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# Holding uncertainties in therapy

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**Portfolio submitted in fulfilment of the requirements for the Professional Doctorate in Counselling Psychology (DPsych)**

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# Declaration

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# Preface

This portfolio is made up of three parts; first part, is an empirical research project, part two, a publishable paper which is based on one of the research themes, and the third component is a combined clinical case study and process report. The first two parts look at psychotherapists experience of working with suicidal clients, and the clinical case study reflects on the work with a young man where learning to connect through uncertainty lay at the core of the work. This learning was for him as well as me, and in many ways reflects the journey through my research as well, as I have had to learn to trust the analytic journey through stages of unknown. Daring to trust the process and the connection. This is the common thread throughout this portfolio and also my journey to becoming a counselling psychologist.

Connection through uncertainty was not something I set out to write about. It is what happened, and what I learned to embrace through my years on the doctoral course. So much of this journey has been about learning to hold the uncertainty of the process in therapy, trying to not 'do to' the client in an attempt to gain confidence through an illusory certainty, but rather to 'explore with', to make sense.

In the first year of the training we read Judith Jordan's paper 'Valuing Vulnerability: New Definitions of Courage' (2003) and its humanity and realness moved me deeply and it awoke an interest in the idea of courage through connection. A real human connection, where I as a therapist am also open to being vulnerable and being changed by my clients. This has then been a real seesaw journey of moving between a need for certainty to feel like I 'know what I am doing' and then being reminded – in both the process of therapy as well as of research – that certainty is a kind of smoke screen. The only real certainty lies in human connection and in my own constant curiosity and openness to asking questions of the work, the clients and myself. This has been a wonderfully challenging process, but I have had the privilege of teachers and supervisors who have created the necessary safe spaces to reflect and to not know where I have been able to make sense rather than make answers.

It was this wish to work in a way that recognises complexity that lead me to the secondary care placement, where I worked with Joe, which I describe in Part Three: Combined Client Case Study and Process Report. Joe struggled to make sense of his emotional world, which made his

relationships and interactions feel deeply uncertain and unsafe. Our work together was one of jointly daring to sit with the deafening discomfort of uncertainty, and slowly making sense of his feelings through trusting the connection. This piece of work was done prior to my finishing my research and is independent from it, other than that it is part of my own journey as described above.

That same wish to make a space for the uncertainty and vulnerability of this work underlies the research on the experience of working with suicide risk, how to hold the complexity necessary for therapy to happen, in the face of something with such a frightening and potentially definitive outcome. This research is found in full in part one of this portfolio: doctoral research. While in part two of the portfolio is the Publishable paper, which looks at the supraordinate theme 'Navigating through the risk', which explores the participants experience of sitting with someone who is contemplating suicide, and how they confront and navigate through this.

Thus, in this portfolio you will find:

**Part one: Doctoral research (thesis)**
"*It is like walking a dangerous tightrope*": Psychotherapists experience of working with suicidal clients

**Part two: Publishable Manuscript** (based on one of the themes from the thesis)
"*She Did Not Want To Live*": Psychotherapists experience of working with suicidal clients
[This part has been redacted for reasons of confidentiality]

**Part three: Combined case study and process report**
Learning to hold uncertainty through connection – a shared journey
[This part has been redacted for reasons of confidentiality]

# PART ONE: DOCTORAL RESEARCH

# "*It is like walking a dangerous tightrope*": Psychotherapists experience of working with suicidal clients

**Julia Betancour Roth**

**Supervised by Dr Susan Strauss**

# Abstract

Psychologists, Counsellors and Psychotherapists have always had to manage risk of suicide. In the mental health context of the UK today the assessment and management of suicide risk holds an expectation that the psychotherapist will predict and prevent suicides. Working with someone that is suicidal evokes a myriad of responses in therapists and can impact them profoundly both professionally and personally in many different ways. This experience holds both the immediacy and urgency of facing a human being who feels unable to live, as well as the expectations in a wider context that they ought to be able to predict and prevent the suicides. This research study explored eight psychotherapists (three Counsellors, three Psychotherapists, and two Counselling Psychologists) experience of working with suicidal clients. Employing an Interpretative Phenomenological Analysis (IPA) methodology and utilising semi-structured interviews as the method of data collection. Analysing the transcripts according to the method recommended in IPA, three supraordinate themes (traditionally known as 'master themes') emerged: 'Emotional labour', which refers to how working with suicide risk impacts the participants; 'Navigating through the risk', which looks at how the participants understand and navigate the risk work; and 'What makes or breaks', which discusses the structures and processes that facilitate or impede this work for them. The themes are explored in relation to the existing literature on working with suicidality. The possible implications for clinical practice are discussed.

**Key words:** qualitative research; interpretative phenomenological analysis (IPA); suicide risk, psychotherapy

## 1. Introduction

"*There is no one "bump on the head" that will tell us whether a patient is suicidal or not, much less how suicidal that person is. Furthermore, all predictions ultimately depend on the skill of the clinician. In that sense, suicide prediction is a task like many others that a clinician faces: a problem of understanding a number of evaluations of the same person.*" (Leenaars, 2004, p.105)

This is what psychotherapists grapple with when working with a client[1] who is experiencing suicidality. A complexity of understanding the multitude of dynamic evaluations of that person, trying to make sure the clients stay safe while enabling a process of insight for and with them. This process happens to the backdrop of the wider policy context, both in the immediate work setting, as well as the more overarching, national policies (Reeves, 2010; 2017).

Suicide is an experience that can bring such devastation to everyone affected. Thus, it is perhaps understandable that the debate around suicide in the context of mental health work evokes strong responses, I would even describe it as polarised. Between one side arguing the need to use formalised risk assessments – even if it entails a large number of 'false positives', and another side arguing the importance of the clinical know-how and the relationship. The current policy-context in the UK is based on the more medicalised model of using risk factors to predict potential suicides. The so called 'predict and prevent' culture, with its main aim being to reduce the number of suicides (Reeves, 2010). Something I believe we all would like to see. But the work with someone who is feeling suicidal is deeply complex and requires an equally complex and attuned response (Fowler, 2012). And to me, as a pluralistic therapist-researcher, this means trying to stay open and not being wedded to one 'side' or theory.

How to assess risk is not the focus of this study. I especially want to move the focus away from this dichotomised conversation and highlight the idiographic and multi-layered experience of the psychotherapists that work with people with suicidal pain. Nonetheless, this debate is an intrinsic part of the work with suicide risk, therefore I find I first need to describe the context of this work.

I believe that Reeves (2017) offers a significant and helpful starting point for this reflection. He argues the importance of firstly being clear on what we believe suicidality to be, what is its

[1] I will be using the term 'client', unless the research literature I refer to uses a different word such as 'patient'.

ontology: "*how do we conceptualise the nature of being, and how might we go about understanding knowledge that underpins it*." (Reeves, 2017, p.607). Depending on how we answer this, we will likely approach this work in different ways.

I will try to illustrate this with an example. Let us consider the role of psychopathology and suicide. There is research evidence that at least 90 percent of people that have completed suicides can be said to have had a diagnosable mental illness (Fowler, 2012). However, a majority of people with a diagnosed psychopathology never attempt suicide.

Thus, if we think of suicidality as a symptom of mental illness (something which in and of itself might require unpicking; Marsh, 2010), the assumption will be that it can be predicted and 'fixed' by virtue of following certain diagnostic criteria (Reeves, 2017). These being a wide range of factors that have been found to statistically increase the risk of suicide (e.g. demographic factors, past high-risk behaviours/suicide attempts, psychiatric diagnoses, family history of suicide; Fowler, 2012).

If we then move on to another (ontological) view, where suicidality is understood as "*a mechanism of living and not living*" (Reeves, 2017, p.607), a disconnection of sorts, from oneself and the surrounding world (Murphy, 2017). In this view, the way to approach the suicidality would be moving beyond a possible diagnosis of psychopathology. It would be about trying to understand this experience, its meaning and functions for the individual (Reeves, 2015).

With both these outlooks the clinician's intention and wish for the person to live might be the same[2], but the mode of approaching it, such as the knowledge sought and the tools to respond, are likely to differ (Reeves, 2017). The first outlook seeks for more defined ways of assessing and preventing suicides, through the use of nomothetic risk factors as a diagnostic tool. The latter would entail a focus on understanding the idiographic suicidal experience, its meaning and function for the person. As a pluralistic practitioner-researcher myself, I do not consider these outlooks to be mutually exclusive, in fact I firmly believe that in my work as a psychologist, supporting my clients to be safe and to grow through understanding themselves, I need to use

[2] I am leaving aside the important existential discussion of if there ought to be a choice to suicide and what 'choice' might be or not be in this context as that is beyond the scope of this study. For more on this, see Murphy, 2017; Reeves, 2010; Marsh, 2010.

all the tools that can help this process. As long as I understand what these tools are and how to use them.

However, in the current UK (and global; Reeves, 2010) mental health context, the focus on how to work with people experiencing suicidality encompasses mainly one of these outlooks, that of assessing and preventing risk through the use of static risk factors (Reeves, 2010; 2015). This seems to feed into what Marsh (2010) describes as a "*compulsory ontology of pathology in professional accounts of suicide*" (p.28, Marsh, 2010), a view of suicidality as something that needs to be 'cured' and stopped, rather than understood and hopefully altered. Fowler (2012), in his review of suicide risk assessments in clinical practice, describes why this approach is problematic from a clinical point of view:

"*From epidemiologic and social policy perspectives, this information may be useful in developing targeted programs for intervention and prevention; yet, distal data alone are marginally helpful to clinicians—the odds of any of these factors predicting suicide-related behaviors is relatively low, with excessively high false-positive rates for each risk factor*." (Fowler, 2012, p.83)

Fowler (2012) offers an extensive discussion of existing research around various different risk factors as well as protective factors and the dangers of false-positives. Through his mapping Fowler (2012) illustrates the complexity of suicide risk prevention and the difficulty of utilising a risk factor approach to the clinical work with individual clients, showing how these nomothetic, distal factors are useful to develop suicide prevention programs on a wider scale, but lacking specificity in the individual work. This seems to be supported by Large, Kaneson, Myles, Myles, Gunaratne, and Ryan, (2016) in their meta-analysis of longitudinal suicide risk assessments with psychiatric patients. They found that the accuracy of suicide prediction and prevention through actuarial risk assessments in high-risk psychiatric patients has not improved significantly in the last forty years (Large et al, 2016). They conclude that a "*statistically strong and reliable method to usefully distinguish patients with a high-risk of suicide remains elusive*" (Large et al, 2016, p.2).

Many practitioner-researchers increasingly argue that there needs to be a space for an open exploration of what the suicidality means for the person (Jobes and Bowers, 2015; Reeves, 2015; Fowler, 2012; Michel, Valach and Gysin-Maillart, 2017). Reeves (2015) talks about how we ought to conceptualise the work with suicide risk as a 'risk exploration' rather than 'risk

assessment'. He argues that 'risk assessment' (mainly using risk factors) ought to be one part of a more in-depth exploration focus on understanding the client's suicidal distress, but not the main tool – "*talk first, tick later*" (Reeves, 2017, p.608).

Several prominent suicidologists from varying therapeutic modalities (e.g. Leenaars, 2004; Orbach, 2001; Michel & Jobes, 2011; Reeves, 2010) particularly highlight the dangers of unacknowledged transference and countertransference in the assessment of suicidality[3]. These interrelational processes occur in the interaction with the client and are not an aspect of the risk assessment forms. Yet if not recognised and named they can have serious consequences. It can leave the client feeling rejected and unheard, possibly increasing their suicidality (Leenaars, 2004). While, if brought to awareness, these dynamics can open the possibility to explore the underlying experiences and functions of the client's suicidal pain (Jobes and Ballard, 2011).

However, the current culture of suicide prevention is focused on 'prediction – prevention' from a more biomedical point of view, where the expectation is that mental healthcare professionals ought to predict and prevent suicides using predictive criteria based on nomothetic risk factors (Reeves, 2010). This expectation can also lend itself to a culture of blame (Reeves, 2010). Some authors argue that since the 1990's shift towards a clinical governance and an increased focus on risk in mental health, the responsibility for the risk, and the expectations to prevent said risk, has become less collective and more individualised, putting more strain and responsibility on the individual practitioner (Harper, 2004; Rose, 1996). There has been a move in focus from risk management being primarily a part of the clinical work to keep the client safe, to now more encompassing the organisational responsibility and preventing potential blame (Power, 2004).

In other words, the risk that therapists need to relate to and hold, is dependent on the context in which they are working. This means varying expectations as to how to act when there is suicide risk (e.g. referring on, hospitalising, involving family members) and whether it is their individual responsibility or it is shared and supported (Reeves, 2015). "*Risk factors are framed not only by*

[3] Transference and countertransference are processes occurring in therapy first identified in the psychoanalytic school of thought, but which are now widely acknowledged and reflected on in many different approaches (Leenaars, 2004; Kahn, 2001). Transference entails a reactivation for the client/patient of early (difficult) experiences and relational dynamics within significant relationships mainly from early childhood (Kahn, 2001). These experiences are unconsciously re-enacted in the therapeutic relationship. A similar process can be recognised in the therapist in response to what the client brings. This is called countertransference and is an important process for the therapist to recognise, both in the possible intrusions from their own personal experience and as a possible aid to further understand the client's difficulties (Kahn, 2001).

*their meaning for each client concerned, but also by the context in which they are being interpreted*." (Reeves, 2010, p.43).

When working with someone who is experiencing suicidal distress, psychotherapists are holding a myriad of things brought up in the immediacy and urgency of this encounter. Alongside that, is also the awareness of the wider expectations and possible repercussions on them from this work.

I wanted to get an in-depth idiographic insight into how therapists navigate and make sense of all of this and how it impacts them and their work with their clients. Therefore, I pursued this research, in which, I explore how working with clients presenting with a risk of suicide is experienced by eight psychotherapists in the UK and carries a further interest in seeing how they perceive how this impacts on themselves and the therapeutic interaction with their clients.

### 1.1 Literature review

The literature review begins with a brief overview and introduction to the relationship between therapy and suicide risk. Following that, I look at the experience of losing a client to suicide, considering the impact it has on the therapist and on the therapeutic work. I then go on to examine the specific experience of working with the risk of suicide. Here, again, I explore what this might mean for the therapist, for the therapeutic interaction, the role of the therapeutic relationship (with a particular focus on the Aeschi group) and the impact of the context in which the work is done. I conclude the chapter turning to my study, explaining its relevance to counselling psychology and articulating my research aims and questions.

Developing my literature review, I began with broad literature searches[4] and spread across various search engines[5]. I also followed up relevant references in the articles and books I read.

---

[4] My search terms: 'suicidality'; 'working with suicidal clients/patients'; 'suicidality AND psychotherapy'; 'psychotherapy with suicidal clients/patients'; 'suicide risk assessment'; 'suicide risk assessment AND psychotherapy'; 'suicide risk management'; 'suicide risk exploration'; 'suicidality AND therapeutic relationship'; 'suicide risk AND impact on psychotherapist/psychologist/therapist'

[5] My search engines: Psych Info; Google scholar, Psych Articles, PEP-Web, Cochrane Library, The British Library's EThOS, Google

My thematic approach to the literature developed out of a pluralistic and qualitative stance, of wanting to move away from the above-mentioned polarised debate around suicide and the current prevalent positivist policy focus. I have purposefully chosen to approach the literature review as I did the analysis, trying to find meaning rather than 'answers'. It has been important to me to not lose sight of the experience of working with suicide risk behind other louder discussions of risk management, or different therapeutic modalities and techniques.

Overall, I have chosen the literature on the basis of its relevance for my study. Wanting to specifically get a meaning-based insight into what it is like to work with a person who is feeling suicidal, noting common experiential themes across the literature. I especially focused on research that I found contributed to explain or query what my research wanted to explore. Further, as I wanted to get an insight into the specific lifeworld of this work in the context of the suicide reduction policies of the recent decades (as described above), I paid specific attention to more recent studies.

My choice to describe the Aeschi school of thought in particular, in regard to the role of the therapeutic relationship in the work with suicide risk, was twofold. One reason being their practice-focused evidence-base (e.g. Michel, Valach and Gysin-Maillart, 2017; Jobes and Bowers, 2015; Michel & Jobes, 2011; Leenaars, 2004). And the other reason is part of my humanistic-pluralistic stance, to move away from polarised discussions. Aeschi come from different modalities, but with a shared focus on the importance of truly listening to the client and honouring their experience, emphasising the importance of the relationship in the work with a person experiencing suicidal distress (see Michel & Jobes, 2011 and all the different contributing authors).

### 1.1.1 Therapy and suicide risk

"*In treating suicidal patients, a psychotherapist must face the risk and very possibly confront the reality of a patient killing himself.*" (Goldstein & Buongiorno, 1984, p.392). Working with a person who is suicidal is about life and death. Considering the prevalence of working with suicidality in psychotherapy, it is surprising how little research there is about how this work impacts the practitioner. In particular as some of the existing research, highlights how difficult this work is and the possible negative impact it can have on the therapists (Reeves and Mintz, 2001; Richards, 2000, Rossouw, Smythe & Greener, 2011; Clancy & Happell, 2014; Vail et al, 2012;

Moerman, 2012; Nicholl, et al, 2015), and with possible repercussion on the clients as well (Hendin, Polliner Haas, Maltsberger, Koestner, and Szanto, 2006).

Reeves (2010) describes therapeutic work as 'potholing', a collaborative process with the client of shedding light into- and making sense of emotional caves and caverns, while ensuring the safety of such an emotional excavation. Considering the readiness of the client, and the therapist themselves too, to do such an exploration safely (Reeves, 2010).

Doing this in-depth exploration with a suicidal client, "*makes this cave system profoundly perilous and unpredictable*" (Reeves, 2010, p.136) and without realising, we as therapists can feel a pull away from exploring this in depth due to the fear it evokes in us (Reeves, 2010). "*We might feel aghast at the thought of asking our clients to go in and explore it on their own, but that is often what we do through our own fear and terror*" (Reeves, 2010, p.136). The weight and difficulty of this work needs to be continuously understood and acknowledged, both for the safety of the clients as well as the safety and wellbeing of the therapists. Reeves (2017, p.608) describes what this work with suicidal clients asks of the therapists "*The demand to be brave is a very real one, and one that demands commensurate courage and attention to self-care.*" (Reeves, 2017, p.608). 'Courage' is a word that acknowledges the therapist is taking a risk in doing this work, committing themselves to this difficult journey, using their own person to accompany the client on this hard journey of uncovering and making sense of their deeply difficult and painful experiences, memories and emotions.

This is one of the ways that the impact of this work on the therapists is of direct relevance for the client's experience and safety even. But exploring the impact on the therapists from the point of view of their own wellbeing is important in and of itself and needs to be nurtured in order to avoid burnout and vicarious trauma, two things that have been found in therapists working with suicidal clients (Fox and Cooper, 1998, Moore and Donohue, 2016). The complexity of therapists' experiences of this work, are discussed in the following sections, looking at some of the existing empirical and theoretical literature on this subject.

### 1.1.2 Client suicide – impact on the therapist

Losing a client to suicide happens with such frequency in psychotherapeutic work that it has been deemed a professional hazard (Chemtob, Bauer, Hamada, Pelowski and Muraoka, 1989; McAdams and Foster, 2000). The impact of a client suicide can be deeply distressing and even traumatic for the therapist (Baba Neal, 2017; Tillman, 2006; Goldstein and Buongiorno, 1984),

with therapists experiencing a range of emotions, such as grief, shock, disbelief, sadness, helplessness (Veilleux, 2011, Castelli-Dransart, Gutjahr, Gulfi, Didisheim and Séguin, 2014), numbness, and anger (Tillman, 2006). The response to a client suicide can also manifest itself through nightmares, intrusive thoughts, dissociation, feelings of guilt, shame, fear of blame, avoidance of triggering situations (Tillman, 2006; Hendin, Lipschitz, Maltsberger, Pollinger Haas, and Wynecoop, 2000), self-doubt and loss of confidence (Moore and Donohue, 2016) and social withdrawal (Baba Neal, 2017). Fear of litigations can also complicate this and limit this grieving process further for the therapists (Tillman, 2006).

In their questionnaire-based quantitative study, of psychiatric hospitals across Germany, Wurst, Kunz, Skipper, Wolfersdorf, Beine and Thon (2011) found high levels of distress amongst the therapists (psychiatrists and clinical psychologists) in the immediate aftermath of the patients' suicide. With around a third of the clinicians also having more enduring distress, possibly indicating a traumatic impact. The main feelings described as the overall 'distress' were sadness, guilt, shame, anger and disbelief. However, this study does not offer the specificity of the meaning of the loss or of the distress.

