)… and he had quite significant mental health problems… and I'd done an assessment… and I'd… he was being*

picked up by the NHS… (sucking gums)… erm… and so we kind of… like, he was going to be treated on the NHS… we kind of left it… but obviously, he cou… he could come back to the service if he wanted to…

8, 25, 697-704 *there was a Visiting Psychiatrist and a Mental Health Advisor there, as well as here…erm… but you… you just were used to phoning the GP, writing to the GP, doing risk management on your… on your own…*

8, 28-29, 803-28 *erm… but, yeah… so last Friday, one of my colleagues, a counsellor, had… he's not worked in HE very long… or just here actually… he worked in a private GP practice, and he hasn't had that much experience of managing risk… so, we have 'Open Door', which is like a drop-in… so this guy came and drop-in… so the counsellor came to see me… said, 'this… this student has plans to end his life'… erm, you know… so we talked it through, and I said, 'is he registered with the GP?', 'cause that's another… if the students aren't registered with the GPs, we're really, really stuck, because unless they're like… (sucking gums)… you know, immediately at risk, and we can call an ambulance, and send them to A&E, we're, you know… but if they've got a GP, that… so I said, 'try and talk to the client about getting his permission to contact the GP, contact the GP, make an urgent appointment'…(sucking gums)… erm… and then, the counsellor came back… 'no, eh, he won't… he won't let me'… so then I go in, talk to the client, and then eventually get his agreement to contact the GP, and, erm, get an urgent appointment for him…*

8, 43-44, 1228-52 *well, almost like, you know, if there's… (sigh)… if it's a Friday, it's worse, isn't it?… but like, if it's a… (chuckling)… if it's a Tuesday, you can… you can assess whether they're… they feel safe today, 'cause they can come back tomorrow, and w… we can do a further… you know… erm… we can do a safety plan… (sucking gums)… erm… but, yeah, I like ph… I like using GPs… that's my… so, if they've got a GP, I b… I like to phone them, ask them to be seen urgently…*

8, 45-46, 1290-1311 *yeah, I can go… go into (name of Mental Health Advisor)'s room, and say, '(name of Mental Health Advisor), I've got a client here… de, de, de… you've… I can see that you've got a space at two… please can you see her'… (chuckling)… or that… that kind of… you know, for a further assessment… so, more… erm… if you… you know, for more time… erm…(sucking gums)… but, if you haven't, yeah, just to ha… have the confidence to extend the time… and phone… yeah, phone the GP… erm… and follow it up… like, so phone the client the next day, or ask the client to come in… it's that kind of protocol… if they haven't got a GP, it's a lot more difficult…*

8, 46-47, 1318-53 *because the GP has statutory responsibility, so… and it's our… so it's our limit of confidentiality… it's the go-to person… and it could be like the Mental Health Liaison Team if you can get… it's harder to get the client to go to A&E than to get them to go to their own GP, 'cause they've been… they've probably been before… and it's a… it's a more… it's a lower-key thing for them to do… but if you've passed on concerns, then the GP could engage the… you know, Mental Health Home Treatment themselves, or… they could do a medication review… you know, they… there's lots of things… but it's joined-up… and that's what's been highlighted in… some of the Coroner's… err… some of the inquests here… is that, wh… why haven't you linked more in with the G…?… and I think (former higher education employer)'s better at doing that than here… why haven't you linked with th… in with the GP more?… why dun't the GP know about this, and…?…*

8, 48, 1358-61 *I mean, to put it very bluntly, if the client… (chuckling)… if you've told the GP the client's suicidal, and the client kills themselves, then, eh… it's the GP that's gonna be more criticized…*

8, 48, 1365 *covering your back…*

8, 48, 1369 *covering your back…*

8, 50, 1417-23 *yeah… 'and how about we contact your GP, if you're feel… you're feeling this bad, and maybe they could… you know, talk to you about a medication review, and…'… you know… (sucking gums)… yeah…*

8, 82-83, 2355-70 *yeah, so then we'd… then… so my co… I got his permission, so my colleague could phone the GP, and got a GP appointment that day… (sucking gums)… I asked my colleague to tell the receptionist why we wanted the urgent appointment… erm… and… I agree… and we booked we in with the Student Support Officer, and then I agreed with the client… it was a Friday… so I agreed that I would phone him on Monday, and I did… he was… he'd seen his GP, and… he seemed to be on a tra… on a different track… (drawing in and letting out air)…*

8, 83, 2374-79 *yeah… he seemed to be engaged in a process of… 'right, I'm gonna try and sort this academic situation out, and…'*

8, 89, 2536-61 *erm… I've just lost what I was gonna say… erm… (pause)… yeah, I think what helps me is if like I've got an idea about what I want from this situation… it's kind of like… c… c… client… (pause)… (sucking gums)… (sucking gums)… I'm not a very directive coun… like, counsellor… any… and CAT… some people would describe it as 'busy'… you know, there's lots of like things to do… and homework-setting, and all of that… but I'm not like… I'm not a… (sucking gums)… I'm more collaborative… I'm more person-centred than control… like, directive, but in that situation, it's not that I would be directive, but I've got a… I've got an idea about what I want out of the interaction, and I'm gonna… I'm going to get it… (chuckling)… that's… that's what's going on in my mind… like, 'I am gonna phone this GP today, and you are going to agree'… (chuckling)… err… not that I would say that, but that's what I've got… so I'm quite…*

8, 90, 2565-86 *yes, this per… that I need to make sure this p… that… I need to assess what stage of risk they're at… is it a kind of A&E?… is it a…?… can they…?… are they going to agree to go to the doctors?… do we trust that they're gonna go?… erm… can… we… we can check… we can… 'can I phone your GP afterwards, or can I phone you afterwards?'… and just get a sense of whether that feels okay or not… so I think I have the kind of… and it… it… it can be a choice, but it's gonna be a choice of… with some clients, it's a choice of… 'we can contact the Mental Health Liaison Team for you… at (local hospital) at A&E, and you're going there, or you're going to go to your GP… (chuckling)… which one is it?'…*

8, 91-93, 2618-58 *I've never… I've never co… contacted… I don't think I've ever contacted somebody without someone's consent, but I have taken a risk, where, for the sake of the relationship… this is at (former higher education employer)… it was a medical student, and she said that she ha… she had a rope in her boot of her ca… ca… of her ca… her car… (sucking gums)… erm… so she had means, plans, whatever… (sucking gums)… erm… and she was adamant that she did not want me to contact anybody, because she was a medical student… she was concerned about the impact on her training if I contacted her GP, and we'd been working together for quite a while… and she said that she was going to see a friend that evening, and dededede… (sucking gums)… and so we ma… we kind of had an agreement that she would do this, and then I would call her the next day… and that was… like, I know… I've spoke to colleagues about that, and they said, 'there's no way on Earth I would have done that… I would have been… it doesn't matter… I would have phoned the GP… doesn't matter what she would have wanted, or that she'd know'… she said, 'I will never come back here if you phone my GP'… erm…*

	so, other colleague… other colleagues were saying… I remember talking about it… it was years and years ago, but I remember the talk… and they would say, 'there's no way I would have risked that'… so that was a ri… that was a… that was just trusting in her… in the relationship, I suppose…
8, 93, 2662-66	*oh, awful… awful…*
8, 93-94, 2676-90	*yeah… I th… I suppose I believed that she would seek her own informal support, and that she valued her career, I suppose… her reputation over that, the intention to kill herself… (blowing out air)… (sucking gums)… (pause)… yeah…*
8, 94, 2697-2705	*yes, it's anxiety-provoking… yeah… yeah… it's a gamble, I think…*
8, 96-97, 2754-74	*not always… not always… yeah… yeah… yeah, exactly, and then… so, I might go through the notes… and think, 'well, when was the last time we had any contact with the GP, and do they know?… and is this case… is this situation serious enough for us to call the GP now, and say, 'look, we've lost contact with this person… we're concerned'… erm… or… you know, I like contacting the student… often, that will bring people out of the woodwork… (sucking gums)… you know, 'I've been trying to contact you… I'm really concerned… erm, please do get in touch with me… if I don't hear from you by, whatever, I will need to update your GP'…*
8, 103, 2950	*yeah… it… it… it's internal resources, and then external…*
8, 105-06, 3014-27	*eh… sometimes we might use, like, 'my friend's coming to collect me'… and we can do a safety plan, and the friend is… they feel safe with the friend, and they're gonna come back tomorrow… that kind of thing… erm… but I'd alw… I'd… you know… or that they've agree… you know, we try and get them to agree to register with the GP if they haven't got one…*
8, 106-07, 3041-56	*I think we would… it… would… if… you said, refer on to the GP… we… we'd always have them back… you know… it's a joint… it's a joint thing… oh, yeah, if I… if… if they've… if… if… if they're registered with the GP, and I can get them an urgent appointment, that's my ideal… ye…*
8, 107, 3064-68	*yeah… yeah… I'd love… I love that…*
8, 107-08, 3073-99	*because it's easier, and we don't have to think about how they're gonna get to A&E… do we trust that they're gonna get to A&E?… so, here, we can call a taxi… at (former higher education employer), we weren't allowed to call a taxi… we had to call… we either had… had to entrust that they're gonna get there, or could call an ambulance, depending on how ill they are… and both of those are risk… risky… we can call Mental Health Liaison Team there… give them the name and everything, and then… (intake of breath)… if it's serious enough, hopefully they will then follow it up… or if the cli… if the student arrives, and then buggers off… so registers at A&E, and then they think, 'I'm sick of waiting'… then they will contact the police sometimes to… if they can't get hold of the student…*
8, 109, 3112-17	*yeah, because, eh… the… eh… you… you know… it's less scar… it's less intimidating to go to your GP than to… go to A&E… and, also, A…*

8, 117-18, 3367-88	*I'd only… I'd only seen him once… d'you mean him?... had to go… yeah… I'd only seen him once for assessment, and he was about to be taken on in Psy… in Psychology in the NHS, so we agreed that he would do that… I contacted his GP at the time… erm… (intake of breath)… and then… (letting out air)… yeah, so I hadn't… I… I mean, I… there was another case where… I had been working with somebody… I'd really tried hard for the client to go and see the G…*
8, 126, 3611-20	*yeah, but she knows that she can come here, and 'Open Door'… I've given her 'The Sanctuary' phone number, and…*

Subordinate Theme #2.5: "Being pulled off course": experiencing risk management obligations as compromising the therapeutic relationship

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Transcript Ref:	Quote:
6, 3, 72-77	*I think the main issue for me is, erm, you… you know, when you talk about risk management, and organisational risk management, is that you're… you're dealing with your exp… or I'm dealing with my experience of the client… but, also… and my duty to the client… but, also, my duty to the organisation, and…*
6, 14, 384-86	*no… no… and… and, I guess, it makes you realise that… that part of what risk management is about is about an attempt to control… when you haven't been able to change…*
6, 14-15, 397-409	*yeah, if… if… if… if you haven't, in your eight to ten sessions, been able to help this person get to a point where they don't want to kill themselves, then everything else is just kind of… erm… (sucking gums)… partly for the benefit of the organisation… partly for the benefit of your own peace of mind…*
6, 17-18, 470-501	*but then, talked a lot about quite active suicidality… and when I started talking to him about the fact that, you know, we would… we would like his permission to contact his GP, backed off, refused permission to contact his GP, and said, 'actually, no… no, I'm not gonna… no… no, I'm not gonna… I'm not gonna to kill myself'… and that was a very tricky one, because… (clearing throat)… I felt like, erm… I… I wanted to keep the… erm… keep the conversation open to… to being able to discuss his… his suicidal ideation… but not in a way that would, sort of, threaten him, with the… you know, he… he… he was worried he would be sectioned… he was worried about all of these sorts of things… and, of course, I couldn't give him any guarantees about what would happen after we'd alerted his GP… erm… and so, that had the effect of kind of shutting down a lot of… mmm, potential, sort of, therapeutic interventions… and after that, he… you know, he kept insisting, 'no, no, no, no, no, no, no, no, no… I don't… I don't wanna kill myself… I'm not gonna kill myself… I'm not gonna kill myself'… and I… I wasn't sure I believed him… erm…*
6, 18-19, 505-21	*yes… of avoiding intervention… erm, and then you're drawn into… or I was drawn into… a dynamic where I sort of felt… well, I… I… I either become someone who, sort of, persecutes him with this, sort of, erm… err, I… I don't know… I… I felt like a… a… a parent with a… with a… saying a child was crying wolf, or something… it was like, 'ahh, well, that's how you feel?… well, I better… well, then, I guess we'll have to tell your GP, won't we'… you know, that… that was, sort of, what the dynamic felt like… erm… and it was very difficult to get out of it… err… so, I don't know if that's really, erm…*

6, 19-20, 529-66	*(sucking gums)… it was very frustrating, because again, it brings in the third party of the organisation… I mean, it brings in, sort of, like, 'well, you… you know, he has said', and… and, 'what does it mean… what does it mean, erm, then if he does do something?'… 'what if he does harm himself?... and I've tried to discuss this with him, and… erm… you know, in the… in the way that we're trained to do, and we're asked to do… and he backed off, and, sort of, denied it, and… and I… I wasn't then able to, kind of, follow it up… and what if something really did happen?… and… what would my part in that be?... and how do you claw that back without, erm… without impinging on someone's autonomy?... how do you protect and also respect their boundaries?… and what are you supposed to say if someone says, 'no, I… I don't', you know… 'I was just… I was just speaking… it was just a figure of speech… I don't actually want to kill myself'?… what part of what they say do you believe, and what part do you not, essentially?…*
6, 21, 585-98	*well, it's really difficult, 'cause it pulls you out of a relationship… a straightforward relationship with the client… it… erm… it sort of pulls you back into, sort of, an agent of an organisation in some sort of way… and it can collaborate to a sort of dynamic where someone feels that they are being persecuted… that, you know, you don't really care about them… you are just sort of going through the organisational motions… erm… eh… eh…*
6, 21-22, 602-27	*erm… (pause)… I suppose, in… in that particular case, I ended up, sort of, working quite hard to sort of say… (sigh)…. 'I… you know… I, as a… as a person… as a… as a practitioner, but also as a person… you know… care about you, and I want to… to see what we can do to help you here… and one of the things that… you know, we… we want to be able to keep you safe… we can't do the work if you're not, you know… if, eh… if you're not here to do it… erm… and, we think that this might be helpful'… and so, I ended up talking through… you know, what were his reservations about our contacting the GP… what were… erm… you know, what the benefits might be… was it about his relationship with his GP?… (sigh)… eh, eh, you know… eh… and then, before you know it, you're not talking about what he's come to talk to therapy… you… you know… he's come to therapy to talk about any more… so I think what it often felt like is that I was being pulled off course in a… in lots of different directions from… from what he was actually… he had actually come to talk about… and, I'm sure, he had unconscious dynamics that… you know, that played a part in that as well… but, erm…*
6, 23, 635-50	*frustrating and anxiety-provoking… erm… and sometimes a bit… (sucking gums)… not angering, but kind of despairing… (chuckling)… sort of, like… erm… (pause)… err… understanding why we need these protocols, but also understanding that they're a very blunt instrument… and also understanding that, you know, to a large extent, they do exist to protect the organisation… erm… and that you can scare someone off using your service by… by invoking… you know, some of the… responsibilities, I suppose, that you have to the client to report things…*
6, 25, 694-703	*(sucking gums)… errgh… err… I mean… it's funny, because, on the one hand, and of course, this is, you know, partially my, sort of, background in IAPT speaking, but, you know, you… you… you have a sense, in this day and age, in a counselling organisation, of incredible organisational vulnerability anyway, because budgets are being cut… and so, you know, you do feel that you have to do your part to make sure that we're… eh… you know… (pause)… not 'looking after ourselves', because that does make it sound, sort of, sinister in some way… not, sort of, 'watching our backs', but, erm… (pause)…*
6, 40, 1126-43	*erm… and I think, you… you know, there are all sorts of things that are in the Staff Handbook that you can fudge a bit… diary management… things like that… (chuckling)… you know, sort of, who fills up the water filter… erm… but the… the… the big things… erm… you don't want to be on the wrong side of that if something goes wrong… erm… so I suppose that becomes a tension for me,*

is, erm… and I don't know how that would feel differently in private practice, for example… erm… you know, how I would feel about that on my own behalf if I was making the rules, and I was making the, sort of, protocols… well, you know, and my… you know, UKCP, or the BACP, but, erm…

6, 48-50, 1381-1415 *yeah… well, and I think… I think they… I think they are useful… I think… eh.... but I think there's some… (whispering)… there's something almost punitive, I think, maybe… I don't know why I'm… maybe it's just because of my experience of this client, who when I said, 'we might write to your GP', and he went, 'oh, no… no… no… it's fine… no… no suicidal feelings at all'… it feels like, sort of, reporting someone to the headmaster, or something… it's like, 'I'm gonna tell your GP on you'… erm… and that's… that's quite potentially my stuff… I don't know… but, erm… (sigh)… but sometimes, it feels like that could be a function to shut someone down… sort of saying, 'we're gonna call you on it'… if you say… you know, if you say… 'oh, yeah'… alright, we're gonna call your bluff… 'I'm gonna tell your GP'…: it's gonna go on your record'… erm…*

6, 50, 1419-24 *yeah… yeah… I don't think I've ever kind of articulated it quite like that to myself before, but I think that is, some level, how it feels…*

6, 55-56, 1590-1615 *yeah… to some extent… yeah, exactly… I… I mean… yeah… yeah… well, because I… 'cause I also wouldn't want to fall into, err… if the dynamic is the opposite… that… that someone presents in this very, kind of, emotive, high drama way… and everyone brushes them off… everyone says, 'ah, you know… you know, that's what they're like'… you know, it can be potentially really transformative to… to be able to be someone who gets past that feeling of 'you're manipulating me'… and sort of goes, 'well, sounds like you're really hurting'… 'can we talk about this?'… 'can we look at this?'… you know… 'I'm gonna take this seriously'…'I don't want this to happen', and… I'm not, 'I don't want this to happen', but, you know, it dep… (sigh)… umm… in a way, to preserve the other person's autonomy… you know, like, eh… 'I want to help you not to suffer like this'… 'what can we do to… to protect…?'…*

6, 84-85, 2417-34 *it's quite… quite unique to this case, 'cause it… you… you know, if you… eh… I guess the other who I mentioned was someone who's had, erm… you know, who I'd said, I… I… I might need to contact your GP, and he went, 'no, no, no, no, no, no, no'… erm… and that didn't feel humdrum at all… that felt very much like, you know… I was sort of saying, 'you know, I've mentioned this, and we've discussed confidentiality, and I'd like your permission to, sort of, write to your GP', and I explained why we needed that, and, you know, what his GP might be able to do, and it… but he… he… he… eh… erm… this one…*

6, 85-86, 2450-58 *yeah, the… eh… eh… I suppose, erm… (sucking gums)… yeah, I suppose in the… in the latter case, I was very much left holding the anxiety… sort of, like… this person had said, 'I want to kill myself', and I said, 'okay, let me help you', and, then he said, 'no, I don't want to kill myself', and… and so…*

6, 86, 2462-66 *'you can't share it was anyone'… 'I've ju… no, I was just saying that… I didn't mean it'… and then… and so… I was stuck, sort of going… 'well, but… uh… uh… uh… uh… uh'… 'but technically, I mean… eh'…(sigh)… you don't want to split hairs… you know, you don't want into… to go into, sort of, technicalities on this…*

6, 87-88, 2509-17 *unfortunately, with this particular client, it… it sort of… it makes me weary of… of… of… (chuckling)… err… (pause)… because it's a way of distancing me from… from working with him… it's a way of distancing himself from the emotional work that needs to be done… and he'll sort of… eh… eh… well…*

6, 88, 2521-25	*that… that… he'll say, 'I feel like this'… and I'll say, 'well, let's look at that, and let's take that seriously'… and then he'll go, 'no, no, no, no, no… no… no, I don't really, no'… a… and you never know what you can talk about, and… and what you can't, and what his… what he's willing to engage with is…*
6, 92-93, 2651-64	*yeah…eh… whereas wi… you know, with this other client, who sort of rescinded, erm, all suggestion of suicidality, I think I felt more like I was being identified as the sort of… a persecutory kind of… erm… you know, old-fashioned, kind of mental institution person, out to catch him in a net, or something… (chuckling)… you know, it was… it was this, erm… I guess, really… strong projection… yeah…*
6, 94-95, 2689-2721	*what's that like?… yeah… I guess, it's… I guess, it's tricky… and I guess it, eh… at the end of the day… so much of it is informed by, you know, what it feels like to be part of an institution… what your feelings are about institutions and organisations and groups… erm… and the nature of the institution… I guess, I feel like this is a really supportive service compared to other places I've been… erm… but it's also a workplace Counselling Service, with… so you are identified by the clients very much as either part of a paternalistic, caring, 'looking after you' organisation… or a kind of oppressive, you… you know, conflict-ridden… ha… erm… controlling institution… so you're a… you're a functionary of… of either of those relationship…*
6, 95-96, 2735-58	*yeah… yeah…. well, and actually, what I haven't… have… there's a bit of a, kind of, 'Goldilocks and the Three Bears' scenario here, because there's also another client who I've worked with, who… who reported… was a 'client of concern' at the beginning… who reported suicidal feelings, and… I worked that through with him in the first session… you know, I would like permission to sort of speak to your GP… and, erm… he was sort of su… surprised, and… and kind of impressed… and he said, 'oh, okay… really, would you do that?'… and, erm… and that has… has actually gone, you know, really well… I don't know what his GP did with it… he hasn't sort of said anything, but he… but he found that kind of touching, so… y… you know…*
6, 97, 2774-75	*yeah, whether they s… whether they see it as, kind of, an expression of care, or…*
6, 98, 2803-14	*oh, it was great… yeah… yeah… well, because it… it felt very straightforward… it felt like… eh… eh… he understood what we were trying to offer, and the spirit in which it was being offered… erm… and he sort of accepted it in that spirit… erm… and that actually facilitated the rest of our… our work…*
6, 99, 2832-45	*yes… but he was also… a less complex, I would say, case than the other two… so, yeah… yeah…*
8, 89, 2536-61	*erm… I've just lost what I was gonna say… erm… (pause)… yeah, I think what helps me is if like I've got an idea about what I want from this situation… it's kind of like… c… c… client… (pause)… (sucking gums)… (sucking gums)… I'm not a very directive coun… like, counsellor… any… and CAT… some people would describe it as 'busy'… you know, there's lots of like things to do… and homework-setting, and all of that… but I'm not like… I'm not a… (sucking gums)… I'm more collaborative… I'm more person-centred than control… like, directive, but in that situation, it's not that I would be directive, but I've got a… I've got an idea about what I want out of the interaction, and I'm gonna… I'm going to get it… (chuckling)… that's… that's what's going on in my mind… like, 'I am gonna phone this GP today, and you are going to agree'… (chuckling)… err… not that I would say that, but that's what I've got… so I'm quite…*

8, 90, 2565-92	*yes, this per… that I need to make sure this p… that… I need to assess what stage of risk they're at… is it a kind of A&E?… is it a…?… can they…?… are they going to agree to go to the doctors?… do we trust that they're gonna go?… erm… can… we… we can check… we can… 'can I phone your GP afterwards, or can I phone you afterwards?'… and just get a sense of whether that feels okay or not… so I think I have the kind of… and it… it… it can be a choice, but it's gonna be a choice of… with some clients, it's a choice of… 'we can contact the Mental Health Liaison Team for you… at (local hospital) at A&E, and you're going there, or you're going to go to your GP… (chuckling)… which one is it?'… so, sounds like… I say it like that, but that… yeah, I have an idea about what I… this is… this is the result…*
8, 91, 2596-2613	*ye… yeah… yeah… that helps me, having that kinda… that's my goal… I'm not… they're not walking out, or it's very rare that they'd walk out…*

Subordinate Theme #2.6: "Going through the motions": experiencing risk management as an empty gesture, unlikely to protect client well-being

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Transcript Ref:	Quote:
6*, 4, 90-109*	*so, erm… so, anyone who mentions suicide at all, I will tend to, sort of, bring that up in… in supervision… and sometimes it can feel like I'm doing that for bureaucratic reasons… you know, to sort of, pu… just to make sure that I've, sort of, covered my back, and covered the organisation's back… erm… even if I don't feel that a client is, sort of, actively suicidal, but, I feel that it needs to go on the record… erm… and I think the trouble that I sometimes have with that is that you get… or I get in… so much into the habit of, sort of, saying, 'this person has mentioned suicide… erm… eh… you know, they have no plan… they have… blah, blah, blah… but, eh… eh… but I feel like I need to just, kind of, share this, and… and have this… erm… have this out there somewhere'… (sniffing in air)…*
6, 5, 128-39	*but, I think, when it comes to… I'm sort of rambling a bit… but when it comes to someone who you… who you feel really is on the brink of doing this all the time, and is, sort of, attempting and attempting and attempting… erm… it can really bring you up against the hard limits of what you as an organisation can do… and it can sometimes feel like an empty gesture… just, sort of, putting the protocols into place, and asking for permission to write to the GP, and things like that…*
6, 10, 264-79	*I think it was… it was, sort of, fairly hopeless, in a way… and it… and, I guess, where the… where the organisational aspect of that came into it for me was thinking, 'well, at least… at least, I can check with all of these people', and say, 'is there anything else we can be doing?'… 'what are we doing?'… 'what are we doing?'… but, on some level, there's always the worry that that feels like what you're seeking is validation… like, 'well, we've done everything, right?'…'we've done everything, right?'… erm… 'what more can we do?'… so, it can almost feel, sort of, like a giving up…*
6, 11, 291-96	*yeah… there's a reassurance in that… but then, there's always this, sort of… there's also this sense of, erm… 'well, we've done our bit'…*
6, 12, 321-44	*well, no… it's… well... it… well, it… well… well, it's… it… yeah… it's sort of ticking… ticking boxes, but also, sort of saying… (pause)… kind of like, handing over the situation to a protocol… sort of going, 'well, okay… so, we've done this… we've done this… we've done*

this… we've done this… we've done…'… like having a fire drill, or something, you know… we've taken attendance… everyone's, kind of, exited the building in an orderly fashion… erm… and, we've… we've done all we can… but at the same time, sometimes you… you, sort of, think, 'could we be doing more?'… could we be…?'…'what… what more could we be doing?'…