Also, within the quantitative research there is some variation in the findings. For example, in their questionnaire-based quantitative study of 314 mental health professionals (psychologists, nurses, psychiatrists, social workers and educational psychology professionals) in different psychiatric settings in Switzerland, who had lost a client to suicide, Castelli Dransart and colleagues (2014), found some of these commonly reported distress responses. These included initial shock, sadness, and also helplessness, but they did not note high levels of shame or self-blaming, and they also found a low level of traumatic impact on the clinicians. The highest and most enduring levels of distress were found in the clinicians who had felt emotionally close to their patients, having felt responsible for them (Castelli Dransart et al, 2014). This leads the authors to highlight the importance of understanding the relational factors in this work and how that might impact the experience of the patients' suicidality on the clinician rather than focusing mainly on sociodemographic variables (Castelli Dransart, 2014), as might be more common in quantitative studies. This seems to lend support to a more qualitative enquiry to understand the relational elements involved in the impact of this work.

Castelli Dransart et al (2014) offer several explanations as to why they found lower levels of traumatic responses and of self-blame and shame. The main aspects are that the clinicians

reported feeling supported when the suicide occurred. Also, they suggest that the clinicians age and years of professional experience might have influenced their findings, with these clinicians being older and having more years of experience. While Wurst, Kunz, Skipper, Wolfersdorf, Beine, Vogel, Müller, Petitjean, and Thon (2013) found no significant impact of years of experience in how a client suicide was experienced by the clinician.

Further, Castelli Dransart et al (2014) also explain that most of the people that answered their questionnaire had experienced several patient suicides and the authors acknowledge that if the respondents would have been asked about their first experience of a patient suicide, their answers might have been different and possibly indicating more distress. Further, they noted that most of the clinicians in their study were not blamed by the patients' families nor did they fear accusations of malpractice, likely contributing to the lower levels of traumatic responses. Regarding the few participants that were traumatised by this experience, the authors emphasise the importance of specific support through therapy, as they explain: "*Professionals' distress might constitute a risk to themselves or to other patients because the vigilance and judgment of those professionals may be altered. The general well-being of professionals, together with appropriate training and support, are the best guarantee for effective prevention and postvention.*" (Castelli Dransart et al, 2014, p.320)

These quantitative studies are important to get an insight into the wide spread of these difficulties and highlight the imperative to address them in any mental health setting. Although these studies are focused on clinicians in psychiatric settings (both in the community and inpatient), so are not representative of private practice nor third sector. Nevertheless, much of the findings seem to overlap with studies looking at a wider sector (Moore and Donohue, 2019; Veilleux, 2011; Nicholl et al, 2014). What these quantitative studies offer a limited insight into, is the meaning of this experience for the individual clinicians, how this was felt, processed and understood, professionally and personally. The suggestions mentioned above, from Castelli Dransart et al's (2014) study of the need to understand the relational dimensions of the work as well as how the emotional impact on the clinicians could have ripple effects on the work with their patients, are aspects that some qualitative studies have explored further and will be discussed in section 1.2.3 (Working with suicidal clients – impact on the therapeutic work).

### 1.1.3 Client suicide – impact on the work

Veilleux (2011), and to an extent Tillman (2006) argue that the main difference between losing a client to suicide and a client dying but not through suicide, lies in the "professional injury" (Tillman, 2006, p.159), the impact on the therapist as a professional (Veuilleux, 2011). They explain that the emotional responses to the loss of a client to suicide are very similar to non-suicidal deaths, but that the differing emotions to a client suicide lie in the feelings of guilt (a sense of having 'failed' the client), self-doubt (of not having done enough, or doubting own competence) and fear of possible litigations (Veilleux, 2011; Tillman, 2006). Veilleux reflects on this as the main difference in losing a client to suicide being about the therapists' experience of responsibility (Veuilleux, 2011).

One aspect of this 'professional injury' that Tillman (2006) found amongst the psychoanalytic psychotherapists she interviewed in her hermeneutic phenomenological study, was what the participants called 'grandiosity'. This was a sense of being able to save the patients prior to the suicide, yet after the suicide losing this belief. Tillman (2006) makes an interesting observation about the therapists use of this word, 'grandiosity', noting that it is as if the hope the therapists held of being able to help the patients prior to their suicide, instead, after the loss of their patients, is viewed as a pathological ideal of 'grandiosity' in the therapists' minds. Tillman (2006) describes this as a double loss for the therapist, losing the client as well as a professional belief/ideal of being able to help the client grow and stay safe (Tillman, 2006).

She reflects on how there was a complex balance in that the therapists had chosen to work with "*profoundly troubled individuals*" with "*the hope that interpretation in the context of a therapeutic relationship would provide these patients with a foothold*", something she explains it did for many of them (Tillman, 2006, p.170). Yet, after losing a patient to suicide these hopes and beliefs that therapy could help their patients seemed to be shattered for some of the therapists and turned to disbelief and doubt in their own work as well as in the profession (Tillman, 2006). This lead some of them to no longer want to work with suicidal patients (Tillman, 2006).

This avoidance of working with suicidal clients after a loss of a client to suicide is also described in other studies (see Hendin, et al, 2000; Goldstein and Buongiorno, 1984). While there are also other findings of therapists coming out of this process of grieving and self-doubt thinking that they then feel more equipped to work with these clients than they initially thought. This

experience was expressed by some of the therapists in Moore and Donohue's (2016) study of Irish psychotherapists and counsellors working in a suicide prevention service.

Further, Tillman (2006) describes how one of the therapists experienced losing the ability to stay empathically present with the suicidal patients in their depths of their distress and pain, and instead would hospitalise them if feeling anxious about their suicidality, this left the therapist feeling that their subsequent patients were no longer receiving the same level of empathy. If considering this through Reeves' (2010) metaphor of 'potholing', one could perhaps understand this as losing the courage to explore the emotional caves and caverns with the suicidal client, a form of 'avoidance' of the suicidality and the pain and distress that underlies it. Such an avoidance can be found even without having lost a client to suicide, but from the fear it evokes of the possibility of a suicide (Jobes and Ballard, 2011). This is what the following sections look at, the work in therapy with a suicidal client, what the suicidality might evoke in the therapist and how it might impact the therapists themselves as well as the therapeutic work.

### 1.1.4 Working with the risk of suicide

#### 1.1.4.1 An emotional roller coaster – the impact on the therapist

The face to face work with a person who is suicidal is multi-layered and complex, and evokes a range of emotions and responses from the therapist (conscious and unconscious) very similar in kind to those that arise from a client suicide (Reeves and Mintz, 2001), such as powerlessness (e.g. Moerman, 2012), hopelessness and helplessness (e.g. Richards, 2000), self-doubts and diminished self-confidence (e.g. Montgomery, 2018), feeling responsible (e.g. Montgomery, 2018), and fear of litigations (e.g. Moerman, 2012). However, a difference lies in that when working with a suicidal client, when they are still alive and attending therapy, there is still some level of possibility of change. This is something that is completely wiped out when a client suicides, like Anderson (2013) describes:

> "*Following a patient suicide, we are forced to confront the reality that this act carries with it the unambiguous rejection of the therapeutic relationship we were attempting to create together. Such a stark decision denies the grieving therapist access to the wide array of possibilities for change and healing that are otherwise contained, at least in embryonic form, within the latent capacity of even the most difficult therapeutic relationships. The*

*suicide thus marks the death not just of the patient but also of the possibility that existed within the dyad for the eventual construction of shared therapeutic meaning.*"

(Anderson, 2013, p.127)

This also resonates with Tillman's (2006) description mentioned earlier, of the therapists' 'double loss', where the therapists, after losing a patient to suicide, experienced the loss of the professional belief and hope that they could help their clients through therapy, a belief they had previously held and that had motivated them to do this work (Tillman, 2006).

Furthermore, there seems to be additional differences of perspectives, for example, the uncertainty described by therapists working with suicidal clients in several studies (e.g. Nicholl et al, 2015; Moerman, 2012; Reeves and Mintz, 2001), appears to be about the fear of the client possibly taking their life. While the uncertainty after the loss of a client seems to be – alongside the uncertainty of possible litigations which is present in both situations (Tillman, 2006, Baba Neal, 2017; Montgomery, 2018) – about the not knowing what happened. Anderson, again, describes this experience as "*all hopes of eventual relational repair are thwarted; there is no possibility to resolve any treatment errors and failings that we may later painfully identify. As a result, we are caught between the simultaneous experience of knowing the facts of the death yet still not truly comprehending what transpired within the relationship or within each of us. We are suspended in a fundamental state of confusion. The narrative remains unformed.*" (Anderson, 2013, p.127)

There also seems to be certain aspects that are highlighted and emphasised in the work with suicidal clients. For example, that wish and felt need and possible urgency to prevent a suicide, which brings a range of emotional, cognitive and behavioural responses in the therapists (Jobes and Ballard, 2011). These are considered below.

There seems to be more similarities than differences between these experiences. Nevertheless, with the possible distinctions I have mentioned here, I have chosen to distinguish between working with someone suicidal, and the loss of a client to suicide. These can of course overlap in many ways, and several studies explore these experiences interchangeably, or at least jointly (e.g. Moore and Donohue, 2016; Moerman, 2012). I am not disagreeing with such a merging of perspectives, but I believe establishing a distinction is important in this study. This is for the

purpose of understanding the specific immediacy of the experience of working with a client who is suicidal.

#### 1.1.4.1.1 Uncertainty and self-doubt

In spite of the substantial amount of research into possible risk factors and ways to assess for these, this has not led to a visible improvement in suicide prevention over the last forty years (Large, et al, 2016). Thus, assessing the risk entails a great deal of uncertainty for the therapists working with suicidal clients. This uncertainty is voiced in various manifestations in several studies (e.g. Moerman, 2012; Moore and Donohue, 2016; Montgomery, 2018; Nicholl et al, 2015; Reeves and Mintz, 2001).

Montgomery (2018), in his grounded theory exploration of psychotherapists working with suicidal clients, describes feelings of self-doubt as a result of what he defines as 'an expectation of omnipotence' (Montgomery, 2018, p.32), where there appears to be no room for uncertainty. He explains this expectation as the "*pressure that the therapist feels from society (media, government, relatives, professional bodies) to be omnipotent when it comes to risk and the client's wellbeing.*" (Montgomery, 2018, p.32)

In their narrative analysis of psychotherapists working with suicidal clients in private practice, Nicholl and colleagues (2015) found one of their participants' main narratives to be about the "certainty versus uncertainty" (p.563). Their reflections revolved around the difficulty in knowing whether to refer the client on to GP or other services when they were suicidal. With some therapists describing an experience of referring being solely to protect themselves, to offer them certainty, rather than for the wellbeing of the clients. While another therapist expressed that she felt able to work with suicidal clients to a certain point, but that past that point, when the risk was too high, she felt the need to refer the clients on to someone with both more resources as well as more expertise in high suicide risk. Another therapist spoke about how involving other professionals might not be helpful when trying to explore meaning with the client, as then the focus is moved to the risk and away from the client's experience (Nicholl et al, 2015). She was seemingly expressing that holding the uncertainty was part of the exploration with the client. Thus, there appeared to be a great deal of uncertainty in how much risk the therapists felt able to hold, both for themselves as well as their clients. However, the one thing that seemed to hold a level of certainty within this was the imperative to seek out some kind of support when working with a suicidal client, even if choosing not to refer them on, they asserted that "*seeking some form of support is vitally important when working with suicidal clients*" (Nicholl et al, 2015,

p.604), to be able to make sense of and cope with the difficult emotions that the work with suicidal clients can evoke (Nicholl et al, 2015).

In her qualitative exploratory study of person-centred counsellors' experience of both working with suicidal clients and also of client suicide, Moearman (2012) found that the counsellors experienced self-doubt and feelings of anxiety from the uncertainty of not knowing what the client might do (Moerman, 2012). Expressing a sense of powerlessness bringing on "*overpowering feelings of responsibility*" (Moerman, 2012, p.217). Moerman describes this in the context of the emotional impact the process of assessing the risk had on the counsellors, where they also spoke of "*an overwhelming sense of helplessness and hopelessness*" (Moerman, 2012, p.217) facing the intense immediacy of a client's suicidal thoughts. Moerman (2012) describes how the most helpful antidote to the anxiety of the not knowing what the client might do, was a strong therapeutic relationship and understanding the client's experience. This referred to actively and collaboratively exploring the client's feelings and 'hidden layers' (Moerman, 2012, p.217). The counsellors also emphasised the role of bringing their own strong emotional responses to supervision (Moerman, 2012). Supervision, and peer support was, as in Nicholl et al (2015), found to be crucial in making sense of their own responses as well as to not hold all the responsibility alone (Moerman, 2012), something that was echoed in several other studies as well (Moore and Donohue, 2019; Montgomery, 2018; Reeves and Mintz, 2001).

**1.1.4.1.2 The responsibility**

The aspect of responsibility runs through most studies looking at the work with suicidal clients (e.g. Montgomery, 2018; Rossouw et al, 2011; Streicher, 1995). With observations ranging from the emotional weight of the responsibility felt by therapists towards suicidal clients (Moore and Donohue, 2016; Montgomery, 2018) to explorations of how therapists own views and values regarding the work with suicidal clients impact their felt responsibility (Moerman, 2012; Montgomery, 2018), as well as the role of external, societal expectations on the felt responsibility (Montgomery, 2018; Rossouw et al, 2011; Jobes and Ballard, 2011).

Montgomery's (2018) overarching theme is about "*how therapists resolve responsibility*" in the work with suicidality (Montgomery, 2018, p.31). He identified various different aspects of the therapists' experience of responsibility, ranging from more internal factors to external.

As an internal factor he describes the fear of suicide partly being impacted by the therapists' own beliefs. For example, "*the more the therapist believed in the right to suicide, the more prepared they were to take risks*" (Montgomery, 2018, p.32).

Within this category of more internally fuelled aspects of the felt responsibility, he also lists the role of collegial support (supervisor, peers) easing the weight of the responsibility. Alongside also having more experience.

He explains that these factors would contribute to being less risk-averse, although this is something he also highlights as seemingly changing due to increasing external pressures (Montgomery, 2018).

This leads to Montgomery's (2018) definition of the external pressures of the responsibilities the therapists felt in this work, explaining how some of these seem to have become internalised. These are aspects of feeling expected by society and institutions to be 'omnipotent' (Montgomery, 2018, p.32) regarding keeping the client safe. Something that for the therapists he interviewed would give rise to self-doubt in their work (Montgomery, 2018). This seemed to exacerbate the therapists' immediate worry about the client's safety intertwined with their anxiety "*about being held accountable and liable, within reason or not, if harm were to come to a client in their charge*" (Montgomery, 2018, p.32). Montgomery (2018) especially highlights an aspect of the therapists' holding a sense of 'persecution', of being monitored, through these heightened external pressures, these "*expectations of omnipotence*" (p.32).

A key aspect of this felt responsibility in Montgomery's (2018) research, was holding the uncertainty that this work generated. He comments on the need to feel confident in the work in order to be able to hold a level of risk and stay open and flexible in the work, attuned to possible changes in the risk (Montgomery, 2018).

What Montgomery describes under the overall umbrella of "*how therapists resolve responsibility*" (Montgomery, 2018, p.31), is also illustrated in various other studies, considered through different perspectives. In several studies the responsibility is held alongside the anxiety and uncertainty. Reeves and Mintz (2001), in their qualitative exploration of four counsellors' experience of working with suicidal clients, give the example of a participant's reflection on feeling it was their responsibility to break confidentiality to protect the client. While Moore and

Donohue (2016) describe how therapists they interviewed expressed holding this worry and uncertainty in their own time, when at home, as well as going above and beyond the set-out therapy structures to support the clients to keep them safe, leading to the therapists 'overworking'. Their findings illustrate "*the excessive engagement required as therapists attempted to reclaim lives from the brink of death*" (Moore and Donohue, 2016, p.28).

The meaning and impact of responsibility was also at the forefront in Rossouw and colleagues' (2011) hermeneutic-phenomenological exploration of therapists' (psychologists, psychiatric nurses and psychiatrists) experience of working with suicidal clients in mental health services in New Zealand. They describe the difficulty for the therapists in their study to come to terms with, on the one hand, their professional and institutional expectation (seemingly both internal and external) that they ought to be able to save their patients at all costs. Where they "*are reassured by this clear and unambiguous culture of care and responsibility. In this culture there are rules and formulas for managing people, just like there are rules and formulas for managing unchangeable substances.*" (Roussouw et al, 2011, p.6). Part of this assumption was the need to protect oneself against litigations, as they were expected to save the patients.

However, when facing the reality of the human complexity of this work, the therapists realised that they "*could not live or die for their clients and that it was the specific client who decided to end his or her existence. Their powerlessness to assume this responsibility created turmoil and conflict for the therapists.*" (Roussouw et al, 2011). This complexity had little space within the institutional culture they worked within, leaving them with a dilemma of staying open to the clients' experience, but then holding that risk and responsibility alone, or staying within the institutional procedures of risk work, and not being able to stay fully present and hear the people they work with (Rossouw et al, 2011). This work, brought on profound existential reflections for the therapists, both from the suicidal clients struggles with their own existence as well as the therapists attempt to stay attuned to this and to their own humanity within a highly formalised structure of care (Rossouw et al, 2011).

#### 1.1.4.1.3 Emotional and embodied impact

In their comparative methods qualitative study of counsellors working with suicidal clients, Reeves and Mintz (2001) describe a wide range of emotions experienced by the therapists they interviewed in their work with suicidality, "*anxiety, fear, panic, impotence and doubts about their ability to practise, as well as doubting their own professional competence and their ability to*

*work safely and appropriately*." (Reeves and Mintz, 2001, p.174). Feelings that are echoed in various other studies in addition to feelings of dread (Streicher, 1995), reflections on own mortality (Rossouw et al, 2011); fear of blame (Moerman, 2012; Rossouw et al, 2011; Montgomery, 2018); exhaustion (Webb, 2011).

Fear is a prevalent emotion in relation to working with suicidal clients (Moerman, 2012; Streicher, 1995). Fear for the client's life, and fear for oneself – of being accused of malpractice or litigations. This fear can be present in the immediacy of the therapeutic encounter with the client, as well as outside, in the uncertainty and worry held between sessions (Moore and Donohue, 2016).

The work with suicidal clients has been found to have a deep, and sometimes enduring, impact on the practitioners themselves, professionally as well as personally (Fox and Cooper, 1998). Moore and Donohue (2016) describe a range of ways that the risk work impacted the therapists they interviewed personally and in relation to their clients, such as burnout, compassion fatigue and a change in their perception of the world as more unsafe, from bearing witness to their clients' despair and life narratives. Another manifestation was of an emotional withdrawal with clients' traumatic experiences, which Moore and Donohue (2016) highlight risks leading to a lessened attunement with the clients. They also spoke about how this work impacted the therapists' personal lives, such as becoming over-protective of their children, or having no energy or space for their partners, bringing feelings from work back to their home environment (Moore and Donohue, p.29). Further, they describe embodied responses to the work, such as somatic discomfort and sensations, which the authors understand as embodied countertransferential experiences (Moore and Donohue, 2011).

However, in addition to the heavy emotions described above, they also spoke about the therapists experiencing a sense of 'privilege' to do this work and to be part of the clients process of growth (Moore and Donohue, 2016), something that was also found by Nicholl and colleagues (2015), who described how the therapists they interviewed also expressed this sense of privilege. In their study, this referred to the privilege, or 'honour' of being entrusted with sharing this moment of despair with their clients', and nurturing hope amidst the anxiety and worry, as they held a belief that they might be able to help their clients find other ways (Nicholl et al, 2015). The authors understood this experience as possibly being related to the fact that all the therapists had been practicing for many years and might have felt less overwhelmed by the

clients' suicidality (Nicholl et al, 2015). Although they also describe how this experience of privilege was "*counterbalanced by the anxiety*" (Nicholl et al, 2015, p.6), acknowledging that even if having worked for a long time, this is an anxiety-provoking experience.