6, 21, 585-98 — *well, it's really difficult, 'cause it pulls you out of a relationship… a straightforward relationship with the client… it… erm… it sort of pulls you back into, sort of, an agent of an organisation in some sort of way… and it can collaborate to a sort of dynamic where someone feels that they are being persecuted… that, you know, you don't really care about them… you are just sort of going through the organisational motions… erm… eh… eh…*

6, 23-24, 658-65 — *well, and also, and, I guess, the despair… the hopelessness is a sense of that… (intake of breath)… on a particularly jaded day, you think, 'well, I'm gonna tell his GP… what's the GP gonna do with it?… you know… it's gonna sit in a file…*

6, 37, 1054-57 — *yeah… I mean, and… eh, you know, in an ideal world, I would manage to strike some sort of balance… (chuckling)… where I wasn't just, kind of, going through the motions… but, err… you know, and I… and I would try to do that…*

6, 42-43, 1207-21 — *and then, you know, if they seem to have a plan… if they're thinking of, sort of, how they would do it… if they've attempted, and things like that, then, erm, you say… because, you know, we have the clause around confidentiality bit, sort of saying, 'if we… risk… there's a… I think, there's a risk of serious harm to yourself or a third party, erm, then we would, sort of, ask to contact their GP'… erm… and I think that's always the bit that dismays me, because I sort of think, 'God, I mean, I don't know what my GP would do with that information'… (chuckling)… 'they would just, sort of, look at it, and chuck it in a filing cabinet'… you know, I… I don't know what happens from there… erm… I don't know what that kind of does…*

6, 45-46, 1270-1313 — *yeah, well, I think it's… err… eh… you know… erm… (sucking gums)… (sigh)… or w… you know, ringing the GP… erm… and in fact, I haven't done it in this job… I've done it in IAPT before… erm… and what would happen is, you would sort of write a letter, and you would sort of call them and say, 'a letter is arriving… we're concerned about your patient'… and they would go, 'okay'… (chuckling)… I remember saying, erm, 'we'd really… you know, we would suggest that you undertake a… you know… invite them in for an appointment, undertake a medication review… we are… we are, eh, concerned about…'… and they would go, you know, 'noted… thank you'… and that was kind of it… erm… so it feels like a nothingy thing to do to me… it feels like a… erm… it feels like a fob off… and I'm sure that there are lots of… I mean, you know, I worked in IAPT in London, and I'm… I… I… I'm sure… people talk really nicely about their GPs here… I have clients whose… whose GPs sound fantastic, so it's possible it's very different here… erm… and I really would hope that it… that it is… erm… but I think it's a… it's a real lottery who your GP is, and whether they care, and… umm… what their own risk management protocols are… and we don't know that, and that's, sort of, beyond our sphere of influence…*

6, 46-47, 1326-32 — *yeah… err, particularly because, you know, a lot of people don't… they don't know who their GP is… they don't see the same pers… you know, it's a… it's a sort of rotating group of locums, and…*

6, 47-48, 1349-58 — *(blowing out air)… I don't know… I kind of… I guess I can… (pause)… err… I don't… I don't… I don't like it, because I… I guess, I can't think what even a very resourceful GP, what resources they might have to deal with a situation that… that we don't have, and that we*

haven't… tried, and that we don't know of… erm… what do I feel about it?... (long pause)… (blowing out air)… dreary… (laughter)… erm…

6, 48, 1363-70 *yeah… I don't… I don't feel like… we're… we're… you know, it might be, but it… it… it feels like a pretty lacklustre somehow response… erm… and we do have a whole lot of other resources… you know, we do have a whole lot of… you know, we can refer people to… depending on what sort of their issues… we can refer them to alcohol services, and drug and… you know, we have this huge… really, really helpful… really exhaustive, sort of, list of resources…*

6, 81, 2326-34 *(sucking gums)… yeah, I mean, I remember saying… and I remember feeling, as I said it, like a… a bit of an automaton… sort of going, 'okay, so, you know, you… you've told me that you took an overdose on… ha ha… on Saturday… erm… and… and, what happened?'… and, 'okay, you called A&E'… 'is your GP…?'… 'you… you know… we've spoken about confidentiality, and the limits of confidentiality, and, erm, you know, I'd… I would like permission to, sort of, speak to your GP'… 'oh, no… my GP already knows'… (chuckling)…*

6, 82-83, 2362-78 *yeah… I guess, it's kind of… it was… it was, sort of, tough… I mean, on… on… on one level, I was grateful that he wasn't alarmed by any of it… I was grateful that he knew what support was available… I was grateful that he didn't feel like I was sort of imposing, or, you know, taking away his power or anything… erm… but it did feel like making something quite serious, quite humdrum…*

6, 84, 2417-22 *it's quite… quite unique to this case, 'cause it… you… you know, if you… eh…*

6, 92, 2630-47 *yeah, it is… it's… err… and I guess it's… eh… you know, as with any bit of client work, so much depends on your experience of the client, and your relationship with the client…erm… (pause)… (sucking gums)… and I guess… yeah… I guess, I suppose in the first instance, with the person where, you know, the risk management was just a kind of humdrum formality in some way in his chaotic life… that there was a feeling that, I… I suppose, in some way, I kind of identified with him against the organisation or something, or… eh… at the same ti… or…?… not that he identified against the organisation, 'cause it was, kind of… it was looking after him, and he felt a real sort of affinity for it, but I… eh… I guess I identified as being part of a sort of faceless machine that couldn't actually offer him much substantive help, that was sort of going through the motions, but, you know, what could it really do, whereas… (sniffing in air)…*

6, 105-06, 3013-33 *exactly… that… yeah… and it was, kind of like, referral… and if anyone was at all complex, refer, refer, refer, refer, refer… get them off your books…whereas… whereas, you… you know, I think what feels nice about having, erm, you know, a policy that we all are aware of, and is written down, and we revisit, and… an, eh, eh… and… and that is, sort of, enforced here, is that actually, having that containment, eh, contains the clinicians, and allows you to feel… eh… eh… a little bit freer, I suppose, to work with the clients… and I suppose, actually, this goes back to what I was saying about, sometimes, you know, with my supervisors, who are very experienced, sort of saying, 'well, you know, do you think that's really a risk?… well, let's see where else we can go with that', and… and maybe it's my anxiety held over from the NHS, that I think, 'eww, is that good enough?'…*

Superordinate Theme #3: "It's good to ask for help": experiencing both isolation and organisational support when working with client suicidality

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Subordinate Theme #3.1: "Handcuffed": struggling with the restrictions on disclosure of suicidality imposed by confidentiality requirements

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Transcript Ref:	Quote:
3, 7, 174-78	*and, when he was away, I remember talking to another member of senior staff anonymously… in looking at our policies and procedures, and, erm, having a really clear idea of… of what the college, err, promises in terms of confidentiality, and what's expected of me…*
3, 35-36, 1001-13	*but, I suppose, my… my role is different… I generally work very much on my own… erm… and I can't share information because I feel anxious… you know, the ethical guidelines… that's another thing, of course, is the ethical guidelines… a very important part of decision-making… erm… but I can't share information because I feel anxious… I have to manage my anxiety…*
3, 40-41, 1150-62	*when I want to talk to my line manager, which I don't… I don't do that often… and actually, when I do talk to him, it's almost always going to be anonymously, and… because he's not a counsellor… he's a kind of side… sounding board… and actually, he will almost always say, 'well, you… you'll know yourself'… because, he can't really say much more… so, usually, if I'm saying to him, erm, that I'm thinking… well, it would usually be… 'cause, I'm thinking if… I… I would suggest to a client that they contact their GP… if they don't do that… erm… and that… that's sharing responsibility, isn't it?...*
3, 41, 1170-78	*erm… but if… if somebody's suicidal, and they're adamant that they're not going to go to their doctor… erm… then, there's a situation… well, am I going to… am I going to share this with somebody?... and, of course, it's not… it doesn't always feel necessary, but there are times when... when it does…*
3, 42, 1187-88	*yeah… and I might discuss… and I might discuss that with my client, as well…*
3, 63-64, 1810-19	*I said, 'I'm going to let you know that that person has not turned up for their appointment, and I'm going to let her know in an e-mail that I have let you know'… erm… and that's actually a bit of a break for me… but I sat and thought about it for three-quarters of an hour, and I decided… and I'm still to take that to supervision… I've got supervision this Friday…*
3, 66, 1878-81	*so, I e-mailed back to say, erm, 'I have actually let Student Services know that you… you didn't, erm, come to your session today'… so, that I would be completely transparent… I'm not entirely comfortable about it…*
3, 74-75, 2130-41	*umm, hmm… but then, what's the alternative… if we offer our clients confidentiality… and, I know… eh… 'cause I've discussed this at conference… that other… in other universities and colleges, I… well, my understanding is that counsellors have to share information at an earlier stage… erm… that the… that senior management kind of… eh… they make the rules about the policies and procedures… expect that… but then, are you holding confidentiality in the same way?...*

3, 78, 2219-24	*umm, hmm… yeah… but then, I suppose, as counsellors, that's what we sign-up to, isn't it?… you know, to maintain confidentiality…*
3, 79, 2257-61	*and I sat… she was my last client in the morning… and I sat then, in the room… in the surgery, on my own… I tried to get hold of my supervisor, and I couldn't… and, I thought, 'she is at risk'… 'far as I know, apart from her making an appointment, she's going to go and kill herself'… 'so, do I share information?'…*
4, 3, 75-85	*so, in education, erm, we have a lot of people that we work alongside, but… we work alongside them, but within our boundaries of confidentiality, so it's really hard, that… so, we have students who are suic… who have suicidal thoughts, but unless they are active, we can't actually break confidentiality… so we're really sitting with it ourselves in the session, week-to-week, and, I guess, talking to our managers, but… so, it is really tricky…*
4, 22, 614-31	*so, I… I know clinically… like, I know, I've done my job… I've written the notes… I've flagged it… I spoke to my line manager… she knows… but essentially, the feedback is, 'well, you've done everything you're supposed to do'… but I keep thinking, 'well, is there more'… and, I think, confidentiality is difficult here, because we're not allowed to speak to anyone without the client's permission… unless, obviously, they're actively suicidal… but a suicidal ideation doesn't always… I think…*
4, 24-25, 670-701	*so, for… for example… so, I worked in, erm, psychiatric hospitals in London… so that was my initial training and practice… and it was great, because obviously, we were in a medical setting, and confidentiality was there in the sense of, err, we didn't discuss with the nurses and doctors the content of what we were saying in our one-to-ones… but, I could very well go back to the nurse after, and say, 'there are… there is a lot of suicidal ideation today, or even self-harm, thoughts, whatever'… you know, 'I just wanted you to hand that over, keep that in mind'… you can't do that here… you can't phone a tutor, and say, 'look, I just want you to be mindful that I saw so-and-so today… they are expressing suicidal thoughts, but I think we're just at a thought level'… so you can't do that… so, err, there's no… err… 'cause that would be breaching confidentiality… we're not allowed to do that…*
4, 25, 715-16	*exactly… exactly… where it's not the case here… you know, this is a completely confidential service, so if I…*
4, 25-26, 721-41	*oh, yes… so even if a tutor says, 'you know, I referred you that student last week… did they come?'… we're allowed… we can't say… I have to say, 'well, I'm sorry, I can't even tell you if they've come or not'… which is really hard when the tutors are responsible for their student's welfare in college… so, err, this is a big issue with all of us… it comes up a lot in our team meeting… and that is hard…*
4, 26-27, 745-60	*well, on a Friday… I wanna be able to pick up the phone if I've just worked with someone who's… a… a bit… is really a bit wobbly… and say, 'I've just had the session… this is what they are thinking'…'I don't know what will happen over the weekend, but just to let you know'… and then, they're mindful, so……*
4, 27, 765-73	*yes, I guess…. yes… I guess, in some ways, so that they're aware…*
4, 28, 784-805	*and often, with suicide, it's often the people who are not making a fuss who tend to kill themselves, you know… I don't know if… it's been my experience… often, students who are making the biggest fuss, and demanding all the attention, tend not… not to… there's*

	no correlation… (chuckling)… I'm just saying, from what I've realized… so, it's those students who are kind of really hiding that… that worry me… but still, without their permission, we can't talk to anyone…
4, 29, 818-28	*exactly… and that's a fine line of do… is this warrant enough for a breach of confidentiality, or not?... and… and I think… I guess that's where you have to really assess in the session… where that client is…*
4, 50-51, 1423-53	*(sigh)… it's difficult if we don't ever get… if we… if we don't have, erm, consent, because the truth is we can speak to no one, and that's what's really frustrating… so, if they say to us, 'look, erm, I'm gonna be alright'… 'don't worry'… 'we don't really know, but… you don't need to talk to anyone'… you're stuck with it, and that's what's really infur… really frustrating… yeah… so, I find it really hard… so, you have a really intense session… you know what the student's thinking about… and, other than telling my line manager, and writing the notes, there's nothing I can do, and I'm sort of stuck a bit… or that, you carry that…*
4, 52, 1494-95	*yes… that I don't have always access to… or that I can't always initiate…*
4, 53, 1511-21	*absolutely… yeah… so, it is really hard… so, erm, I'm based at one of the colleges on a Friday… and, erm, we often meet with the tutorial team… so, that's the senior tutor, and the tutors who are responsible for the well-being of the students… and I'll sit there, and I can't often say very much… (chuckling)… unless they are students that have given me consent, and I'm allowed to talk about what's going on… but often, my contribution is very general…*
4, 53-54, 1526-44	*ahhh, it's just so difficult… I hate it, because it… to me, it negates teamwork… and it negates, erm, the welfare team working together… and, if the crux of the matter is the student's well-being, and I can't say anything, and oft… often I'm the person they're relying on to say… (chuckling)… it's really frustrating… it's really difficult… I don't like it…*
4, 54-55, 1552-67	*yes… I really don't like it, because it feels pointless… they're all getting together to talk about a student, and they all are… and, you know, I can't say anything… it… I feel… it just… I feel… not silly, but it just… it just feels counterproductive… yeah…*
4, 55-56, 1571-1619	*no… and they're talking about things that I know about… and there are times when I could say something that would really help them understand what's going on for the student, and I can't, so it just… it just… I just feel… helpless… I feel silly… I feel a bit… I don't know… I mean, they… and… and… and… and, actually, to their credit, they completely understand… like, no one ever puts pressure… they know… they understand the… and actually, there's a purp… I think, it really works in our favour for the student, because they really want somewhere they can go that's not linked to the college… but the students actually like the fact that that happens… that we're away… we're anonymous… we're also a neutral party… because we work a lot with students who are intermitting, and there's a lot of tension in the tutorial teams when the students don't like what the tutors are saying… erm… and, I got involved in all of this with one student, who was very depressed, and… kind of, quite suicidal… erm… but because he'd given me consent, I was able… we were able to have discussions… but, also, in him knowing that I was having these discussions, it does eff… effect then how the relationship… you know, you… you query… he never said anything, but, I think, he… they like to know that you're on their side… I guess, they want someone on their side…*
4, 57, 1624-41	*yes… tutorial meeting… yeah… I was very partial to all the decisions that we're making, and… yeah… so, it's complex…*

4, 58, 1653-69	*yeah… yeah… it's neutral, yeah… I do… but I don't know if that advantage outweighs the… ha… disadvantages of not being able to say anything, especially when the students are very unwell… because they are… and they teeter on the border of suicidal ideation to suicide… they're… it's… like I said to you, where do you judge… where do you decide that this is, eh, you know…*
4, 59, 1681-1703	*yeah… yeah… I do… I find that really difficult… and, I guess, in private practice, I'd err… always err on the side of caution, and I would… but, eh, I think, when you talk about it with a client, it's… I think, usually they're open to you having contact with professionals… I don't… it's very rare that I've heard someone say, 'no, you're not allowed to talk to anyone', so I feel the students would be the same… you know, if we contracted at the beginning that it was really helpful if you sign, consent, and we can then have contact with your tutors… I don't know… (sigh)… I haven't done that…*
4, 61, 1754-61	*(sigh)… yeah… I don't like it… I don't like it… it doesn't… it's, erm… I go home, and I find it hard to shift it… I find it really hard to shift, so, I guess…'cause I'm new, and, I guess, I don't… I kind of know my line manager, but not 100% yet…*
4, 115, 3299-3306	*yeah… yeah… and again, so, I've been to line management… (chuckling)… I've told them what I've done… everything's documented… and I can't let anyone else know… it would be breaching confidentiality now, so there's nothing I can do…*
4, 115, 3310-21	*(sigh)… it's just terrible… 'cause I would be mortified if she came up as having tried to kill herself, or been successful… it's just… it's just… it's ridiculous…'cause, by rights, if I was able to talk to her tutor months ago, I could… we… at least, I could have brought them… her to their attention… it really… I feel like my hands are handcuffed…*
4, 116, 3329-30	*it's horrible… ha… not being able to move, or do anything… it just feels infuriating…*
5, 59, 1688-94	*well, I think, what… what the difficulty is… as with any counsellor, is the… is the organisation versus the counselling room, and I think…*
5, 59-60, 1698-1704	*yes… well, I do feel that, because you're trying to maintain a person's privacy… confidentiality… but when you put them on the 'cause for concern', people want to know more… and Student Su…*
5, 60, 1708	*well, the Student Support Services…*
5, 60, 1712-13	*and it's like, 'no'… you just need to know that this person's at risk…*
5, 60, 1717	*and there's a real tug…*
5, 61, 1729-47	*well, because, you know, people are… ha ha… people are actually, erm, quite devious trying to get information out of you… and, erm… they just can't accept that that's the counsellor, and that's the relationship… it's really like, you know, erm, 'so… eh…' (blowing out air)… can't give you an example just now… but, erm, it would be something like… erm… 'so, how long, eh, erm… d'you think this is going to go on for, this situation?... and it's this like prising things out of you, which actually, you know, it's not going to happen… you know… 'well, I don't know… how long's a piece of string?'… and you have to keep going back with saying things like this to maintain the confidentiality, but also, you need the… your… org… organisation to know in case there is a problem… err… so…*

5, 62-63, 1765-1804 *well, there was… there was an example I can give was that I… I had to take it to my supervisor, 'cause my student was at risk, and from a home situation of… eh, basically, physical abuse at home… wa… wasn't affecting the university as such, but it could become an issue for the university… and I was told by my supervisor, 'you should really put them on the 'cause for concern', 'cause there's a major risk there'… and obviously, I was trying to get her linked in with 'Woman's Aid', and all the rest, but at that point of time, there was a risk that she could come in, and she needed accommodation from us… yeah… so they were saying, 'what kind of risk is she at?'… and, you know, I wasn't to say… I was just to say, 'well, she's at risk… but it's… it's… it's… you know'… erm… 'oh, does she self-harm?'… 'does she…?'… and… and… and it's like, 'no, I… I can't say, but she's at risk, and may need accommodation… you know, and that's why I've put her on'… so that was okay to say, but there's this like nagging, you know, 'we need to know more and more and more'… (chuckling)… 'why?'... and it's, 'you don't'… you know, if… if she came in, she would be black-and-blue, and you… you would see… (chuckling)… that she needed accommodation…*

5, 64-65, 1834-51 *yeah… and that… that's what… you know, that was an easy example to give, but it's a similar kind of thing with the, you know… the normal suicidal intention, or… the… the normal… you know, somebody has done something… and then, it's like, you know, 'well, what did they do?'… and it's like, 'it doesn't really add to this conversation'… 'the person's at risk, you… you know'… so I suppose there's that…*

5, 66, 1884 *you begin to feel quite devious… in…*

5, 66, 1888-89 *(chuckling)… yes, as I said, like, 'how can I get myself out of this one?', and… and… and… and be… you know…*

5, 66, 1893-96 *well, no, being more tactful, like… you… you… de… devious ways of not telling lies, but you have to emphasize the need the person may have, but also, erm, make sure that you're not being, erm, tricked into… it's like a tricking… ha ha ha…*

5, 66-67, 1901-11 *yes… yeah… yeah… and, you see, the mental health adviser feels that she's got a need to know exactly what it is, and it's like, 'no, you don't… you don't'… ha ha ha… ha ha… so… erm… I think…*

5, 67-68, 1925-40 *yeah… yeah… yeah… and that's… that's… that's… that's… that's exactly what I mean… and it's the deviousness of trying to work it all out… (chuckling)… 'cause I'm very direct… I find it very difficult and tiring… it's actually tiring to sit… having to sit thinking about it, 'cause I'm…*

5, 68, 1945-46 *I think… I think everybody in the counselling position here probably feels that…*

5, 68-69, 1955-89 *okay… so, there's… there's special people within the university that have actually been trained for this, and as part of the training, the person can, erm, explain to them what happened, and they have the choice, even if they name the person, to go further with it… however, due to the institution's actual, erm, pre… just recent experience… they've discovered that they got themselves into trouble with the me… information being withheld… so there's been a statement from the institution that, if somebody comes to us, and says that they have been a sexually assaulted, and they tell us a name, we have to tell the institution now… it's… we have no choice… it's not up to the student any more… and this goes very much against the grain of what people have been, you know, taught as sexual trainers, but also, from a counselling perspective, so that has been… erm… where the institution, erm, need versus ethical and, err,*

	respectful considerations… but that's a very open one about the sexual… it's… it's… it's very much alive that one just now, but this… this can happen at… with a suicidal thing…
5, 72-73, 2059-96	*it's an institution… it's to fulfil the institutional's need, because, at that point in time, the institution got sued for, and so, therefore, they reacted something… a new policy… and, so that it doesn't happen to them again, and we were told as counsellors… so… so, now, as a counsellor, to cover that person's, erm, privacy, the counsellors in the ser… agreed that if we get someone saying, 'listen, if you tell us the name, the institution insists we tell, so this is your decision if you tell us'… and we've had to put that as a contractual thing in now… so, therefore, as counsellors, we're not ethically breaking any confidentiality… and it's caused a bit of a problem, but we've all agreed to doing that now, because we feel that we have to put that in place…*
5, 74, 2113-23	*yeah… and I… I think we… we can't do any other way… you know, 'cause the institution are wanting us to… ha ha… erm… to get the name… you know, they're looking for us to get that name, but we're not doing that… it's up to the student whether… you know, I would feel very… as… as if we'd been… been deceitful if… 'oh, by the way, you've told us the name, so we'll just go and tell the institution now… that… that's what we have to do'… it… it has to be a… an agreement…*
5, 86, 2458-67	*erm… but… erm… I suppose… and, as part of the contract, you're… you're telling people what you're doing… you're being honest… you would discuss it… you would work it out with you… and nobody I have come across has ever not wanted the institution not to know, and that's been an interesting one, as well, for me, erm, because…*
5, 86-87, 2475-86	*yeah… they don't mind the Student Support Services knowing, and that they may get more further help through it… they… they absolutely don't mind… erm… which I've, you know, found… slightly surprising really, but there you go…*
5, 105, 3010-20	*yeah… yeah… well, that's where I said earlier that, erm, sharing it is good, because it… sometimes, you… you obviously can't share the problem…*

Subordinate Theme #3.2: "Everybody's head goes underneath the water": feeling isolated and unsupported in the process of managing risk

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Transcript Ref:	Quote:
2, 25, 695-97	*that, initially, as a counsellor, one can be quite omnipotent, and be reluctant to share the support…*
2, 25-26, 712-17	*I… I could have felt in the past… that it was my job to keep this student alive so that he could stay on at the university… and not to take into the count that he had pre-diagnosed mental health difficulties… he's felt suicidal long before he came to university… lots has got stirred up by coming to university…*
2, 28, 777-86	*yes… that I might be judged as not being able to manage it on my own…*

2, 28-29, 802-25	*I think, as a trainee counsellor, you can fear that you ought to be able to manage this on your own, and I think that… some of that is the countertransference from the student, who is feeling alone in his suicidal feelings, and feeling that he should manage alone… and then that can get, you know, transferred into me as the counsellor, feeling I should manage him on my own...*
2, 48, 1372-74	*it cuts both ways… having said that, because there is a high level, and we all have a caseload that includes suicidal students, one is also aware of not wanting to burden others too much…*
2, 50-51, 1436-37	*it's only fortnightly supervision, so it can feel… I might have three students who are feeling… err… in some sort of, erm, crisis mode…*
2, 51-52, 1449-67	*I think that is a common experience… as one becomes more experienced in counselling, you tend to have less supervision… you're felt to… to… there is only a limited amount of supervision, and it must be given more to the trainees, and those who are newer to counselling, which is good, but it does mean you manage with very limited help… it's inevitable… so, you could have a caseload of fifteen students, and twelve of them, you'd like to bring to supervision, but there's only time to bring one or two… so, those other ten…*
2, 62, 1769-79	*you know, there are students who say, 'no, please don't tell my parents', and that in itself stirs up a lot of anxiety, because it increases my burden… I've now got to manage without the parents… and it's…*
2, 67, 1902-18	*it's crucial… it's crucial… yes, because if I was holding it by myself… and say I had ten students I was holding by myself, I wouldn't last very long, I don't think, in… in the work, and I would quickly become depleted by it, and would begin to feel very deprived myself… and then I would not be in a position to help the student, because I'd be too preoccupied with my own feelings…*
2, 67, 1925	*I think I've come close to it…*
2, 83, 2367-84	*yes… yes… and… and then, the feeling of responsibility that I might be the only person that that student is… seeing, or talking to… feels quite onerous… and that's at the point I then need to engage more people to be with me again, to… so I don't feel…*
3, 28, 803-05	*well, for a student… or a member of staff… I see staff as well… erm… (chuckling)… the… any procedure or protocols that we've got, I… I have written…*
3, 29-30, 832-52	*erm… and I spoke to… as I said, my line manager was away… and I spoke to somebody else, and… erm… her attitude was, eh, very much, erm, 'do you think we could get him off campus, and get him away?'… erm… (chuckling)… like, we don't want somebody on campus who's suic… who's suicidal… umm… yeah… which was quite interesting…*
3, 31, 867-74	*erm… and, actually, what happened was, he took the doctor's advice, and he actually did leave, and he continued his studies, erm, at a distance… and the academic staff were actually extremely supportive of him doing that… I think that he hadn't been easy as a student in class…*
3, 31, 882-83	*but that was quite interesting… that was… it was like, 'let's get rid of this problem'…*

3, 31-32, 889-903 *I wasn't… erm… (pause)… what was that like for me?... err… (blowing out air)… it felt… well, she wanted the problem to go away… she wanted rid of the problem, which wasn't really supporting me… I didn't feel, in my role… and I suppose I felt there was a little bit of, she wanted rid of my problem… you know, not just the student… but, as she did of me, as well… erm… and I suppose… I suppose, if… if you're not a counsellor, you can't really understand what it's like…*