In their hermeneutic phenomenological study of therapists' experience of losing a client to suicide, Rossouw and colleagues (2011) found that working with suicidal patients brought the therapists face to face with their own existence and mortality. "*Working with suicidal clients confronted therapists with professional, institutional and personal issues that brought them to experience their own crisis of existence during the course of assessment and treatment. They were confronted by their own humanness and mortality, which lay concealed under institutionalised models of care and challenged with what they understood regarding the meaning of life and death, not only the life and death of a suicidal client, but also their own life and death.*" (p.7, Rossouw et al, 2011)

These experiences highlight the intensity that this work entails. Webb (2011) emphasises the key role of self-care in the work with suicidal clients, exemplifying it through her work with a severely suicidal client. Her self-care is an intrinsic part of her reflections on the work with the client and how to ensure she was able to do the work without getting consumed by- or 'unconsciously replicate' the clients difficult relational dynamics. And in a similar vein, Moore and Donohue (2016) describe how the therapists in their study had different ways of creating boundaries between their work and home lives, for example showering and getting changed when coming home, having a separate wardrobe for work.

However, the main tool for coping with this work appears to be the various kinds of support (Reeves, 2010), such as supervision (Moerman, 2012; Nicholl et al, 2015), peer support (Moerman, 2012), personal therapy (Nicholl et al, 2015) and organisational support (Moore and Donohue, 2016; Rossouw et al, 2011). There seems to be a consensus in the combined function of support as both a space to make sense of own feelings evoked through the work and for emotional support, as well as to feel supported in holding the responsibility and the uncertainty.

#### 1.1.4.2 Working with suicidal clients – impact on the therapeutic work

The focus in this section, is on how the client's suicidality impacts the therapeutic interaction and work, from the perspective of what it evokes in the therapist.

One aspect of this work that has been found to be potentially difficult for therapists and unhelpful and potentially dangerous for the client, is that of talking about the suicidality with the clients, naming it (Reeves, Bowl, Wheeler, and Guthrie, 2004; Vail et al, 2012). Vail et al (2012) found that the clinicians, especially those less experienced, had difficulties in explicitly naming risk with the client. This same difficulty was described by Reeves and colleagues (2004), from their discourse analytic study of counselling sessions with suicidal clients (who for the purpose of the study the clients were actors), where the counsellors were not able to directly name the suicide risk when in a session with a client that was implicitly talking about it. Instead the counsellors offered reflective responses, which did not explore the clients' experience, and, according to the authors "*failed to engage with a redefining process*" (p.68, Reeves et al, 2004). Staying present and hearing and addressing what the suicidal client is bringing, is thus not straightforward.

In Vail et al (2012) having a formal assessment was seen as a potential help to be able to name the risks. While Moerman (2012) speaks of how directly addressing the risk with the clients and exploring it was a way for the therapists she interviewed to feel less anxious about the risk they were assessing. "/.../*being able to talk about it and be comfortable through knowledge and experience provided a secure base*" (p.217). These two views might simply be a reflection of two different therapeutic approaches (although the main therapeutic approach in Vail et al 2012 is not stated) and/or different organisational cultures, but it might also be other factors, such as perhaps experience (Nicholl et al, 2015) and feeling supported in a certain way of approaching the risk.

Yet another perspective of how to 'name' or address the suicidality is offered by Richards (2000). In Richards (2000), she describes the findings from the qualitative part of a wider mixed methods study. Having interviewed four psychotherapists about their experience with suicidal clients, Richards (2000) describes how the therapists voiced how they would often find themselves feeling hopeless and helpless when working with suicidal patients, and how that countertransference, as she describes it, was in itself a way for the therapists to assess the risk and work with it in the room, as a way of managing it. Her participants describe how naming the feelings that came up in the transference relationship enabled the clients to begin to work through those difficult emotions that they might not yet have been able to verbalise or acknowledge (Richards, 2000).

Yaseen, Galynker, Cohen and Briggs (2017) did a quantitative enquiry in a psychiatric service, of how countertransference feelings in the clinician could be understood and utilised as a risk assessment tool, finding that these feelings were predictive of suicidal behaviour irrespective of the risk factors measured in the traditional risk assessments, lending support to Richards (2000) findings of the need to pay attention to countertransferential feelings, and to name them.

In an attempt to increase the understanding of what problematic factors and dynamics might be occurring in therapeutic work with suicidal clients, Hendin, Polliner Haas, Maltsberger, Koestner and Szanto (2006) did an in-depth study of the therapy processes of 34 clients who had completed suicide. They did this in a workshop together with the therapists that had treated these clients. They identified six main areas as problematic, two of these are especially relevant to this study, as they relate to how the therapists' fear and anxieties of their clients' suicidality influenced their responses to their clients in deeply unhelpful ways.

One of these areas they describe as "*Permitting patients or relatives to control the therapy*" (Hendin et al, 2006, p.68) and illustrates how either the patients, or their relatives, in 17 of the cases, had controlled the therapy in different ways, putting up different conditions and demands that were not therapeutic nor addressing the underlying difficulties. "*In each instance the therapist complied, thinking that doing so was necessary to keep the patient in treatment and alive.*" (Hendin et al, 2006, p.68).

The other area they identified, which is directly related to this work, is what they called "*Ineffective or coercive actions resulting from the therapist's anxieties about a patient's potential suicide*" (Hendin et al, 2006, p.69). This is about how the "*therapists' anxiety over the possibility of suicide interfered with their ability to treat their patients effectively*" (Hendin et al, 2006, p.69), in ways such as not acting assertively when feeling that hospitalisation was necessary, leaving the client to make this decision themselves. Or not being able to fully stay present and hear the clients' frustration at not feeling any better, where the push to convince the client to stay alive, instead created a 'power struggle' of sorts which might have caused the patient to feel the need to 'take control' through killing themselves (Hendin et al, 2006).

Firstly, as Hendin and colleagues (2006) emphasise, their study was done with the purpose of increasing our understanding of the difficulties within the work with suicidal clients, but it does not then mean that would the therapists have acted differently that the clients would not have

killed themselves. However, it helps to get an insight into how as therapists, if not actively noticing what the work is bringing up in us and reflecting on our responses, we might be avoiding addressing the suicidality or be unable to hear what the client is communicating.

In their interpretative phenomenological study of seven psychotherapists in Ireland working in a suicide prevention service, Moore and Donohue (2016) also describe a reaction of a therapist emotionally disconnecting from the client's suicidal narrative when feeling overwhelmed. They discuss this as leading to a "*diminished attunement*" which risks re-traumatising the clients (Moore and Donohue, 2016, p.28).

From her own experiences of having lost clients to suicide, Anderson (2013) also talks of the possible 'avoidance' that therapists can engage in as the feelings evoked in the work with a severely suicidal client can be deeply uncomfortable and unsettling and how confronting them can feel overwhelming.

> "*Allowing one's self to be deeply unsettled by the countertransference anxieties that arise during such times has the potential to produce profound, even transformative change in the therapist. However, to work through the anxieties in such a way that we ultimately metabolize these hard-won insights, we must somehow tolerate the destabilization that occurs at the very point in time when we are at our most emotionally vulnerable. This is no small undertaking.*" (Anderson, 2013, p.127)

She goes on to talk about how in order to be able to go through this destabilising process of sorts, it is essential to have the support of peers, supervisor and institution, reflecting on how this often is lacking as there can be a form of denial of this existing risk, "*among therapists, there is a powerful wish to deny the reality that a suicide may occur in our clinical practice.*" (Anderson, 2013, p.127). Anderson (2013) talks about how this happens on both the individual level of the practitioner as well as institutional level, the latter risking to undermine the work with the patients. She states how in order to do this work, there needs to be a recognition, an acknowledgment, that a client might suicide, in order to learn to hold that anxiety, making a space for it within ourselves as part of having chosen this profession, being vulnerable in the service of the client (Anderson, 2013). "*Allowing ourselves to encounter our vulnerability during clinical crises is potentially dangerous for the patient and therapist, since any such encounter is fraught with the painful reality of our inevitable limitations, yet if this vulnerability is not*

*acknowledged, the therapist's anxiety may become overwhelming, leading to poor treatment.*" (Anderson, 2013, p.129).

Anderson (2013) highlights the importance of recognising our own limitations to be able to meet the clients in a real way, yet she describes how precisely this recognition of our own humanity and limitations is often not given space in the face of suicidality, which paradoxically might exacerbate the risk. This paradox resonates with what Hendin and colleagues (2006) found and is also in line with what Castelli Dransart et al (2014) suggest on the possible impact on the patients if the therapists are fearful and vigilant. Which was something that Tillman (2006) also found, how the fear of losing a client hindered the therapist from staying fully empathically present to understand the client's suicidal pain.

This view of the significance of staying present with the clients in their difficult experience and exploring this together is expressed in several studies (Moerman, 2012; Nicholl et al, 2015; Rossouw et al, 2011; Reeves, Bowl, Wheeler & Guthrie, 2004). The psychotherapists in Nicholl et al's (2015) narrative analysis emphasised the importance of the in depth presence with their clients' despair, and some of the therapists they interviewed described feeling less able to do that when they worked in the NHS, feeling more able to stay present with- and explore the client's suicidality with their clients in their own private practice.

Thomas and Leitner (2005) illustrated the difficulty of trying to stay present and attuned to the suicidal client, and the possible negative experience this can entail for the clients as well. They found that most therapists in their study responded with a 'fight' response when confronted with a suicidal patient (Thomas and Leitner, 2005). This meant that they went straight into problem-solving to prevent the suicide. The clients interviewed in the same study, described that they did not feel that was helpful or therapeutic, but that they felt overrun and not helped (Thomas & Leitner, 2005). The clients described wanting to be heard, someone that could listen to what they were going through first and foremost (Thomas & Leitner, 2005).

This echoes findings in other studies, such as Treolar and Pinfold (cited in Michel, Valach and Gysin-Maillart, 2017) exploring what patients' found most helpful after their suicide attempts, they described when staff listened and showed that they cared (Treolar and Pinfold, 1993, cited in Michel et al, 2017). This was also one of the main conclusions in Winter Bradshaw, Bunn and Wellsted 's (2014) systematic review of qualitative studies looking at therapeutic work with suicidal clients, examining studies that interviewed both therapists as well as clients. They found

that the main common factor that was experienced as essential to this work, was the therapeutic relationship (Winter et al, 2014), and amongst the clients' interviewed in the different studies they looked at "*there was a consensus that effective therapists are understanding, empathic and non-judgemental.*" (Winter "et al", 2014, p.76).

Moerman (2012) also talks about of the importance for the therapists she interviewed of being fully present through the work, the risk being openly explored, understood and held through the therapeutic relationship with the clients in their distress. "*The quality of the therapeutic relationship was a crucial aspect enabling participants to understand the client and guiding the course of the client/counsellor interaction in a directive or non- directive manner:*" (Moerman, 2012, p.220).

**1.1.4.2.1 The therapeutic relationship – The Aeschi group**

The central role of the therapeutic relationship in the work with suicidal clients is the core tenet of the Aeschi Group, whose members are Michel, Leenaars, Jobes, Maltsberger, Orbach, Valach, Young and Bostwick, formed in a conference in Aeschi, Switzerland in 2000 (Maltsberger, 2011). They formed this group as a reaction to "*the impersonal and often harmful treatment received by suicide attempters in many clinical settings in Europe and North America*" (Maltsberger, 2011, p.29). It is thus not surprising that the central tenet of their approach is the therapeutic alliance, emphasising the importance to meet the suicidal client and genuinely hear their narrative, and "*the goal is to see the patient's suicidality through the patient's eyes.*" (Jobes and Ballard, 2011). A key thought in this approach, aside from hearing the client's specific, individual experience, is genuinely collaborative work, with shared goal setting, where the responsibility is also given to the client (Michel, 2011). There is a focus to specifically avoid an externalised locus of change, which is often what happens within the current interventions within medical settings (Michel, 2011), where there is often an expectation, often also from the client, for the therapist to 'fix' and 'save' the client (Jobes and Ballard, 2011), not enabling the client to make a deeper, lasting change.

However, Aeschi, recognises the difficulties and possible obstacles for the therapists in order to be able to work in this way. One of them is the therapist's own emotions evoked by the client's suicidality, which if not recognised and processed, can be harmful for the client and the client's risk (Orbach, 2001). And another aspect they recognise is the wider, societal and institutional culture of expecting that the therapists, almost omnipotently (although not the word they say)

have to keep the clients alive, holding the idea that they also can do this no matter what and independent of the client's wishes and motivations (Jobes and Ballard, 2011).

#### 1.1.4.2.2 Contextual influences

This impact of the societal and institutional expectations and pressure on the therapists when working with suicidal clients, is exemplified in Rossouw and colleague's (2011) study, where they highlight how intertwined the participants therapeutic work with suicidal clients was with the institutional values of the organisations where they worked and how this shaped and often limited the kind of work they would allow themselves to do with their clients. Abiding by the institutional 'best practice' of using the formal assessments and procedures with suicidal clients became the priority for the therapists, which lead to a form of existential crisis for several of them when faced by the loss of a patient to suicide, especially as all the participants describe having lost clients that did not present as suicidal on any formalised assessments (Rossouw et al, 2011).

Hagen, Hjelmeland and Knizek (2017), found a similar experience amongst the therapists they interviewed in a psychiatric ward in Norway. They described an experience of not having time, space nor institutional support to form meaningful relationships with the suicidal patients, which they considered more helpful in understanding their patients' risk.

In their qualitative exploratory study in an aged-care mental health service in Australia, Clancy and Happell (2014) found a frustration amongst the practitioners that their 'clinical knowing' (such as 'gut feeling' and 'intuition', which they described having developed through years of experience) was not valued, but instead there was a "*predominance of accountability over care*" (Clancy & Happell, 2014, p.3185). Godin (2004) also describes how the focus on risk assessments often went counter what was good for the patient, sometimes even creating new risks (e.g. iatrogenic effects), leading the practitioners (community mental health nurses in this study) to have to reinvent their work finding alternative ways of practicing in order to not go counter their professional and personal values, although that was often not possible to do, leaving them with the difficult feelings of going counter the needs of the patient (Godin, 2004).

This institutionalisation of the therapeutic work and the fear of repercussions and litigations is named in several other studies as something that impacts the therapists in the work they do with suicidal clients (Moerman, 2012; Nicholl et al, 2015; Vail et al, 2012, Reeves and Mintz, 2001, Montgomery, 2018). Montgomery (2018) describes how this fear of litigations other external

expectations and pressures to an extent became internalised by the therapists. He describes his theme of 'surveillance': "*surveillance highlights one of the irrational aspects of regulation and audit culture, in making the therapists feel as if they are being watched or monitored and therefore more fearful of making decisions*" (Montgomery, 2018, p.32). It seems these external factors are also present in the therapeutic encounter with the suicidal client.

### 1.2 Relevance to counselling psychology and the wider field of psychotherapy

"*for all we now about suicide, there is so much we don't know*" (Reeves, 2017)

These words explain to an extent the relevance of this study for the field of counselling psychology and psychotherapy. There is a lot of research about suicide prevention, but there is no evidence that suicide prevention has improved in the last forty years (Large, Kaneson, Myles, Myles, Gunartane, & Ryan, 2016). Yet, the expectations on psychologists, counsellors and psychotherapists has increasingly become one of that they are expected to always prevent a suicide (Jobes and Ballard, 2011). There is a glaring discrepancy in this, in the gap between policy, societal expectations and the face to face reality within the therapeutic encounter. The policies are increasingly shaped within a positivist framework, which seeks 'truths' – concrete explanations and blanket, or 'tick box' solutions (Reeves, 2017) and yet the reality of therapy, and especially therapy with a suicidal client, is still about human beings. Complex human beings, who, as individuals do not fit into a box. The suicidologist Edwin Shneidman (2001) described this complexity:

"*/.../ there is no simple answer to the enigma of suicide; to know that the end of each individual's universe is, like the universe itself, a gigantic jigsaw puzzle of a seemingly infinite number of pieces, many of which have dropped to the floor and have been swept under the cosmic rug.*" (p.5, Schneidman, 2001)

Thus, understanding the experience of psychologists and psychotherapists working with suicidal clients, can also contribute to our understanding of this field. Further, suicide happens across all therapist modalities and institutions (including private practice) and it is a tragedy every time and can be deeply traumatic for the therapist (Baba Neal, 2017). Baba Neal, who lost a client to suicide, describes the abyss of this:

"*To use the language of chaos, suicide itself becomes a strange attractor, a sort of gravitational force that can pull other minds and destinies into its orbit.*" (Baba Neal, 2017, p.178)

Even the fear of a client suicide can 'pull minds and destinies' into it and make it hard to stay present (Jobes and Ballard, 2011) and can lead to burnout and vicarious trauma in therapists (Fox and Cooper, 1998; Moore and Donohue, 2016). Therefore, understanding more about both the impact on the therapist of the relational, emotional and contextual experiences of this work, and possibly how they interact and impact the therapeutic work, is essential. This study aimed to gain an insight into how these factors might interplay through a phenomenological enquiry.

### 1.3 Research aims

The aim of this research is to get a further understanding of how psychotherapists (Psychologists, Counsellors, and Psychotherapists) experience and make sense of their work with clients who are feeling suicidal. To gain access to the participants 'lived experience', the methodology used was IPA.

Specific aims:

1) To gain insight into the participants personal experience and understanding of working with suicidal clients.

2) To gain an insight into how they perceive this experience to impact on the therapeutic interaction.

### 1.4 Research question

How do psychotherapists experience and make sense of their work with suicidal clients?

# 2. Methodology

## 2.1 The theoretical foundation

### 2.1.1 Rationale for selecting a qualitative approach

As described in the previous chapter, most of the research done on suicide risk is framed within a positivist research paradigm (Winter et al, 2009). The assumption underlying such a paradigm is that suicide is a nomothetic experience (Rossouw et al, 2011), implicitly meaning that it is possible to obtain a generalisable understanding of what brings someone to suicide and, consequently, being able to predict its symptoms (Schwartz & Rogers, 2004).

In Rossouw and colleagues' (2011) research, therapists described how their patients that had committed suicide had not presented with risk in formal assessments. This left these therapists with a feeling of having let their patients down, as they felt they had not stayed with them to explore their experiences (Rossouw et al, 2011). This illustrates the difficulty of navigating between different value-systems or paradigms when working with suicidal clients. The therapist is trying to work through the non-positivist/idiographic lens which therapy holds (Morrow, 2007), but within a positivist/nomothetic (e.g., medical) framework, setting the agenda for the work (Rossouw et al, 2011;). Rossouw and colleagues (2011) describe how utilising a phenomenological approach in their study allowed "*/.../ an epistemological framework to offset the dominant natural scientific orientated psychiatric interview*" (Rossouw et al., 2011, p.8).

In Counselling Psychology, we are interested in collaborative meaning-making with our clients, jointly understanding the unique experiences of their distress (Morrow, 2007). This perspective is in line with a qualitative method of inquiry (McLeod, 2001) and, more specifically, it takes on an idiographic view of mental suffering, which contrasts with the nomothetic/biomedical perspective.

Doing practice-research within the same paradigm as the clinical work is essential for the validity, relevance, and usefulness of the findings, which can then impact policy and service provision. Trying to explain the multiplicities and complexities of psychological distress with categories developed and defined by research based on positivist criteria can be like trying to fit a circle through a square, as exemplified by mental health professionals' critique of the methodology behind the NICE guidelines for depression in adults (Roast & McPherson, 2019).

"*The evidence-based medicine paradigm has been shaped by medical science. This requires some adjustment when comparing and contrasting medical treatments with psychological treatments. The overall methodological approach in the guideline inherently favours (a) medical trials over psychological trials; and (b) particular psychological treatments over others. This is not an acceptable scientific stance and creates biases that are based on subjective choices rather than good scientific evidence of treatment effectiveness.*" (p.5, Roast & McPherson, 2019)

Therefore, in contrast to the predominant medical paradigm in the context of mental health work in the UK today (Boyle, 2007), this study takes a qualitative approach.

### 2.1.2 Ontological and epistemological position

Qualitative inquiry is based on a view of 'knowledge' that does not look for 'truth' (as quantitative research often does) but for 'meaning' (Madill, Jordan & Shirley, 2000). As meaning-making is inherently subjective – and intersubjective – this process of knowing entails reflecting on what can be known and of what (McLeod, 2001). As 'objectivity' is no longer a way of controlling for the rigour of the research process, being explicit about one's subjectivity becomes essential. I will therefore describe my own position.

In my view, there is a material reality of nature and social structures in the world, a reality that human beings are impacted by and impact upon, but have limited access to understanding objectively/fully, as our human existence is intrinsically subjective and intersubjectively constructed.