3, 32-33, 904-28 *erm… I… (blowing out air)… I think… the… the… yeah… I think, it's probably not unusual for… for colleges just to want the problem to go away… and, erm… we haven't… you… we do… the… the university has a 'fitness to study' policy… we're in an odd situation, because I was explaining about us being an academic partner, which pre-existed even being part of the university… so, we have our own policies and procedures, but we also have certain university ones… and, if we didn't have them in place before, we use the university ones… we didn't have a 'fitness to study' policy, so we use the university one… erm… there are certainly some people in this organisation, I think, if a… if a… if they knew that a student was suicidal, they might want to use the 'fitness to study', but then, they're unlikely to know, you see… ha ha…*

3, 33, 940-42 *I think there was a part of me wasn't terribly surprised… erm… I think there was a part of me was thinking, 'I don't even know why I got in touch, really'…*

3, 35, 976-1006 *erm… because I don't know if people do appreciate what my job involves… and, I think, for other members of staff, where they've… they've less confidentiality… d'you know, they… they can share a lot more, and they can discuss things as a team… erm… so, for example, if they felt that someone was too much of a risk in Student Residences, they could make the decision that the person couldn't stay in Student Residences, and then, it's very difficult to get accommodation out with the college here, because it's such a busy tourist area… that would almost necessarily… almost always mean the student was going to have to leave… we do have distance learning courses, so they… they could continue… but, I suppose, my… my role is different… I generally work very much on my own… erm… and I can't share information because I feel anxious…*

3, 36, 1023-24 *but… it was back… I felt it was back to me, because she wanted the problem to go away…*

3, 40, 1136-55 *it's quite hard… I mean, I think it's quite hard in general, actually, to be a lone counsellor… erm… and, when I'm hearing about other discussions… about residency, for example... it's only that I might hear about that… I might very well not hear about it… erm… and, I suppose, I am a bit of a loner, actually… erm… I mean, it wouldn't be for everyone… I work in an office on my own, and… well, obviously, as a counsellor… but, erm… I suppose there's a certain amount about being a counsellor that you are… you are used to… well, I certainly am used to… reflecting and considering things… thinking about risk… thinking about what I'm gonna take to supervision… considering what I can manage… when I want to talk to my line manager, which I don't… I don't do that often… and actually, when I do talk to him, it's almost always going to be anonymously, and… because he's not a counsellor… he's a kind of side… sounding board… and actually, he will almost always say, 'well, you… you'll know yourself', because he can't really say much more…*

3, 74-75, 2131-40 *and, I know… eh… 'cause I've discussed this at conference… that other… in other universities and colleges, I… well, my understanding is that counsellors have to share information at an earlier stage… erm… that the… that senior management kind of… eh… they make the rules about the policies and procedures… expect that…*

3, 75, 2145-47	*I mean, maybe I've… it's something I've misunderstood… but I have got the impression that people are maybe under more pressure than I am… to share…*
3, 76-77, 2180-98	*well, that… that's been my impression, but I don't know how accurate that is, to be honest… erm… but that has been my impression that there's a… there's more of a tension… erm… between maintaining confidentiality and sharing information…*
3, 78, 2219-25	*umm, hmm… yeah… but then, I suppose, as counsellors, that's what we sign-up to, isn't it?… you know, to maintain confidentiality… and then, it's that interpretation of somebody being 'at risk'…*
3, 78, 2230-38	*I reflect on it… (chuckling)… my own internal supervisor… take it to supervision…*
3, 79-80, 2255-92	*erm… but I didn't know that she wasn't going to go out to kill herself… and I sat… she was my last client in the morning… and I sat then, in the room… in the surgery, on my own… I tried to get hold of my supervisor, and I couldn't… and I thought, 'she is at risk'… 'far as I know, apart from her making an appointment, she's going to go and kill herself'… 'so, do I share information?'... she'd been referred by the GP… and I thought, 'I think I have to go and share that information with the GP', and I think… I think I have to do that now, and not wait until I see my supervisor, because then the GPs might have gone home… so, I went… the GP was sitting… it was lunchtime… she was sitting with her door open, and I said, 'can I have a word with you?'… and I… I told her, and she said, 'well…' said, 'there's nothing we can do about it'…'we don't offer a twenty'… I think this is what I told you before… we don't open a… offer a twenty-four hour, seven… a 24/7 service to people who might be going to kill themselves, so we'll wait and see… ha ha… well, what was the point of that?… so now, I've breached confidentiality… I've told someone else… shared that information… it's made absolutely no difference whatsoever… ha ha ha… erm… so, I think that was a bit of a steep learning curve… erm… and I suppose I quite often think of that when I think about holding… holding confidentiality… I'm thinking, 'well, what… what difference will it make if I share this information?'…*
3, 82, 2353-57	*and, erm… so, I spoke to my line manager about it, and he said, 'you know, we… we need… we need to do something about this, but what do we do?'… and, I'm actually thinking now, I don't know why we didn't just call the police… but anyway, we didn't…*
3, 84, 2395-2401	*and my line manager completely forgot that I'd been trying to get hold of her and trying to get hold of her, and nobody was answering the bloody phone, and eventually, I said to him, 'I got hold of her'… and he said, 'he'd forgotten that I was doing that'… (chuckling)… ha ha… so, there was me with all that anxiety for all those hours, and it was easily forgotten about by someone else…*
3, 86, 2465-73	*yeah… see, I'd never… I'd never worked… well, I do… I work with… well, I work for the university online service, but we don't discuss our clients, except in group supervision… erm… so, I've never really worked alongside other client… other counsellors… I've always been a lone counsellor…*
3, 88, 2526-35	*well, it's happened… it's not so much that I had a choice… and I'm okay with it… I don't know how I'd find it working in a team of counsellors, to be honest… erm…*
3, 89, 2556-61	*yeah… I suppose, though, what I do quite like is, I'm quite autonomous… I mean, I make a lot of my own decisions…*

3, 90, 2568-74	*but I suppose, ultimately, being a lone counsellor, I've also got a lot more autonomy, which I like… erm… so…*
3, 90, 2579-93	*exactly… so, I've got the anxiety, but I have also got the independence, and, at the end of the day, though, even if you work in a team, I imagine you've still got to make your own decisions… erm… so, maybe, if you're on… on your own, making them… I don't know, is that easier?… I don't know…*
3, 91, 2598-99	*like, you can't always get hold of your supervisor…*
4, 3, 77-84	*so, we have students who are suic… who have suicidal thoughts, but unless they are active, we can't actually break confidentiality… so we're really sitting with it ourselves in the session, week-to-week…*
4, 25, 711-15	*team… exactly… exactly… where it's not the case here…*
4, 111-12, 3208-11	*so, she was restricting her food… she was self-harming… she had suicidal thoughts… she was buying detergent… and there was… noth… no one was intervening… so I felt so helpless, and so isolated with her…*
4, 116, 3334-47	*yes, completely… and also, I think, because my experience in the past, before private practice, was always about teams… working in clinical teams… there was something about a team supporting a person… and I found that very reassuring… and, I think, the clients do too if they're supported by a team… and, I guess, there's teams, but we don't necessarily work together… ha… we do, but we don't…*
4, 117, 3355-65	*yes… it's really tricky, that… and especially with her… and I think this is a good example where something can go under the… just, seep away… we still haven't sorted it…*
5, 12-13, 340-58	*so, what she did was… she put us all through… all the counsellors… like, through a training… normalisation process… how we would normalise people… and, you know, not make a big song and dance about the fact that, you know, err, there's somebody gone missing… let's try and work our feelings, accept things, and erm… then there was support being offered on a regular basis of follow-up… so, when it… when something again happened of a similar nature… erm… instead of taking the lessons from that… though… that was one thing that wasn't done well by management… we still have not had a debrief of staff from these incidences to actually work out where we feel we could improve, or how we felt or reflecting… and, it doesn't matter how much I say about it, I… I never… I never get heard… so, that's a real issue for me… because the paperwork's been done… but the actual looking after the staff has not been done well…*
5, 21-22, 603-18	*she's gone away on maternity leave… and, this year, because we've had a seconded manager… and, it's been like chalk and cheese… absolute… because, the main difference is, is that she understands working in Student Support, and that has been a huge, huge, huge difference… erm… that, you know, she's had personal experience of that pressure on you in a different field of Student Support… but she's understood it… and, she's like, 'no, enough'… 'if you're saying that's enough, that's enough'… and what she's done is allowed that waiting-list to grow in the hope that the university will actually recognise we need more counsellors… but, erm, what's actually happened is that they've said, 'there's no funding currently, so get on with it'… so, erm…*

5, 27, 755-77	*I think it did... I think it did land… and I do believe that… I really do believe that, because, erm… it took a while, erm, for the Head of Support to actually speak to me, but, erm, then I felt it was… I've heard, as a consequence, that there's been a lot of… 'although'… un… quote unquote… erm… 'we don't see eye to eye, there's a lot of respect there'… and I've heard that through the grapevine… but, eh, it just felt… it… it feels like it's a battle we shouldn't have to do to care for one another… erm…*
5, 29, 817-27	*I think there wasn't sufficient support put in place for counselling… erm… the other thing where that actually kicks in, is I've been here for ten years, and eventually, erm, at… at the restructuring interview I had, erm, they had said to me, 'ah, and what kind of training programme would you like to be put on?'… 'what… what will it… what do you wish you would like to be?'… and I burst out laughing… and I was quite rude, really… but it came from my gut… said, 'what training do you offer?'… 'I have been here for ten years, and nobody has decide… offered me one ounce of training in all the time I've been here'…*
5, 30, 846-48	*so, that's where it comes back to your seesaw… that, you know, there's been really good things… err, but there's also the negative there as well…*
5, 75-76, 2148-63	*erm… (long pause)… (sigh)… I think what it probably does is make you think very much in terms of your own legalities, and where you stand… I contact my… my insurance company and BACP quite frequently… I make sure that I am in a legal standing, and I'm ethically still correct… some of these areas can be a bit grey… because, at the end of the day, they're ju… paying me… and the BACP are saying, 'now, they're your institution, and you have to... abide by the rules', but actually… erm…*
5, 76-77, 2188-2219	*yes… and… and… and I… I… I…I've… I've been grateful to the insurance companies…'cause, erm, although I'm with the BACP… don't know if this is part of my interview, but, erm… eh… although I'm with the BACP, I find it can be very woolly at times… erm… even to get the definition… we contacted them though (local region), and numerous people, erm, about the GDPR… and it was like, 'go to your comp… go to your, erm, insurance companies, and ask them about it'… and, 'we don't…' and, although Tim Bond and people have been very… erm… eh… eh… been, eh, very prominent in BACP… when you ask people, 'well, what's Tim Bond say?'… 'oh, no, he's not a legal man… so, he's kee… he's nothing to do with this'… and, you know, that's the feedback we've been getting… so, it's, erm… it's a bit difficult… sometimes you feel that, even though you're with a… a… a body… an ethical body… eh… you're also sometimes… I feel sometimes that… you know, it… it's only ethical, as… it's not clear sometimes what they're trying to say, you know… when you go with direct questions, they find it very difficult to answer…*
5, 78-79, 2223-51	*yeah… and… and that, funnily enough, was one of the ones with the suicide… because I didn't know… I was… I… I was… eh… eh… you know… felt a wee bit put out to dry, 'cause nobody could help me on it… but… but I didn't actually say, erm… I didn't know whether, when I was asked by the Procurator Fiscal, whether I should be handing in my notice or not… I didn't know… there had been mixed messages about it… and, erm, I contacted… erm… BACP, who weren't actually very useful about it… 'oh, we don't have any dealings with anything like that'… 'you'll have to go to your, err, legal department… you know… erm… in the institution'… well, our legal department is rubbish, because they… our… our university won't actually… erm… err… even pay for insurance for counsellors… erm, so, then, it was left again…'what do I do to make sure that I'm ethically correct?'…*

5, 80-81, 2304-20 *yeah… and your own… your own… the… the one thing I've learned about being working in an institution… is that there isn't a lot of support… they… they'll just say, 'oh, we don't know, 'cause you've got… you… you know, you need to do what your ethical framework body says', but, in one hand, I'd to do what my ethical framework, body does… and in the other…*

5, 81, 2324-27 *yeah… yeah… so therefore, you know… when it… when this murky word, 'suicide', does come into it, everybody's head goes underneath the water, and you're left there, wondering, 'what… what am I to do that's correct?'… and, which…?*

5, 81-82, 2331-41 *above the water… and they're all underneath it… swimming away merrily… and I'm… they're not wanting to know anything about it…'oh, you'll be able to do it'… 'you'll manage"… but actually…*

5, 82, 2345-47 *I… I think it's because people haven't got a framework that they understand… they don't understand the counselling framework… I think BACP are too worried in case we quote BACP at them…*

5, 82, 2356 *umm… erm… it's not a good time…*

5, 83, 2381 *nobody knows…*

8, 25, 697-718 *there was a Visiting Psychiatrist and a Mental Health Advisor there, as well as here… erm… but you… you just were used to phoning the GP, writing to the GP, doing risk management on your… on your own… I mean, you could go and talk to somebody, but it wasn't… (drawing in and letting out air)… (sucking gums)… manager wasn't really readi… readily available for that… erm… (sucking gums)… here, eh, the risk is managed at the top, so the manager, me, and then (name of Mental Health Advisor), who's the Well… who's the Mental Health Advisor… so, if somebo… if a counsellor sees somebody at risk, they should talk to… immediately, in a way… they should talk to me, or the manager, or (name of Mental Health Advisor), the Mental Health Advisor… (sucking gums)… so they're not… so, in a way, I feel, 'cause this is confidential… ha… I feel that they end up being deskilled, and in… a bit infantilized…*

8, 26, 722-29 *the counsellors… erm… and, almost like… I think, it's very problematic, for a number of reasons… almost like, they can think, 'well, this isn't my job… this is…this is the manager's job, or (name of Mental Health Advisor)'s job'…*

8, 26-27, 733-77 *yeah… there's a reluctance, and there's a deskilling, and it worries me, because… we're ad… we're currently advertising for a new Mental Health Advisor, so we'd have two, but our current one is term-time only, so in the summer, she's not here… my manager's off a lot… so then it's just me… I was on leave… when am I gonna take my leave?… who's… if I'm not here, who… who's gonna be the risk manager in the service… if my manager's not here?... (name of Mental Health Advisor) only works term-time… so, I'm… like, yesterday… I'm… I'm e-mailing them, saying, 'if anything crops up… not sure if my manager's working from home'… which I don't… she's… she's not well, so I don't know… 'erm… so, please ring me'… on… on my day, I'm saying, 'please… here's my number, please ring me if you need to discuss anything'…'cause I feel responsible… I feel like, 'well, who's…'*

8, 28-29, 791-834 *this is not… it's ridiculously set up… (chuckling)… so… I mean, we are advertising for a new Mental Health Advisor, that will be all year round, so that will be good… (sucking gums)… yesterday, there was our Visiting Psychiatrist… so I knew he was in… so that made me feel okay about being on leave… erm… but, yeah… so last Friday, one of my colleagues, a counsellor, had… he's not worked in*

HE very long… or just here actually… he worked in a private GP practice, and he hasn't had that much experience of managing risk… so, we have 'Open Door', which is like a drop-in… so this guy came and drop-in… so the counsellor came to see me… said, 'this… this student has plans to end his life'… erm, you know… so we talked it through, and I said, 'is he registered with the GP?', 'cause that's another… if the students aren't registered with the GPs, we're really, really stuck, because unless they're like… (sucking gums)… you know, immediately at risk, and we can call an ambulance, and send them to A&E, we're, you know… but if they've got a GP, that… so I said, 'try and talk to the client about getting his permission to contact the GP, contact the GP, make an urgent appointment'…(sucking gums)… erm… and then, the counsellor came back… 'no, eh, he won't… he won't let me'… so then I go in, talk to the client, and then eventually get his agreement to contact the GP, and, erm, get an urgent appointment for him… and then get another appointment with someone in the… his department… 'cause he's worried about his academic work… that… you see, that worries me… I think, 'well, he needs… that counsellor needs to be able to do that'…

8, 30, 838-46 *don't have the… (nodding)… yeah… because I think, 'well, if we're off, what's gonna happen?'…*

8, 30, 852-61 *well, yeah… I mean, the first time I came in, that's why I said, 'try and do it', 'cause I thought, 'you g… you go and do it'… you know, I wanted him to do… to try and do it… erm… but then he came back, and he was like, 'no'… and I kep… I… so I get the fe… I got the feeling that… it's like… almost a bit like… 'I'm not…'… so, it… it… you… you know, counsellor's reaction can be… a bit like, 'well, he just wouldn't… the… the client just wouldn't engage'…*

8, 30-31, 865-70 *yeah… that worries me… yeah… or, eh… or, 'well, where were you?'… if I'm not… if something like this happens, and…*

8, 31, 874-79 *me… and manager… yeah… and, eh… then… then it's… it's the service to blame…*

8, 31, 883-85 *and I'm kind of thinking, 'what I'd like is some more…'… we do have risk training… 'but, like, more risk training… and people to take responsibility'…*

8, 31-32, 889-919 *yeah, not… (clearing throat)… not be completely on their own with it, but like… be… fe… just feel more able to build that rapport, and y… you know… because what… you know, what happens if they… they are… in the sit… I mean, they can always go and talk to a colleague, obviously, but they can't… eh… so I think, here, they've been taught to have that… (sucking gums)… 'oh well, I need to go and hand it over, or talk to someone else about it… it's not really my thing to do'… some… I mean, not all couns… not all of them, but some of them…*

8, 33, 926-36 *yeah, worry for the counsellor, and how they… you know, they feel alone, or they feel not supported, and… but just the set-up… the… it worries… like, the set-up of the service, I think, needs to change, because… eh… eh… you know… they need to be able to… this is, ahh… this is a university counselling… they need to be able to manage it… they need to be able to… (drawing in and letting out air)… talk to…*

8, 33-34, 944-58 *it's every… it's every day… it can't just be with… it can't just be with… or if you're gonna have a service that's… the risk is managed by certain people, then you have to have cover… like, one or the other, right?… you know, like, one… ha… you can't…*

8, 34-35, 964-96 *the people on the ground should… yes… and I would like them to, or… you know… have more cover… you can't set up… this is a criticism of my manager, I suppose… you… eh… you know, to me, how can you set up a service where the responsibility for risk lies with the manager… (sucking gums)… err, a Psychiatrist that comes in one day a week, and a Mental Health Advisor that's term-time only, and like my post is quite new… the Senior Counsellor… so before I came, it was those three… well, (name of Mental Health Advisor)'s not here over the summer, and if the Manager's off, which she is a lot… well, what… and it's a Wednesday, not a Tuesday, when our Psychiatrist isn't in… what… I don't understand what… what s… people are supposed to do…*

8, 35-36, 1000-18 *yeah, and then I hear that from other couns… like, hear that from the counsellors… that they feel on their own… and then I think, 'well…'… so I am caught between the two… I'm kind of thinking, 'well, wouldn't it be good if you felt more confident, number one… and maybe there could be more… (intake of breath)… availability of other colleagues that are… (letting out air)… you know… are here to manage risk'… (sucking gums)… so, yeah… so, we are advertising for another Mental Health Advisor… yeah…*

8, 36-37, 1030-61 *it's weird, because I… I think, that… they just have… they have suicides… (sucking gums)… so it's not, eh… it's not like it's… (blowing out air)… I think… umm… I think there were more experienced counsellors, basically, over there… that were used to dealing with risk, and didn't have this system whereby they just handed it over, or… I mean, here, there's more support, because you have to go and talk to somebody… so, over there, it was a kind of… yeah, you can do, and… but it is isn't really… the door really wasn't open that often… but here, it's like, you have to… go and talk to someone, if you get a client at risk… you have to tell the manager, or me, or… you have to do that…*

8, 39, 1102-19 *erm… I just, err… I suppose, the main thing is to help them talk about it as much as possible, and… I think it's really important to ask… quite de… you know, detailed questions… like, what I've found… like, if I've been… like, supervising somebody, or helping someone… erm… you know, their experience of working with a client that's suicidal… I'll… I'll say, 'well, how many…?'… like, they'll say, 'ohh, that they took an overdose of Paracetamol last week'… and I'll say, 'well, how many Pira… Paracetamol did they take?', and they don't know… so, I think, from my risk training, I've picked up that you ask… you ask… it's important to ask… and don't be frightened to ask…*

8, 44-45, 1265-75 *yeah, you need to do a safety plan, and there's a form… erm… you need to talk… here, you need to talk to someone about it, like the manager, me, or b… or refer them to (name of Mental Health Advisor), if she's in…*

8, 54-55, 1554-69 *I suppose, to just to flag it up that we need to be… you know, I've come from a service that it's just hot… like, it's just rea… eh… risk is just… hot… like, you… you're aware and alert to it all the time, and I've come to a service where it's almost like it's been sectioned off to a couple of people in the team, and I can't even think…*

8, 57-59, 1641-79 *I don't mind if I'm here, so, like… 'cause I know that the counsellors will come and talk to me… erm… so, I don't mind that… I mind when I'm off on leave, and there's no one else in… but I've got to take my leave… we've got to take leave by the end of August… I'm gonna lose my leave… my Manager's approved the leave, so… b… bu… but she's not here, so what…?… oh… oh, also, I should say, I'm responsible for approving people's leave… so I'm responsible for looking at the calendar, and thinking, 'who's in?'… and I'm looking, and thinking, 'okay, there's quite a free week… they're quite new, these three counsellors… so… but (name of Psychiatrist)'s in, the Psychiatrist… okay… that's okay… and then tomorrow…'… and I'm responsible for… so then, that's an extra level… layer of*

responsibility on me… like, if there's just two relatively inexperienced counsellors in, then… and something hap… you know… it might become a bit of a nightmare…

8, 59, 1688-98 *I think… yeah, I think the counsellors… I trust the counsellors to be alert to it… I just then think, 'well, what they gonna do?… if they don't feel confident about managing it, what they gonna do?'…*

8, 60, 1711-28 *yeah… and, also, them feeling let down, I think… I think I worry about that… like there's some kind of… I've… I know… eh… it's not all my… but, somehow, I'd feel I failed… I'd not managed the staffing properly…*

8, 61, 1732-36 *by not manage the staffing probably… properly, that's what I mean…*

8, 61-62, 1746-81 *yeah, either that they're gonna feel confi… confident, or that they can ring me, or that there is somebody here that's… it… it's the set… it's the set-up of the service… there's three… you know, there's three people ba… well, there's… th… there's (name of Psychiatrist), but he only works one day a week, so if those three aren't here, then what do… what do they do?… and I think they would c… they… they would feel… they would complain about that if anything happened… they'd feel like, 'well, no one was here'… they say, you know, 'our manager says… no, a manager of the service says, we… we need to discuss risk… well, what do we do when then… when she's not here?'… so, there's a risk…*

8, 63, 1798-1808 *yeah…'how stupid that you're on leave at the same time'… but… you know, that kinda… but my manager is off a lot, and she's not well, so… (blowing out air)… is… you know…*

8, 63-64, 1812-33 *yeah… yeah… that's me, though, as well… I… I… I… you know, I would… I do feel responsible anyway, so I'm bringing my own… that's my personality anyway… so it's not to s… say…*

8, 95, 2716-18 *like, that, say, someone'll come and talk to me here, and say, 'we've done this, this, and this'…*

8, 116, 3311-38 *how I want things, yeah… well, it's changing now… because I think that it's… my manager has handed more over, I think… 'cause she's leav… I think she… she is gonna leave, so… but… so now, we're looking at those forms… eh… we've met with Legal, and, err, we're looking at the forms… I feel a bit lonely with it, because they've said… I met with Legal… and then they say, 'leave it'… instead of saying, 'oh yeah…'… I… I gave them the forms… I said, 'this is what I think needs changing', and then they will kind of say to me, 'okay, well, you… you create some new forms then'… and I kind of think, 'okay'… (chuckling)… I just…*

8, 117, 3343-59 *massively… massively… massively… yeah… yeah… (chuckling)…*

8, 120, 3434-54 *erm… I just try… it's a bit overwhelming… I don't… (intake of breath)… like I said, I don't mind the… in a way, dealing with the sui… dealing with that is… let me have a think about this… I think, sometimes, that can be quite straightforward… like, I've always got an idea about what to do… if someone… says, 'right, they've said this, this, this, and this'… there's usually a way… to… eh… erm… (sucking gums)… to not make it a loose end… there's usu… there's usually something… erm… I think the other part of the job's more lonely… like the… I'm… I've gotta rewrite these legal forms, and my manager's off… erm…*

8, 121-22, 3482-87	*yeah, it's more the pressure of like thinking, 'can I have a day off?', and who… you know, 'what's gonna happen here?'…*

Subordinate Theme #3.3: "That steadies me up": appreciative of empathetic managerial support when working with suicidal clients

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Transcript Ref:	Quote:
1, 6-7, 178-87	*since my immediate manager has got a much better manager, who was a counsellor, and, in fact, was my supervisor for many years… she came from (first higher education employer)… (senior manager's name)… I've been less anxious, because I have some sense that, even if my immediate manager is… doesn't get it… that (senior manager's name) actually does…*
1, 7-8, 211-26	*in (first higher education employer), it wasn't a feature at all… erm… and interestingly, I worked there as a sessional… as a placement counsellor, and as a sessional counsellor…and I saw at least two people there who… (pause)… had well worked-up plans… and were clearly at risk, and I never… never felt any of that anxiety… I felt the anxiety that I felt about… the client, and the safety of the client… (pause)… but nothing with the institution, because that was held very well at (first higher education employer)…*
1, 9, 248-53	*and then, we got a new permanent manager, who was much more containing… and, err, the Head of Student Services did actually come and talk to me… and she… 'cause she dealt with all the student deaths, which are quite a lot at (second higher education employer) one way and another… erm, and she was unusually containing…*
1, 11, 311-18	*whereas, as I say, since (senior manager's name)'s come… err, it feels like (senior manager's name) is much more able to hold… that's (manager's name)'s manager… hold the fact that people die, and no one's to blame…*
1, 11, 332-38	*yeah… yes, and actually, erm, the Head of Student Services at (second higher education employer) was really good… she just said, 'these things happen'… erm… (pause)… and, she kind of… she was very… (pause)… sensible about it…*
1, 48, 1470-77	*yeah… erm, and I would say, (senior manager's name), and (name of HoSS), who is the Head of Student Services… their implicit expectations are that we… work given the constraints on the resources we have… to meet the need… the need, and mitigate the risk…*
1, 49, 1493-99	*erm… and (manager's name), because she's the closest, is the loudest… but there's a sense that if… (pause)… if something actually happened… that the other voices would be the loudest…*
1, 50, 1517-43	*erm… well, I just… I just feel that (senior manager's name) and (name of HoSS) are the only grown-ups in the room… I think the COO and (manager's name) are both unreasonable… erm… which is why I asked about confidentiality before we started talking… but I think they're both unrealistic about what can be done actually… whereas I have some faith that (name of HoSS) and (senior manager's name) are quite grown-up in their expectations, and quite reasonable in their expectations… erm… and that's… that's the bit that feels quite steady institutionally for me…*

1, 51, 1553-61	*and there's a sense, I think, with both the COO and (manager's name) is that if blame was flying around, their first instinct would be to make sure it didn't land on them, whereas with (senior manager's name) and (name of HoSS), I don't have that sense at all… I have considerable respect for them…*
1, 52, 1578-91	*erm… but I do feel that there is… it's kind of… I could appeal to (senior manager's name) and (name of HoSS)… and that I'd get a fair hearing… so… so that steadies me up… just… while there are some people, it's not a completely…*
1, 52, 1596	*yeah… yeah… to be reasonable…*
1, 56, 1706-17	*erm… and I spoke to (name of HoMH), and said, would you mind… I can't be trying to referee between (manager's name)… a row between (manager's name) and the GP… would you mind just stepping in… he's on your books as well… and picking up the liaison with the GP, and dealing with that… you're a manager… you go, and… would you just manage these people?… ha ha ha… (laughter)… and, bless him, he said, 'yes… yes, of course I'll do that'… is there anything else you need?', and I said, 'no, I don't'… (laughter)…*
1, 56, 1721-24	*yes… (laughter)… and bless him, he did… and he was… he was very… he went and poured oil over everybody… (laughter)… and actually that just then created the space, and then (client's name) came back…*
1, 83, 2547-53	*so (name of HoSS) was the only one in, so he was covering… so, I thought, 'well, that's okay, because if there's a problem, and can go and talk to him, and he's sensible… erm, so there was quite a sense of relief…*
3, 6, 168-70	*erm, I… there isn't another counsellor here… I'm the only counsellor, and my line manager is not a counsellor, but I can talk to him anonymously…*
3, 28-29, 803-10	*well, for a student… or a member of staff… I see staff as well… erm… (chuckling)… the… any procedure or protocols that we've got, I… I have written, and that is in discussion with… particularly with my line manager…*
3, 32, 902-04	*erm… and I suppose… I suppose, if… if you're not a counsellor, you can't really understand what it's like… though, I think I've… I've trained my line manager as much as I can…*
3, 40-41, 1146-62	*I suppose there's a certain amount about being a counsellor that you are… you are used to… well, I certainly am used to… reflecting and considering things… thinking about risk… thinking about what I'm gonna take to supervision… considering what I can manage… when I want to talk to my line manager, which I don't… I don't do that often… and actually, when I do talk to him, it's almost always going to be anonymously, and… because he's not a counsellor… he's a kind of side… sounding board… and actually, he will almost always say, 'well, you… you'll know yourself'… because, he can't really say much more… so, usually, if I'm saying to him, erm, that I'm thinking… well, it would usually be… 'cause, I'm thinking if… I… I would suggest to a client that they contact their GP… if they don't do that… erm… and that… that's sharing responsibility, isn't it?...*
3, 82, 2353-55	*and, erm… so I spoke to my line manager about it, and he said, 'you know, we… we need… we need to do something about this, but what do we do?'…*

3, 84, 2395-98	*and my line manager completely forgot that I'd been trying to get hold of her, and trying to get hold of her, and nobody was answering the bloody phone, and eventually, I said to him, 'I got hold of her'…*
4, 3, 77-84	*so, we have students who are suic… who have suicidal thoughts, but unless they are active, we can't actually break confidentiality… so we're really sitting with it ourselves in the session, week-to-week, and, I guess, talking to our managers, but…*
4, 4, 90-104	*erm… I find it slightly easier than in private practice, because I felt that was really difficult… you know, I really carried it alone… whereas here, there is… there is levels of management, which is great… so I felt reassured that after… at the end of the day, I could got to say to my line manager, this is what's happening… she'd make sure everything's okay… that I've done all the things that I needed to… and, in a sense, although I still worried, I've felt I've done… I'm covered… I've done what I need to do…*
4, 10, 269-70	*well… well, that's what I was battling with… and, I think, I've been tryna figure that out with my line manager about, well…*
4, 22, 614-19	*so, I… I know clinically… like, I know, I've done my job… I've written the notes… I've flagged it… I spoke to my line manager… she knows…*
4, 44, 1252-59	*yeah… yeah, I understand… erm… so, I think, foremost, we have to… err… I mean, in terms of procedure, it's really about alerting our line managers… that's… that's the procedure… so I wouldn't ever do anything on my own… I would alert the manager…*
4, 46, 1316-24	*and I've seen him quite regularly… and he's alw… it's always there… there's always a… a… playing… and it is… it's really tricky, just to know… erm… so… well, putting in… in… things in place… so, for example, I might offer a second session… if that's viable… for them to come in… I would let my line manager know… err…*
4, 86, 2474-84	*again, I'll tell my line manager… and, actually, my line manager also checks things out with our Head of Service… so, they have, erm, line management meetings, I think, is it every…?… senior meeting… no, senior team… senior team meetings… every week… every day… or two or three times a week… and all of these things get discussed… so, they will discuss… anything that they need to at the moment… yeah… so it will kind of go that way…*
4, 90-91, 2599-2615	*(pause)… so, yeah… so, I guess, in… just going back to your question… it's always to the line manager… I think that's what we… we… we're kind of guided to… so never just act directly on something… always go to the line manager, have a discussion, and then the line manager will decide the next steps, so it's never my… my decision…*
4, 91, 2620-31	*yeah… I'm happy with it… yeah… I do… I'm happy… it's nice not to have to make all the decisions by myself… I like… and the… the managers here are amazing… and they've always been very supportive… and, err, always available when you need them… and I've found that it is good…*
4, 92, 2635-39	*it's like you need someone objective about it…*

4, 92-93, 2648-68 *yes… for sure… yeah… definitely… it's like a little mini case conference… and, err, I do feel after that, at least, you know, they know… I do… the responsibility feels shared… I don't feel like it's just on me… yeah… which is a big deal… (clearing throat)… it's a big deal… yeah… I do… and that's… so far, that's worked well… it's never had to go anywhere further than that at the moment, so… yeah…*

4, 93, 2673-88 *very… yeah… no, I do… I do feel real… it does… it feels… it feels… 'cause I… 'cause I feel like I can just… (sound and gesture, indicative of release)… I can just let it all out… talk about my concerns, my worries, everything… my line manager hears it, and then, is able to take from it what she needs and then, together, we can say, 'well, what do you think the next step is?'… and then, we decide… and then, if she's really worried about it, even more, she will then go to our… the Head of Service…*

4, 94, 2692-99 *and, erm, our Head of Service is great… I mean, if something needs acting on, she will… straight away, so… yeah… so, I feel that that works… I don't feel alone at all with the suicide… no… yeah…*

4, 115, 3299-3300 *yeah… yeah… and again, so I've been to line management… (chuckling)… I've told them what I've done…*

5, 21-22, 603-17 *she's gone away on maternity leave… and, this year, because we've had a seconded manager… and, it's been like chalk and cheese… absolute… because, the main difference is, is that she understands working in Student Support, and that has been a huge, huge, huge difference… erm… that, you know, she's had personal experience of that pressure on you in a different field of Student Support… but she's understood it… and, she's like, 'no, enough'… 'if you're saying that's enough, that's enough'… and what she's done is allowed that waiting-list to grow in the hope that the university will actually recognise we need more counsellors…*

5, 22, 618-30 *but, you know… again, what we have to do is rebalance as counsellors what we're doing, because we have a sense of dread of… the… eh, our… our, eh, immediate m… manager coming back from maternity leave… because, at least this year, we have had a little bit more space in-between… we have actually done the legalities of five sessions, with the odd helping out, whatever… but, the bottom-line is, is that our… our actual diaries have looked much more like a counselling diary…*

5, 23-24, 657-82 *yeah… yeah… she's gone and… and she's also gone and done some homework on it, as well… you know, she's gone and a… asked us for BACP stuff… she's asked, what might… what would you recommend us reading… what can I do to learn more about it… so, there's been an investigation more on the BPA… the BACP's guidelines… and she's tried adamantly to stick to it as well… so, you know…and again, because of that, it's been interesting, because the feedback that I've got from other counsellors… and we've discussed it… is that we've all become more creative… because we're not actually going banging on from one session to another session… what we've been able to do is take time out, and maybe, eh, we've agreed to meet, say, an hour on a Wednesday… an… and, we've had our coffee, but there's been a real creativity about what we think needs… 'well, how could we do our workshop?'… 'what could we do?'… and this year, we've done more, erm, external work, which we hope will help the, y… you know, the wider population of the university, because of that creativity space, rather than being bang, bang, bang, bang, bang with c… students…*

5, 26, 727-46 *yeah… yeah… but, what actually was a consequence of that… because it came from me, and I… and I have a high, high tolerance level, I think it did make them secretly shut the doors, because what they did was, in August, they came back, and when… you know, the original manager left for maternity leave… what they did was, they said, 'we must care'… 'we… we're going to look after our staff'… 'we're going to put in a tea… tea break'… and, I know it's only for an hour a week… a… a… a week… but, it makes a huge difference*

	to the counsellors to be able to sit over a cup of tea, and actually have a chat about anything they want, whether it be, err, a bit of fun, a bit about what you're doing, or, actually, work… it's… it's actually good…
5, 27, 755-68	*I think it did... I think it did land… and I do believe that… I really do believe that, because, erm… it took a while, erm, for the Head of Support to actually speak to me, but, erm, then I felt it was… I've heard, as a consequence, that there's been a lot of… 'although'… un… quote unquote… erm… 'we don't see eye to eye, there's a lot of respect there'… and I've heard that through the grapevine…*
5, 29-30, 818-42	*erm… the other thing where that actually kicks in, is I've been here for ten years, and eventually, erm, at… at the restructuring interview I had, erm, they had said to me, 'ah, and what kind of training programme would you like to be put on?'… 'what… what will it… what do you wish you would like to be?'… and I burst out laughing… and I was quite rude, really… but it came from my gut… said, 'what training do you offer?'… 'I have been here for ten years, and nobody has decide… offered me one ounce of training in all the time I've been here'… so, they then immediately put me on a course of my choice afterwards, and then, what's happened this year… has been, there has been, actually, quite a lot of training this year, and there's been a much more acknowledgement that the… counsellors do need further training… do need that resource from an emotional, psychological… erm… and, it's a well-being… I think it is a well-being… to be able to go, and go to these events, and hear what people are saying… grounding, and acknowledge what's going on… so, there has been a huge change…*
5, 31, 866-72	*umm hmm… umm… and I think, as I say, the only m… the massive change has been this new seconded manager, and it's made a huge difference… erm, a massive difference…*
5, 32, 896-900	*yeah… and I think, again, it comes down to experience, because, as I said earlier, the Student… the… the one we've currently got, she's had Student Support Serv… err… you know, experience… whereas the… our… the real manager, she's… she… she hasn't had any…*
5, 38, 1087-89	*so, erm… but, however, that assessment counsellor post, I think, is going to be maintained this year… so, a… we only do a couple assessments over a week…*
6, 89-90, 2565-78	*I guess, I'm never using the risk management protocols and procedures on my own… so, I'm always kind of talking it through with my supervisor, line manager… erm…*
6, 90, 2582-93	*there's a… yeah… there's a… yeah… erm… and that's helpful… and that's he… he… yeah, and I guess that's helpful from a, kind of, an organisational perspective, that I sort of think, 'well, I'm… you know, I'm… I'm doing the right thing by the organisation'…*

Subordinate Theme #3.4 "Being able to offload": appreciative of supervisory containment and reassurance in relation to suicidal clients

Transcript Ref:	Quote:
1, 17, 498-516	*erm… I suppose it makes me much more reliant on my supervision… I think I use my supervision a lot… to hold that tension… erm… because it's almost like I need another voice… to… and another conversation… a conversation which isn't… which puts the client back in the middle… back to that… back to the client being in the middle…*
1, 25, 743-53	*and my work with my supervisor feels real as well… (pause)… and that's… that… you know, I feel that in supervision, we hold the client in mind… erm… and the client is central…*
2, 10, 283-84	*in supervision, to make sure that I'm always processing it…*
2, 11-12, 305-20	*and as long as that is constantly processed and thought about… with colleagues… in supervision… perhaps if I was having personal therapy, which I'm not now, but if I was… but in my own, you know, the way I sort of talk to myself about my work… as long as that's constantly thought about, I think I can maintain a distance…*
2, 17, 475-80	*so, I can have those feelings… which I then need to process at the end of the session, or in supervision…*
2, 20-21, 548-73	*umm… umm… and, the other thing I was going to say is… my own experiences, of course, in my external life, which, actually, over the past year, have involved my partner having cancer… so although it's not terminal, I have come into touch with… life and death… and, you know, the reality of death in a very personal way… so, I had to, therefore, process that quite a lot in my supervision in order not to be too infected by… or affected, rather, by students…*
2, 25, 698-704	*it's so much more helpful for the student, but also for myself, to share the load… to be able to talk with colleagues… to talk in supervision…*
2, 49-50, 1394-1414	*yes… yeah… and my supervisor, in turn, will get supervision with their supervision… because otherwise, a lot gets put onto my supervisor… that two or three of us counsellors will be in supervision, talking about suicidal students, and that supervisor holds a lot… and therefore, she also has to make sure she can, you know, unburden herself of her anxieties about the students… so, supervision plays a crucial role… yeah… as… as I think I've said…*
2, 50, 1422-35	*well, in… in hearing from my supervisor and my peers, their thoughts about how I'm managing the student, and how they might have ideas that I haven't thought about… about how the student's feeling, and how I could… other things I could think about with the student… erm… in me being able to offload, and then leave supervision feeling, 'phew', you know, 'I'm… I'm… I'm doing okay'… or, 'oh, that's a good idea'… 'I could think about that next time with the student'… erm… so, it… I've shared the load… I feel relief… I've distanced myself again at a time when I might have been feeling a bit too immersed in the student's feelings… so, I've now maintained that boundary again between myself…*

2, 52-53, 1489-1504	*yes… yeah… and… and also, my supervisor will make herself available on the phone… and, so she also will contribute to that by saying, 'look, you know, if we haven't got time in supervision, do feel you can always contact me if you're worried about someone', so the supervisor also acts as a… a holding… in that… in that support…*
2, 53, 1509-20	*in theory it is, but in practice, it… a helpful supervisor will say, 'if you're worried, you can get in touch'… and it could just be ten minutes, but it's enough to just check in about one of the other students you're worried about… to make sure you're doing the right… the right things…*
3, 7, 184-87	*erm… but, I was working previously with a client, and she said that she was suicidal… erm… and when I asked her if she had a plan, she said, 'yes', but she didn't want to tell me about it… and it's interesting… I took that to supervision…*
3, 10, 261-63	*erm, but I do find it difficult… and I do find… and I… and I certainly take clients with suicidal ideation to supervision frequently…*
3, 12, 335-42	*sometimes, I reflect on my clients… that's usually at a time when I've decided that's what I'm going to do… I don't have too many intrusive thoughts… and, of course, supervision… and I would arrange additional supervision if I felt that I needed it…*
3, 21, 597-99	*but, I think, what I discussed in supervision was the fact that actually… (chuckling)… three was really quite enough… (chuckling)…*
3, 40, 1146-49	*I suppose there's a certain amount about being a counsellor that you are… you are used to… well, I certainly am used to… reflecting and considering things… thinking about risk… thinking about what I'm gonna take to supervision…*
3, 55, 1566-68	*erm, I remember taking it to supervision, and agreeing in supervision that I would contact her one more time after she'd gone…*
3, 55, 1579-80	*erm… and, in supervision, we decided that it would be okay to do that…*
3, 78, 2230-38	*I reflect on it… (chuckling)… my own internal supervisor… take it to supervision…*
3, 79, 2255-59	*erm… but I didn't know that she wasn't going to go out to kill herself… and I sat… she was my last client in the morning… and I sat then, in the room… in the surgery, on my own… I tried to get hold of my supervisor, and I couldn't…*
3, 89-90, 2561-68	*and when I'm saying, 'I'm writing'… 'I've written procedures and protocols'… I mean, I… I send things to my supervisor… I'll ask for copies, you know, from the College and University Jiscmail… I'll ask other people for their opinions about things…*
3, 90-91, 2587-99	*and, at the end of the day, though, even if you work in a team, I imagine you've still got to make your own decisions… erm… so, maybe, if you're on… on your own, making them… I don't know, is that easier?… I don't know… I'm not making it entirely on my own, 'cause it would always be in… like, you can't always get hold of your supervisor… but, as much as possible…*
4, 85, 2442-44	*erm… so, very similarly to what I said before… just about, erm… so… well, first of all, I talk about obviously all of this in supervision… erm… so that's my go-to-place to just be able to air stuff out…*

6, 3, 72-83	*I think the main issue for me is, erm, you… you know, when you talk about risk management, and organisational risk management, is that you're… you're dealing with your exp… or, I'm dealing with my experience of the client… but, also… and, my duty to the client… but, also, my duty to the organisation, and, erm… so, for example, I always in my supervision will prioritize any issues of risk… erm… and I tend to be quite conservative about that, and I tend…*
6, 4, 90-91	*so, erm… so, anyone who mentions suicide at all, I will tend to, sort of, bring that up in… in supervision…*
6, 7, 179-98	*yeah, I mean, I suppose… erm… in terms of risk management, I think… you know, for someone who mentions it… you know, 'I some… I sometimes think about it, but I have no plans, and I wouldn't want to do that to my family, as such'… someone who doesn't have an active, kind of, plan… or… or actually, really, a kind of… an entire desire to, erm… to harm themselves… then, I think I will discuss it in supervision, and, sort of… I… lay out my reasons why I don't think we need to write to their GP, for example…*
6, 8, 204-09	*for someone who is, erm… sort of actively overdosing a lot, or, erm… you know, has a serious history of self-harm… err… eh… (clearing throat)… it's… it's a matter of, sort of, looking into who they're in touch with already… who already knows?… are they talking to their GP?… erm… I will talk to the supervisor about it…*
6, 31-32, 878-912	*I mean, there is something, in some ways… God, I won't say 'comforting', 'cause that's quite macabre, but… of someone who sort of says, 'yeah, sure, I think about… I think about the possibility of having a break… of… of not having to go on like this, but also, I don't wanna… you know, I don't wanna hurt myself… I don't wanna do that to my family'… blah… erm… there's something reassuring about, sort of, saying to my supervisor, 'yes, they've… they've talked about suicide, but they've talked about it in this way, and that's why I'm not actively concerned', and having someone else say, 'that sounds about right, but keep checking in'… you know… erm… so, it allows me to, kind of, have said it… to have, sort of, taken it from my mind, put it, sort of, in the public domain, and… and move on with the rest of the work… so, in some senses, the… it's helpful…*
6, 38, 1072-76	*I'm lucky to work with some very, very experienced supervisors, who have worked in, sort of, personality disorder clinics, and things like this… and who have worked with people with some pretty severe presentations and complex presentations…*
6, 42, 1196-1203	*so, it's, if you have any concerns… about a client's, erm, suicidal ideation… and they have a… a, sort of, a… a list of things that constitute risk… so, sort of, prior attempts… suicide of family members… erm… self-harm, past or present… erm… then, y… you speak to your supervisor…*
6, 70-71, 2011-21	*yeah… well, and it's interesting actually, 'cause I… 'cause I… I pi… I picked him to talk about now… and actually, hardly spoke about him at all in supervision, now that I think about it… erm… you know, I mention… I mentioned, you know, risk…*
6, 86, 2462-81	*'you can't share it was anyone'… 'I've ju… no, I was just saying that… I didn't mean it'… and then… and so… I was stuck, sort of going… 'well, but… uh… uh… uh… uh… uh'… 'but technically, I mean… eh'…(sigh)… you don't want to split hairs… you know, you don't want into… to go into, sort of, technicalities on this, but you just sort of think, 'but you did… you did s… you did say, and I have the feeling that you're saying now this, because you don't want me to contact your GP'… and, you know, and you can talk about all of that, but at the end of the day, it… it kind of left me with this feeling of, 'so, what do I do?', and, you know, I talked it through with my*

	supervisor, and…(sniffing in air)… erm… eh… the feeling we had was that there was not an active risk, and I… I ag… I agree with that…
6, 89-90, 2565-78	*I guess, I'm never using the risk management protocols and procedures on my own… so, I'm always kind of talking it through with my supervisor, line manager… erm…*
6, 90, 2582-93	*there's a… yeah… there's a… yeah… erm… and that's helpful… and that's he… he… yeah, and I guess that's helpful from a, kind of, an organisational perspective, that I sort of think, 'well, I'm… you know, I'm… I'm doing the right thing by the organisation'…*
6, 105-06, 3013-42	*exactly… that… yeah… and it was, kind of like, referral… and if anyone was at all complex, refer, refer, refer, refer, refer… get them off your books…whereas… whereas, you… you know, I think what feels nice about having, erm, you know, a policy that we all are aware of, and is written down, and we revisit, and… an, eh, eh… and… and that is, sort of, enforced here, is that actually, having that containment, eh, contains the clinicians, and allows you to feel… eh… eh… a little bit freer, I suppose, to work with the clients… and I suppose, actually, this goes back to what I was saying about, sometimes, you know, with my supervisors, who are very experienced, sort of saying, 'well, you know, do you think that's really a risk?… well, let's see where else we can go with that', and… and maybe it's my anxiety held over from the NHS, that I think, 'eww, is that good enough?'… eh… and maybe actually what they're saying is, 'don't worry… we've got everyone's back, and you can just continue to, sort of, be a therapist'… so, I don't know…*

Subordinate Theme #3.5: "It's like a sort of basket, holding you": experiencing relief in sharing the burden of responsibility with others

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Transcript Ref:	Quote:
2, 23, 645-47	*making sure that I don't try to omnipotently be the only person who is able to look after the student, and keep them alive…*
2, 25-26, 695-722	*umm… well, I think that does actually come with experience… that, initially, as a counsellor, one can be quite omnipotent, and be reluctant to share the support… and it's a great relief, I think, to realise, one day, that actually, it's so important… it's so much more helpful for the student, but also for myself, to share the load… to be able to talk with colleagues… to talk in supervision… to, erm, receive other viewpoints on how this student might best be managed… erm… and to link in with NHS support… erm… to realise that there's a limit as a student counsellor to the… to how much one can support a student… or how much one even should be… that, you know, one… I… I could have felt in the past… that it was my job to keep this student alive so that he could stay on at the university… and not to take into the count that he had pre-diagnosed mental health difficulties… he's felt suicidal long before he came to university… lots has got stirred up by coming to university… but it's not my job, solely, to keep this student on the course, and alive… that actually, I'm one of many people who are here to support him…*
2, 28, 790-97	*and I think, with experience comes the feeling that, far from being judged, it's more mature and professional, and helpful for everybody, including the student, to share the experience… and to get help… you… you know, it's good to ask for help…*

2, 29-30, 825-32	*actually, the more people that are brought in to support… erm… the… obviously, the better… and… and helps the student to feel that he's held in lots of people's minds, not just mine…*
2, 30, 845-53	*yes… yes, it's like a sort of basket, holding you… there is actually a lot of help out there…*
2, 46, 1311-17	*erm… there's a… there's a… a good level of support given… you know, extra time will be made to check in with me, and to see how I'm feeling, and time given to talk about it with, erm, Head of Counselling…*
2, 47, 1333-46	*yes… absolutely… and that's really important, because that enables me to support the student… is feeling supported myself, and helped within the organisation… erm… not to feel on my own…*
2, 48-49, 1355-86	*absolutely… and… and… and also, I experience that they empathise… they also have worked clinically, or… erm… yes, clinically with… with students with similar feelings, so there is a… an understanding that this is a shared experience… they get it… they get it… and I also, in turn, am aware of what they may be experiencing… that, I also will be aware of wanting to offer them support… erm… it cuts both ways… having said that, because there is a high level, and we all have a caseload that includes suicidal students, one is also aware of not wanting to burden others too much. and one has to be aware of that, I think… that it is okay to burden… and that they will, in turn, can burden me… because, if I began to hold… withhold my concerns, because I felt that the others had too much on their minds, that again wouldn't help the student, or me to support them… so, we sort of have to share…*
2, 49-50, 1394-1413	*yes… yeah… and my supervisor, in turn, will get supervision with their supervision… because otherwise, a lot gets put onto my supervisor… that two or three of us counsellors will be in supervision, talking about suicidal students, and that supervisor holds a lot… and therefore, she also has to make sure she can, you know, unburden herself of her anxieties about the students…*
2, 65-66, 1859-83	*so, it all… it all adds up to… it lightens my feeling of burden… it helps me feel that I'm not alone, 'cause I'm sharing this, and just, it acts as another reminder that I'm not wholly responsible for this student's staying alive, that there are others who are helping me…*
2, 67, 1902-18	*it's crucial… it's crucial… yes, because if I was holding it by myself… and say I had ten students I was holding by myself, I wouldn't last very long, I don't think, in… in the work, and I would quickly become depleted by it, and would begin to feel very deprived myself… and then I would not be in a position to help the student, because I'd be too preoccupied with my own feelings…*
2, 67-68, 1925-38	*I think I've come close to it, but good clinical leads and supervisors, I think, have noticed it, and talked about it… and reminded me that I'm not on my own with this, and that if I were to share it more, there is help available…*
2, 68-69, 1942-64	*so, I think, as a trainee, perhaps that is how one becomes aware of the support more… by going to that place of feeling a bit deprived… erm… and a bit worrying at night, or on your own, about the safety of a student, and then, by talking about it, or it'll come up in a… in a light conversation, and someone will say, 'well, haven't you thought about taking it to supervision, or talking more about it with… in such and such a meeting', and then, that immediately feels a relief…*