Bhaskar (in Buch-Hansen, 2005) differentiates between what can be known about the natural world and the social world, arguing that the social sciences are made up of systems that cannot be experimentally isolated as in natural science. Further, he argues that another central difference is that of human agency:
"*the role of agency is to reproduce or transform structures. Structures provide us with the means, the wherewithal, and the particular form in which we do this in social life.*" (p.62, Bhaskar in Buch-Hansen, 2005)

This is a 'critical realist' stance, which concords with my view of what is real, and the limitations to what can be known of that reality. My ontological stance is therefore critical realism.

Regarding my epistemology, I share the position of Counselling Psychology in its assumption of multiple realities (McLeod, 2015), and of co-constructing meaning. Seen in this light, I share an affinity with the idea of knowledge being constructed by our discourses. However, I struggle with the relativist position of social constructionism, feeling that it denies important structural realities, such as oppression and human agency and that limiting our being to language denies us as embodied agents beyond language (Elder-Vass, 2012). Dave Elder-Vass's (2012) philosophical stance of 'realist social constructionism' helped me bridge this gap through his argument that a critical realist ontology is compatible with a Foucauldian social constructionist epistemology, which merged my ideas and positions mentioned above (Elder-Vass, 2012).

This epistemology allows me to acknowledge the constructs that to a great extent make up our understanding and meaning-making, while also acknowledging that "*social structures are causally powerful*" (p.9, Elder-Vass, 2012). This joins together under my theoretical umbrella of the critical-ideological paradigm (Morrow, 2007). This paradigm is particularly linked with research that aims to create a social change or challenge oppression. While this study does not directly engage in issues of social inequality, this is nevertheless where my theoretical and political lenses position me.

### 2.1.3 Rationale for Interpretative Phenomenological Analysis (IPA)

My initial intention with this study was twofold. Firstly, I wanted to obtain an insight into the work with suicide risk from the lived experiences of therapists. And secondly, to shed light on how the concept of risk is constructed by therapists working in the UK today. I wanted to make a tentative exploration of how these different aspects might be intertwined. This would have meant me pursuing a pluralistic study, employing a phenomenological methodology to gain insight into therapists' lived experience of working with suicidal clients, and a discursive approach to illustrate the use of language in relation to suicide risk.

However, due to the limited scope of time and resources for this study, I decided to focus on the first of these aspects. This choice was informed by my interest in the therapeutic practice and the scarcity of literature on the topic. I was interested in understanding experiences and perceptions of working with suicidal clients. Further, I reasoned that, if I would like to do an additional analysis at a later stage, it would be more organic to go from an 'empathic' form of interpretation in IPA, to the more 'suspicious' FDA (see 2.1.4; Willig, 2013).

Once I realised that pursuing a phenomenological inquiry was the most suitable choice for my research interest, deciding which approach to use felt rather intuitive. As I also wanted a relational insight into this experience, I reasoned that I would need to engage with the material in a similar way. In other words, on the one hand trying to 'bracket off' my assumptions in an attempt to see things beyond my own existing understanding, and aligning more closely to the participant's (similar to the Rogerian notion of 'emptying oneself'; Rogers, 2004), while at the same time acknowledging the role of intersubjectivity and the human inevitability of interpretation (McLeod, 2001). As it encompasses all this, Interpretative Phenomenological Analysis (IPA) seemed the perfect fit.

Further, the existentialist outlook within phenomenological philosophy is an appropriate lens for an exploration of this subject, as a non-pathologising perspective of a human experience in a lifeworld circumscribed by the finality of death (Langdridge, 2007).

As for the ontology and epistemology of IPA, it does not make claims to subscribe to a particular epistemology, but holds the possibility of various lenses (Smith, Flowers & Larkin, 2009). The phenomenological view of our being in the world as an embodied experience, a physical reality of existence, but one that no one else can fully understand, concurs with my ontological position of critical realism. While its hermeneutic acknowledgment of the inevitability of interpretation coincides with a realist social constructionist epistemology of what form of knowledge can be accessed.

Finally, IPA - alongside other hermeneutic phenomenological methodologies - is particularly relevant to counselling psychology. As our work in therapy is intrinsically intersubjective and we work with a joint process of sense-making of the client's lifeworld (Morrow, 2007). Therefore, "*if we can understand the potential for using hermeneutic phenomenology to explore people's 'lived experiences' through in-depth learning, sound critique and methodological evaluation, we can gather rich data to influence service delivery, treatment of patients and policy agendas* (p.137, Rapport, 2005). In other words, utilising IPA to understand the work with suicidal clients offers a way towards client needs being heard and met in policy decisions, which impact service provision and treatments.

### 2.1.4 IPA – the methodology and its philosophical underpinnings

"*Life is not intrinsically meaningful and, as such, we alone have the responsibility to make life meaningful as we face the dizzying anxiety of knowing the limits of existence*" (p.31, Langdridge, 2007).

In this quote, Langdridge (2007) is describing Heidegger's philosophical idea of 'being-towards-death', how human beings ultimately live with the constant awareness of death and of how what they do with their existence is their choice, which according to Sartre (in Langdridge, 2007) in itself creates anxiety. The notion of being-towards-death resonates with Sartre's idea of 'nothingness' of human existence, how "*consciousness (the self) is not something we are or have but something we constantly create through our lived experience*" (p.34, Langdridge, 2007). This philosophical contemplation resonates with the existential matters of life and death that the therapists interviewed in this study grappled with through their clients' experiences. The experience of being-towards-death is to an extent suspended, as the clients' unbearable emotional pain makes it impossible to render meaning to their lives (Pompili, 2010). "*This view reveals suicide not as a movement toward death but rather as a remedy to escape from intolerable emotion, un-endurable or unacceptable anguish*." (p.241, Pompili, 2010). Rossouw and colleagues (2011) illustrated another perspective of the existential resonance of this work. They found that losing a patient to suicide brought up deeply existential feelings in the therapists about their own death.

The idea of consciousness and meaning being something constantly created by us in relation to the object/phenomenon is also known as 'intentionality' (Spinelli, 1989). Merleau-Ponty, took this idea further, emphasising the embodiment of being (Morris, 2008), a contrarian stance to the Cartesian duality of body/mind (also rejected by Heidegger) and describing how our being in the world, our intersubjectivity, is understood and enabled through our embodiment of it (Morris, 2008). Merleau-Ponty (2008) argues that "*our relationship to space is not that of a pure disembodied subject to a distant object but rather that of a being which dwells in space relating to its natural habitat*" (p.42-43 Merleau-Ponty, 2008). This intersubjective embodiment of being, reaching beyond language, is acknowledged in IPA, through recognising that we cannot fully be in someone else's world of perception and that any meaning we make from the participant's narrative is an additional way of understanding, rather than the 'essence' of their experience (Smith et al, 2009). IPA holds the idea that there are no universal truths of the world (Smith et

al, 2009).

This is the rationale behind the view within phenomenological research of understanding experience through experiencing (Langdridge, 2007). The researcher seeks to understand a phenomenon through someone else's meaning-making of their experience of that phenomenon. As IPA moves away from Husserl's transcendental ideas of early phenomenology (Langdridge, 2007), and places great importance on the role of interpretation, this process of the researcher making meaning of the participant's meaning-making happens through interpretations, and is called double hermeneutics, which is central to the approach (Smith et al., 2009). Hermeneutics in phenomenology, and more particularly in IPA, is not about interpreting the data with a particular focus, but rather about acknowledging that it is not possible for any human being to interact with anything without making some form of meaning, however preliminary (Willig, 2012). "*IPA is concerned with examining how a phenomenon appears, and the analyst is implicated in facilitating and making sense of this appearance*" (p.28, Smith et al., 2009).

A central idea is that the interpretation is cyclical, going from the parts to the whole and to the parts again (Smith, et al., 2009), moving between knowing and not-knowing as we shape and reshape our interpretations (Willig, 2012). This hermeneutic circling enables us to see the parts within a bigger picture and vice versa. It becomes a tool for rigour, to ensure that the interpretations stay grounded in the participants' narratives, while also enabling a more in-depth understanding through seeing the individual utterances within the wider context. "*So, the phenomenon lies, in part, latent, underneath but connected to the manifest, and it can come into visibility.*" (Smith, 2011a).

Part of this wave-like process is also utilising a combination of Ricoeur's (in Willig, 2013) 'empathic' and 'suspicious' forms of hermeneutics. This means that the researcher moves between positions of conveying the participant's explicit narrative in an attempt to be as close to it as possible and then moving 'away' from it into a more inquisitive perspective which aims to gain other viewpoints and that way enable a new/different understanding (Willig, 2013).

In other words, the processes of hermeneutics in IPA are not about just taking one single word, sentence or segment and giving it an in-depth interpretation of something explicit (descriptive/empathic) or non-explicit/implicit (conceptual/suspicious), but rather using the participants' whole narratives to find these meanings throughout. And after a myriad of these

cycles, eventually landing in certain meanings, representing something which echoes throughout the participants' experiences (Smith, 2011a).

The final aspect that is central to IPA, but also to this study specifically, is the idiographic focus, which entails the level of detailed analysis as well as an engagement in understanding a phenomenon as experienced by an individual in a certain/specific context (Smith et al., 2009). This focus in IPA came about as a "*critique of nomothetic psychology as only allowing actuarial or group level claims*" (p.49, Smith et al., 2009). In the present study, similarly, the idiographic aspect was sought out to create a possible contrasting space to explore the therapists' experience of risk. 'Contrasting' in the sense mentioned earlier, that in most mental health services today 'risk' has a highly nomothetic framing, as it is increasingly being conceptualised as something that can be predicted through set indicators and consequently prevented (Wand, Isobel & Derrick, 2015; Schwartz & Rogers, 2004).

### 2.1.5 Reflexivity

One of the key means of measuring the quality and rigour of a qualitative study is the researcher making their theoretical position and 'social location' in relation to the study known (Morrow, 2007), especially within IPA, where intersubjectivity is an essential part of how knowledge is understood and generated (Finlay, 2003). I have tried incorporating my reflexivity through the whole body of work, as a kind of 'transparent dialogue' – as I have used it in the research process – while also being mindful of not becoming only introspective and losing the focus of the research aim (Finlay, 2003). And so, having described my theoretical position, I will trace my 'social location', what brought me to pursue this study – a coming together of several experiences.

Going back several years, to my work as a Street-based Youth Worker, where I frequently had to fill out risk assessment forms (about all kinds of risk). I often experienced these as a 'tick box' exercise, not anchored in the actual work. I *did* have to assess risk on a continuous basis, but it was rarely the questions on the risk assessment form that brought on the different preventative measures. Rather, it was a context-specific, relational process, often done partly with the young people. When assessing risk, I would take numerous factors into account, but the relational factors (the mutual knowing, trust and respect in the relationships with the young people) were key. However, that element did not transpire in the formal assessments. This left me with an

inherent distrust of formal risk assessments, which I might even describe as a 'bias' when I initially began considering risk assessment as a possible area for my research.

Another aspect of this work that impacted me profoundly, was the role of top-down positivist/nomothetic and neoliberal policies, discourses and agendas about young people, shaping the targets and funding streams, and consequently our work (de St Croix, 2016). Leaving me and my colleagues standing alone if trying to work in a more youth-centred way. This was a difficult and stressful responsibility to hold, especially when there was risk involved.

Later on, when working in a Psychiatric hospital as a Mental Healthcare Assistant, I met a lot of people who were feeling afraid and powerless in their current life situation in a closed psychiatric ward, while also struggling to make sense of their own emotional lifeworld. This could understandably sometimes lead to strong emotional outbursts, which could be difficult for staff to deal with at times. It struck me how, when staff felt afraid of the patients, there was little space for attunement and empathy, which would then often escalate (or create) the conflicts. This was not a surprising or even novel reflection, but it was a visceral one. It became so clear to me how vital it was to ensure that staff felt supported and able to reflect on their feelings, both for their levels of stress, but also, and vitally, for the safe and attuned containment of the patients.

Fast forwarding another few years, I was training to be a Counselling Psychologist. In one of my early placements, I was working with a person who had suicidal thoughts, but no wish or intention to act on them. However, one day, they came in, experiencing a crisis, in deep despair and struggling to find a way to live. I still recall that session, the intensity and my feeling of total presence. I gratefully was able to connect with them and by the end of that session I felt less immediate worry. But I still felt shaken afterwards, I cared about this client and it shook me seeing them in that depth of despair.

All these experiences trickled back to my awareness as I began searching for a research focus. Initially my interest lay in the use of actuarial risk assessments, influenced by my experience as a youth worker, I 'expected' to find them inhibiting the openness, and ability, to stay present and attuned. However, as I began to engage with the existing literature on this, I realised that this was more nuanced than I had thought and that my interest was less about the risk assessment

procedure, and more about the full experience of the therapeutic work with a person who is feeling suicidal.

This brought back my experience from the psychiatric hospital, when reflecting on if and how the fear of a client committing suicide could impact on the therapist's ability to stay attuned and open, and consequently might affect the therapeutic relationship, and work. I also wondered about the role of support, and, on a wider level, if and how policies and discourses of suicide risk might be present in that therapeutic encounter with the suicidal person, as had been the case for me in youth work.

It was these confluent experiences that lead me to my initial idea of doing a pluralistic study. When realising a pluralistic study was not viable, I had to choose one perspective over the other. This is where my own experiences of working with someone suicidal came into play, wanting to understand more about this experience, the emotional and immediate, and to potentially at a later point look at the structural-political influence.

## 2.2 Design and Procedures

### 2.2.1. Participants

#### 2.2.1.1 Selection process

I use the word 'selection', following Polkinghorne's (2005) rationale that 'sample' relates to a more positivist line of research, where the findings aim to be generalisable.

IPA seeks to balance finding shared perspectives through delving into the individual, idiographic experience, "*/.../ the very detail of the individual also brings us closer to significant aspects of a shared humanity /.../*" (p.43, Smith, 2004). If interviewing too many participants there is a risk of being overwhelmed with data, preventing that essential, in-depth understanding of the individual meaning-making, consequently clouding the contextual threads that make up the shared experience. IPA does not stipulate an explicit number of participants but offers a recommendation of six to ten interviews for a doctoral study (Smith et al., 2009). To be able to engage in-depth with each participant's individual narrative and the shared experiences, I interviewed eight participants.

#### 2.2.1.2 Inclusion and Exclusion Criteria

In line with the idiographic focus, the selection was purposive (Langdridge, 2007). IPA requires a homogeneous selection of participants, but how that is defined depends on various factors. Some of these relate to the research question (having a lived experience of the phenomenon), or practical conditions (e.g., who can take part), and some to interpretative aspects (Smith et al, 2009).

The participants needed to be chartered/accredited Counsellors, Psychologists (Counselling or Clinical) or Psychotherapists. I chose these professions because of their commonalities of working one-to-one and face-to-face with people experiencing suicidal ideation.

I reasoned that any clinical differences between these practitioner-professions relevant to this study would primarily be organisational, diverging therapeutic approaches or differing values, as well as possible differences in training. And that these variations could be found even if only interviewing Counselling Psychologists. To my knowledge, there is no explicit indication in existing research of any of these factors influencing risk work in distinctly different ways. There are studies focused on specific modalities in work with suicide risk (e.g., Moerman, 2012; Nicholl et al, 2015; Richards, 2000; Carrick, 2014), and considering the possible impact of values (e.g., Nicholl et al, 2015; Moerman, 2012; Montgomery, 2018) and organisational settings (e.g., Sciberras & Pilkington, 2018; Nicholl, 2015), but no conclusive findings indicating differences in this specific lifeworld of working with a suicidal person. Thus, I concluded that the homogeneity of the specific experience required for this study would still be respected – and allow an openness true to IPA – even if interviewing a wider group of professionals. Practically, this also facilitated recruitment.

Another requirement was that the participants had to have been qualified for at least two years in order to have experience of risk in a role as a qualified therapist and not a trainee. Trainees do encounter risk, but they are not ultimately responsible, nor do they have full agency of their work, and they are also being assessed **(**Gill, 2012; Baba Neal, 2017).

Having worked with suicidal clients was a requirement. Further, this experience needed to have been with an adult client, as working with children could add distinctly different layers to the experience (Christianson & Everall, 2009).

I chose to follow the participants' own definition of 'suicidal', reasoning that it is their own lived experience of this phenomenon that is in focus. Participants who had worked for many years in tier two and three services were used to almost constant high levels of risk, so their definition might have been different from someone working with less frequent high risk. Nevertheless, the immediate experience of the phenomenon, within each participant's own frame of reference, was the same.

There was no gender preference as nothing in the existing body of research, nor in my line of inquiry, indicates relevance of that. The same applies for age and any other demographic features. Nevertheless, I asked for age and ethnicity. In the case of ethnicity, I did not want to assume that there is no impact of this, as I know that there is a history of White, Western normative assumptions in research (Fernando, 2017). Therefore, I did want to make visible/transparent any possible hetero- or homogeneity that might be present in the research due to ethnicity and/or cultural heritage. Regarding age, I asked, in case there might be an overlap or connection with years of practice, as there are indications that experience does influence how risk is perceived and managed (Nicholl et al., 2015), however, my findings did not contribute age-related insights.

#### 2.2.1.3 Recruitment

Participants were recruited through a mix of advertising and word of mouth, at my placements, through colleagues on the course and through friends knowing people in these professions.

The initial contact with potential participants was by email, listing the inclusion criteria (also on the research advertisement – Appendix A). If they met these, I sent them the participant information sheet (Appendix B), asking them to read it before deciding to take part. We then arranged to meet at a time and place suitable for them. I travelled to the participants for the interviews, as they all had spaces suitable for a confidential conversation. I interviewed people in various UK cities. To maintain anonymity, I will not name the locations.

I was aware from other colleagues who had recruited therapists that it could be difficult due to the potential participants having busy workloads and receiving research requests frequently. Therefore, I made the decision to offer an incentive in the form of a £20 voucher to Waterstones bookshops. The British Psychological Society's (BPS) Code of Human Research Ethical guidelines (2014) stipulates that remunerations ought not be "*disproportionate rewards for consenting or indicating disincentives for not consenting*" (p.20, BPS, 2014), but that it can be appropriate recompense for the participant's time and inconvenience of taking part (BPS, 2014). I reasoned that as the participants were practicing therapists, they would most likely be earning wages and the voucher would mainly be an additional incentive.

#### 2.2.1.4 Participant Demographics

I started each interview asking a few demographic questions (Appendix Z). I chose to do this verbally, as I felt it allowed an 'easing in' and building up rapport before starting the actual interview (Finlay, 2011).

To ensure the participants anonymity, I decided to keep the biographical information disclosed here to a minimum, only describing what might be of essential contextual relevance. I invited them to choose a pseudonym, which some did and for those who did not, they were happy for me to choose for them. Below is a brief description of each participant.

**Catherine** is a Person-Centred Integrative Counsellor, incorporating Psychodynamic, Gestalt and Transactional Analysis. She has worked in the NHS previously, and is now working in private practice. When I interviewed her, she had been accredited for four years, having had several other careers previous to this. Catherine identified as White European-British.

**Lisa** is a Counselling Psychologist who qualified more than fifteen years ago. She works in a secondary care service working with people with severe and enduring mental health problems. She practices integratively through mainly CBT and CAT, with Psychodynamic supervision. Lisa identified as White European.

**Martin** is a Psychodynamic Counsellor and Psychotherapist, and qualified more than ten years ago, having had other professions previously. He has worked in third sector services and still does. Martin identified as White European.

**Peter** is a Person-Centred Counsellor, who works integratively with CBT. He has worked in a variety of mental health settings, qualifying more than ten years ago. Peter is currently working in a third sector service, and in private practice. Most of his professional life has been in mental health. Peter identified as White Other.

**Sam** is qualified both as a Psychodynamic and a CBT therapist. At the time of the interview he had been qualified for four years, before then having had other careers. Since qualifying he has always worked in the NHS, and he currently works in primary care. Sam identified as being from a Middle Eastern country.

**Simon** is a Person-Centred Psychotherapist who, at the time of the interview, had been accredited for four years, but practicing for more than six years. Prior to that he had trained in a different area. He works in a third sector service, with previous experience in the NHS and private practice. Simon identified as White British.

**Susanna** is a CBT therapist working in primary care. At the time of the interview, she had been a qualified therapist for six years and before then had other careers, both in mental health and other areas. Susanna identified as White British.

**Yvette** is a Counselling Psychologist, with experience of tertiary care services with acutely suicidal clients. She now works in private practice. At the time of the interview she had been qualified for seven years, before then having had other careers. Her approach is pluralistic with a humanistic base. Yvette identified as White European.