2, 83, 2367-84	*yes… yes… and… and then, the feeling of responsibility that I might be the only person that that student is… seeing, or talking to… feels quite onerous… and that's at the point I then need to engage more people to be with me again, to… so I don't feel…*
2, 96, 2759-60	*I now know that I can bring other people in… you know, into the team to help…*
3, 82, 2338-39	*I do have a story where my line manager did encourage me to share information…*
3, 83, 2370-76	*anyway, there was actually a lot… there was encouragement, both from my line manager, and from the GP to breach confidentiality…*
3, 83, 2386-88	*erm… so, that was a lot… there was a lot of anxiety around that… erm, but it felt like there was a lot more, kind of, support…*
3, 85, 2422-42	*I did feel more supported, actually… I did… umm, hmm… yeah… yeah, I did feel more supported, definitely… it's not… when I say that, it's not that I don't feel supported… it's just that… I think it's the nature of my job…*
3, 85-86, 2448-60	*it was easier… it was better… I suppose I felt less alone… umm, hmm…*
4, 4, 90-91	*erm… I find it slightly easier than in private practice, because I felt that was really difficult… you know, I really carried it alone…*
4, 24-25, 675-702	*and it was great, because obviously, we were in a medical setting, and confidentiality was there in the sense of, err, we didn't discuss with the nurses and doctors the content of what we were saying in our one-to-ones… but, I could very well go back to the nurse after, and say, 'there are… there is a lot of suicidal ideation today, or even self-harm, thoughts, whatever'… you know, 'I just wanted you to hand that over, keep that in mind'… you can't do that here… you can't phone a tutor, and say, 'look, I just want you to be mindful that I saw so-and-so today… they are expressing suicidal thoughts, but I think we're just at a thought level'… so you can't do that… so, err, there's no… err… 'cause that would be breaching confidentiality… we're not allowed to do that… so, I guess, that's where I felt there's a safety net in a hospital…*
4, 94, 2703-15	*(sigh)… yes, in my private practice, but not here… not here…*
4, 116, 3334-42	*yes, completely… and also, I think, because my experience in the past, before private practice, was always about teams… working in clinical teams… there was something about a team supporting a person… and I found that very reassuring… and, I think, the clients do too if they're supported by a team…*
5, 4, 106-14	*yeah… so, a 'cause for concern' register is whereby… it's like… erm… only you counsellors, and the manager of the service, and the Head of Support, have got access… and, if they're… erm… we can monitor the care of what we think's happening with a suicidal patient… err, eh, eh, student… so, if, for instance, we feel that they need, erm, a mental health adviser, or if we feel… we have documented and logged that we have contacted these people… erm, so that there's a follow-up of high risk, eh, with these students…*

5, 11, 314-18	*err… it's interesting, because I feel that… erm… on one hand, it is really good, because there's more pro… more people out there to support you… there's more… as a counsellor… there's more support… there's a structure in place… we have done our level best to help that student…*
5, 85-86, 2445-54	*yeah… ah, ha… err, we meet as a group once a week… and because of that, if somebody is at risk, erm, there's, erm… there's a… by putting someone on that register, there's an acknowledgement that this person is at real risk… and therefore, it's… it… it's… it's weird in a sense… it takes away a bit of the burden, err, because you've shared it…*
5, 105, 3010-25	*yeah… yeah… well, that's where I said earlier that, erm, sharing it is good, because it… sometimes, you… you obviously can't share the problem, but sharing the knowledge that something… th… that you're carrying something…*
5, 106-07, 3046-62	*well, like, one of my fellow colleagues… un… unfortunately, this year, she must have had six students on her caseload which are very, very high risk, and in the knowledge that we have the 'cau… cause for concern', we were able to identify, and try and help ways to ensure that she got no more, and we were able to feel as if we could support her… 'look, you know… you know, (colleague's name), you've… you've… you've really got too much on there… you need to be self-cared… you need to look after yourself… and we need to work as a team to know how to help you…*
5, 107-08, 3083-93	*yeah… and I think that is what the new system offers… and that is like helping as like a self-care… not just for the student… but also for us, so that we were able to offer, you know, (colleague's name), the help that she required, you know…*
6, 10, 264-87	*I think it was… it was, sort of, fairly hopeless, in a way… and it… and, I guess, where the… where the organisational aspect of that came into it for me was thinking, 'well, at least… at least, I can check with all of these people', and say, 'is there anything else we can be doing?'… 'what are we doing?'… 'what are we doing?'… but, on some level, there's always the worry that that feels like what you're seeking is validation… like, 'well, we've done everything, right?'…'we've done everything, right?'… erm… 'what more can we do?'… so, it can almost feel, sort of, like a giving up… (beeping noise)… I don't know if that makes sense, but… it's on the one hand comforting to be able to… to… (pause)… to have sort of proof-readers, in a way… to have people you can go out to, and say, 'have I done ev… ev… ev…?'… you know, 'we got this covered?'… 'are we…?'… 'are we…?'…*
6, 28, 780-98	*yeah… yeah… and, I remember, you know, the… the… the… hmm… sort of language that used to go around IAPT, and fortunately, really, really, really doesn't in this service, but was, 'remember, if anything happens, the NHS does not have your back… you have to have good insurance, because they will throw you to the wolves'… (chuckling)… and I think that is, erm… you know, it's… it's… it's not a feeling that I get here at all… this is a really supportive service…*
6, 29, 828-31	*(sucking gums)… I guess it has, erm… (long pause)… err… the awareness of the, sort of, the… the… the vulnerability generally of, sort of… err… well, as I say, it doesn't feel half so vulnerable as IAPT did…*
6, 40, 1147	*I actually anticipate I would… I would have a lot less support…*

6, 89-90, 2565-78	*I guess, I'm never using the risk management protocols and procedures on my own… so, I'm always kind of talking it through with my supervisor, line manager… erm…*
6, 90, 2582-93	*there's a… yeah… there's a… yeah… erm… and that's helpful… and that's he… he… yeah, and I guess that's helpful from a, kind of, an organisational perspective, that I sort of think, 'well, I'm… you know, I'm… I'm doing the right thing by the organisation'…*
6, 94, 2689-2701	*what's that like?… yeah… I guess, it's t… I guess, it's tricky… and I guess it, eh… at the end of the day… so much of it is informed by, you know, what it feels like to be part of an institution… what your feelings are about institutions and organisations and groups… erm… and the nature of the institution… I guess, I feel like this is a really supportive service compared to other places I've been…*
6, 102-04, 2937-81	*yes… yes… and also… and also, that I think, erm… I think, all avenues should be exhausted before anyone gets just, sort of, left to it… ha ha… I think… erm… yeah… so… so, I suppo… I… you know, I'm… I'm very grateful for… risk protocols and procedures… I'm… I'm grateful for the clarity with which they're spelled out here… and this is a very safety-conscious service… you know, it's… it's rea… they're… they're very, very serious about lone worker policies… they're very serious about, you know, sort of, safety alarms and things like this, and that actually feels… very containing in lots of ways for… for the… for the clients… you know, for… for me with my clients, as well as, sort of, for us… erm, in a way that I think… I think risk management protocols felt v… very different in the NHS… and felt very defensive, and very, erm… they weren't spelled out very clearly…and it was always very… ver… you know, made very clear that if… if anything went wrong, you, individually, would… (chuckling)… be held responsible, so I… so I… eh… I think it does feel more shared here, and I… I suppose I think that… that is ultimately, in some ways, for our benefit, as well… yeah…*
6, 105-06, 3013-42	*exactly… that… yeah… and it was, kind of like, referral… and if anyone was at all complex, refer, refer, refer, refer, refer… get them off your books…whereas… whereas, you… you know, I think what feels nice about having, erm, you know, a policy that we all are aware of, and is written down, and we revisit, and… an, eh, eh… and… and that is, sort of, enforced here, is that actually, having that containment, eh, contains the clinicians, and allows you to feel… eh… eh… a little bit freer, I suppose, to work with the clients… and I suppose, actually, this goes back to what I was saying about, sometimes, you know, with my supervisors, who are very experienced, sort of saying, 'well, you know, do you think that's really a risk?… well, let's see where else we can go with that', and… and maybe it's my anxiety held over from the NHS, that I think, 'eww, is that good enough?'… eh… and maybe actually what they're saying is, 'don't worry… we've got everyone's back, and you can just continue to, sort of, be a therapist'… so, I don't know…*
6, 107, 3070	*exactly… it's the organisational culture around it…*

Subordinate Theme #3.6: "Being affected, but not infected": engaging in self-protective boundary-setting in the interests of self-care

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Transcript Ref:	Quote:
2, 10-11, 283-95	*I need to constantly check in on myself… that… to… in supervision, to make sure that I'm always processing it… and to keep my work-life balance, you know, as balanced as possible… make sure that I am keeping things like Pilates, or choir, or whatever brings me joy, into my life, to balance the fact that I am being confronted with death on a daily basis…*

2, 11-12, 304-20	*well, I don't… I think that part of my training is to allow a distance between myself and the client's issues… and as long as that is constantly processed and thought about… with colleagues… in supervision… perhaps if I was having personal therapy, which I'm not now, but if I was… but in my own, you know, the way I sort of talk to myself about my work… as long as that's constantly thought about, I think I can maintain a distance…*
2, 12, 329-43	*and so, I think… one of the ways I deal with it is to think, you know, how long will I do this work for?… perhaps put a boundary around it… perhaps think that in six… seven years' time, I might think about… re… retiring… or work… moving away from student work, because of the high level of suicide… you know, I might not… but it's my way of putting a boundary around it, and… and constantly monitoring the effect it's having on me…*
2, 13-14, 370-83	*yes… yes… yes… and that possibly helps me to keep myself safe in a way that I am helping students to keep themselves safe who feel suicidal…*
2, 14, 392-96	*and then, I have to think, actually, I must also keep myself safe… my own sanity… my own health…*
2, 16-17, 457-68	*it feels… (pause)… well, there's always a knowledge that it's not me… so, knowing that, which I think is part of the training, to be able to separate myself from that… is, of course, always a relief… you know, that in the end, it's… the student feeling suicidal, not me…*
2, 17, 480-81	*erm… you know, there's a part of me that will be resisting being brought into that feeling myself…*
2, 18, 488-95	*but I can also then, at the end of the session, begin to… separate myself from them… and that, of course, is what maintains my ability to be able to… work then with another student, or with that same student next week…*
2, 18, 500-09	*yes… being affected, but not infected, is the phrase that, you know, I'm sure you've heard, which is… is so important…*
2, 20-21, 548-73	*umm… umm… and, the other thing I was going to say is… my own experiences, of course, in my external life, which, actually, over the past year, have involved my partner having cancer… so although it's not terminal, I have come into touch with… life and death… and, you know, the reality of death in a very personal way… so, I had to, therefore, process that quite a lot in my supervision in order not to be too infected by… or affected, rather, by students…*
2, 21-22, 581-607	*it actually hasn't… I think, if my partner had felt suicidal, that it might have done… I have had one or two people in my family who have felt suicidal, which has allowed me to empathize with the feeling… it hasn't over the last year… what it has affected is… is students who've come to counselling because of a relation having cancer, but not suicidal students actually… interestingly, I've been able to put it aside… but, what it… the way it has affected me is that when you come into… into contact on a personal level as a counsellor with… death… erm… your own feelings of hopefulness can be affected… erm… you can feel slightly flatter about life in general… for a period of time… so, I think it's very important to… to be able as the counsellor to process those thoughts… to se… separate them from the work that you're doing, and most of the time, actually, I can…*

2, 22-23, 613-31	*I think, I've had to be aware that I need to address that… because it could have impacted on my work… it hasn't as it happens… but, I had to be aware of my own feelings of hopelessness that are related to my external life… that could have come into my ability to… work with the… student's… the part of the student that is engaged with life…*
2, 38, 1085-86	*erm… so, although I can switch off, and I do switch off between sessions…*
2, 40, 1119-28	*it's reminding me, actually, of… if I were not doing this work, or if I were to leave the university, some great weight would be shifted from me… so, I think I do carry a weight around all the time… I think we all do…*
2, 42, 1200-05	*I understand that it's part of the work, and I am… you know, because of the training, and because of my own personal therapy in the past, I am able to still keep it separate from me… so I can allow myself to think about it, and to… do the relevant e-mail, which brings me into touch with it, but I can then, 'okay, I'll put it down again now', and I walk away from it…*
2, 43, 1209-32	*I'm aware that the student can't do that, and that's sad… so that makes me feel sad… but it's also reality… I'm not the student's parent… I'm not responsible wholly for that student, and I… my responsibility is to make sure that student is kept safe… that's where it ends… and… and keeping that boundary around me… and… and that's how I maintain my ability to… to be a good parent to the student… if I were to fall apart, and to become depressed and anxious and sad to a level where I couldn't function, I then wouldn't be of any help to him… so I have to maintain my separation…*
2, 44, 1242-57	*yes… yeah… so, back to the affected, but not infected… yeah… the minute one… one detects infection in oneself, I think is the time to question whether I need to stop this work, or have a break, and… and address that… I… I mustn't… you know, that would be unprofessional and unethical to do it if I were getting too infected myself… too depressed by it…*
2, 44-45, 1261-69	*step away, and yes… and… and, erm, have therapy, or… erm, think hard about the ability to do the job…*
2, 50, 1430-35	*I've distanced myself again at a time when I might have been feeling a bit too immersed in the student's feelings, so, I've now maintained that boundary again between myself…*
2, 56, 1594-96	*you know, if I were to hear that he had committed suicide, I think I would find that really difficult… I still wouldn't feel responsible for it…*
2, 62, 1754-69	*absolutely, and the link with the student's parents… I mean, obviously, at the student's… with the student's consent… that the organisation will act as a link between the student and the parent… and acknowledge the university's… the boundary around the university's responsibility… that the… that it's also the parental responsibility… or, even though the student's over eighteen, that there will be… (pause)… there… there is the parental… umm… link if the student wants it, and if the parents want it…*
2, 62-63, 1779-91	*and it's… it's nice to be able to say, 'here's your child', 'you deal with it'… in… in so many ways… not in such a sort of cold term, but, you know, 'let's bring you in, and let's think together about this student, and whether the best support is at home, with the local services, or whether it's here'… but at least bring the stu… parent in… erm…*

2, 63, 1795-1804	*yeah, absolutely… absolutely… and it's what the parent normally wants to be informed of…*
2, 66, 1878-83	*it acts as another reminder that I'm not wholly responsible for this student's staying alive, that there are others who are helping me…*
2, 68-69, 1953-65	*and then, by talking about it, or it'll come up in a… in a light conversation, and someone will say, 'well, haven't you thought about taking it to supervision, or talking more about it with… in such and such a meeting', and then, that immediately feels a relief, and brings back the professional distance… yeah…*
2, 71, 2035-37	*yes, it's helpful… every time you think these things, you're processing a bit more, and working through what… what is going on between us in the room, and, err…*
2, 94-95, 2689-2710	*yeah, there's always anxiety… that's the other thing, at the end of university counselling work, it's going to come to an end… they've then got to leave the university… another transitional time, when those feelings are going to get stirred up again, and really, I have to manage that feeling of… 'I'm now handing over'… 'this is where my management ends'… and, you know, I can refer them to external or low-cost counselling… and will always do that if that's what they'd like, but that's where it ends…*
2, 96, 2748-62	*I think, every time you work with someone, you become more aware of your ability to manage, and therefore, not to be stirred up in the same way… to… to acknowledge that there is a limit… and I know now, I've got lots of tools that I can draw on to work with this student, and to try to help them… I now know that I can bring other people in… you know, into the team to help… all that helps me to feel less traumatised by it, and therefore, more able to be a calm, thinking mind with them… to be there…*
2, 98-99, 2807-21	*it's, err… it's always helpful to think about, and so every time it's thought about, I learn a little bit more about how I work with it… and, err… yes, remind myself of the complexities of it…*
2, 99, 2835-45	*erm, but… but because it's all about managing… risk and death, which inevitably stirs up a lot of anxiety in myself and the student, that ability to remain able to think is what it's all about… only then can I… can I help them…*
3, 11, 289-315	*well, I think, in some ways, it's very worrying, and, in other ways, erm… there's nothing really I can do about it… because the… I… I suppose, one of the things I really like about a counsellor… and I don't… I don't see clients more than once a week… it's always once a week… because, I work here one day a week… erm… and, one of the things which I really like are… are the boundaries, and there isn't any… there might be an occasional e-mail to check a… err, a client occasionally gets in touch to check the time… but, generally, there's no contact at all… previously, in this college, I was also Head of Student Services, and counsellor… so I had two roles… and that, actually, was much more difficult… because, I knew students with different hats on… so, I suppose, one of the things that I like about it is the fact, that's the deal, and my clients know that… that I'm not going to get in touch with them… so, I may be feeling anxious, but… I… I wait until next week, and see what happens, unless… unless I hear anything in-between…*
3, 29, 830-32	*so, I picked up the phone when he was there, and made an appointment, and I also made an appointment for him to come and meet with me again…*

3, 52-53, 1491-1523 *erm… I've got quite a clear way of communicating… if somebody doesn't come to their appointment… and it's… it's taken a long time to come to this… but what I do is, if they haven't arrived within fifteen minutes, I e-mail… 'cause e-mail is our… is our way of contact… it's our mode of communication… so, I will e-mail, and I will say something like, 'I'm just wondering if you're going to make our appointment'… erm… and then, if they don't appear… and quite often, that does prompt somebody to say… to come along… erm… and, if they don't appear, then when… the session… and I will say, I'm here until the end of the session, whatever it is… erm… and then, I will e-mail, and I'll say, 'I'm just acknowledging that you've missed your appointment'… erm… and, 'we can meet at the same time next week'… erm… and, 'it'd be helpful if you could confirm that you'll come', and then, when they miss the second one… then I e-mail, and I say, 'you've missed your appointments, and I haven't heard from you'… 'I'm assuming you don't want to continue with counselling, but, if you do want to make another appointment, please get in touch'… and, I think that's pretty standard… erm… so, we did that…*

3, 56, 1605-08 *and then, I offered her an appointment, and she didn't come… so, then, I e-mail her, and I say, erm, 'we had an appointment'… erm… 'd'you want an appointment at the same time next week?'...*

3, 57, 1624-30 *I had said to her… erm… that it would be really helpful if she could either attend her sessions, or let me know that she can't… because, actually, I got… apart from anything else, I actually got very busy… and I was actually seeing people, erm, up until seven o'clock at night in order to fit them in… not that I was doing more than five… but because I've got (name of university) meetings and… and other things…*

3, 60, 1709-21 *absolutely… absolutely… yeah… and, of course… (blowing out air in indignation)… we do… we do contract… so, the contract is that you come every week, and if you're not able to come, you let me know… so, there is that part… erm… you know, it is actually… we have contracted to do that…*

3, 65, 1851-53 *you know, in counselling, it's… it's… (bangs table)… it's an arranged appointment, once a week… you don't have contact with your clients in-between time… well, I don't… erm…*

3, 72, 2056-65 *erm… I wonder, actually, if there's also the fact that she really needs sometimes to miss appointments without… erm… telling me, because it does kind of… it… it reconfirms, doesn't it, about the relationship… eh… what I mean by that is, I say, 'I'll be here next week at the same time'… and then, I say, 'it's up to you'… 'the ball's in your court'…*

3, 73-74, 2078-2107 *well, that's what I'm wondering… that it is really clear… you know, this is what we contracted for… and this is what (counsellor's name) does… this is what she said she would do, and this is what she does… I mean, I think that's one of the things that counselling really offers is that clarity… I mean, the boundaries… I… I think… I… I remember (previous supervisor's name), my previous supervisor, describing them as being like a bouncy castle, 'cause they're rigid, but they're also flexible… ha ha… and, I think that's true… but, I think, that that's one of the things which counselling really offers, is the fact that this is what we offer… erm… and, so she doesn't make an appoint… she doesn't manage to come to an appointment, so I acknowledge that… I don't ignore it, and I also say, you can come next week at the same time… and then, if you don't come next week at the same time, I'll be in touch after about fifteen minutes to remind you… and then, if you're not in touch, it's up to you… come back if you want… I'm not, at this point, offering you another appointment, but you're welcome to come back…*

3, 79, 2248-52	*and… and I had to end a session, when she was still… 'cause I knew that I had another client, you know, in ten minutes… it was incredibly difficult to keep the time boundary… but, you know, I… I said to her that her time was up… erm… and, you know, she… she pulled herself together, and stopped crying…*
5, 25, 701-15	*yeah… and, the… returning back to the original question about management, we have, erm… 'achieving success'… erm… where you write what you have succeeded… and, that year, I wrote, 'I have succeeded not being ill'… and, 'I have managed to still pre… maintain a high level of service, but it's been at the cost of my personal life'… 'cause I was going to bed at seven o'clock… I was really having to… really, really debrief myself… really look after myself…*
5, 82-83, 2356-76	*umm… erm… it's not a good time… and I think what I've found is that it's been really good, and dare I say, going back to self-care… you have to be absolutely rigid in times like these about self-care… erm… and really do what you need to do… and, you know, my supervisor's great… erm… but, also, erm… I… I think, grounding yourself, and having, eh, that… erm… normal situation… normal grounding… having to do the dishes… having to go shopping… all that normal stuff helps to ground you in situations like this… to give you, dare I say, mindlessness, so that you can actually go back and think about it and reflect…*

Superordinate Theme #4: "Noisy, but unhelpful": grappling with the institutional expectations and anxieties occasioned by client suicidality

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Subordinate Theme #4.1: "The third chair in the room": organisational expectations and anxieties as intruding into the clinical work

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Transcript Ref:	Quote:
1, 5, 128-40	*erm, the questions that, particularly my manager, who comes from a very different background, might be asking about why I'm seeing someone for the length of time I am… erm… so, it… so, it… it feels like the institution is in the third chair in the room sometimes, and that… can be quite hard to shut that off… erm, and it… feels like an additional pressure…*
1, 6, 161-73	*and I've worked in different institutions… and I've experienced that third chair… sometimes it's out in the corridor, and the door's shut, and it's just me and the client… erm, and other times, it's kind of parked in the doorway… ha ha… (laughter)… and other times, it's kind of… as… as close as… in the room as… I allow it…*
1, 7, 200	*yes, that it is… sometimes feels intrusive…*
1, 8, 230-37	*erm… at (second higher education employer)… when the client who I assessed went on to commit suicide, we had a temporary manager who, erm… went into my… I wasn't… it happened on a day I wasn't working… went into my filing cabinet… and took and copied my notes…*

1, 12, 358-63	*erm… and that came from the Vice-Chancellor's Office… because it had caught his eye, and he… I think he was worried about reputational damage…*
1, 17, 520-21	*I think the institution can kind of push the client… push you… (hand gesture indicating being pushed)…*
1, 22-23, 667-81	*yes… erm, as an individual, kind of, really, and I think… I think, working with suicide, it… you always do hold stuff… 'cause it's an individual relationship, isn't it… but there's that sense felt of holding the institution's stuff as well…*
1, 25, 754-70	*it just … just feels… depends on the quality of your manager… quality of your manager's manager… whether the Vice-Chancellor sees something in the newspaper… erm… (pause)… whether the person you see happens to be, erm, the PA to the Head of HR… erm… erm, you know, it just all… it just all seems… I don't know… noisy…*
1, 29, 876-81	*so, for instance… the GP will phone… say they're concerned about somebody…*
1, 29-30, 886-96	*and the GP will come, and… and then, it will be a kind of a fuss, because the GP's being unreasonable, and they're panicking that we're not doing the job… the job of the NHS, and… you know, they should be providing this person with CBT and IAPT, and dadidadidadidadida… so, a very noisy, defensive reaction, and actually… GP's worried… and they're right to be worried…*
1, 30-31, 901-927	*and I… I do understand it's resources… I know that our GP… because we've got a GP on campus… that they know that they've got a long wait for the IAPT service… and that they believe that the students are paying £9,000 plus a year, and they shouldn't have to wait twelve weeks for counselling if they are in need, and I know…. my boss, and there is some justification for this as well, says, 'well, we are not the NHS'… that's… you know, they have that… access to that budget… they have access to IAPT… so, it's like a boundary dispute…*
1, 32, 957-58	*yeah… so then my boss'll troddle down, and say, '(counsellor's name), they mustn't get dependent on you'…*
1, 32-33, 985-97	*oh yeah… yeah, keep it short… keep it short… keep it short… keep it neat…*
1, 47, 1440-46	*I think (manager's name)'s very clear thing is about throughput… she came from an EAP… it's about throughput… it's about seeing people for the shortest length of time we can…*
1, 48, 1462-66	*yeah… and it's about… avoiding dependence, because that takes longer…*
1, 48-49, 1481-85	*erm, and I think the Head of Operations… who is Chief Operating Officer… COO he's called, (name of COO)… his fairly explicit expectation is that (current higher education employer) isn't in the papers… as having had somebody die while they were on the waiting-list…*
1, 49, 1493-94	*erm… and (manager's name), because she's the closest, is the loudest…*

1, 54-55, 1666-70 *and they'd had the police… and he was known to other people, and the mental health team here, and so on… they had the police out, erm, several times looking for him, and they found him on the bridge over the M1, wondering whether to jump off, so… so there was a lot of concern…*

1, 55, 1676-82 *so, Dr (doctor's name) from the medical practice had phoned… because she was worried about him… and he'd told her that he was coming to counselling, and was on the waiting list… and she'd said that he needed to be seen immediately… so (manager's name) was very cross about that, and saying that she was just panicking, and it was none of her business, and how dare she tell us what… who to see, and dadidadida…*

1, 55-56, 1688-99 *erm, and then he said he'd come back again the next week, which he did… erm, but, there was a bit of a row, because, of course, because he had been silent, I hadn't been able to write any assessment notes, because he hadn't been able to speak… erm… so (manager's name) was cross about that, and saying, 'well, we can't do anything with him if he's not going to be prepared to talk and engage, and dadidadida'… and he had given me permission to liaise, so… and the GP was phoning again…*

1, 56, 1724-26 *and it turned out he'd… the police of the… the time that they'd found him on the bridge… the… the last time… the last event… it had happened three or four times…*

1, 63, 1917-22 *yeah… yeah… so, I'd get a phone call… (name of HoSS) once popped in, and he said, 'would you just let me know… 'cause you… you see (client's name)'… he said, (client's name)'s surname… he said, 'every Monday at nine, don't you?'… I said, 'yes'… he said, 'would you just let me know if he doesn't turn up, 'cause there's some anxiety about where he might be'…*

1, 63, 1931-33 *erm… I like (name of HoSS), and I think he's very competent, but I just thought, 'he's squeezed', because this has gone up to the Chief Operating Officer, 'cause (client's name) said that it had…*

1, 63, 1934-35 *and also, the GP had been on the phone to (name of HoSS), 'cause she'd escalated her anxieties…*

1, 66, 2014-16 *yes… what I find more difficult is actually… at one point (manager's name) came, and said, 'I notice you've seen him for a long time'…*

1, 67, 2048-54 *yeah… oh, it was like (manager's name) came trundling down, and said, 'you know, you're working with him rather a long time'… and I said, 'well, he is suicidal'… and she said, 'well, is this the right place for him?'…*

1, 67-68, 2062-68 *and she said, 'well, just because there isn't an easy place for him, we don't want him to get dependent'… the big 'dependent' word again… and I found that more unsettling…*

1, 68, 2082-83 *but that made me more unsettled… because I think… 'cause, I thought, there's a fantasy that… that I can leave, and he'll be fine… there's a fan… there's some fantasy that I can do something that I can't do…*

1, 69, 2100-14 *and I found that more unsettling… erm… because then I started to think, 'well, maybe there is something'… 'maybe it is dependence'… 'no, but it is ridiculous'… it's kind of… I'm any port in a storm… this is a ridiculous way of thinking… but it rocked me at the time…*

1, 72, 2197-2214 *well… well, to start with, I was a bit floored… and I did kind of examine my conscience, and think, 'well, maybe he is getting dependent?', and, 'is that a bad thing?', and, 'is that… is that going to cause, umm…?', and so, it did wobble me, and then I thought, hang on a minute…this is about me having seen him for fifteen sessions… erm… this isn't about me and him… this is about (manager's name)'s issue…*

1, 89, 2732-39 *I think it's just really having the chance to focus on just what the institution… what bits of the institution… (pause)… erm, intrude… and what... what I can tolerate reasonably well, and what really… makes me cross…*

8, 70, 1997-2003 *yeah… and… and just dealing with… (pause)… like, we had a meeting… me and my Manager had a meeting with the… the people from the Media Office at (current higher education employer) a few weeks ago, and… oh, God… they just… they didn't… they didn't listen… they don't under… like, I suppose, tryna… deal with people that don't understand… that… like, they think we can just phone anybody… they don't un… understand…*

8, 70-71, 2007-25 *yeah, and… eh… they don't understand why… I mean, they're saying things like, 'why don't you give the CORE form to people in Residential Life?'… who's the accommodation… sort of, pastoral care people… like, 'why would we give th… the client's CORE form to someone in Resi…?' (whispered)… thing… questions like that, that you just think, 'what?… like…'… I don't know… just strange questions, that… (sigh)… (chuckling)…*

8, 71-72, 2030-51 *but I don't see… it wouldn't really be useful to say… like… on… in certain… like, in this latest inquest, the Coroner really focused on the CORE form… (chuckling)… things like… the C… and we're… we're try… I'm trying to explain to the people from the Press Office… the CORE form is just a form… it's not like… you don't put it in some magic computer, and something comes out, and then… some… it's just a for… it's just a for… it's a basis of a conversation that you have with the client… it's not a risk management… service… the CORE… I don't know… it's just really strange tryna explain that… it's not an exact science…*

8, 73-74, 2089-2115 *yeah, and also, who… who's our… so, the Director here… the Director of Student Services is getting really fed up with the Press Office, becau… and she actually said the other day… we were in a team… we were in a meeting with Legal… our Legal Department… sh… she said, 'it's… it's one thing having pressure from external… like the papers… but another, having pressure from within your own institution'… which is what we're getting from the media office… it's kind of like bizarre… we're all working for the same organisation, and yet we're getting… it feels hostile from the media office here…*

8, 74, 2120-29 *yeah, the reputation, and like, how 'bout work with us?… you know what I mean?... like… (chuckling)… we're on the same side… we know… (intake of breath)…*

8, 75, 2148-59 *well, it just feels like… (sucking gums)… eh… like it's all a bit of a loose cannon… eh… especially here… I mean, it wasn't like this at (former higher education employer)… like, a bit like everyone's just going off… (chuckling)… shooting from the hip…*

Subordinate Theme #4.2: "Sound and fury, signifying nothing": impatience with inauthentic organisational noise as distracting from client needs

Transcript Ref:	Quote:
1, 6, 155-61	*because it's hard enough to hold the client without having to hold… erm… a lack of understanding by my immediate manager… erm… and that's… that is… difficult… it is difficult…*
1, 10, 281-84	*yeah, who was, you know… who was… who was responsible?… were we responsible?... were we… had we been at fault, I suppose... and that just seemed to me to be an extraordinary response…*
1, 13, 371-85	*yeah… and actually, I think the bit that I experience is that the client gets lost… it's like, this was a person… and… somehow, they are lost in the institutional response… that's very much how it felt…*
1, 13-14, 393-403	*it's seen… yes, it's not seen as a… the… the kind of tragedy it is, really… that it's just seen as something that's a prob… a problem for the institution…*
1, 21, 619-34	*erm… and the institution talks about supporting students, so… but… and mind, there is no money… erm… and last week, we were told to… err, that there won't be any more resources, so we need to come up with solutions… and that makes me angry, I think, because… don't make this about me, and about the team… it's kind of… there isn't a solution… it's denying that it's complicated, and…*
1, 23-24, 695-712	*sometimes, that feels like the easiest bit… because the client is the client… they just come, and you're kind of… doing the best together with what you both bring, and that feels… (pause)… (sigh)… well, it can feel connected… it can feel not connected… it depends on how the client is… but it feels authentic and real, and the rest feels like noise and stupidity… it just feels stupid… (raucous laughter)… whereas, actually, the work with a client never… never feels stupid… (laughter)… but the institution frequently feels stupid…*
1, 24, 716-27	*erm… and so, in a way, even if the work is really difficult, and I feel very anxious and very worried about the client… erm… (pause)… it feels authentic, I suppose… it feels real… whereas, I think, quite a lot of the institutional dynamics feel a bit concocted, or a bit… (pause)… a bit about other stuff…*
1, 25, 744-71	*and my work with my supervisor feels real as well…(pause)… and that's… that… you know, I feel that in supervision, we hold the client in mind… erm… and the client is central… but… but the institution, it doesn't… it just… just feels… depends on the quality of your manager… quality of your manager's manager… whether the Vice-Chancellor sees something in the newspaper… erm… (pause)… whether the person you see happens to be, erm, the PA to the Head of HR… erm… erm, you know, it just all… it just all seems… I don't know… noisy… noisy, but unhelpful, and not… often very real…*
1, 26-27, 784-802	*(pause)… I think, erm… I feel impatient with it… (pause)… because I've worked in higher education… pretty much, on and off, all of my life… my working life… and I worked in a managerial capacity before I was a counsellor… and… isn't there a poem?... isn't there… noise… noise and something… signifying nothing… it just feels, erm… (pause)… so, I… I suppose… I work quite hard just to screen*

	it out… (pause)… 'cause I'm aware of just being impatient, feeling impatient about it… I think… probably, if I have to settle on a word, it's 'impatient'…
1, 27, 814-29	*and I'm aware, you know, that… I'm not working in private practice… there's a lot of stuff that's good about working at a university… I'm aware of all of that, but the… I do find the noise a big downside… yeah… and lack of understanding, I suppose…*
1, 28, 842-47	*well, it just makes a difficult job more difficult, I suppose… I think that's the… that's the unhelpfulness…*
1, 28-29, 852-68	*erm… (long pause)… it takes away the focus… again, it's a… a kind of… (pause)… that sense of, instead of it being, 'what does this human being need… from all of us, as an institution, and as a community to be as safe as they can be… and to recover from this distress or despair?'… erm… (pause)… it feels like that's not kind of the centre of it… as far as the institution's concerned…*
1, 30, 896-97	*and could we not just all put the client in the middle, and say, 'what can we all do to help this person?'…*
1, 31, 935-44	*unhelpful… just unhelpful really… because it's not about where the client sits… it's about what the client needs…*
1, 32, 967-79	*but it's not my most central thought in my head is, 'don't let them become dependent on me, because we're a short-term service, and… if they really are going to get dependent, they should go to the NHS, because they've got the set-up'… you know, it's like, it's just not… that's not the way I am thinking when I'm with the client…*
1, 49, 1493-94	*erm… and (manager's name), because she's the closest, is the loudest…*
1, 50, 1517-28	*erm… well, I just… I just feel that (senior manager's name) and (name of HoSS) are the only grown-ups in the room… I think the COO and (manager's name) are both unreasonable… erm… which is why I asked about confidentiality before we started talking… but I think they're both unrealistic about what can be done, actually…*
1, 62, 1903-09	*umm… I think, from time to time, I was aware… of quite a lot of noise, because he did have a couple of episodes… and his pattern would've be to disappear…*
1, 63-64, 1939-51	*and I thought… so there's a noise… there's… there's anxiety rattling around, and now it's come tumbling down to me… erm, and I'm supposed to hold it, really…*
1, 67, 2048-62	*yeah… oh, it was like (manager's name) came trundling down, and said, 'you know, you're working with him rather a long time'… and I said, 'well, he is suicidal'… and she said, 'well, is this the right place for him?'… and I said, 'well, he's not engaged with the mental health team... he's supposed to see (name of mental health team member), and he doesn't go and see her… erm, and… he's actively suicidal, and he does engage with me, so it does seem like there isn't another easy place for him to go'…*

1, 68, 2068-78	*but, fortunately, when there was a fuss right at the beginning, I'd sent an e-mail, and said, 'I'll either see him, but it might be all year… or I will be not prepared to see him at all… because of how he is, it's unethical to kind of do it half-way'… and she'd said, 'yes, that's fine'… so I said, 'well, this feels like it's different now from the e-mail, and bases of…'... so, I was able to kind of head it off…*
1, 71, 2163-76	*yeah… and that somehow that was being called into question in a therapeutic way… when actually, it was a management issue… but it was masquerading as a therapeutic… that I'm encouraging dependence…*
1, 71, 2185	*yeah… and that, actually, that was about a management…*
1, 72, 2214-18	*and then, I thought, hang on a minute… this is about me having seen him for fifteen sessions… erm… this isn't about me and him… this is about (manager's name)'s issue…and then I just got really cross… ha ha… (laughter)… 'piss off'… (laughter)…*
5, 13, 362-69	*and also, obviously, what happened the second time it happened, we had to get another new manager in place, who had never had anything to do with Student Support… she was managerial hat… not even from a Student Support Service… and, when it landed on our doorstep, she didn't want to take anything… any advice… any prev… previous experiences from any of the counsellors… she went off, and did whatever she did… and, it was really not beneficial…*
5, 21, 598-600	*and, I said, 'd'you know what I've had in my morning?'… and she said, 'oh yes, we've all had our problems'…*
5, 22, 618-22	*but, you know… again, what we have to do is rebalance as counsellors what we're doing, because we have a sense of dread of… the… eh, our… our, eh, immediate m… manager coming back from maternity leave…*
5, 25, 701-22	*yeah… and, the… returning back to the original question about management, we have, erm… 'achieving success'… erm… where you write what you have succeeded… and, that year, I wrote, 'I have succeeded not being ill'… and, 'I have managed to still pre… maintain a high level of service, but it's been at the cost of my personal life'… 'cause I was going to bed at seven o'clock… I was really having to… really, really debrief myself… really look after myself… and, erm… I got pulled up to Head of Student Support, saying, 'rewrite that'… that… you… 'we… we cannot accept that'… erm… that this is actually, you know, 'very negative'… and I'm saying, 'well, no, that's how I feel'… 'this is what I've been through this year'… and, 'well, you… you… you have to write that'… and, I was basically at threat of losing my job… because, the… what she said was, 'if you have that negativity, we'll have to relook at your contract'… and I…*
5, 31, 866-86	*umm hmm… umm… and I think, as I say, the only m… the massive change has been this new seconded manager, and it's made a huge difference… erm, a massive difference… and we are very concerned about when th… this previous one comes back, because… you know, the funding may stop for us… the fu… the… you know, we're trying to put things in place before she comes, so therefore, it's actually… feels a safe department… because one of the counsellors and myself were there in the… in her time… and… we… you know, neither of us could go back to that system… umm…*
5, 32, 896-913	*yeah… and I think, again, it comes down to experience, because, as I said earlier, the Student… the… the one we've currently got, she's had Student Support Serv… err… you know, experience… whereas the… our… the real manager, she's… she… she hasn't had*

any… so her perception is not, erm, of having worked with the students, so it… it's just paperwork exercise, or th… theoretical exercise… it's not a practical exercise, having worked with a student…

Subordinate Theme #4.3: "Thrown under the wheels of the car": fearful of being blamed in the event of client suicide

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Transcript Ref:	Quote:
1, 4, 117-24	*but it does mean that it comes down much more to your judgement in a way… there's nowhere to hide… erm, and you're balancing… the risk… that… that you think the individual is at against the knowledge of the length of the waiting-list…*
1, 5, 145-46	*erm… (pause)… I think it feels… it makes me anxious… makes me anxious…*
1, 8, 230-37	*erm… at (second higher education employer)… when the client who I assessed went on to commit suicide, we had a temporary manager who, erm… went into my… I wasn't… it happened on a day I wasn't working… went into my filing cabinet… and took and copied my notes…*
1, 9, 270-73	*also, it was like, 'is that your first thought?'… this man has died, and your first thought is, 'let me look at the notes… to check that we're not going to get into trouble', you know…*
1, 10, 281-84	*yeah, who was, you know… who was… who was responsible?… were we responsible?... were we… had we been at fault, I suppose... and that just seemed to me to be an extraordinary response…*
1, 10-11, 297-311	*I think there's a huge institutional fear… and I think my current manager feels that… erm, that there might be blame… and the blame will be flying around… and, as long as none attaches to her, it doesn't really matter where else it is…*
1, 11-12, 339-63	*sometimes, it feels like I don't know how real it is… how… how real the threat is… it seems like a lot of anxiety that somehow someone will point the finger… and there have been a couple of incidents in the papers… and, certainly, there was, I think, a Chinese lad, who threw himself off the… one of car parks in (name of town)… he wasn't a… err… a client of ours… he hadn't used our service, but… there was… it got into the papers… and there was a huge… flurry… of, kind of, 'did he access the service?', 'what you know… did he have to wait?'… dadidadida… erm… and that came from the Vice-Chancellor's Office… because it had caught his eye, and he… I think he was worried about reputational damage…*
1, 48-49, 1481-85	*erm, and I think the Head of Operations… who is Chief Operating Officer… COO he's called, (name of COO)… his fairly explicit expectation is that (current higher education employer) isn't in the papers… as having had somebody die while they were on the waiting-list…*
1, 51, 1553-55	*yes… erm… and there's a sense, I think, with both the COO and (manager's name) is that if blame was flying around, their first instinct would be to make sure it didn't land on them…*

1, 51-52, 1574-87	*yeah, that you could be thrown under the wheels of the car… erm… but I do feel that there is… it's kind of… I could appeal to (senior manager's name) and (name of HoSS), and that I'd get a fair hearing, so… so that steadies me up…*
8, 6, 147-59	*yeah… yeah… oh yeah, there would be blame… self-blame, and blame from…*
8, 6, 163-72	*well, specially at (former higher education employer)… erm… there was just a very… eh… (blowing out air)… you di… you… you… you got blamed if… if, erm, something happened to your client while you were seeing them… so, erm, like an overdose, or… if somebody was successful in ending their life… you… you know, you were attacked for that… it's less so here… ess…*
8, 7, 177-87	*(nodding)… yeah… and that… and that's one of the… reasons… sort of… umm… umm… like, living in fear of it, because of that… I'm not sure how I'd… cope with that attack… that blame…*
8, 7, 192	*within…*
8, 7, 196	*the manager of the service…*
8, 9-10, 243-69	*yeah… and I'd miss somebody, or I'd… like, I suppose my fear would be… someone doesn't turn up for an appointment… I need to contact them… I don't contact them, because if you've got space, then s… you just get asked to do something else… several other things would take over… and then it's… you know, you… you're… you're tired… it's the end of ter… and you'd think… and you didn't contact that person, and then they'd do… they'd do something to hurt themselves, or… and then you'll be blamed for not contacting them… that kind of… that's my… that was my fear mainly…*
8, 11-12, 315-37	*yeah… and that you… 'well, why didn't you contact them after they missed the session?'…'you knew they were… you had some risk… why didn't you do that?'… and it's kind of like… 'I know… I need to do that… it's…'… this hasn't actually happened… it's just a con… it was just a constant fear, and other people have been criticized for that… you know, 'why didn't you contact her… you know, after the… she missed the session, and…?'…*
8, 14-15, 389-417	*like, there was… there was, erm, a client over there who I saw… eh… eh… the previous year, and, erm, it was still when we had paper notes… (sucking gums)… and he had quite significant mental health problems… and I'd done an assessment… and I'd… he was being picked up by the NHS… (sucking gums)… erm… and so we kind of… like, he was going to be treated on the NHS… we kind of left it… but obviously, he cou… he could come back to the service if he wanted to… then fast-forward about a year, or some… or I can't even remember what… but it was quite a significant amount of time… I saw his name in the diary, booked-in as an initial assessment with another counsellor… so I b… got… I found the notes, and I gave it to… gave them to her… and I said, 'oh, this guy is coming in… I've seen him'… you know, like… 'cause, I remem… he had a very distinctive name, and I remembered he had quite a significant mental health problem… so I gave her the notes… he didn't come to that initial assessment appointment with her, and she didn't contact him, and he killed himself shortly after… erm… and that was criticized that she didn't contact him… things that… eh… you know, so there's…*

8, 20-21, 558-82	*(intake of breath)… (sucking gums)… erm… (blowing out air)… (pause)… I just… I think… (blowing out air)… (intake of breath)… (sucking gums)… it's a complicated question… I think… ha… I was just thinking of a recent… so, we've had a recent, erm, inquest here… from a student that killed herself about two or three years ago, so beyon… so, before my time… we've had two inquests recently here… (sucking gums)… that were before my time here, but I've been affected by it, because of the impact on me… so, our Well-Being… our Mental Health Advisor was in… was questioned in Coroner's Court… and she… I saw her when she came back to the service, and she was white and upset… erm… I… I've just spoke to my… the Director of Student Services earlier, and that… eh… eh… and the report of that, eh… of this inquest has… the final Coroner's re… report has come out, and even though we're not blamed… (sucking gums)… she said that the Coroner criticized (name of Mental Health Advisor), the Mental Health Advisor's perform… whatever… in court… so, she wasn't… pr… she wasn't professional… for… in a nutshell… I suppose, is her… the… the… the criticism… and then, I… 'cause, erm… in this position… I suppose, in the position of responsibility, to some extent, of managing the service… so then, that gets to me… I think, we need to be… you know, we need to protect people that are in that position… we need to help them be able to represent, I suppose, themselves and the service better… erm… and just the professionalism of the service it…*
8, 21, 582-93	*so, I mean, that's just one… I supp… and then, the one before that was more messy… and I didn't know the cou… the counsellor involved… she's left… but we… we were… you… you know, the… the service was very… blamed, and… it was just a mess… I don't like mess… (chuckling)…*
8, 24, 683-89	*(pause)… even though you get more… you get more blame over there, or wherever we are to over there… (sucking gums)… erm… I felt safer…*
8, 46-47, 1318-53	*because the GP has statutory responsibility, so… and it's our… so it's our limit of confidentiality… it's the go-to person… and it could be like the Mental Health Liaison Team if you can get… it's harder to get the client to go to A&E than to get them to go to their own GP, 'cause they've been… they've probably been before… and it's a… it's a more… it's a lower-key thing for them to do… but if you've passed on concerns, then the GP could engage the… you know, Mental Health Home Treatment themselves, or… they could do a medication review… you know, they… there's lots of things… but it's joined-up… and that's what's been highlighted in… some of the Coroner's… err… some of the inquests here… is that, wh… why haven't you linked more in with the G…?… and I think (former higher education employer)'s better at doing that than here… why haven't you linked with th… in with the GP more?… why dun't the GP know about this, and…?…*
8, 60, 1711-28	*yeah… and, also, them feeling let down, I think… I think I worry about that… like there's some kind of… I've… I know… eh… it's not all my… but, somehow, I'd feel I failed… I'd not managed the staffing properly…*
8, 61, 1732-39	*by not manage the staffing probably… properly, that's what I mean… even though it's not me that agreed that the Mental Health Advisor was term-time only, and it's not me that agreed my leave… d'you see what I mean?… eh… so, rationally, I recognize it isn't my responsibility, but I feel like it is…*
8, 63-64, 1812-33	*yeah… yeah… that's me, though, as well… I… I… I… you know, I would… I do feel responsible anyway, so I'm bringing my own… that's my personality anyway… so it's not to s… say…*

8, 76-77, 2183-95 *yeah… you're right… yeah… yeah… yeah… and attacked from manager over there… yeah…*

8, 77, 2200-09 *oh yeah, you'd get attacked by the manager over there… yeah… yeah… yeah… if you had anything… yeah…*

8, 78, 2236-44 *I don't… I don't think I would m… manage the attack very well… that's what I was saying, sort of, at the beginning… I think that I… I'm not sure I would be able to… if… if a client killed themselves, and they were on my caseload… (sucking gums)… I… eh… eh… and I was attacked… I… I don't know how I would have managed that… I'm not sure I'd have been able to go to work…*

8, 79, 2258-62 *the attacks I experienced were of others who… whose clients had killed themselves…*

8, 80, 2279-84 *yeah, 'cause I'd feel to blame anyway… I don't need somebody telling me I'm to blame… I just… I would just feel awful…*

8, 113, 3226-34 *erm… I mean, the… even though I didn't know the students… I didn't know the counsellor that was involved in… the second to last inquest that (current higher education employer) have been involved in… that is really… those things have really affected me… I just feel quite… I think I feel a bit ashamed… err…*

8, 113-14, 3238-73 *the service, somehow… like, I feel… I… I feel respons… I feel responsible, even though… even though, I was not… yeah… like, I'm in a… a bit… well, I'm in a bit of a tricky situation, because, erm… so, I'm my manager's deputy… and I have some responsibilities… like, I manage the counsellors… but on some things, there's a block… so, for example, in my first week, I noticed some things… like, some of the information that's given to clients about data protection was out-of-date… and I said, 'oh, d'you know this is out-of-date?'… that was February 2017, and it's still… we… I mean… eh… I… it's… it's like… it's tricky, as in… what am I allowed to say?… 'we're not giving that information out anymore'… but I'm not the manager of the service… but I think… it's har… it's hard… but I think, 'why?'… but it's appalling that we're giving out… we're lying… this information is out-of-date… we're still handing it to clients… 'what are we doing?'… and the answer is, 'oh, it's with Legal… the Legal are looking at it'… and I'm thinking, 'we need to stop giving that information out'… so this… so I've been in a tricky position from the start here, I feel… yeah… ha… 'cause…*

8, 115, 3285-3307 *yeah, I think… I think, because, often… say, like… in… within the institution as well… so someone's tryna get hold of my manager… my manager doesn't answer… my manager's off… they've learned to get hold of me, so they'll e-mail me, and I think, 'well, okay… that's fine… but… eh… eh… I've got lim… I suppose, eh… I end up feeling responsible, but without the control… it's that stress equation, isn't it?… if you feel res… got responsibility without the control, it's stressful… so I end up feeling… I end up doing a sigh… you know, like, kind of… 'yeah, so…'… (chuckling)… you know… 'yeah, I know… I know about that situation, and I've discussed it with my manager, and…'… (delivered in a tone suggesting despondency)… it's kind of… it's like that, sort of… so I fee… I sort of represent the Service, but I can't change…*

8, 116, 3311-17 *how I want things, yeah… well, it's changing now… because I think that it's… my manager has handed more over, I think… 'cause she's leav… I think she… she is gonna leave, so…*

8, 118-19, 3386-3418 *I… I mean, I… there was another case where… I had been working with somebody… I'd really tried hard for the client to go and see the G… I'd put it… I… I really put all the detail in the notes, and that's another pressure… (sucking gums)… because the… (sucking*

	gums)… you know… we were taught in (former higher education employer), the best… you know, if you've do… done really detailed notes about risk, then that's the safest thing to do, but what kind of time have you got to do that, right?… (chuckling)… well… it's just like… anyway… (sucking gums)… and this c… client had taken a very serious overdose, and she was in a c… she was in In… err, you know, what's that unit called?… High Intensity Unit at, eh… do I mean that?… you know, like Intensive Care… and I felt awf… I felt, eh… I thought… I was waiting for the blame… I was waiting for the blame… (sniffing in air)… (sucking gums)… and, erm… my manager came, and said, 'oh, d'you want to have a look at your notes?', and then… I kind of pre-empted it… I think, I asked her, and she said, 'oh, no… it looks like you did all you could'… I mean, she didn't blame me… (sniffing in air)… but I was wait… I was… but I didn't trust that… I thought, 'oh, the blame'll be… (chuckling)… the blame'll be next week… you'll be… she'll change her mind'… ha… (chuckling)…
8, 131, 3755-63	*yeah… and, also, you'd get told, 'why haven't you seen them sooner?', even though…*
8, 132-33, 3787-3810	*(pause)… I don't think so… I think it's… I think… eh… you know, it's a horrible… it's a horrible time to be a counsellor in higher education, I think… that… it's like… like… in my private practice, I'm seeing a… a Psy… a Psy… a… a Psychiatrist-in-Training… (sucking gums)… and she was off work because of her experiences at a Coroner's Court, and I just think… (sucking gums)… y… you know, the Coron… maybe the Coroners need to work with the people in mental health a bit more to understand… it… it's kind of like… eh… we're all under pressure in all these services… and then you're at a Coroner's Court, and you get attacked…it's kinda… like, what d'you think's gonna happen?… there's gonna be… you're undermining the very people that we're relying on, you know, in the NHS… like, she was off for fourteen months, because…*
8, 133-34, 3814-34	*yeah… like, she got du… dumped with the blame from somebody higher up in her hospital, and… ahhh, you know… do they know what junior doctors on call are… what they have to contend with, and the decisions they have to make?... and they're doing it on their own… I don't know… I just think it's a bit… (pause)… umm… eh… you know, like… we're getting attack… we're getting pressure and attacked from all sides, but we haven't got adequate resources… mental health services don't have adequate resources… it's kind of… like, a bit unfair really, isn't it?… (chuckling)… obviously… ha…*