All participants had experience working with adult suicidal clients. One participant trained abroad, all the others in the UK. They were all fluent English speakers.

Two participants had lost clients to suicide. However, as this was not a shared experience throughout, nor the expressed focus of my study – therefore not the participants' expectation to talk about this – I chose not to bring these experiences into the analysis.

*I battled with the decision of whether to do a so called 'negative case' with this (Patton, 1999), as not acknowledging such traumatic experiences initially felt almost unethical and unempathetic. However, as I got deeper into the analysis, I did not perceive any distinctive*

*difference from the other participants in their narratives about working with suicidal clients, nor did this experience "cast doubt" on the existing themes (Patton, 1999, p.1192). I also did not feel that I could do their experience of this justice, as it had only been a small part of the interviews. I also had concerns about potentially jeopardising their anonymity if bringing this in. Thus, after extensive reflection, I decided to pursue the analysis of their experiences alongside the other participants.*

### 2.2.2 Language

Terms such as 'complex' clients or 'high'/'severe' suicide risk I am hesitant to use without a clear, shared framework of what this means in a specific context. However, in line with the methodology, focusing on making sense of the idiographic experience, I used the participants' own language. They spoke about their experiences in their own professional contexts, describing their work using varying adjectives. If a client was 'complex' or 'severely suicidal', that was the situation they were relating to.

Further, on my use of the words 'client' and 'patient', as a therapist I do not find the choice of these terms straightforward, and I find myself revisiting my wording frequently. But there is not the scope in this study to discuss this (for further discussions on this, see, for example, Costa, Mercieca-Bebber, Tesson, Seidler, & Lopez, 2019; Christmas, 2013). However, for the purpose of this study, I use the term 'client' throughout. As a humanistic, pluralistic therapist and researcher, I find that the term 'client' has less connotations of a biomedical, positivist outlook, even if I find the word problematic due to its resonance with a business transaction. But my main reason for using the word client is because seven out of the eight participants used this word. I use 'patient' only in relation to the participant who preferred that wording.

As part of my acknowledgment of research, and in particular IPA, being subjective- and intersubjective, I have chosen to write up parts of this study in first person. At the same time, with it being an academic piece of work, where I describe other people's work, as well as the participants' narratives, I do also write in third person as I find that better allows for their views and voices to take centre stage. If solely writing in first person I find that it comes across as being more about me than about my participants' experiences or other existing research findings. Therefore, I have chosen to move between the two in a kind of dialogical way.

### 2.2.3 Data collection

#### 2.2.3.1 Interview rationale

The participants were interviewed through semi-structured, one-to-one interviews, lasting between 60 to 100 minutes.

Interviews are the most commonly used form of data collection in IPA (Smith, 2011b), enabling rich and in-depth material (Finlay, 2011). The conversational format allows for a collaborative element to the research (Reid, Flowers & Larkin, 2005). I chose semi-structured interviews because they combined a level of structure with a transparent procedure and thread of key questions. I felt that semi-structured one-to-one interviews, rather than for example diaries or focus groups (Finlay, 2011), would make space for collaborative meaning-making with the participant (Reid et al., 2005).

Writing my interview schedule (Appendix C) I was guided by my research aims and the recommendations offered by Smith et al. (2009). They suggest areas to consider when formulating questions, as well as different angles of inquiry (e.g., descriptive, comparative) to elicit a diversity of answers (Smith et al, 2009). I used these as a guide, as well as incorporating my supervisor's suggestion to simplify the questions and find multiple ways of asking about their experience.

After my first research interview I added a question at the end of the interview schedule (see question 12 in Appendix C), after conferring with my supervisor.

#### 2.2.3.2 Piloting

Having obtained Ethical approval, I piloted the interview with a fellow Trainee Counselling Psychologist and a friend who is a qualified Counselling Psychologist, both having worked with suicidal clients. The purpose was to test out the questions, and to practice interviewing, as the quality of the interview to a great extent determines the quality and richness of the data, and consequently the overall analysis (Smith, 2011b). I followed the same procedure as with the subsequent research interviews, giving the pilot participants the information sheet to read before agreeing to take part, having them sign a consent form (see appendix D) prior to commencing the interview and informing them that they could stop the interview without giving an

explanation, and they were also given the debrief information (see appendix E) at the end of the interview.

During the pilots I realised the usefulness of having additional prompts in the interview schedule, as an aid to follow up certain areas and to not go off track. The pilots made me aware of the necessity to manage time in order to include everything.

*Conducting the pilot interviews, I found myself pursuing narratives that were not directly about my research topic. I experienced in vivo what McLeod (2015) describes as one of the two main potential pitfalls for therapist-researchers conducting interviews, namely being so open and non-directive that you do not get the data you need. I realised how I needed to reign in my curiosity, trying to find a balance between hearing what they were telling me and ensuring my research aim stayed in focus. This taught me to glance through my questions throughout the interviews in order to not miss anything out.*

#### 2.2.3.3 Interview process

Before starting the research interviews, I talked through the participant information sheet (see Appendix B), and then the signing of the consent form. Then starting the recorders and explaining the interview format.

To elicit an experiential account, I began posing open-ended questions to enable the participant to freely narrate, then, following their train of thought, inquiring further through probes (Pietkiewicz & Smith, 2012). The first question, about what made them take part in the study, had two purposes: firstly to get an insight into their interests and motivations around this topic, and secondly, to begin talking about the topic without a specific focus, to facilitate their opening up and feeling more comfortable with the interview situation (Smith et al., 2009). After the first question (and the preceding demographic questions), I asked about their recollections of a specific experience working with a suicidal client. I wanted to get to their phenomenological experience and felt sense, being mindful of not moving into a more intellectual account too soon.

However, one participant expressed surprise and disagreement at my way of starting the interview. Although appreciating my asking why she had chosen to take part, she then felt that going straight onto her experience was too immediate. She had expected me to ask her about

her thoughts and possible values around working with suicide. She is experienced with research and IPA. As I explained my reasoning behind doing the interview this way to get to the phenomenological experience more directly, she understood, but maintained her view that she thought that was too upfront/direct. No other participants expressed this view, nor did I note anyone seeming uncomfortable with this question. However, that does not mean they did not feel this.

*I have afterwards reflected that I ought to have done a pilot with myself as the interviewee, to be on the receiving end of the questions. I did ask the people I interviewed for my pilot, how they felt about the questions, and they said they thought they were good. One person said they enabled him to really think about his experience, to bring what it felt like to the fore. However, I knew both of them well, which could mean that, as they felt comfortable with me already, they did not feel the need for a different order of asking the questions.*

#### 2.2.3.4 Transcription

All the interviews were audio-recorded and transcribed verbatim. In line with the phenomenological-existentialist view of experience being embodied, I chose to also transcribe any prosody and nonverbal behaviour that I observed in the interview or heard in the recording (Finlay, 2011). I was also aware that my choices at this stage, what I transcribed and in what way, as well as what I omitted, would already be influencing the analysis (Kvale & Brinkman, 2009).

To ensure anonymity, I removed identifiable features, giving any names (e.g., places, services) an algebraic letter (X, Y, Z, etc).

### 2.2.4 Analytic strategy and process

Below I outline my analytic strategy, following recommendations of Smith et al. (2009) regarding stages of analysis.

#### 2.2.4.1 Step one: Data immersion – Listening, reading and re-reading

My analysis began to an extent already during the interviews, but it started in earnest at this stage of listening back to the recordings and transcribing. This stage is essential to get close to the data, to ensure a rich analysis in later stages (Smith et al., 2009).

*I found the first transcription challenging, as I kept stopping to reflect on my mode of 'translating' the interview into writing, repeatedly going over the recording to ensure I had captured my participants' words and tones as closely as possible. I felt I was already making interpretations of sorts in the way I was denoting their narratives – verbal and non-verbal. I was aware of the importance of epoché at this early stage: "the rule of epoché urges us to impose an 'openness' on our immediate experience so that our subsequent interpretations of it may prove to be more adequate" (p.17, Spinelli, 1989). However, I eventually noticed that, as long as I held the participant's live narrative close in mind, my way of transcribing was mainly a vessel to enable that narrative to remain dynamic through the next stage of analysis, the initial coding.*

Carrying out this stage, immediately followed by the initial coding and emergent themes (see below) ensured that the richness of this familiarisation process stayed present throughout the analysis. This became one of the ways of 'bracketing off' premature interpretations and/or assumptions, staying close to the text.

**2.2.4.2 Step two: Initial noting**

This stage was the most detailed and time consuming, going line by line, reading the text through three different lenses, in line with Smith and colleagues' (2009) recommendations: Descriptive (blue), Linguistic (red) and Conceptual (green), making colour-coded notes in the right column of the transcript (Appendix F).

As a starting point, I followed Spinelli's golden rule of phenomenological research at this early stage of "*Describe, don't explain*" (Spinelli, 1989, p.17), by focusing firstly on the descriptive coding, to 'hear' the participants and ensure, as much as possible, I did not impose my own views.

Moving onto the linguistic coding, I was initially hesitant to analyse language and prosody, as I did not want to move into a too suspicious form of analysis or to venture into a more constructionist reading, where the language precedes meaning. I found guidance when reading Willig's (2012) discussion on language and meaning and how in a phenomenological reading we do need to pay attention to language (verbal as well as non-verbal), but with the view that experience precedes it, so that language in IPA is "*a means to an end rather than being an end in itself*" (Willig, 2012, p.65).

Bringing nonverbal communications to my awareness was also part of my personal reflexivity, given that, if I were, unknowingly, responding to that rather than the verbal content, it could shape my interpretations without my cognizance (Spinelli, 1989).

In parallel with the linguistic annotations, I also did conceptual reading of each line. This was a more interpretative stage, where I made particular use of Smith and colleagues' (2009) recommendations to ensure I stayed within the frame of IPA. I wrote a list of bullet points of these methods to have present when encoding each transcript. These are not the authors' format, but my way of visualising their methodical considerations. I was aware that these were described as tools rather than a stipulated method (Smith et al, 2009, pp.88-91), but, being new to IPA and wanting to be transparent and ensure rigour, I tried to make use of them systematically.

My understanding and use of these were as follows:

- **Interrogating the text**:
  Asking questions of the text (What? How? In what way?). An aid to consider different perspectives.
- **More overarching reflections on the text**:
  I took this to mean making particular use of the hermeneutic circle. Throughout my coding I used the abbreviation 'H.C.' highlighted in yellow, whenever I thought this specific point might have a wider resonance. As I analysed more participant data, these notes came to encompass associations with other participants as well. In those cases, I made a particular note of this, as a way of 'bracketing it off'. During later stages, I revisited these H.C. notes and in some cases, they turned out to form part of themes, while in others, I found no commonalities.
- **Paying more attention to my personal reflexivity – 'dialoguing with the text'**:
  Moving between knowing and not knowing (Willig, 2012), recognising my preconceptions (Smith et al., 2009). I mainly did this in three different ways.
  1) Noting my own personal reflections/associations evoked by the words;
  2) Writing any personal experiences the text resounded with;
  3) Observing any emotional reactions I might have in reading the participant's narrative.
  I would then revisit these reflections, aided by the hermeneutic circle, considering if they added to the understanding of the participant's experience or if they were simply a reflection of my own lifeworld, keeping in mind that "*the analysis is primarily about the*

*participant, not oneself. One is using oneself to help make sense of the participant, not the other way around.*" (Smith et al., 2009, p.90).

- **Putting myself in the participant's shoes**:
  To me, this was about getting a more immediate insight into what the participant was saying and what they might have been feeling. I applied this more actively if I came across a segment I struggled to engage with, make sense of, or relate to in any way. Or if I thought that I might be assuming the meaning out of my own experiences, thus trying to move closer to their experience in this way.
- **Time frames/sense of time**:
  I used this tool a lot, finding this lens of 'time' offered layered perspectives of the participants' narratives at these early stages of analysis, enabling me a more dynamic and multifaceted reading.
  E.g. Narratives moving between past and present; the 'relativity' of time when recalling some of their experiences (offering an insight into the intensity of some of these emotions and the embodiment of their recollections); and time as a process.
- **Deconstructing questions or statements**:
  I understood this as reading the text from different angles to further my perspectives of the participant's meaning-making. I did not use this method as much as those above, rather mainly when I found the participants narratives to be 'contradicting' somehow. Then considering the idea of "multiple selves" (p.89, Smith et al., 2009), reading their narratives in deconstructed ways, e.g., as being within a profession, a service and a socio-political context.
- **Things that would strike me as important**:
  I used this method in the context of the above-mentioned tools. Something somehow striking, offering possible insights into divergences and convergences. Making a note of a lingering question of why this might have caught my attention, or why I thought it was noteworthy – then exploring it through the hermeneutic circle.

*'Beating around the bush' is a good way to describe my initial relating to the process of analysis. As much as I found these tools hugely helpful, in the beginning I struggled to deepen the levels of interpretation out of concern that I might move too far away from the participants' experiences. I knew that I had a lot of views of my own and was concerned that they would colour the participants' narratives. I was also cognisant of the budding therapist in me,*

*potentially making interpretations of the participants' feelings rather than making sense of their own meaning-making.*

*Crucially, I was reminded by my supervisor to continuously return to the participants' quotes, letting their own words verify each new level of interpretation, doing "hermeneutics from within, not without" (Smith, 2011a, p.15). Following this advice and making constant use of the hermeneutic circle, I slowly dared to venture beyond description in my interpretations.*

**2.2.4.3 Step 3: Developing Emergent Themes (ETs):**

With my having completed the initial coding, the next stage entailed the first more distinct – still empathic – level of abstraction from the text, as I tried to synthesise the meaning of their account, through my initial annotations, into emergent themes (ETs) (Appendix F).

This became a two-step process, as I first wrote potential ETs in the left-hand column of the transcript. Having done that through the whole interview, I went back to the beginning of the transcript to move them onto my computer for printing for the subsequent clustering stage. However, as I would go through the ETs again, I found that many of them no longer rang true to the participant's account, thus bringing me back to annotations and participant's words, reconsidering, changing or discarding the ET.

*During this process of re-reading the ETs, I was reminded of something I learnt years ago, when training to be a dance teacher. I was told I needed to 'kill my darlings' when developing choreographies. This referred to how we gravitate towards our familiar movements and how I needed to take active steps away from these, in order to find new ground as a dancer. Going through the encoding and trying to formulate ETs, I found this echoing in my mind, how certain interpretations were too much 'my own' – my own familiar directions or specific interests, and not following or enhancing the insight into the participant's experience. That is when I would go back, close to the text, reading each word descriptively again, while also considering the hermeneutic circle, and 'putting myself in their shoes'. This was a fruitful and interesting (and challenging!) process where I became a bit more confident that my interpretations were grounded in the participant's meaning-making.*

#### 2.2.4.4 Step four: Searching for connections across emergent themes

Beginning to find commonalities across the ETs (within individual interviews still) – the superordinate themes (STs). All the ETs jumbled up in a bowl, then, one by one spreading them out and starting to look for possible ways to cluster them (Appendix G). Utilising methods recommended by Smith and colleagues (2009), in particular abstraction, subsumption and polarisation, but also, contextualization and numeration.

I found that the first round of clustering would often be more on a 'surface level', perhaps following themes I 'expected' to find to an extent. But, doing several rounds, exploring different conglomerations, I felt they went beyond a descriptive level. Eventually I settled on relevant clusters of meaning (STs), named according to their commonalities.

*I found myself feeling somehow closer to the participants at this stage. There was something in the way their words stood out like concentrated spurts/snippets of meaning, as if conveying a more intense or highlighted experience than when reading the joint/whole narrative. This also became a guide in the clustering.*

#### 2.2.4.5 Step five: Moving to the next case

In accordance with the idiographic commitment of IPA, I performed steps one to four, one participant at a time, trying to maintain epoché (Smith et al, 2009). However, acknowledging the intersubjectivity, where "*the phenomenological researcher will change or transform the account as well as be changed or transformed by it.*" (Willig, 2012, p.37), I also came to realise that I might not have the same mind frame throughout. Therefore, I found practical ways to ensure as much openness for each participant as I could.

My main tools were reflexivity and spacing out the analysis, e.g. noting any possible comparisons between participants coming to mind; any emotional responses in me; and paying attention to how my reflections might have changed through the research process. I began to take a break for at least a few days before moving onto the next participant.

*After having performed steps one to four with my second participant, I went straight to transcribe my third interview. However, as I did this, I found myself struggling to 'put myself in the participant's shoes', I noticed that I was being 'suspicious' in my listening, which I definitely ought not be at this stage! I found this particularly surprising as I had been deeply engaged in*

*the interview with this participant. Stopping to make sense of this, I realised that I had been so moved by the analysis of the previous participant that I needed to let that settle in me before starting on another interview. So, I took a break for a few days to be able to fully and fairly immerse myself in the next participant's experience. I found that this helped, and I thus continued making space between participants.*

**2.2.4.6 Step six: Looking for patterns across cases**

Having all the participants' superordinate themes, I spread them all out and began to look for divergence as well as convergence (Smith et al., 2009). Noting how the themes across cases communicated with each other, adding and deepening – or at times lessening – the levels of meaning as new supraordinate themes with corresponding subthemes were created (Smith et al, 2009).This process was a combination of looking across the superordinate themes and also tracing them back to their origins, the participants' quotes, seeing if the participants 'spoke' to each other in a way. I found commonalities in likeness and difference. Such as one participant's theme highlighting the importance of their support networks, while another's voiced the isolation and heaviness of the lack of support. Starkly different accounts, but jointly offering a shared sense of needing support in their work with suicidal clients.

*This was a deeply exciting process! Grounded in the quotes and the rigour of the preceding analysis, I felt this stage left scope to be creative. While also finding I had to keep returning to my research question to remind myself of what specific aspects I was looking for, as otherwise I could go off-piste with so many different fascinating trails to follow.*

I think that the expression 'fusion of horizons' that Gadamer speaks of (Gadamer, 2004, in Suddick, Cross, Vuoskoski, Galvin, & Stew, 2020), encapsulates what this stage entailed, where the "*hermeneutic circle, dialogue, and process of interpretation leads to a fusion of horizons as understanding takes place*" (Suddick et al, 2020, p.3). I found that this is where Smith's (2004) emphasis on the idiographic bringing out a shared lifeworld fully came into being. Enabling "*to discover something more; a new perspective and shared understanding of the subject matter*" (Suddick et al, 2020, p.3).

I chose to call the overall themes 'suprathemes' rather than the more traditional 'Master themes' to avoid its gendered and socially/historically laden meaning.

## 2.3 Ethics

This research complies with the British Psychological Society's (BPS) Code of Human Research Ethical guidelines (2014). Ethical approval for this study was obtained from City University of London Ethics Committee (Appendix H).

Obtaining ethics should not be seen as a one-off occurrence at the beginning of the research, but rather as an ongoing process throughout, with different focus at the varying stages of the study (McLeod, 2015). Below I discuss my main ethical considerations (see also Reflexivity, section 2.1.5 and throughout).

### 2.3.1 Informed consent

Before obtaining consent, I ensured the participants understood what taking part entailed, going through all the research stages (interview participation, data analysis, up to what point they were able to withdraw from the study, the possible dissemination of any published material, and how their details and data would be stored and for how long; Appendix B). They were also informed that they could stop the interview at any point without giving a reason.

### 2.3.2 Confidentiality and anonymity

Prior to consenting, the participants were informed that their accounts would be confidential and also anonymised throughout the whole research process. Any identifying traits would be changed or removed, and they could choose a pseudonym or be allocated one. Their personal details were kept separate from any research material. They were also notified that the recordings and transcripts would be stored with password protection for five years following publication, as stipulated by the BPS's Code of Human Research Ethics (2014), after which they would be destroyed.

To ensure the anonymity of any clients the participants would consider in their accounts, it was made clear that I was interested in their (the participant's) experience, and details about their clients were kept to a minimum in order to ensure their anonymity.

### 2.3.3 Risk

The participants being therapists, I reasoned that they were likely to be reflecting on their work with suicide risk on a regular basis and would therefore be at low risk of harm from taking part in this study.

However, I could not assume this, nor that they would have a support network. Further, they could experience an unexpected difficult recollection, potentially causing them distress.

I therefore emphasised that they could stop the interview at any point without giving an explanation and provided a debrief sheet with details of support services (Appendix E). The last two questions in the interview were an invite to debrief about how they had experienced the interview and to voice if they felt there was anything they wanted to say or add. Given this space, a few of the participants expressed that talking about these things had brought back some of the difficult feelings they felt during this work, while also reflecting on how they rarely had so much time and space to talk about these experiences in such depth, noting and appreciating the value of this. One participant also recognised/identified how this in-depth reflection would be difficult to do in her everyday work, as she expressed that a level of 'bluntedness' was needed to cope with the constant high-risk levels.