Subordinate Theme #4.4: "It can be a bit knee-jerky": experiencing the vulnerability occasioned by reactive organisational politics

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Transcript Ref:	Quote:
5, 2, 36-37	*it's… it's drastically changed over the last ten years from where I was when I started to… as a qualified counsellor… to now…*
5, 3, 64-84	*yeah… erm, but as the processes have… come through the process… erm… we've had a couple of real major incidences here… one which was at a (regional) level, where someone had gone missing… and they thoug… they didn't know what'd happened to him… and several months later, they found him, err, up a hill… and, err, he had died through, err, basically… erm… erm… erm… it was a very cold night… and he'd lost his way… disorientation due to alcohol… and then he died… so, with that in mind, there was, erm, major kind of look at our policies, and how we were going to manage things, and the old manager left, and the new manager's came in… we've actually had four different managers over the period of ten years… erm… and, erm, through each transition period, there's been*

something that's developed further… erm, and more guidelines set, and more policies, and more structure… how to deal with these incidences…

5, 5-7, 131-80 *it was quite horrendous, because, I think, what, erm… my, eh, sense and observ… observation of being in this game… and, ehhh, I feel it is a bit of a game… it is… the fact that it's got… very political… when the first, erm, manager left, he left under a bit of a cloud… erm… of… erm… there was great words that, erm… eh, you know, that the hierarchy didn't like him, so he kind of got put out, 'cause he was near due to retirement… so, he was offered an early retirement package… then the second person that came in, came in from a different, I think, it was (regional) university, and she was… known to be troubleshooting… and she was going to come in, and make suggestions how our… our, err, department could be improved… so that went up… the… and then she left… and then, actually, it was the Deputy Secretary who was in charge, then… who, if we had any issues, we went to her… and then, she basically covered for a year, until we got our… our current, erm… erm… manager in… and then there was a massive restructuring process, erm… in the university… in… in the counselling department, and, erm, it… it was very hard interviews… and, it was quite threatening, really… it was all very threatening… erm… and, eh, you know, anybody that survived… eh, survived it… did well to survive it, to be honest… it was really quite difficult… erm… I… I probably felt I had a bit more experience to survive it, because, coming from a nursing background, I'd already been structured four times in two years… err… when… it was when the community, erm… erm… was being implemented… community psychiatric nursing was being implemented… so, they were shutting down the wards… so, we kept being restructured and restructured… so, I probably dealt with it a lot better than a lot of people… that… there was a lot of sickness… there was a lot of very… it was really very, very hard…*

5, 7-8, 195-210 *it was… well, I think it was, erm, everything… I don't think… I think it was to see if they could… because they restructured it all… from departments to the Hub environment… so they did that part… but I also think it was about, erm, dare I say, new broom, getting rid of some old stock, and, erm… I do think there was an element of that going on… erm… and… ye… yeah, I would say that… yeah, that was it…*

5, 9-10, 223-73 *yeah, the… the… the risk management came about, 'cause, at that time, erm, there was a couple of things that had happened… that young man went missing, which went to the national papers… but, also, erm, prior… just before we've got the current manager in, I had, erm… had a suicide, and there was a couple of, erm… there'd been a couple of incidences that has been suicide, and we had to look after people… so, erm, I think that, it being… eh… err… the… I'm not saying there was a cluster, but there was sufficient for (name of university) University… (name of university) University had a problem at one point, and, in history… this was before I came, that it was called the… it was the 'suicide university' of (the region)… err, which is not true now, but… it still has that… people remember it for the headlines… and I can't tell you of any more than that about it… erm… so, they were fighting statistically, getting students into the environment, I think, for a while… so, this is why it was all being politically…'we need to make sure that this is done… this is done'… 'we need this'… so that their reputation changed… so, I think it was a political thing to try and get everything reinforced… get everything… paperwork correct… so, therefore, they could actually, erm, show that they'd done the most intense service… and, erm, 'cause one of the things we've always been told, and, I slightly do believe it, that… the counselling department won't go… because of this… structure… this… this hap… pa… past events…*

5, 12, 325-29 *erm… it was the weirdest situation… the Vice-Chancellor came down, and landed on my doorstep… knocked on the door… basically, found out I was counsellor, and said, 'what do we do?'… erm… 'cause there was real panic about this…*

5, 13, 362-68 *and also, obviously, what happened the second time it happened, we had to get another new manager in place, who had never had anything to do with Student Support… she was managerial hat… not even from a Student Support Service… and, when it landed on our doorstep, she didn't want to take anything… any advice… any prev… previous experiences from any of the counsellors…*

5, 15, 400-14 *but actually, what happened was… it's taken them over two years to actually, erm, come to terms with things, whereas the first time it happened, it seemed a lot more… erm… because it was more reactive… it was more counsellor-led… it… the peace seemed to be, within the students, a lot quicker… erm, but because it was more managerial… this is the policy… this is what we've decided… you don't know anything… then, actually, it was very, very hard for the, y… the… the, erm, counsellors…*

5, 16-17, 461-73 *yeah… so, err… but those two have been, if you like… and that's why I refer to them… 'cause they were at (regional) level basically, you know… I… I don't know about (national) level… it… it would have been at (regional) level… it wasn't probably England… but, you know, there was a lot to be said in the papers about it all…*

5, 70, 2002-17 *and it… the changing… and this is, again, a managerial thing… it's not happened so much this year, but it does happen… they change the goalposts… so, like, these people have got trained for the sexual… and then they, all of a sudden… (clicking fingers)… that's it… they just… goalposts have been changed… nobody's told… there's no literature to say it… you just hear, because it is a… a reactive thing, instead of proactive… instead of thinking it out, and writing it down… it is reacting to a situation…*

6, 25, 694-704 *(sucking gums)… errgh… err… I mean… it's funny, because, on the one hand, and of course, this is, you know, partially my, sort of, background in IAPT speaking, but, you know, you… you… you have a sense, in this day and age, in a counselling organisation, of incredible organisational vulnerability anyway, because budgets are being cut… and so, you know, you do feel that you have to do your part to make sure that we're… eh… you know… (pause)… not 'looking after ourselves', because that does make it sound, sort of, sinister in some way… not, sort of, 'watching our backs', but, erm… (pause)… I guess, it does highlight… the vulnerability of… of the organisation, and the profession in a way, as well…*

6, 25, 708-19 *well, in terms of… err… because, I'm thinking, very often, people will say… you know, there's a lot of, sort of, public discourse about mental health… people say, 'someone should…'… you know… someone say, 'if you're… if you're suffering from this, you should get help'… and, the idea is, you will be helped… you will… you will get helped, and you will be helped, and you will be better, and you will be, sort of, fixed… and, of course, when you work in mental health, you realise it's not often quite that clear-cut…*

6, 26-27, 723-54 *erm… and, so, there is very often a feeling… you know, you see a lot of headlines, erm, about… eh… eh… struggling with, sort of, mental health organisations… and… and… and… eh… eh… systems that have failed individuals, and people who went on to kill themselves, and things like this… and how 'there's not the support'… 'there's not the support'… and yet, it… that's going on against a backdrop of, sort of… you… you know… cutting funding for all of these services, and I think, within universities… I know lots of universities that don't have a Staff Counselling Service… their Student Counselling Services are very underfunded… there's a lot of back-and-forth between, sort of, the NHS and the University Counselling Services, where the NHS will sort of say, 'our waiting-lists are really long, you should go to your University Counselling Service', which doesn't have a lot of funding anyway, but they're sort of mopping-up what the NHS can't do… and so, there's a lot of… I've kind of gone into… all sorts of socio-economic things here, but… you know, there is a sense of vulnerability of… of… of the profession… and… and expectations that people have of counsellors and*

	psychotherapists of being able to fix people… being able to prevent suicide… being able to, kind of, interfere in people's autonomy in a way… eh… eh… protect them from themselves…
6, 28, 780-801	*yeah… yeah… and, I remember, you know, the… the… the… hmm… sort of language that used to go around IAPT, and fortunately, really, really, really doesn't in this service, but was, 'remember, if anything happens, the NHS does not have your back… you have to have good insurance, because they will throw you to the wolves'… (chuckling)… and I think that is, erm… you know, it's… it's… it's not a feeling that I get here at all… this is a really supportive service… but, at the same time, there is a lot of talk about… we need to keep demonstrating our value to the university, so that they don't, kind of, slash us in the next budget cuts…*
6, 29-30, 828-37	*(sucking gums)… I guess it has, erm… (long pause)… err… the awareness of the, sort of, the… the… the vulnerability generally of, sort of… err… well, as I say, it doesn't feel half so vulnerable as IAPT did… erm… but, I guess, it's just the… it's just the… the context you're operating in all the time… erm… (long pause)… and you've just gotta do the best you can…*
6, 30, 841	*you've just gotta get on with it… yeah…*
6, 102-03, 2937-71	*yes… yes… and also… and also, that I think, erm… I think, all avenues should be exhausted before anyone gets just, sort of, left to it… ha ha… I think… erm… yeah… so… so, I suppo… I… you know, I'm… I'm very grateful for… risk protocols and procedures… I'm… I'm grateful for the clarity with which they're spelled out here… and this is a very safety-conscious service… you know, it's… it's rea… they're… they're very, very serious about lone worker policies… they're very serious about, you know, sort of, safety alarms and things like this, and that actually feels… very containing in lots of ways for… for the… for the clients… you know, for… for me with my clients, as well as, sort of, for us… erm, in a way that I think… I think risk management protocols felt v… very different in the NHS… and felt very defensive, and very, erm… they weren't spelled out very clearly…and it was always very… ver… you know, made very clear that if… if anything went wrong, you, individually, would… (chuckling)… be held responsible, so I… so I…*
8, 21-22, 597-618	*yeah… yeah, and again, before… it was… it was a suicide before my time… but, just like, we were… eh… you… you know, there's a, kinda… I, kinda, felt, eh, here, that… that it's a little bit… bit more behind the, (former higher education employer), in terms of how hot… (former higher education employer) was so hot on risk… k… (sucking gums)… and so hot on… obviously, the media… how people are gonna be represented… what's gonna happen in Coroner's Court… and it's… it… it's less so here, and I think that's… (sigh)… I felt a bit like… (gesture suggestive of heaviness)… about that… like, a bit, just, sort of… I feel the weight of that, I suppose…*
8, 22, 622-26	*(blowing out air)… oh, it's massive… yeah…*
8, 22-23, 631-39	*yeah, it's huge… that's a huge issue here, yeah…*
8, 23-24, 648-74	*yeah, you know, it's… it… like… not so much right now, but only a few… a few weeks ago… it's just like in the news every day… menta… menta… HE and mental health… and suicide… you know, (another higher education institution) wanting parental consent… parent… you know, consent to contact parents to… to come in… and all of that, eh… and the government minister saying, 'yes, that should happen', and… and then our VC saying, 'yes, we should do this'… and then Legal saying, 'no, the GDPR, and…'… it's just like ma… you know, it's really big at the moment… yeah…*

8, 65, 1852-63 *well, it's… it's… it's… it's two di… like, within the Service is different from within the organisation… so, within the… within the organisation, they don't want any suicides, do they?… they don't want… their reputa… they want… they don't want to be in the paper… (sucking gums)…*

8, 65-66, 1867-77 *oh… err… err… (pause)… the Director of Student Se… my… so, my boss… the Director of Student Services, and then she will say, the VC… wants this, this, and this… you know… there's a panic… there's a panic at the moment in HE Counselling Services…*

8, 66, 1882-95 *massive… yeah… and then it can… it can be a bit knee-jerky, I think… it can be a bit like, 'let's…'… like, what's happening at, erm… (sucking gums)… (another higher education institution)… is it (second higher education institution), as well?… like, places that are just getting… wiped, and external providers brought in, and… I read in the paper…*

8, 66-67, 1899-1927 *yeah, or let's do it cheaper, or somethi… like, some strange… ex… excuse to get rid of… it's scapegoating, I think… it's scapegoating… and then I was reading… was… I don't know if it was at… was it at (second higher education institution)?… that people that have no mental health ex… training at all are assessing risk… they just need two A-levels… I don't… I just think… I don't understand… but the… so there's a lot of… yeah… so, no suicides would be the expectation of the… (chuckling)… of the organisation…*

8, 68, 1932-52 *I think it… it's… it feels fright… it feels scary… but, I mean, I think this kind of thing's been around… it's much worse at the moment, but I think it's been around for a long, long time, this fear about… there… there definitely was over there… you know, a fear of… 'so, we're all gonna get... sacked, and replaced by IAPT service, or some…'… you know, like, there's been a… it's been around for a long time… like, we… we… there's a pressure to show our worth, and our value, and to be seen…*

8, 68-69, 1957-61 *a sense of that… we're all gonna lose our jobs, yeah…*

8, 69, 1966-77 *I think a suicide happens, and it's all in the paper, and we're… and it's really bad p… we've been… erm… criticized by… the Coroner, or criticized by… the… the student's parents, and it's in the press… I think that would be… if we get more of that, I th… I think we'd be very vulnerable…*

8, 69-70, 1981-93 *(nodding)… at risk… yeah… being overhauled…*

8, 72-73, 2063-76 *yeah… yeah… oh, God… ha… it's not a good time to be… (chuckling)… in HE mental health… (chuckling)… errrr…*

8, 73, 2081 *massive…*

8, 100, 2861-77 *it's quite… we g… we get quite a few… (intake of breath)… clients in that state when they've been… when they've failed the year, or they've got… they've got results… there's a cluster of results, and then we get these… you know… so, the other day, we had a concerned e-mail from… (sucking gums)… Student Life, they're called… so people that deal with exceptional factors… that… so this girl had said…*

8, 100-01, 2881-93	*yeah… so this client… this student had said, erm… (sucking gums)… erm… 'I failed this… dedededede… no one's helping me'… like, 'I… I feel like killing myself'… so then it's like… (sound suggestive of an explosion)… and then it's… the e-mails are like flying around to like… here… the… like, the… Student Support Officer, and here, and… we, eventually we got this girl in… this student in…*
8, 123, 3522-32	*yeah… yeah… like, I've got a client who… she was ref… she was referred… sort of a weird… so… (sucking gums)… some students… her flatmates… had gone to their tutor, and their tutor had contacted us, and said… we often get this… and said… (sucking gums)… this g… this g… this girl is s… s… erm, self-harming… tried to hang herself… suicidal… they're in a private house… I mean, 'what…?'… you know, basically, 'do something!'…*
8, 132, 3787-3801	*(pause)… I don't think so… I think it's… I think… eh… you know, it's a horrible… it's a horrible time to be a counsellor in higher education, I think… that… it's like… like… in my private practice, I'm seeing a… a Psy… a Psy… a… a Psychiatrist-in-Training… (sucking gums)… and she was off work because of her experiences at a Coroner's Court, and I just think… (sucking gums)… y… you know, the Coron… maybe the Coroners need to work with the people in mental health a bit more to understand… it… it's kind of like… eh… we're all under pressure in all these services… and then you're at a Coroner's Court, and you get attacked…it's kinda… like, what d'you think's gonna happen?… there's gonna be…*
8, 133, 3814-29	*yeah… like, she got du… dumped with the blame from somebody higher up in her hospital, and… ahhh, you know… do they know what junior doctors on call are… what they have to contend with, and the decisions they have to make?... and they're doing it on their own… I don't know… I just think it's a bit… (pause)… umm… eh… you know, like… we're getting attack… we're getting pressure and attacked from all sides, but we haven't got adequate resources… mental health services don't have adequate resources…*
8, 135-36, 3880-3914	*yeah… absolutely… I don't think it's poss… I don't think it's possible for everybody, obviously… I think people that… you know, there's these… is it in some NHS Trusts, they've got Zero Suicide Policy?… and I just think, 'oh, how you gonna do that with inadequate resources?'… I don't really understand… yeah…(pause)… so, I don't know… yeah… I don't know…*

Subordinate Theme #4.5: "It's a no-win situation": forced to make difficult choices about competing priorities when overloaded with clients

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Transcript Ref:	Quote:
1, 4, 106-24	*it's sometimes difficult, because… and I think we'll probably talk about this more… because of the pressure on the service… erm, we work in a time-aware way… we don't at the moment have a rationed number of sessions… which… is very positive overall… but it does mean that it comes down much more to your judgement in a way… there's nowhere to hide… erm, and you're balancing… the risk… that… that you think the individual is at against the knowledge of the length of the waiting-list…*
1, 6, 155-61	*because it's hard enough to hold the client without having to hold… erm… a lack of understanding by my immediate manager… erm… and that's… that is… difficult… it is difficult…*

1, 15, 433-44	*erm… (pause)… it's another factor in the mix… (pause)… I'm aware, for instance, erm, if I'm sitting with someone, and they were actively suicidal a couple of weeks ago… they're a bit better... things seem to have settled down a bit… erm… then I'm aware that… I've been in a meeting, say, in the morning… and… so part of me is with the client, but the other part is thinking, 'we've got three 'at risk' people on the waiting-list, one of them's been waiting three weeks'… can I afford to let this person… go without an appointment?…*
1, 16-17, 489-94	*so, and that… and that's part of the mix in a way that it just wouldn't be if the waiting-list wasn't there…*
1, 18, 535-40	*so, (manager's name)'s supposed to see five clients a week… and we will sit, and she… I know she has two clients… ha ha… and she'll sit and say, somebody needs to pick up… there's an 'at risk' on the waiting-list and somebody needs… and… someone needs to pick them up… and, err… somebody in the team will always crack, and say, 'well, I think I might have a space', and…*
1, 20-21, 604-19	*erm… (long pause)… stressed and overwhelmed, really… yeah… and a knowledge that, if I'm in that headspace for too long, I'll burn out… and that's always kind of at the back of my mind… that… is not a good place to feel that the demands are so much greater than my resource…*
1, 28, 842-47	*well, it just makes a difficult job more difficult, I suppose… I think that's the… that's the unhelpfulness…*
1, 28-29, 852-68	*erm… (long pause)… it takes away the focus… again, it's a… a kind of… (pause)… that sense of, instead of it being, 'what does this human being need… from all of us, as an institution, and as a community to be as safe as they can be… and to recover from this distress or despair?'… erm… (pause)… it feels like that's not kind of the centre of it… as far as the institution's concerned…*
1, 30, 896-97	*and could we not just all put the client in the middle, and say, 'what can we all do to help this person?'…*
1, 31, 935-44	*unhelpful… just unhelpful really… because it's not about where the client sits… it's about what the client needs…*
1, 32, 967-79	*but it's not my most central thought in my head is, 'don't let them become dependent on me, because we're a short-term service, and… if they really are going to get dependent, they should go to the NHS, because they've got the set-up'… you know, it's like, it's just not… that's not the way I am thinking when I'm with the client…*
1, 46-47, 1420-40	*I think they're implicit… there aren't explicit expectations… but there are implicit ones… and I think… they're in tension… so, I think… I think they're in tension…*
1,49, 1489-1508	*so, I think there are different… yeah, competing pressures… erm… and (manager's name), because she's the closest, is the loudest, but there's a sense that if… (pause)… if something actually happened… that the other voices would be the loudest… so it is competing… which is why the irritability with the noise… (laughter)… yeah… yeah… because they all want different things…*
5, 8-9, 223-40	*yeah, the… the… the risk management came about, 'cause, at that time, erm, there was a couple of things that had happened… that young man went missing, which went to the national papers… but, also, erm, prior… just before we've got the current manager in, I*

had, erm… had a suicide, and there was a couple of, erm… there'd been a couple of incidences that has been suicide, and we had to look after people…

5, 12, 323-46 *so, an example of that would be when, erm, that young man went missing, we had put into place, like, err… and this was through my supervisor and me, at the time… erm… it was the weirdest situation… the Vice-Chancellor came down, and landed on my doorstep… knocked on the door… basically, found out I was counsellor, and said, 'what do we do?'… erm… 'cause there was real panic about this, and, erm… I… I have never been in this situation, so I had got my supervisor involved at the time… and, erm, she's very, very, very… umm… you know… d… been there, seen it, and worn a T-shirt… so, what she did was… she put us all through… all the counsellors… like, through a training… normalisation process… how we would normalise people… and, you know, not make a big song and dance about the fact that, you know, err, there's somebody gone missing… let's try and work our feelings, accept things, and erm… then there was support being offered on a regular basis of follow-up…*

5, 13-14, 373-78 *and, so, there was no notification given out to staff… there was no… they just ignored everything… it went into 'secret mode'… we didn't know… erm… we just heard something had happened to him… but yet, we were to put on the place where students were coming in to us… and they're telling in graphic detail… the ones that had found him… what happened…*

5, 14, 389-94 *but there was also… the fact was that these other students found him… they hadn't been normalised… and I ended up with something like thr… three out of six… I… I think… four in total, actually… whereby, over the period of the following three months, they came in… and what I discovered I was doing was doing normalisation work with them…*

5, 15, 411-23 *erm, but because it was more managerial… this is the policy… this is what we've decided… you don't know anything… then, actually, it was very, very hard for the, y… the… the, erm, counsellors, because I dealt with, like… the… it just so happened, the way it worked… I dealt with that… but there was other… there was drop-out… you know, secondary people… there was the girlfriends of the boy… he had girlfriends… and there was all these other issues… and it were… infiltrating the whole of the counselling department… erm…*

5, 18-19, 516-45 *and what was happening is… alongside this… because there was so much… eh… eh… this… there is a new manager in post… and with that came the worry for her of getting the waiting-list down, because she wanted people assessed, and she actually became quite illegal about it… and, erm… err… it was a real, real dramatic… this was… this was… I would have been near to leaving the… my job, to be honest…'cause, what happened was… would I would have a space for administration work, like a supporting letter, etc, etc… and, I would look at my calendar, knowing that I had that space, and she'd put an assessment in, and I'd have a student sitting there, saying, 'I'm ready to be seen' kind of thing… and there was umpteen days that I was seeing seven hours of counselling because of that… which was totally illegal… went and told her that you can't do this, especially with the client load I was having with the… knock-out… the drop-out… of the suicide… erm… and she… she just said, 'oh, but, we don't want any more suicides'… 'you'll… you'll… you'll just work alongside'… so, there was a fear from management that there was going to be more suicides… and we had to get these assessments done at any cost…*

5, 20, 550-62 *it wasn't a fact… and this is the worst of it… it was… it wasn't a fact that it was a… a leverage… it was just done… you're booked, and you've got a student… when you've literally… it was within a five-minute space, and somebody… she'd pop somebody in… and there's that poor person, sitting there, waiting to be seen… so, what do you do, you know?... and that put us under a moral obligation…*

5, 24, 682-88	*which, eh, to be honest, as I said earlier, I was really lucky to be able to stay in the university… I was… I was nearly on sick leave, and I've never been on sick leave…*
5, 24, 693	*oh, it was horrendous…*
5, 25, 697	*yeah… it was… it was at breaking point…*
5, 38-39, 1093-95	*erm, but, you know, it's… and, I think, she's finding it very difficult… erm… because a.), I'd say, there's not enough time given…*
7, 47, 1334-43	*yeah… that's right… I wasn't trying to… to get her to change… I was just being with her… I must admit, I did also think, 'oh, I wonder if I could still do that now with the numbers of students that we're… would I be one of those people that was kind of trying to get her to… get moving on, and get the treatment?… I hope not, but… but it did make me think… yeah, all those years… you know… (chuckling)… way back, we seemed to have more time…*
8, 7-9, 200-37	*yeah… I think… (letting out air)… what's… what I was fearful of is not that I didn't know what to do… not that I would feel unsure about trying to implement it with a client… it was being too busy, and then missing something… that was my fear… 'cause I was so, so busy… so, specially sort of around November, December-time, maybe… that kind of time… you're reaching the end of that long term… risk goes up at Christmas… y… you know… there's just… it's just crammed in terms of the… your caseload… and that fear of that I'm gonna miss… I'm gonna forget somebody… or I should have called somebody… or I'm gonna miss something, or… you know… that, err… that was… it's not that we don't… it's not that I don't know what to do… it's that I'd… I'd be too overwhelmed…*
8, 9-10, 243-64	*yeah… and I'd miss somebody, or I'd… like, I suppose my fear would be… someone doesn't turn up for an appointment… I need to contact them… I don't contact them, because if you've got space, then s… you just get asked to do something else… several other things would take over… and then it's… you know, you… you're… you're tired… it's the end of ter… and you'd think… and you didn't contact that person, and then they'd do… they'd do something to hurt themselves, or…*
8, 11, 290-300	*erm… with clients… my fear would be that I've miss… that I've dropped… somebody's dropped through the cracks, and I've missed something, 'cause I'm overwhelmed… that was always my fear…*
8, 88, 2525-32	*(drawing in and letting out air)… I think, I feel… I always feel a bit like this is a… like a, kinda… it's a high… what's the word?… you're on high alert inside, but… what was I gonna say?… I've forgotten what I was gonna say… erm… (sucking gums)…*
8, 112, 3199-3210	*yeah, and I… but… yeah, and… but I totally understand why that kind of thing happened, because if you get a DNA, something else will just be put in, and it's another cris… it's another thing, it's another thing, it's something… there's no space over there… there's no reflective space…*
8, 118-19, 3386-98	*I… I mean, I… there was another case where… I had been working with somebody… I'd really tried hard for the client to go and see the G… I'd put it… I… I really put all the detail in the notes, and that's another pressure… (sucking gums)… because the… (sucking gums)… you know… we were taught in (former higher education employer), the best… you know, if you've do… done really detailed*

	notes about risk, then that's the safest thing to do, but what kind of time have you got to do that, right?… (chuckling)… well… it's just like…
8, 120, 3434	*erm… I just try… it's a bit overwhelming…*
8, 122, 3491-3510	*yeah… yeah… (intake of breath)… I think what worries me, which it did over at (former higher education employer) as well, is that, because I'm like… you know, I'm… I've got to… I've always got too much to do, I'm going to miss something of my own clients… that wo… still worries me…*
8, 123, 3514	*missing something again… yeah…*
8, 127-28, 3631-77	*so that it causes anxiety… so, like, at (former higher education employer)… eh… eh… eh… at (former higher education employer), we had too m… too many clients on our caseload… so what people used to do… so you wer… you were stuck between a rock and a hard place… so you had the counsellors that protected themselves, and they'd book clients in… in three weeks sometimes… I mean, I supervise someone from there now… and sometimes, she's not able to see somebody for another four weeks… so what I used to do, if someone was at risk, which they often were, is… I'm not gonna book them in… in three, or two, or four weeks… I'm gonna book them in wherever… like, the soonest I can… in my lunch hour… so that's what I'd do… to avoid suicide, but s… but people… keep that…*
8, 128-29, 3681-93	*well, yeah, it's crazy… both… it's… it's a no-win situation for both, isn't it?…*
8, 129-30, 3697-3725	*(intake of breath)… well, you… you can't a… eh… in a way, you can't offer a client appropriate care, or the care that you would like to have done… 'c… 'cause you know what it's like… like… ke… often risk is really grey, and when you see them, they're not saying, 'I'm gonna… I'm gonna go and kill myself right now', or… you… they might be saying, 'I haven't got plans'… but you know that there's risk… they're vulnerable, and there's risk there, and… and so you'd quite like to see them next week, or in a few days' time, but if you've got no space in your calendar, because you… you're expected to see all these new initial assessments, which we were… then… and you book them in, then that's more risky… to me, that's more risky… so I used to just try and see them, but then I'm… that's not good for me, obviously… so… yeah… it's one of the reasons why I left… (chuckling)…*
8, 131, 3751	*or they… or they felt that it could only be strict booked…*
8, 131, 3755-63	*yeah… and, also, you'd get told, 'why haven't you seen them sooner?', even though… it's a mad sys… you have two new…*