### 2.3.4 Ethics of interpretation

"*/…/ the act of interpretation always involves a degree of appropriation /…/ the interpreter has the power to shape what comes to be known about another person's experience.*" (Willig, 2012, p.45)

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*The process of interpretation is often described as a 'dialogue' with the text (Smith et al., 2009), however I struggled to embrace this idea, being aware of my power to choose what and how I wrote, making it feel one-sided. I came to experience what this 'dialogue' entailed in the final stages of the analysis, where I felt there was a form of 'conversation' between the different participants' quotes and my own interpretations. To reach this place, I had to go through both a rigorous process of taking practical measures to ensure I stayed as "true" to the participants' words as possible, but also a journey of 'owning' the responsibility for my interpretations. Acknowledging and accepting that I would be transforming the participants' accounts, perhaps in ways that another person may not, and accepting that responsibility, made me able to fully engage in the analysis.*

That responsibility entailed being rigorous in doing what I set out to do, what I told the participants I would do – pursuing the research question through the lens of the outset methodology. Willig (2012) offers three strategies to ensure an interpretation is ethical.

Firstly, staying close to the research question. This ensures the researcher's motivations are made clear when entering the interpretative process (Willig, 2012). Secondly, to not lose sight of the participant's voice (Willig, 2012). In IPA, I understood this as not trying to make sense of the participant's possible underlying motivations, but their own meaning-making, staying close to their accounts to get an insight into their experience. Willig's (2012) third strategy is to hold an openness to other ways of understanding the text and to write the interpretations in such a way that this openness is made explicit. I have tried to do this, being tentative in my interpretations, as well as through reflexivity and transparency, attempting to show my positions and reasoning, the intersubjectivity made explicit – acknowledging my analysis as one perspective in a wider kaleidoscope of meanings.

### 2.4 Quality and Validity

Due to the prevalence of positivist paradigms in psychology research (Ponterotto, 2005), one could argue that there is a particularly strong need to be clear about how to measure the quality of qualitative research as otherwise it is easily misunderstood and devalued, being judged by quantitative criteria (Madill et al, 2000). Quality refers to how rigorous the research process has been. From the suitability of the research paradigm, through the choice and exploration of the literature, to the clarity and depth of the data collection, analysis and presentation (Yardley, 2000). A rigorous study increases its trustworthiness, its validity (Morrow, 2007).

Lucy Yardley (2000) defines rigour as one of several criteria to ensure quality and validity in qualitative research. I have followed Yardley's (2000) criteria throughout my research, with additions from Smith's (2011b) quality criteria for IPA articles.

#### 2.4.1 Sensitivity to context

Yardley (2000) refers to a variety of contextual aspects such as situating the study within the existing body of research. Further, as the research is about meaning making, it is essential to have a transparent grounding in the philosophy of the methodology. In addition, she speaks of the importance of an awareness of the socio-cultural setting of the research and researcher.

And finally, she emphasises the necessity of actively recognising and addressing possible power imbalances within the specific research encounter, and the research overall.

In my literature review, I have attempted to acknowledge the wide field of suicide research, focusing more specifically on the area of working with suicidality. Moreover, having explained my choice of research focus, and paradigm, the relevance of my methodology, and my motivations behind this choice, I have positioned myself and my study within the existing context of working with suicidal people in the UK today.

Regarding the possible power imbalance inherent in research, being in an academic position of 'expert', holding the privilege and status ascribed to such a role, I view this power dynamic in two ways. Firstly, I believe that, in relation to my participants, who were all qualified and experienced practitioners, the power imbalance was greatly reduced – if not reversed – as I was both less of an expert on the actual phenomenon, and not yet a qualified professional.

However, there is another potential imbalance, which is not about the participants but about the clients, the people accessing therapy at a point of suicidal despair, about whose experience I am in a way indirectly writing. The participants in my study kept their clients' identity entirely anonymous throughout the interviews, but I want to acknowledge that my findings here could, if disseminated, have, even if very limited, an impact on the work with people who are feeling suicidal. The main thing I have done to try to minimise this possible imbalance is to be tentative and transparent my process and reasoning and continuously emphasise how this mirrors an interpretation of an experience, one way of understanding it, and not a nomothetic truth. Additionally, my research is an endeavour to employ an idiographic, non-pathologising approach to anyone feeling suicidal.

### 2.4.2 Commitment and rigour

'Commitment and rigour' refers to how exhaustive, in-depth and clear the data collection and analysis are (Yardley, 2000).

I followed these criteria through my commitment to staying as close to the participants' narratives as possible and following the six-step analytic strategy outlined above. I have sought out my supervisor's views on the resonance of my participants words in my themes and

interpretations. I have also ensured that each one of my subthemes in the analysis is represented by a minimum of five of the eight participants (Smith, 2011b).

### 2.4.3 Transparency and coherence

Transparency and coherence refer to the clarity of the researcher's interpretation, including how this is conveyed in the way the interpretations are presented, but also, how the steps of the whole analytic procedure are delineated, from data collection, through interviews, and analysis, to the final write-up of the work (Yardley, 2000).

I have transparently described my research journey, step by step. From acquiring ethical approval for the study, through how I recruited and interviewed the participants in line with the methodology, followed by a detailed description of my analytic process. Including my own reflections and struggles, as well as discussing the limitations of the study (see 15). Having kept a paper trail of the transcripts with annotations, and my process reflections, I have provided excerpts of these – and subsequent analytic steps – in the appendices.

Additionally, I have articulated my personal and professional motivations, perspectives and rationale behind my choice of this research topic and the specific philosophical and theoretical lenses I have held throughout this process.

### 2.4.4 Impact and importance

The criteria of impact and importance is about just that, the possible impact and value that the research can have for a wider field or community. This can look in different ways, but in qualitative research it commonly entails a theoretical impact, on ideas, views and/or understanding of a phenomenon (Yardley, 2000).

As described earlier, my initial intention was to try to gain an insight into the possible interaction that a wider discourse about suicide risk might have on the individual practitioner's experience of direct work with the suicidal person, and vice versa. However, focusing on the phenomenological experience, my lens moved to the meaning and felt sense of this work for the practitioners. My hope is that my work might contribute to a more attuned, idiographic understanding of, and approach, to people who are feeling suicidal and the people who work closely with them.

## 3. The analysis

### 3.1 Overview of the themes

In this chapter I will be presenting the three supraordinate themes and their subthemes that emerged from my analysis, carried out as described in the previous chapter. These supraordinate themes are not distinct entities separate from each other, but rather, interrelated pieces of the puzzle of the participants' shared and individual experiences as I understood them through the lens of my research question and research frame.

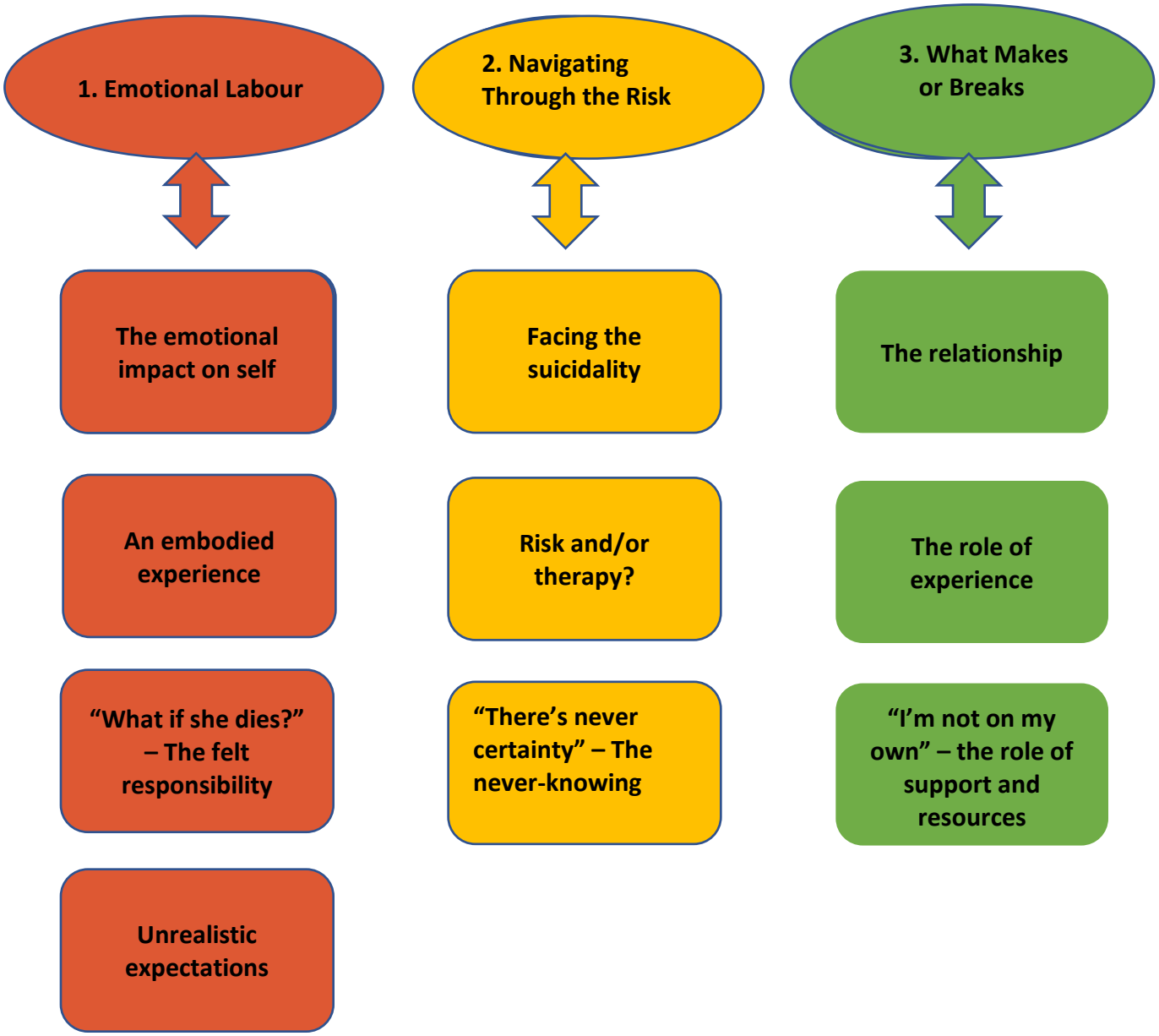


**Figure 1: List of supraordinate themes and subthemes**

The three supraordinate themes are, as depicted in Figure 1: Emotional Labour, which refers to how working with suicide risk impacts the participants; Navigating Through the Risk, which looks at how the participants understand and navigate the risk work; and What Makes or Breaks, which discusses the structures and processes that facilitate or impede this work for them. With each theme, I will provide a brief overview before going through them in depth.

For clarity when reading the quotes, the symbol /../ is used when I have removed part of the dialogue, maintaining the parts most relevant to the specific subtheme. Three dots … are for when participants pause (varying length, often brief); <u>underlined</u> words indicate an emphasis in their speech; and anything written in square brackets [] within a quote represents additional information of either how they spoke, or what they were referring to in content.

### 3.2 Supraordinate theme one: Emotional labour

This first supraordinate theme explores how the participants made sense of how the work with suicidal clients impacted on them. The first subtheme looks at how working with someone suicidal influenced the participants personally. Subtheme two reflects on their embodied responses to their clients' suicidality. The third theme discusses how they experienced and made sense of their responsibility. And the fourth theme considers the expectations held within and without their professions regarding risk work and how these were understood and experienced by them.

#### Subtheme 3.2.1 The emotional impact on self

The participants' accounts revealed that working with suicidal clients had made impressions on them on deeply personal levels. There was a lot of overlap amongst their narratives, with several of them experiencing a sense of powerlessness, worry, distress, fear, tiredness and often a sense of stagnation in the work with suicidal clients. But there was also individual difference and specificity in how this work had impacted them personally.

In the quote below we can follow Susanna's experience of sitting in the room with a client who had previously tried to commit suicide, and the impact that hearing this had on her, as a practitioner but also as a fellow human being.

> *"/…/ it then came up that he'd actually made an attempt. And that was much more, I found that more, sort of distressing, uhm, around the attempt. Because just seeing the man in the room, you know he's a nice, you, you know, he's a nice honourable man that's just got caught up in an awful political situation."* (Susanna, 247-252)

Susanna offers an insight into what it was like for her to hear from her client how he had previously tried to end his life. Her emotional response to him telling her this reveals her deep empathy for him, but also, perhaps, her realisation, that, to an extent, anyone can reach that point of contemplating suicide. Her description of "*just seeing the man in the room* /…/ *he's a nice honourable man that's just got caught up in an awful political situation*" sounds like a humbling and maybe also somewhat startling realisation for her. This impacted Susanna personally, hearing about someone she related to and cared about as a person, reaching such a point of despair. Susanna later explains the toll that risk work takes on her.

> "*it's very very tiring* [risk work]*. It's very emotionally tiring and taxing for people and I think you go home feeling very tired. And I sometimes go home, and I don't really wanna talk to people. Because I've just kind of, had enough. /../ It, it does kind of have an impact on your personal life. And it's not just me, I spoken to some other therapists and they say the same thing,*" (Susanna, 1460-1469)

Susanna expresses the exhaustion she feels doing this work. Not wanting to talk to people when she goes home, as if the risk is all consuming, encroaching on her personal realm, possibly her family life. Her explanation that other colleagues feel the same, makes me wonder if it might be difficult to voice this. Almost as if there is an expectation/idea that she ought not be affected personally. And the fact that other colleagues feel the same, makes it more acceptable. This experience, of being invested in the client, of caring about them and how their suicidality became a personal concern, and takes up personal space was echoed by Lisa.

> "*she was one of those people that sometimes, you know, you wake up at two o'clock in the morning and you just feel really worried. You know, she sort of got under my skin.*" (Lisa, 507-509)

Lisa's description of how her client "*got under [her] skin*", gives a sense of no separating space, almost claustrophobic. The worry for her client penetrated into her personal world. She highlights this experience further:

> "*Uhm, so, yeah it wasss, she had a big impact on me, that lady…was really, and I think because I really liked her I desperately wanted…her not to die, but at the same time it was so difficult because she was making it so hard all the time /…/ you know it was just constant, constant, constant.*" (Lisa, 536-541)

Lisa seems to be coming back into our conversation as from a place of poignant remembrance, pensively hanging on the words "*uhm, so, yeah it wasss*". As if still making sense of this experience, she contemplates on the impact the client had on her – and to an extent still has. Lisa's description of 'really liking' her client, "*that lady*", is an acknowledgment that she is invested as a person, a human being, not just as a professional. The relentless worry she felt about her client potentially killing herself echoes loudly through her words 'it was just constant, constant, constant'.

That relentless worry, can also be heard in Sam's account, where the constant high risk lead to a sense of loss of self-confidence. The worry for the patient's safety brought on a questioning of his own competence.

> "*It makes me feel powerless, inadequate, aaand, ou-out of my depth, if there is a very clear, suicide presentation, because, it's something I can't control. It's something that I don't [brief silence], I'm not with the patient all the time, aand, and I'm <u>always</u> <u>doubting</u> whether I have done, <u>right</u>, whether I have, whether I have done <u>enough</u>, whether, I can, rely on, what I have done, and uhm, so it's always doubt, and it's always doubt about my, ability… power and, sort of, if I feel, but most of the time it makes me feel powerless, inadequate, aaand, not good enough.*" (Sam, 971-982)

What I hear reverberating throughout Sam's words here is a vast sense of powerlessness and fear. The uncertainty with possible fatal consequences makes him question himself on all levels. Ensuring the patient does not kill themselves becomes personal, about being "*good enough*" to keep them alive. Evaluating the efficacy of his own actions, his own ability or lack thereof to prevent the patient's suicide seems to be a search for some level of reassurance, some sense

of control, but when he cannot satisfy that expectation, this makes him question his overall competence as a therapist.

Simon explains how he considers being impacted by his suicidal clients an essential part of the work.

> I: *So, you're not often holding, this kind of work, outside of work?*
>
> S: *No I don-, yeah, I don't think, I, I think… I think I am, and I've got used to it. [laughs – then serious again] I, I can't not feel it, I can't not think about, for example, that session, I will think about her, she's there, somewhere in me, but I'm used to, I'm, I think like, I'm used to holding, I'm used to holding it, [inhale] and I don't think I'd be completely ok with not ever thinking about, about her, or thinking about anyone who was in that point, because I think, it, is important to…I don't know, it's a bit scary I guess, reaching a point where I'm never thinking about suicidal clients between sessions, cos that to me, sounds like quite a desensitised, place to be and I think we need all our sensitivity and feelings in those encounters…*" (Simon, 966-982)

Simon's process of formulating his thoughts here, offers an insight into his felt experience of working with suicidal clients. With his initial response that he does not think about it outside of work, only to immediately realise, that he definitely does. Possibly indicating how this is something he is used to holding, something he expects himself to hold. He describes how the client is "*there, somewhere*" in him, and emphasises not being comfortable "*not*", "*not ever*", "*never*" holding a suicidal client in mind between sessions. For Simon, it seems necessary to be impacted by his clients, to hold them in mind, as part of keeping them safe. His repetition of being "*used to holding it*", suggests something he has grown accustomed to through experience, something endemic to his work. Saying, "*anyone who was in that point*", resounds of a categorical place on the edge, that point of no return where he knows the client might go. His fear of becoming "*desensitised*" acknowledges just how hard this work is, an awareness of how it could be to be drawn towards shutting off emotionally. For Simon, working with suicidal clients means inevitably – and necessarily – engaging his whole being, allowing the clients to make an impact on him as a person and to hold them in mind, even in his own time.

Throughout the interview, Yvette described various experiences with suicidal clients, some distressing and difficult moments which have shaped her professionally. But there was one, more existential, aspect of this work that she particularly valued on a personal level.

> "*So there's a, I like that paradox, and that there's sort of the intense, intensity of the, uhm, of life and death, uhm, and, uhm, that pushes you into really considering what life means to you*" (Yvette, 1016-1020)

Yvette reflects on the existential awareness this work gives her personally. The way she expresses this through the words "*intense, intensity*" and how it "*pushes*" her, to me has the resonance of a visceral, almost embodied insight into her own existence, as if moving her beyond the cognitive, philosophical reflections. This work with life and death seems to bring her closer to the meaning of her own life.

### 3.2.2 An embodied experience

As the participants delved into their recollections of specific experiences with suicidal clients, their narratives seemed vivid, and encompassing more than merely a cognitive realm, but also expressing embodied reflections. This theme explores these embodied responses.

*One thing that struck me as I was analysing the interviews was the many indicators of embodied responses in the participants' recollections and narratives, both implicit and explicit. In order to make sense of these responses, I made particular use of the hermeneutic circle, to ensure that I was not adding an interpretation about the experience to something that might simply be their usual ways of expressing themselves. Such as one participant swallowing audibly and frequently through the segment when talking about a client's completed suicide, but not through the rest of the interview. Through this process, I found that there seemed to be a strong element of embodiment in the participants' work with suicidal clients.*

Talking about the work with a patient who had been severely suicidal, having attempted suicide shortly before starting therapy with Sam, I asked him what feelings surfaced as he recalled this.

> "*Uhmm, feeling of, again, feel quite anxious, thinking and talking about that patient is quite uhm, anxiety provoking, even now I feel like [fast inhale] anxious talking about it, as*

> *if, there is a, [mouth smacking], heavy weight, on my shoulder, and, that is with me, was with me and still is if I have a patient like that [said fast], is, every session [swallows],*" (Sam, 394-401)

I find that Sam is inadvertently inviting me to feel his worry, that palpable urgency of the anxiety he feels when working with this very suicidal patient. I hear his tentative beginning saying 'Uhmm, again' as if being aware that he might be repeating himself, followed by "*feel quite anxious*", the word 'quite' lessening the strength of 'anxiety', and repeated twice, as if not too strongly felt, only to grow in intensity and contrast, both through his words as well as his nonverbal communication in his sharp inhale, his almost running through the words "*patient like that*", and his audible swallowing, as if even just saying this is very hard. It is almost like a crescendo, as though he needs to build up momentum, confidence, conviction to feel able to express his feelings in full force – illustrating the weight of the worry, the anxiety taking hold of his physical being as well as his mind. This is highlighted through a powerful use of the rule of three "*and, that is with me, was with me and still is /…/ every session*", emphasising his experience of constantly holding this anxiety, or even, of in a way being held down by it.

Similarly to Sam, Simon, too, as he spoke, noticed how he carries this work in his body. Talking about how he felt when sitting with a client who was very suicidal, Simon closed his hand into a fist on his chest and seemed to only realise this as I asked him about it.

> "*Yeah, I think it is, like, like a…like a knot, or like just the <u>weight</u> as well… I I feel it more like an enveloping weight over all of me, I think… So, through my shoulders and, all the way into me [inhale], and that weight there's [suspended inhale]… at the time it felt very heavy, and, and, I felt, like she was leaving it <u>on</u> <u>me</u>, and, as she walked out and left. [inhale]*" (Simon, 840-846)

Simon begins to unravel what this means to him, reflecting on how he carries this experience in his body. The way he inhales as he talks, as if catching his breath, audibly and frequently through this segment could be an expression of how that weight he describes feels within him – heavy and perhaps constricting, "*an enveloping weight*" that spreads, as if taking up more and more of him, going "*all the way into*" him – as if reaching his person. His wording "*at the time*" is a recognition of how he usually goes on to process these feelings, eventually managing to ease that heaviness. But in the session, he felt like the client left her pain, her wish to not live, on him,

as if these feelings were so heavy as to be physically tangible. Simon was left holding something that the client could not bear to hold themselves.

Lisa voices a similarly all-consuming experience. The work with a client who was acutely suicide during most of the time in therapy, reached Lisa to her core, to the point of her feeling physically ill.

> "*/…/ the sessions were so intense! It was like so much emotion in the room!, so every time I left I almost felt sick afterwards, I had to go and sit down and it just, like took me about half an hour to recover cos it was, it was really difficult.*" (Lisa, 1088-1092)

Lisa's work with this client was emotionally and physically stirring. Her experience sounds like an emotional centrifuge, the way she describes it as so intense and so much emotion in the room, leaving her feeling "*sick*" after "*every*" session. The openness and vehemence with which she talks about this, including her description of having to recover after each session, seems to convey how present and attuned she was with her client, using her whole physical and emotional being in the work. In spite of the time after the sessions to recuperate, it took a toll on her, as can be further understood from what she describes having said to her supervisor when the client was referred back to the service.

> "/…/ *'it nearly killed me seeing her, I can't see her again, it's just too difficult for me', and she* [supervisor] *was like 'wow! that's a really strong', you know, but that's what it felt like, it was just, it was really hard.*" (Lisa, 1109-1112)

Lisa says this in the interview with calm and clarity, as if expressing just how hard this was for her, consuming her whole person, her supervisor's shocked reaction highlighting the gravity of this further. Keeping her client alive seemed to push Lisa to the limit of her own life.

Such intensity of emotion, as to become a strong felt physical presence, was shared, if in a different way, by Yvette and Catherine, who expressed how the immediacy of the suicidality seemed to evoke an embodied alertness in that moment with the clients. For Yvette this was manifested as if suddenly her whole body and mind was switched on to maximum capacity.

> "*/…/ there is a vi-vibrancy, sometimes in that kind of encounter, when working with suicide, that, uhm, that you're really kind of firing on all cylinders, and, you know, everything else, kind of, it isn't, doesn't matter, it's very mindful [slight tone of laughter] of the present moment that you're in there, and you're using all your abilities and, all your… you know, everything [deep inhale] comes together sometimes because of that kind of adrenaline rush maybe that you get when you're faced with something like this and you have to just respond, you know.*" (Yvette, 420-429)

I hear, and even feel, a complete switched-on-ness in Yvette's narrative. So much energy! Facing someone who is immediately suicidal fires up every part of her being – an embodied response of total presence. Yvette describes that "*adrenaline rush*" and "*firing on all cylinders*", her whole being attuned to her client, trying to find a way of connecting to enable them to come out of this urgent, desperate place. The vibrancy Yvette describes, how "*everything comes together*", resounds of vitality, this is about life and death and she seems to face the situation head on with full force, with no space for doubt, "*you have to respond*".

*During the interview, as Yvette described this, I particularly noticed how I did not hear any fear in this narrative, she sounded fearless and just full of fight for the client's life! This stood in stark contrast to a previous description of another risk situation, where she had felt deeply fearful. So I asked her, which lead to her reflecting on the role of professional agency and responsibility in her perception of risk situations. I will be returning to this in the next subtheme, about responsibility.*

Catherine's embodied response seems to come from a similar source of intensely felt urgency regarding the client's suicidality. She speaks of a calm that comes over her when she is with a client that is very suicidal, which she explains is different from the calm she may feel with non-suicidal clients.

> "*It's like… You know when you feel really relaxed? But altogether, so you're not falling asleep, but you are just…Everything is fine, everything is ok. It's a bit like, uhm…an in-inner calm, where something in you is saying, 'everything is ok, everything is fine, just follow your instinct, go with it, listen and everything will be ok…'. I can't even explain it, but this is how it feels. I can feel my body… language is very, very calm.*" (Catherine, 518-525)

This calm Catherine speaks of, in response to a client expressing suicidality, sounds like, similarly to Yvette, a form of highly attuned, embodied presence. 'Listening' with all her senses, seems to enable her to trust that she will be able to see and connect with her client. The way she says, "*I can't even explain it*", recognising it as an embodied feeling, indicates how this perhaps is something she accesses on a more 'instinctual' level – "*follow your instinct*" – in the moment. Catherine seems to use all levels of communication in this moment.

Susanna chimes with these experiences of a physicality in her direct work with suicidal clients, but she also stretches this embodiment into the contextual impact of her pressured work environment in relation to managing the risk.

> "*There is a tension in the service, over risk, and, it's also really quite physically tiring and draining at the time, dealing with it. /…/ I mean, I don't feel, I don't feel tired talking about it with you in this setting… because I don't have the pressures of work, but actually when I'm in work, and suddenly I hit somebody and there's risk… it's, it's really difficult, because I know, basically my admin, will… uhm… The time that I should have for my admin will disappear"* (Susanna, 338-353)

Susanna seems to speak of an embodied exhaustion, connected to the space of work, with the weight of the case load – with its inbuilt expectation of the clinician managing risk within, but also beyond it. The "*tension in the service*", the risk having to be managed, but at the cumulative expense of her own time and energy. Her expression, "*suddenly I hit somebody*", has connotations of the hit her body and mind take when she encounters suicide risk.

### 3.2.3 "What if she dies?" – The felt responsibility

A theme running through all the participants' narratives, was that of a felt responsibility. This emerged without my asking about it. Holding slightly different definitions and meanings for the participants, for some it meant having the agency to respond as they believed appropriate, for others it was almost the opposite of that, an overwhelming feeling of being responsible for this human being's life, making it difficult to move beyond that into dialogue and connection with the client. The magnitude of the potential lethal outcome of a client's suicidality seemed to evoke a strong feeling of responsibility to save their life. This was about the immediate danger for the client, as well as a personal and professional risk for the participants themselves.

Both Peter and Lisa offer an insight into a fear-fuelled responsibility when facing someone urgently suicidal. A feeling of holding the person's life in their own hands in that moment, the magnitude of the clients telling them they are going to kill themselves and feeling it is up to them to stop them.

> "*Well, you, felt. like. It was all on you…to make a difference. And you literally had one hour. [said quicker] Or not one hour cos we didn't have strict rules like that, but you had [quick inhale], you had [slows down] one chance.*" (Peter, 235-238)

Peter's client came in with a gun saying they were going to kill themselves after the session. He describes this experience in second person, perhaps as a way to keep it at a distance. The intensity and urgency of this memory is partly conveyed through the changes in his speech, increasing and decreasing the haste of his words. It sounds a deeply frightening and tense experience, where he felt that he was holding that person's life or death in his hands. Needing to make The Difference that would save That Person in That Moment, he felt he "*had one chance*" to make that difference and save the client – a staggering responsibility.

Lisa mirrors Peter's experience of being drawn into a similarly intense, frightening and almost polarised responsibility, where it is all on her.

> "*/…/ cos it's almost, you can get into the battle of you know 'I want to die' and 'no, I don't want you to die' and you get into this battle almost /…/*" (Lisa, 443-445)

The image of a battlefield brings to mind how much Lisa is also at risk in this encounter. She is face to face with the potential of her client's death and the injurious consequences that could entail for Lisa herself. The felt responsibility to change her client's mind is about keeping both her client and herself safe.

A similar sense of almost going around in circles, feeling responsible to keep the client alive, and struggling to move beyond it, was also expressed by Catherine.

> "*/…/ because when it's suicidal, especially at the beginning when I started, there is this *[loud strong inhale]*. This fear, what if, what if they do it, and what, what will happen to*

*me as well [!], but what will happen to them, the consequence for the family… And then I found myself going into a roller coaster, and I said, woa, woa, woa, I need to take a step back here. Cos at the end of the day, I'm not going, I'm not here to be a saviour. I'm here to support them. And since then, it's been easier.*" [Catherine, 442-449]

With an audible gasp, Catherine conveys an embodied experience of her initial encounters with suicide risk. As she puts this into words, Catherine, similarly to Lisa, expresses a sense of risk, not only for the client, but also for herself, and for the client's family. The way Catherine describes this myriad of felt responsibilities – the many 'what ifs', the 'what will' – offers an insight into that roller coaster of thoughts and fears. How she found herself overwhelmed and needing to take a step back, calibrating her role, finding that she could not hold all that responsibility, that it was not hers to hold. Realising that she can support but not save. This process seems to have been a deeply experiential and visceral one, where releasing herself from that all-encompassing responsibility facilitated her work.

Sam, too, voiced how that overwhelming feeling of responsibility almost obstructed the work with his patient.

"*/…/ it was all the time and needed, sort of, attention all the time, and, therefore, for me, it was like walking on an egg shell, and was quite, uhm, anxiety-provoking, because, I wanted to make sure, that this patient is saaffe, and when he leaves this service, or this building, so he's able to, keep himself safe*" (Sam, 202-208)

Sam describes his experience of needing to constantly attend to the suicidality – keeping an eye on it, monitoring it, making sure he did not miss anything. It was his responsibility to make sure his patient was "*saaffe*" – he hangs onto that word as if holding onto its meaning: keeping the patient safe at all times. "*Like walking on an eggshell*", the patient's safety feels so vulnerable, so dependent on Sam's words and actions that one slip could have fatal consequences. This level of responsibility was difficult to work with, as Sam goes on to explain.

"*I was completely consumed by that* [suicidality] *and I felt like, [inhale], paralysed*" (Sam, 232-233)

Sam gives a powerful insight into how debilitating he felt this was. The all-consuming responsibility and worry meant that he felt unable to work as he would wish.

Simon also echoes Sam's and Catherine's experiences of that constant focus to keep the client alive having a counterproductive impact on the work with the suicidal client.

> "*/…/ it's ok, to not feel, co-, so responsible, and, and feel…compromised by that responsibility, because in the end, it's, it's about trying to be there, for them, in the moment, and, and not letting those other feelings get in the way, I guess. and to, and to hold those other feelings that come up in me.*" (Simon, 566-571)

Simon's wording of being "*compromised*" seems to illustrate how the felt responsibility brought on by the suicide risk diminishes his ability to stay fully present with the client. The way he says how "*it's ok to not feel so responsible*", as if giving himself permission, suggests that part of him finds it difficult to allow himself this stance. There is something in this that seems to feel uncomfortable for Simon. He goes on to articulate what he feels is a helpful and unhelpful responsibility.

> "*Being responsible, I think it means… I think I feel a responsibility to…I think generally, in a therapy relationship, I feel a responsibility to facilitate something that's helpful for someone, in some way. And then the moment the fe-, the ff-, the…uhm, area of suicide comes into it and, the prospect of something-, of <u>killing</u> themselves, I then, can feel a sense of responsibility to keep this person alive, which I, I think is what I'm, I work on, loosening that feeling of responsibility as much as possible, uhm, if that makes sense?*" (Simon, 577-585)

Simon seems to say that he almost inevitably is drawn into feeling responsible for keeping the client alive. This makes me wonder if wanting to keep someone alive is almost an intrinsic human reaction, and yet what Simon seems to be describing, is how, in his role as a therapist, if he only focuses on trying to keep the client alive he might not be able to see or hear them – and consequently not help them. Simon seems to try to bracket off that urge to take on the responsibility, containing his own anxiety, offering the client a reflective and connective space, in the hope that this might enable the client to stay alive. Simon explains this.

> "*/…/ even in taking a position where I'm not…uhm…intervening, uhm, I'm taking a sort of non-responsible position out of a hope, that that will be a good thing and that will mean that they won't kill themselves. So there's still, even though I'm stepping back and not behaving in a responsib-, there's the hope that, actually I'm gonna have an influence over this person and [they're] not gonna kill themselves.*" (Simon, 517-523)

Similar to Catherine, Simon describes "*stepping back*". I do not understand this as being inactive, but rather an endeavour to allow the client agency and connection by Simon actively trying to contain his own worry. How difficult and uncertain this might feel for Simon is illustrated by his repeated use of the word "*hope*", emphasised both times. Holding this uncertainty is how he views his responsibility towards the client.

Yvette approaches the idea of responsibility from a slightly different angle. Comparing two different experiences with acutely suicidal clients – one situation which she felt was "*traumatic*" (192) and another "*difficult*" but not "*beyond my competence*" (412-413) – she reflects on the role of her own agency and professional sense of self in how she perceives her responsibility.

> "*/…/ one of the differences, is that, is that sense of self, you know that, that in the previous situation I just felt like, it's up to me, it's my fault, it's my responsibility, I'm not good enough [smiling/near-laughter?], needing to, you know, I need to cope with this, [inhale], /…/ I think in both situations I probably drew on very similar… [smiling/near-laughter?] understandings, and skills, and strategies, and so on, but, in, in the first case, it felt so much like, I was, I was being examined, or, I was, yeah, I don't know…*" (Yvette, 487-509)

What Yvette seems to be describing is an experience of her felt responsibility not just being about the client and needing to keep them alive. The difference between one situation being "*traumatic*" and the other "*difficult*" but manageable, was her own professional "*sense of self*", how she perceived her role and agency in each of these situations. As a trainee she did not have the ultimate choice about how to act with the client and her response to her client was experienced by her as also being part of being examined as a therapist. Later, she was qualified and able to make her own decisions as to how to act. In the encounter with the suicidal client, that shift in 'sense of self' meant going from keeping the client alive being about her own

competence, to keeping the client alive full stop. A move in focus from all responsibility on self, to a different mindset of what to do to enable the client to live.

Yvette's ending this reflection saying, "*I don't know*", communicates a sense of the complexity of this experience, that there are other factors involved in this felt responsibility as well. One additional factor she goes on to explain is that, in the 'non-traumatic' situation, she was aware that there were other people from her team nearby, so she knew she was not alone, whereas she describes being spatially alone in the other setting, being in a room tucked away from where everyone else was, all the responsibility on her.

### 3.2.4 Unrealistic expectations

Describing why he had chosen to take part in this study, Simon reflected on how much therapists have to hold with suicide risk and the importance of talking about this, and he said, "*cos it's always, like I know that's* [suicide] *somewhere someone can go in a, in a point of distress, and, it, it's hard to feel completely ok, with that*" (187-189). What stood out for me were his words that "*it's hard to feel completely ok with that*", with the knowledge that suicide is a possibility. It resounded to me of an expectation that the therapist ought to feel fine knowing this. Simon went on to say that he feels it is important to continuously reflect on this, acknowledging its weight and how he is impacted by it. This perception was in fact something that I kept coming across in different guises in most of the interviews, both as a form of internalised expectation, and also as explicit experiences of unrealistic expectations and pressures imposed on the participants and their work with suicidal clients. Often there would be examples of both internal and external expectations within an interview.
Sam reflected on this explicitly:

> "*/…/ I think, uhm, as a therapist, sometimes we feel like, we're kind of omnipotent and we can have, all the resp-, we <u>do</u> have all the responsibilities, and we can have all the power we want! Like power to <u>save</u> patients, but the reality is that we're only with the patient for like 50 minutes.*" (Sam, 403-407)

Sam describes an aspect of believed omnipotence within the profession when working with suicidal patients, although his wording of how this is sometimes 'felt' indicates that it might not be an active belief, but a felt sense. A sense connected to the level of responsibility held. The way he first says, "*we can have*" and then changes to "*we <u>do</u> have all the responsibilities*"

seems to communicate a felt external expectation. His link between having all the responsibilities with all the power is thought-provoking, as if someone holds all the responsibility, if someone is held responsible for everything, then one might assume that it would be in their ability, in their power, to control everything. Yet, there is a reality discrepancy that Sam points out with the glaring example of only seeing the patients a very limited amount of time – especially in his service which is brief therapy. Nevertheless, the expectation to keep them safe all the time is felt to lie on him.

As Sam speaks of this kind of internalised professional belief, of expecting to be able to save people's lives, no matter what, and to feel confident and reassured in that belief, Lisa speaks of a similar expectation, but more external. She describes having gone to a Coroner's court hearing with a colleague who had lost a client to suicide, and how she went with him as a way of preparing herself if that were to happen to her. Here she talks about the discordance between the Coroner's expectations and her own work reality.

> "*The coroner was really quite hard on the person [swallowing] who was the last person to speak to him – to the person that died – on the phone. Uhm…Asking very difficult questions, and kind of, 'Why didn't you do this? Why didn't you do that?' Uhm, you know, cos the coroner has some understanding of the way we work, but obviously he won't understand that, and it's, I think, in an ideal world, yes, we would have done all those things, but we just haven't got the resources…to do that.*" (Lisa, 789-794)

Lisa voices mixed agreement and disagreement with the Coroners' demands, when she explains that they would have done those things if they had the necessary work conditions. With the words, "*in an ideal world*", she seems to express that those conditions do not exist, that they work under unrealistic circumstances and pressures. Lisa seems to experience, in her view, unfair and uninformed expectations from the Coroner's court, which could have grave consequences for her and her colleagues. But also, a sense of working under conditions that she personally does not feel comfortable with nor agrees with yet has to navigate through daily. Lisa describes this dissonance in a powerful image…

> "*/…/ you know, you feel like you're walking a very dangerous tightrope*" (Lisa, 948-949)

…as if practicing acrobatics with people's lives – both the clients' and Lisa's.

This disparity between the work reality and the experienced expectations is also voiced by Susanna. In her case it comes from within her own service, in particular from the management.

> "*/…/ there's sort of drivers in the service, /…/ in some of the more senior ranks, in trying for this* [suicides] *not to sort of happen. /…/ But, they do happen every now and again, and they're bound to, because the volume of people that come through the service. There's no way, no way around that. So…yeah. It's, it's a tricky one, because you, you know with the risk, the risk that doesn't carry any…funding, or any…that's not what – but it takes up a lot of time.*" (Susanna, 1033-1041)

Susanna's use of the word "*drivers*" brings up the idea of an engine, of being forcefully pushed as if by a machine, without a choice of direction or space for dialogue. There being "*no way, no way around that*", as if knowing that a precipice will undoubtedly come as something has to give, either the volume of patients seen or the risk. Susanna then seems to try to minimise this disturbing dilemma by using the word "*tricky*", as if only a minor problem, which perhaps is a way of coping with that disquieting tension of service expectation and clinical reality on a daily basis. It might also be a form of internalised professional expectation that things are not meant to get to her, that she ought to just cope and get on with it, akin to Sam's idea of omnipotence. Susanna's description of how managing risk carries no funding but is time consuming (raised in her narrative throughout the interview), supports this idea. There seems to be an expectation that she ought to go beyond her work time, without support, all responsibility lying on her.

Yvette also described an early experience of a disproportionate level of responsibility, where the consideration of what was best for the client neglected to account for what was feasible for Yvette to manage on her own.

> "*/…/ it worked, she <u>didn't</u> kill herself, you know [said quietly], but, I had a terrible time with it, and I didn't want to feel like that again.*" (Yvette, 304-308)

Yvette's words here evoke a strong sense of weight, of a cost to her, to her own wellbeing, in the enormous effort she made to keep her client alive. She worked in a service trying to avoid risk-aversity and was told not to call an ambulance. But this risk was too much to hold. From the way she says "*it worked*", said quietly as if the effort and tension were still present, to her

acknowledgment of how difficult this was for her and the clarity that she is not willing to feel like that again, this experience seems to have shaped her deeply as a professional in how much she is ready to hold when working with risk.