Subordinate Theme #4.6: "Rage against helplessness": angered by confrontation with the limitations and demands of an unsympathetic system

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Transcript Ref:	Quote:
1, 5-6, 151-61	*erm… and it also makes me angry, because it's hard enough to hold the client without having to hold… erm… a lack of understanding by my immediate manager… erm… and that's… that is… difficult… it is difficult…*

1, 6, 168-78	*and other times, it's kind of… as… as close as… in the room as I allow it… so sometimes I have to work quite hard to say, 'no, you're not… this isn't appropriate… you need to go to the other side of the door, and be shut'…*
1, 8, 230-43	*erm… at (second higher education employer)… when the client who I assessed went on to commit suicide, we had a temporary manager who, erm… went into my… I wasn't… it happened on a day I wasn't working… went into my filing cabinet… and took and copied my notes… erm, and I came in to hearing about the death, and then she'd sent me an e-mail, saying, 'I've… I've looked over your notes, and they're exemplary'… and I remember just being furious, and thinking, 'well, the client's dead… ha ha… it doesn't matter about my notes'… that's kind of, yeah… (becoming tearful)… sorry, I'm really upset thinking about… erm… (sobbing)…*
1, 9, 247-48	*and I don't think our working relationship ever actually really recovered from that…*
1, 9, 259-73	*well… (long pause)… I think I was very angry… not particularly that she wanted to see my notes… although I kind of, as I say, you know, the… the client was dead… ha… and the fact that I'd said that if his relationship broke down, or if his studies were compromised in any way, that I felt he… he would be very seriously at risk very quickly… and that was what had happened… his relationship had broken-up, and he'd killed himself… so, the fact that I'd seen that seemed to me neither here… neither here nor there… also, it was like, 'is that your first thought?'… this man has died, and your first thought is, 'let me look at the notes… to check that we're not going to get into trouble', you know…*
1, 18, 530-31	*yeah… and also, I'm aware… I think, what it does, is it makes me short tempered…*
1, 18-19, 535-66	*so, (manager's name)'s supposed to see five clients a week… and we will sit, and she… I know she has two clients… ha ha… and she'll sit and say, somebody needs to pick up… there's an 'at risk' on the waiting-list and somebody needs… and… someone needs to pick them up… and, err… somebody in the team will always crack, and say, 'well, I think I might have a space', and… and then… and what is never said, is, 'well, could you not pick them up?'… ha ha… and sometimes, it's… it's that kind of irritability… erm… with that kind of… (pause)… manage… there's a sense that… that she's not pulling her weight… and that that makes me really angry when I'm having these difficult conversations in my head… erm, and she's slacking, I suppose… so that makes me irritable and bad tempered… erm… so I think what happens is she gets a lot of my… rage against helplessness, I suppose…*
1, 20, 589-90	*and then, she's almost like the lightening conductor…*
1, 20, 595-99	*it's very… (pause)… difficult… sometimes I'm better… I think… I think it's difficult when I'm tired…*
1, 21, 624-34	*erm… and last week, we were told to… err, that there won't be any more resources, so we need to come up with solutions… and that makes me angry, I think, because… don't make this about me, and about the team… it's kind of… there isn't a solution… it's denying that it's complicated, and…*
1, 26-27, 784-802	*(pause)… I think, erm… I feel impatient with it… (pause)… because I've worked in higher education… pretty much, on and off, all of my life… my working life… and I worked in a managerial capacity before I was a counsellor… and… isn't there a poem?... isn't there… noise… noise and something… signifying nothing… it just feels, erm… (pause)… so, I… I suppose… I work quite hard just to screen*

	it out… (pause)… 'cause I'm aware of just being impatient, feeling impatient about it… I think… probably, if I have to settle on a word, it's 'impatient'…
1, 55-56, 1688-98	*erm, and then he said he'd come back again the next week, which he did… erm, but, there was a bit of a row, because, of course, because he had been silent, I hadn't been able to write any assessment notes, because he hadn't been able to speak… erm… so (manager's name) was cross about that, and saying, 'well, we can't do anything with him if he's not going to be prepared to talk and engage, and dadidadida'…*
1, 58, 1766-69	*he didn't go to the reception… he wouldn't engage with that at all, and that was another row, because he was supposed to go and sign himself in, and sit in the waiting area, and he just wouldn't do it…*
1, 63, 1927	*(sigh)… I just thought, 'oh, for God's sake'…*
1, 64, 1961-74	*yeah… yeah… that it kind of… I was a bit frustrated, but I also thought, 'well, I suppose that's his job to… to be the squishy bit between the coalface and the Chief Operating Officer'…*
1, 65, 1988-90	*and, it just… I'm just aware of having to really think, 'right, that… that… that stays outside of the door'…*
1, 72, 2214-18	*and then, I thought, hang on a minute… this is about me having seen him for fifteen sessions… erm… this isn't about me and him… this is about (manager's name)'s issue…and then I just got really cross… ha ha… (laughter)… 'piss off'… (laughter)…*
1, 73, 2222-25	*yes… (laughter)… so… so that was… yeah… so that was that really… ha ha ha… this has turned into a long moan about my manager… but, yeah… yeah… in the end, I just got really cross… ahh, dear…*
1, 89, 2732-39	*I think it's just really having the chance to focus on just what the institution… what bits of the institution… (pause)… erm, intrude… and what... what I can tolerate reasonably well, and what really… makes me cross…*
5, 19, 534-37	*and there was umpteen days that I was seeing seven hours of counselling because of that… which was totally illegal… went and told her that you can't do this, especially with the client load I was having with the… knock-out… the drop-out… of the suicide…*
5, 20, 550-51	*it wasn't a fact… and this is the worst of it… it was… it wasn't a fact that it was a… a leverage… it was just done…*
5, 21, 586-601	*erm… well, in a nutshell, I lost the plot one day… I'd gone from, erm, back-to-back, two suicidal s… err, people… and then we… I ended up with somebody… very much on the autistic spectrum, and it's very difficult, as you're aware… and, err, then, I looked at my calendar, knowing that I had half an hour, where I was gonna take myself for a walk, and just debrief myself kind of thing… just, settle down, and ground myself… and, she'd put somebody in… and, I absolutely lost it… and I said, 'no'… 'this is it'… 'this is not good enough'… I said, 'you have to work out what you're gonna do, but I'm not doing it'… and I said, 'd'you know what I've had in my morning?'… and she said, 'oh yes, we've all had our problems'… (noise, suggestive of indignation)… and I'm like, 'no', you know…*

5, 22, 618-20	*but, you know… again, what we have to do is rebalance as counsellors what we're doing…*
5, 25, 701-19	*yeah… and, the… returning back to the original question about management, we have, erm… 'achieving success'… erm… where you write what you have succeeded… and, that year, I wrote, 'I have succeeded not being ill'… and, 'I have managed to still pre… maintain a high level of service, but it's been at the cost of my personal life'… 'cause I was going to bed at seven o'clock… I was really having to… really, really debrief myself… really look after myself… and, erm… I got pulled up to Head of Student Support, saying, 'rewrite that'… that… you… 'we… we cannot accept that'… erm… that this is actually, you know, 'very negative'… and I'm saying, 'well, no, that's how I feel'… 'this is what I've been through this year'…*
5, 27, 755-77	*I think it did... I think it did land… and I do believe that… I really do believe that, because, erm… it took a while, erm, for the Head of Support to actually speak to me, but, erm, then I felt it was… I've heard, as a consequence, that there's been a lot of… 'although'… un… quote unquote… erm… 'we don't see eye to eye, there's a lot of respect there'… and I've heard that through the grapevine… but, eh, it just felt… it… it feels like it's a battle we shouldn't have to do to care for one another… erm…*
5, 29-30, 818-42	*erm… the other thing where that actually kicks in, is I've been here for ten years, and eventually, erm, at… at the restructuring interview I had, erm, they had said to me, 'ah, and what kind of training programme would you like to be put on?'… 'what… what will it… what do you wish you would like to be?'… and I burst out laughing… and I was quite rude, really… but it came from my gut… said, 'what training do you offer?'… 'I have been here for ten years, and nobody has decide… offered me one ounce of training in all the time I've been here'… so, they then immediately put me on a course of my choice afterwards, and then, what's happened this year… has been, there has been, actually, quite a lot of training this year, and there's been a much more acknowledgement that the… counsellors do need further training… do need that resource from an emotional, psychological… erm… and, it's a well-being… I think it is a well-being… to be able to go, and go to these events, and hear what people are saying… grounding, and acknowledge what's going on… so, there has been a huge change…*
5, 38, 1073-83	*so, erm, we now have… this is a different m… method this year… we have an assessment intake counsellor… so, basically, her whole job… err… which is very part-time, is actually seeing students, and again, she's objecting this year, because it's only for half an hour… we've said that you can't do a… err, a total assessment in half an hour, and be able to disseminate correctly if you're needing other people involved and things…*
7, 129, 3720-25	*I mean, I'm more concerned about the pressure that… that they're under these days… so, yeah… this need to be perfect, and all this rubbish…*
7, 131-32, 3758-96	*but maybe there is something… you know… I've got kids, so I know… you know, I… wh… what… err… how… how much I would want them to… to feel okay, and to manage… erm, things, and, err… I feel quite angry about the pressures that young people are put under now… I feel furious with the school environment… erm… and the… you know, how thick it all seems now, with… e… every… you know, all these ridiculous… erm, things… you know, even… even in nursery school now they're meeting targets, and things… I mean… and evaluating, and having… teachers have to be evaluated… all… you know, we don't have… somebody coming in and looking at us, and telling u… you know, reporting on us at the… I think it's… that… you know, they've had all these SATs… they've all these pressures… it's the… it… it… people… anxiety from the school has been fed to the parents, who are also caught up in it… erm…*

7, 132-33, 3801-35 *yeah… what they should be… getting the… the sort of… so now we're hearing students saying, 'oh, well if I can't get a first, what's the point?'… and they're doing all this because of work one day, you know… right from… all the way through school… they've got to do the best… they've got to get these through… they've got to get the top marks… they've got to go to university… they've got to… erm… then you get social media, diet, pollution… a whole list of them, isn't it?... and we've… and these… these are the bosses and the parents of the future… and I'm very worried about it… yeah… so… err, it'll be alright… we'll get there… I hope…*

Appendix M: Excerpts from research log

Recruitment and Interviewing:

01/10/2017 I have been delayed in getting started with my recruitment. I received an e-mail via Jiscmail, the online forum used by counsellors within the BACP division for Universities and Colleges, from a peer who is conducting a similar project focused on client suicidality. She is still recruiting participants, and it does not seem either wise or fair to compete with her efforts, as we are both approaching a similar audience, and I do not want to step on any toes, or to overload the audience to whom we are both appealing for involvement. Thus, with a view to being respectful of her ongoing project whilst mine is still in its infancy, particularly given our overlapping focus, I reached out via her supervisor (who had circulated the request on Jiscmail) to check when she might deem it appropriate for me to make my own approach to the group. I thought it was only courteous to do so. Fortunately, she has very nearly finished with her interviewing, so they have given me the green light to "go to market" in November. I just hope that there will be sufficient interest in this research topic given that someone else has been exploring a similar question so recently, but suicidality is a topical subject in HE right now, so hopefully there will still be fish to bite on my research hook! Time will tell, I guess.

14/01/2018 I recently completed my pilot interviewing and met with my supervisor to review transcripts thereof on Friday. I have my first two participants booked-in for actual research interviews next week, and hence, wanted to get some feedback beforehand, and to establish that my interview schedule was 'fit for purpose'. Two of my colleagues at Birkbeck kindly agreed to be 'victims'. I completed the first interview back towards the end of October, but pressures of counselling work and academic commitments at the end of term meant I have only just been able to squeeze in the second one. I had been slightly worried about my questions after the first interview, because it all felt a little wooden, and the details derived about risk management were somewhat technical, rather than having the more

phenomenological flavour I was endeavouring to capture. However, the second pilot in early January went well, so I have the feeling this was just an anomaly. I was slightly nervous in using the schedule for the first time and met my colleague at the end of a long day of work, when she was quite tired from conducting therapy sessions, both of which may have proved disruptive of our rapport. I think this first interview may also have been undermined slightly by my colleague's defensiveness in communicating about organisational risk management on account of our working for the same employer. I had been clear about my respect for confidentiality in the process, but I think our relationship perhaps felt a bit too "close to home", which meant that the interview lacked emotional depth.

These problems were all dissipated in the second interview, as I had already practiced using the schedule once before, met this second colleague in the morning during the holidays, on a day when she was not meeting any clients, and found that she was more open in disposition in exploring the material, less spooked vis-à-vis the confidentiality of her disclosures. The richness of this second interview has reassured me that the schedule is able to elicit the required depth of data, such that it does not require any substantial revisions. In reviewing these experiences with my supervisor, I have nevertheless realised the necessity of refining my interview technique with a view to gathering sufficient experiential data, avoiding being drawn into intellectualisation around suicide, as occurred in my first pilot, when this was possibly adopted as a defensive strategy of sidestepping emotional vulnerabilities associated with the topic. We also discussed the need to be wary of subtly steering the interview, noting a couple of instances where I had used my own semantic label when summarizing back aspects of my colleagues' experiences, which ran the risk of shaping subsequent contributions, rather than allowing their description of events to emerge on its own terms.

02/08/2018 As of yesterday, I have managed to complete the eight research interviews I was intent upon undertaking with a view to creating robust IPA findings, so it is perhaps worth reflecting on the challenges I have navigated over the past seven months in reaching this juncture. It has certainly made for something of an adventure! I have quite literally travelled

the length and breadth of the United Kingdom with a view to collecting my data. It has been a slow ‘drip, drip’ process in securing participants, which initially saw me slightly concerned about meeting my target. However, my strategy was simply to remain perseverant, and keep knocking on the door, sending out four separate requests for involvement via Jiscmail, recognizing that different clinicians might have interest and availability at different times during the year. A willingness to be flexible has probably helped in this endeavour. I travelled to the various HE locations of all but one of my participants, who was London-based, and asked to be accommodated at City instead, for whom I was equally happy to oblige in booking an interview suite on site. Most of my participants were recruited online, but one emerged consequent to my attendance at a research conference, entitled “Understanding, Preventing and Responding to Student Suicide”, which I attended in April. Furthermore, one of my participants was a staff, rather than student, counsellor. I was initially uncertain as to whether she should be included, but having consulted with my supervisor, we concluded that she fitted within the remit of the research question as someone who managed risk in relation to suicidal clients within an HE organisational context. The bigger problem with this interview ended up being the cold I was suffering from at the time, which saw me perpetually interrupting the flow of dialogue with my coughing!

I have tried, as far as possible, to approach interviewing with an attitude of ‘not knowing’, to remain curious and open-minded. I did wonder, in beginning the process, whether my “insider” status as a clinician with experience of managing risk with suicidal clients might mean I was too close to the subject, but I think my therapeutic training largely allowed me to park my beliefs at the door. As Bion famously opined, the purest form of psychoanalytic listening is without memory, desire, or understanding, and I suppose I have perfected this disposition reasonably well over the years in my work. I disclosed over the phone in my initial vetting of participants that I had a similar background as an HE clinician, and ultimately, I think this may have been advantageous in building rapport, allowing them to let down their guard in the knowledge that I understood the challenges of the profession. I think my biggest disappointment in this interviewing phase is that it has not been possible to incorporate the

voices of any male clinicians. This felt compounded for me when a couple of men responded to my last e-mail request, but after I had already agreed to meet with my eighth female participant. One of my hopes after completing the literature review had been to rectify the general absence of male perspectives in past research. Unfortunately, I was also ethically committed to a principle of 'first come, first served' in my recruitment, and I guess, given the preponderance of women working as therapists in HE, there was always a risk that their voices would predominate, as has proven to be the case.

Transcription and Analysis:

16/09/2018 How I wish that I had paid someone else to undertake the transcription of my eight research interviews! The last couple of months have been truly excruciating as a direct consequence of my engagement therewith, which I undertook with a view to having this task completed by the beginning of my third year of study. I can only describe it as a mental endeavour akin to eating food, then regurgitating said food and eating it again. Truly unpleasant! Listening over and again to the same section of tape to capture the wording, the pauses, the detail of the participant's account was nothing short of mind-numbing, and although my rationale for completing this task myself was that it would help me in the analysis phase through familiarity with the transcripts, and an awareness of the nuances of tone and expression, I am not entirely convinced this possible benefit was not outweighed by the pain involved in realizing it. By the time I begin the analysis, I am not convinced I will retain much of the 'fine print' that I hoped to internalize, in any case. What I have guaranteed, I suppose, in undertaking this task, is the quality of each transcript, and that they represent a more-or-less faithful rendering of the interviews that took place. There would likely have been more errors if the recordings had been transcribed by someone else who had not been involved in the original exchange. However, at this juncture my mind feels rather 'burnt out', and I think it might even take a couple of months to feel properly recovered from this ordeal. If transcribing interviews can be avoided in the future, I certainly will.

24/05/2019 Since submitting my analysis assignment in January, I had, until recently, taken a break from my research. However, in preparing for my third-year research presentation yesterday, I recently revisited feedback from my supervisor vis-à-vis my first stab at analysis over the Christmas holidays, when I dissected the transcript of my first participant using IPA. One of her recommendations was that I perhaps reconsidered my labelling of themes, since my titles were somewhat impersonal and analytic at times, which risked failing to convey the phenomenological depth and emotionality of my participants' experiences. Revisiting my subordinate and superordinate themes again with a view to presenting them to my peers, I decided to integrate an illustrative quote from the text to bring each theme to life through the words of their original author. This certainly adds greater texture to the account, and hopefully will enable my readers to feel more connected to the narrative of my participants. This probably has the additional benefit of augmenting the validity of my research, since it emphasizes more clearly the grounding of my themes in the primary data of the transcript, and my audience can then judge more accurately whether my interpretations are accurate.

12/09/2019 I have begun to focus in earnest on analysis of my research transcripts over the last couple of months. In revisiting the interviews, and then deconstructing them in the context of coding as a means of drawing out themes, I have been delighted to observe the richness of the narrative elicited, and the unique directions taken by each participant in response to my questioning, which should ultimately contribute greater depth to the analysis. However, whilst it would be excessive to claim to be daunted by this undertaking, it has been quite overwhelming to appreciate the scale of what is required in pulling apart each transcript, and then sticking it back together again. Breaking and then mending Humpty Dumpty makes for quite the endeavour, particularly given the necessity of privileging higher order meanings in the process, rather than just leaving a shambolic mess of eggshells. Wading through page upon page of thoughtful participant commentary in my attempts to identify descriptive, linguistic, and conceptual nuances, and then sorting through printouts of themes (and

associated quotes) with a view to identifying what elements of the account fit together, has been quite a struggle. It has left me feeling drained and exhausted.

I met with my supervisor yesterday to review progress so far, and she pointed out the importance of not becoming interpretative too early in the process of analysis. I had framed one of the themes I was considering for inclusion in relation to my second participant in quite psychoanalytic terms, mentioning 'countertransference'. It was understandable why this had occurred, as my participant was a psychodynamic clinician, and had used this term, and the idea of feelings being 'projected into' her by suicidal clients, on multiple occasions, and I work with similar understandings in my own practice, so this conceptual framework was both familiar, and naturally emergent from the data. However, we considered how this might better be communicated in more phenomenological terms, accenting the existential experience, in order not to lose the audience by becoming too technical, and reframed the theme in terms of the clinician's difficulties in differentiating the suicidal client's feelings from her own, under the headline quotation, "That got put into me". It was helpful to reflect on what sort of explorations should be left for the Discussion chapter. Hopefully, fine-tuning my approach will see me stay closer to the data during this analysis phase.

14/12/2019 I must admit, having been embedded in my analysis for some time now, it has proven to be an extremely challenging process indeed. Over the past three months, I have found it difficult to juggle the demands of undertaking therapeutic work at Birkbeck alongside my research. It has been hard to transition from one mindset to another, and thus, the analysis has taken much longer than I originally anticipated. I find myself midway through my fifth analysis, which I intend to complete over the holiday period, but this still leaves me with three more to finish off in 2020 before I even start writing-up. It feels like an interminable process, and my levels of energy and hopefulness are waning somewhat at this juncture. At least I can draw a line under the distractions of my therapeutic work in the New Year, as my short-term contract at Birkbeck has run its course. Henceforth, then, I can turn my attentions more fully to the analysis. I am unsure whether this is a blessing or a curse! It is difficult to sustain ongoing

interest in the same topic over an extended time-period, and I have already begun to experience boredom and fatigue in this endeavour.

20/03/2020 I have finally broken the back of the analysis, but I must admit that I have experienced some dark days in reaching this juncture over the past three months. Slogging it out with the last three analyses turned into a real battle, and there were moments were I genuinely felt like giving up on the dissertation and doctorate altogether. I remain uncertain which of the elements made this most challenging. The IPA process is painstakingly tedious and monotonous, particularly when you have eight detailed transcripts, each between 90 and 140 pages in length, but also, the content, with its focus on client suicidality, risk management, and the difficulties faced by clinicians in navigating these challenges within their organisation, is quite heavy in and of itself. As one of my participants commented, the risk with suicidality is that the clinician becomes "infected" by the client's despair and hopelessness, leaving them dispirited and downhearted. This was certainly how I was left feeling at times, and it proved to be a gradual, seeping process, a cumulative build-up, rather than something sprung upon me overnight. It reached a point, however, where I genuinely wanted to 'commit suicide' on the project at times, to cut and run.

I have always liked Jean-Paul Sartre's notion that the idea of suicide has saved many lives, and I believe that this probably explains my own continued investment, as it was the thought that I could escape, could bring the curtain down on the dissertation, and not continue any further, that probably enable me to remain invested. The last few weeks, completing my master table for the research in its entirety, integrating the eight original tables together, has proven a little more fun. Perhaps it is seeing the light at the end of the tunnel? Perhaps it is the fact that the hard grunt work of aligning quotes with themes had already been done for each participant, such that this was a more creative process in seeing what fitted together, exploring convergences and divergences? Either way, there is no doubt that the continual investment of intellectual energy in cycles of deconstruction and reconstruction has been hard,

and it is fulfilling to finally achieve a finished product, a map of superordinate and subordinate themes that imposes order on the chaos.

Writing-up stage:

22/05/2020 I have just submitted the first draft of my analysis chapter to my supervisor for review, which seems like a good juncture to evaluate my experience of writing-up to date. In its beginning, this felt quite overwhelming given the breadth of categories captured in my table of overarching themes for the eight transcripts. It has been difficult to see the wood for the trees at times, and given the limitations of word count, I have found myself reflecting in moments that my sample size is just too large to do justice to the divergent voices jostling for attention and airtime, each with their own unique insights into my topic, or equally, that perhaps my research question was too complex in the first place, attending as it does to the triangulation of the clinician between needy suicidal clients and demanding organisational requirements, which invited many different directions for exploration, resulting in a substantial variety of issues to explore. In such a context, how does one appropriately assign value? How does one determine what aspects of the whole should be afforded greater focus? In the first instance, I decided to produce written analysis for each subordinate theme, and then to cut things down at a later juncture. However, this ultimately left me in something of a quandary over the past week, as my finished analysis section was at least twice the length of my available word-count. Restricted by these parameters, I have subsequently had to be ruthless in cutting down vast swathes of the trees in my wood! Unfortunately, this has not felt like cutting a pathway through the forest that makes one's route clearer. Rather, it has felt like massive deforestation at industrial scale, leaving an ugly, denuded wasteland in its wake, making it impossible for me to faithfully represent the accounts of my participants.

I have been left reflecting on my experience of limitation in general, and a memory from childhood popped into my mind. Aged 11, I had been asked to produce some poetry by my primary school teacher, and wrote something of an 'epic poem', literally pages in length.

However, my teacher subsequently challenged me to condense my ‘masterpiece’ into eight lines. I did so, of course, because it was required, and he was pleased with, and praised, my efforts in this regard, but I could not help feeling subsequently that what was produced was inevitably not as complete and whole as the original. It felt ‘less than’. It is the same challenge I have found myself struggling with now. Not everything can be included. Difficult choices have had to be made. I have justified this to myself with the rationale that I am remaining focused on the research question, or grounded in the phenomenology, accenting those themes that speak more to the existential experience of my participants, but the reality is that significant aspects of meaningful experiential insight have had to be sacrificed. Not to be grandiose, but it feels like painting the Sistine Chapel, and then being asked to cover up or black-out vast sections thereof. This confronts one with the frustration of loss and limitation, creating an interesting parallel process with my participants, who spoke of their struggles with the limitations of offering short-term counselling to suicidal clients, and the struggles of the clients themselves, whose suicidality itself represents something of a response to existential limitation. Of course, the only recourse when limitation cannot be surmounted, is to accept it, which, of course, is what I have done. However, this acceptance has necessarily implicated the relative arbitrariness of my own subjectivity to a greater extent in determining which segments of my ‘artwork’ to put on public display.