Resembling Yvette's forged boundaries of what level of risk she is willing to hold, Martin, too, seems to have learned the hard way what is and isn't possible for him to manage when it comes to risk. Maintaining these boundaries is still not straightforward, however, under the existing surrounding pressures.

> "*/…/ I need to see that there's [swallows] follow-up, in terms of the medication, and, some level of support in the background [inhale] /…/ Otherwise it's just, uhm, not fair on, on me or, the service… Uhm… That, that, came, became much more apparent, with experience.*" (Martin, 451-465)

Martin has learned to set up a frame of background support before he begins to work with the very high-risk clients referred to his service. His wording, that 'otherwise it is not fair on him or the service' suggests that his past experience has entailed holding an unfair level of risk. Speaking of the role of experience, Martin seems to be saying how initially he might not have fully known what was an acceptable level of risk for him to hold, nor what was needed in order to manage that risk. He has learnt this through difficult experiences. Even so, it seems it is still difficult to maintain these necessary boundaries – Martin voices his frustration over how these high-risk clients are continuously referred to his service with no outside support:

> "*/…/ people just, send them, send, send them /…/ the services, they send them, <u>here</u> [swallows], as the last resort because there's <u>no</u> support, for them.*" (Martin, 473-480)

Martin's initial repetition, "*just send them, send, send them*", resounds of disbelief and frustration with the way these high-risk, vulnerable clients are almost dumped on his service. His sense of being their "*last resort*", with no other support, offers an insight into his dilemma of how to see them safely in therapy. It seems that the lack of resources on a wider level, outside his service, risks creating an unsafe, deeply stressful work situation for Martin and his colleagues.

### 3.3 Supraordinate theme two: Navigating through the risk

The second supraordinate theme revolves around the way the participants confront and navigate the reality and immediacy of the risk, making sense of what it is like sitting with someone who is contemplating suicide, and how they relate to this. There are three subthemes, with the first theme looking at the urgency and intensity of facing an intention of suicide. The second theme considers how the work in therapy is altered when working with a person who does not want to live, and the third theme reflects on the constant uncertainty throughout the work with suicidal clients.

#### 3.3.1 Facing the suicidality

Most of the participants described experiences of sitting with someone imminently suicidal. Their descriptions were sharp and direct, in varying ways eliciting a sense of urgency and stark reality when facing someone so close to death. There was no mincing of words. This theme explores that experience.

*During the analysis, this theme punched out at me from the pages of the transcripts – I felt it to the bone. I was repeatedly struck when coming across the participants' experiences of being faced by someone saying how they were going to 'hang themselves', or 'shoot themselves', the intricate level of detail with its horrifying meaning~~s~~. The stark and shocking reality in this, and yet, how they would all hear these things, some of them frequently…and what hit me was the normality of this abnormality somehow…*

Catherine describes an experience that she still recalls vividly, from one of her earliest clients, where she initially felt at a loss as to what to do.

> "*/…/ she kept saying, 'well, I've got a rope in my bag, and as I leave you, I'm going to such and such place, I already know the tree, I'm going to hang myself.' … And my first thought was, 'oh my god, what do I do with that?!'.*" (Catherine, 1167-1170)

Catherine's words "*she kept saying*" evoke a sense of incessant pressure. Hearing her client's insistent determination in the specificity and detail of their plan seems to have brought on a feeling of something petrifying and unstoppable for Catherine, initially making her feel powerless, not knowing how to respond.

A similar feeling of bewilderment when faced with an almost palpable danger, was expressed by Susanna.

> "*/…/ I've had quite a few people sort of saying, Yes, I'll go to platform X at train station Y, and there are particular platforms, that people… will go to where they know the fast trains are, /…/ I was kind of sitting there and thinking, 'oh shit'. [laughs] You know, they figured, they have actually figured out where they have to go to, to do it.*" (Susanna, 1358-1365)

Susanna is experienced working with suicidal clients, having heard about these platforms several times. Nevertheless, hearing such a concrete plan startles her. She talks about "*people*" here, rather than 'clients' and I wonder if that partly offers an insight into how she experiences this situation: as a person facing another person who is telling her they are going to kill themselves, the immediacy of potential death perhaps highlighting a shared humanity. Her words, "*oh shit*", bringing her to laughter, seem to endorse this as an almost primordial, deeply human experience.

This visceral reaction of fear, and perhaps of shock, can also be heard in Peter's depiction of a situation of similar urgency.

> "*We had scary incidences, I once had a woman walk in with a gun, put it on the table and say: "I'm, I'm going to kill myself tonight*" *[starts chuckling as says 'tonight']*" (Peter, 231-234)

Peter's expression of how scary this was is elucidated by his chuckling as he describes it. There is a sense of this being so frightening that he has to laugh to cope. Peter's chuckle evoked in me a sense of surreality, as if the stark and harrowing reality of this situation was almost too much, and laughing about it enabled him to face it.

Yvette also expressed a kind of bewilderment with one of her clients, if slightly different from the urgency of Catherine, Susanna and Peter's experiences. Yvette's concern did not emanate from an immediate threat of suicide – her client was slowly, if doubtlessly, deteriorating – but from seeing and understanding the unbearable pain that living entailed for her client.

> "*/…/ she Did Not Want To Live, she just simply didn't want to live, yeah. She found, her whole life was such pain, and she had no, uhm, no hope, you know really, she, the way she just kept herself alive was sort of like… I don't know how she did it, it was suu-, such a, such a feat, in itself, from day to day, and when you think about all the things she'd experienced in her life, it's no wonder. /…/ you know, how do you work with that?*" (Yvette, 986-997)

"*she Did Not Want To Live*" each word said as if with a chisel. Yvette is sitting with the weight of the client's wish to die, but also with the felt awareness, the powerful empathic understanding, of how unbearable living is for her client. She seems to be describing a situation where she feels very little hope of making a difference, seeing and feeling her client's pain to the extent that her own wish for her client to live feels hard to hold.

Simon mirrors both this experience of a deep existential empathy evoked by the client's agonising pain, and also the urgency and fear from the direct risk of suicide.

> "*/…/ she was feeling…so so low, so hopeless, so tired, and trapped, and, all those things, and it reached like a real…uhm, sort of, intensity, as she was talking about it* [suicide]*, and our time was running out [fast inhale]*" (Simon, 778-781)

I hear Simon's deep empathy fuelling the heaviness, the worry and the towering urgency that he was feeling in this moment – there is a sense of being on the brink. "*Our time was running out*", ominous words, seemingly holding intertwined meanings of the session running out, and with it, a sense of being able to keep the client safe.

I hear that sense of alarm that runs through all these narratives, also in Lisa's experience. Her way of listening and reacting seems both cognitively systematic and embodied, as if having an internalised warning system.

> "*He'd done all the research, so he knew exactly, he had a plan, he was gonna hang himself, he knew exactly, how to do it, how to make the noose, and there were no protective factors, /…/ So he was just like, all the alarm bells just started ringing,*" (Lisa, 192-198)

"*He'd done all the research.*" Lisa's increasingly heightened awareness can be heard in her every remark here, each utterance making it more real. The way she, in different words, repeats and returns to how "*he knew*" how to do it, "*he knew exactly*". He knew how to make the noose. His knowing setting off her knowing.

For Sam, those alarm bells started ringing even before he had ever met his patient.

> "*/…/ before therapy, three or four weeks before coming to therapy he made an attempt, but the attempt failed, not that he, changed his mind, the attempt failed, /…/*" (Sam, 300-302)

Before having even met his patient, Sam knew he had just attempted suicide – by hanging we later find out. His words resound of an intense, overhanging awareness that he might try again. Knowing this, Sam seems to have felt great trepidation in meeting his patient for the first time. He describes how his patient's attempt almost became a haunting image, still with him today.

> "*[inhale] Well, one major things in my mind that it is, still is, when I'm talking about it, himmm, on a rope, hanging from ceiling. That was his attempt.*" (Sam, 633-635)

The brutal image of his patient hanging from the ceiling seems to have become imprinted in Sam's memory, even when no longer working with him, suggesting just how traumatic hearing about this and fearing it happening at the time might have been for Sam.

This kind of internalised 'knowing', when the risk sets off alarm bells, as described by Lisa, is echoed in various ways by several of the participants. "*I probably have sort of an internal, kind of flow chart, flow map /…/ what I'm talking about is whether you can do therapy, as such, or whether you need to work with the risk*" (770-780) is Yvette's reflection on how she differentiates between risk she has to act on and risk that can be reflected on through the work in therapy. This kind of risk compass is considered in part in the next subtheme.

### 3.3.2 Risk and/or therapy?

One of my questions in the interviews was about the difference between working with suicidal and non-suicidal clients (with the awareness that it is rarely that dichotomised in therapy). In many cases this came up without my asking about it, as the participants reflected on their work.

This theme came out of these reflections. A majority of the participants expressed there being a distinct, detectable difference when the risk was high, leaving little or no space for meaning-making work. Simon describes this as a disconnection in the therapeutic relationship in that moment of immediate suicidality, where therapy became something practical rather than reflective.

> "*/…/ it was like, this person, isn't engaging in therapy, this isn't therapy any more, this is, this is literally like she's setting herself on fire, basically, that was what it felt like, so I, I'm not here, there's no value in me being here, empathising with what she's telling me, because what she's telling me is she's gonna kill herself after this, so the decision was, just, obvious to me, in that case, [inhale] /…/*" (Simon, 1120-1128)

"*literally like she's setting herself on fire*" – a terrifying image, igniting a sense of immediate and palpable danger. Simon seems to have felt a distinct relational alteration with this client – "*this person*", his wording possibly an expression of this move out of the therapeutic relationship in a way. Her lack of engagement signalling to Simon a loss of connection, rendering his presence as a therapist immaterial. Simon appears to partly ascertain when to step out of therapy and into practical action through a kind of relational barometer. And, in contrast to most other levels – or expressions – of risk, he found the decision of how to act in this situation – where the relational connection had been suspended – clear and "*obvious*".

Some participants discussed how all-consuming the risk could be, with the sessions becoming predominantly about managing the risk and ensuring the client's safety. For Sam and Lisa this seems to have felt like they were unable to do their job.

> "*/…/ when I was working with that patient, at the beginning, it was aaall about suicide, and then I found myself that, I'm quite caught up in like, practical aspects, and my [swallows?], treatment is being neglected, and minimised.*" (Sam, 430-433)

Saying "*my treatment*" suggests that Sam felt that his professional purpose was not fulfilled when all his attention was on the patient's immediate suicidality. His description evokes a sense of frustrated stuckness, as if doing CPR without being able to move beyond it. Lisa parallels this sensation of a kind of therapeutic inertia, of not being able to move beyond the suicidality.

> "*/…/ the sessions were more about, kind of keeping her alive, while with another person it might be more about developing skills and doing something different ["developing skills and doing something different" said faster and more run of the mill], /…/*" (Lisa,390-394)

Both Lisa's words and contrasting cadence evoke a feeling of continuous stagnation – "*kind of keeping her alive*". Describing her usual work, with less suicidal clients, in such a run of the mill way, gives a sense of everything else being easy in comparison to this. Lisa offers an insight into the difficulty she experienced in moving towards any form of growth with this client. There was little space for meaning-making or change, with all the focus on S.O.S. – keeping her alive.

Martin also highlighted how the risk impinged on the possibility for a reciprocal therapeutic process, needing to ensure by practical means that the client was safe.

> "*/…/ it was more about managing, the practicalities of their lives, rather than going into the-, any kind of therapeutic wo-, eh, work. This became like a, safe haven /…/ where, uhm, at least the suicidal thoughts would subside, and a lot of it was to manage the practicalities /…/ and then we could do a little bit of the work, on, the, you know, what resources they had.*" (Martin, 361-368)

Martin emphasises and repeats the words "managing"/"manage", as if stressing how this was not a joint labour with the clients, but rather him setting up a framework to ensure they were, and felt, safe – "*a safe haven*". The way Martin says that "*at least*" they would feel less suicidal and that they could do "*a little bit*" of work on their resources, seems to acknowledge how his expectations of doing therapy with these clients at this stage was limited.

Yvette also reflects on this boundary to therapy that risk imposes, and how she experiences the somewhat contradictory aspect of this for her own job satisfaction.

> "/…/ *we're not really talking about, dealing with the underlying issue here, you know, you want to get someone into a place where they can work with the underlying issues, but [inhale], if someone is at such high risk, you have to work with the risk first, you can't, work, you know, although, you could say it's a sort of chicken and egg situation, because, if you're dealing with the situation, if you can solve that, then they won't kill themselves, but, [inhale]…*" (Yvette, 878-886)

"*not really talking about*", I hear a kind of sobering realism in Yvette's description of her experience with high suicide risk. Doing the work that would help these clients process what underlies their suicidality is not possible, the risk becoming the obstacle of its own 'solution'. This dilemma prevented Yvette from doing the work she 'wanted' to do, which partly lead her to moving on to private practice, now seeing clients at a stage where they are more able to work through their trauma, as she explains below.

"*/…/ so that's what I like working in now, much more, in the, in the second stage. [inhale] Uhm, and I, I have clients who have been through difficult things, but are now, able to work with the trauma [swallows] , and that is where you, face, you know, all the needs that weren't met and try to find new ways of meeting those needs*," [1181-1186]

Yvette now finds this stage more rewarding, as she feels able to 'meet the clients' unmet needs' and make more lasting changes. There seems to be a consensus throughout these participants' narratives that risk has to be addressed, but that this often entails a level of trade-off with the therapeutic work that might enable the clients to process their underlying difficulties. Although what they appear to be expressing is that when the risk is that high the clients are not able to engage with that deeper processing, so therapy is not even an option.

Susanna offers an additional, different perspective to this kind of dichotomy, of risk or therapy, where the cut-off in her experience has chiefly come from external demands rather than from the interaction with her clients.

> "*/…/ we can't openly say that, but I think it* [risk] *is an annoyance because, we have to keep an eye on that, you know, and it's a significant aspect of things for the patient. However, that takes up time, and we only have a certain number of sessions with the client and so we don't want to…in, in terms of the way the service judges us, uhm, it's kind of like another pressure, added on top of the pressure of trying to move people through the service and get, get…help them to get recovery. But also, if they have risk like that, that you – it would usually mean that there is more, sort of complexity in the case as well.*" (Susanna, 979-989)

I hear a tension between the need to pay attention to the risk and the limited time - and the targets Susanna has. Risk becomes an "*annoyance*" as it does not allow her to stay on target, the risk derailing the therapy track. Susanna's experience seems to an extent to be a choice between risk or therapy, not delineated by client needs, but service demands, as there is not enough time to do both. Even though higher risk usually means more complexity, there seems to be little acknowledgment of this from the service. The way Susanna's "*annoyance*" cannot be voiced openly, along with her description of how "*the service judges us*", makes me wonder if risk is something which is approached from a point of view of a monitored individual performance, in her service, rather than a professional shared responsibility to keep the clients safe. The service does not make space for the additional time and complexity of the risk, treating it as the therapists' moral duty to manage that. For Susanna risk inevitably means losing time from therapy.

### 3.3.3 "*There's never certainty*" – The never-knowing

Most participants differentiated between a suicidality that required immediate action, from all other levels of risk, which by no means meant low risk, but rather that there was still scope to support the client in keeping themselves safe, maintaining their autonomy. For the therapists, this meant carrying the awareness of the risk between the sessions, not fully knowing if the clients would be safe. This experience of uncertainty is what this theme explores. Sam described what it feels like for him carrying this uncertainty, how he sees it as an inevitable part of the work with suicidal patients to never be really sure.

> "*But, it's never, certain. There's never certainty in working with the suicidal patient. /…/ I think… I…have, I've learned to accept that?... but, when I say I accept that, it's not that it's easy, it's not that I'm quite, comfortable and calm going home, no-o, but I accept that, I can't, I can do my best, my best of my abilities and experience, but I can't prevent it.*" (Sam, 1023-1032)

There is "*never*" certainty, Sam repeats this, as if wanting to share just how prevalent this is on his mind, throughout this work. Explaining, with a slight intonation of a question as if not completely sure, whether he can "*accept*" this never-knowing. Accept it as a deeply uncomfortable part of his work. Accept that the constant uncertainty permeates his consciousness, even encroaching into his own time. Sam's emphasis on doing his "*best*", giving it his everything, and how that might still not be enough, offers an insight into how much of

himself he might be engaging in the work with a suicidal patient and how he still tries – and hopes – for certainty.

Peter also conveys that sense of doing everything he can, but ultimately relying on hope.

> "*/…/ it's that, you know, that feeling that…I've done what I can…and…[pause] you know you've gotta…hope for the best that they…don't do anything, silly between now and the next time you see them.*" (Peter, 517-519)

There is a limit to what Peter can do to keep his client safe. The uncertainty leaves him relying on hope until the following session. Hoping that he will see the client again. That they will still be alive. Not having done something "*silly*", which sounds like downplaying the magnitude of what could happen, perhaps a way of lessening the worry, to facilitate holding the felt powerlessness of the not knowing. But there seems to be something else in this wording too, a tone of familiarity, a sense of knowing the client – perhaps a trust in knowing the client. Hoping for that to be enough. Simon also expresses a similar sentiment of holding this between sessions, relying on trusting his knowing the client.

> "*And, then, the next week she didn't come, but she texted me to say she-, why she wasn't coming, so I knew she was still alive, and, and… [long inhale] Yeah, and we go on kind of thing…*" (Simon, 829-832)

The week after a session when his client had been very suicidal, receiving her text message was a life sign for Simon, offering an insight into how he had been carrying the worry, the not-knowing if she was still alive, since their session. His long inhale gives a sense of release, as if almost having been mentally holding his breath. His wording "*Yeah, and we go on kind of thing*", suggests that this is a familiar experience with this client. He describes elsewhere how having worked with her for a while, he knows she goes into cycles of feeling trapped and very suicidal, but that she does not act on this because of a strong protective factor. Therefore Simon, has come to realise that he mainly needs to contain her when she feels this way, rather than act on it. Nevertheless, the client's suicidal wish is so strong, that it still leaves him with that question mark and concern until he next sees – or hears – from her.

Catherine explains how, to be able to work, she is not willing to hold that uncertainty over the client's safety during the work in therapy, making this clear to her clients.

> "*Well the first thing I do, which I found worked, so far, with people who <u>are</u> really suicidal, is that we make, a pact. While they come to see me, they cannot try to kill themselves again. /…/ <u>Why</u> I do that, it's a kind of container. <u>Here</u>, we contain everything. But I have to be certain and sure /…/*" (Catherine, 325-331)

Catherine seeks to ensure some certainty that her clients will not attempt suicide while in therapy. This "*pact*" seems to be a communication about the need for reciprocity, how she cannot fully help them if she is worried about them killing themselves. Her description that this approach has worked "*so far*" seems to hold an awareness that this can change, a level of uncertainty still remaining. That space where 'everything is contained' resounds of somewhere where the client's pain can be safely processed with Catherine listening and holding it, like an anchor. But this requires certainty. If she is concerned for their life, she cannot stay anchored. It needs to be safe for both of them.

Susanna describes how her service tries to ensure a level of certainty, through persistent monitoring of risk.

> "*/…/ we have to keep, we have to check every session to make sure that they're not then thinking of… if they have, we just have to keep monitoring suicidal ideation just, just to make sure that it doesn't then shift into…uhm, plans and possible actions if, if people for whatever reason have a setback or something, it happens, and they fall down.*" (Susanna, 139-145)

Susanna seems hesitant articulating what it is she, or they – "*we*" – need to keep 'checking' for. Perhaps a discomfort saying out loud that the client might attempt suicide, maybe making it feel more real. The uneasy uncertainty in the work with suicidal clients seems partly instantiated here in her difficulty to express this in words. Susanna's mode of saying "*we have to*" resonates as a mandate from the service. The recurrent, and seemingly insistent – in view of her repetitive description – 'monitoring' and 'checking' seems to be an attempt from her service to have some level of certainty – "*just to make sure*" – that no clients will take their life. There appears to be a somewhat implicit service assumption that, if Susanna and her colleagues do the monitoring

frequently and thoroughly, no client will commit suicide. Yet her description of how the clients can have a "*setback*" sounds like a reflection on how unexpected things can happen that are out of everybody's control.

### 3.4 Supraordinate theme 3. What makes or breaks

The third supraordinate theme looks at different structures and processes that facilitate or impede this work. The first subtheme is about the therapeutic relationship and the various roles it has in risk work, as a vessel for the suicidal thoughts being expressed; as a means of assessing the risk and a space to try to understand it, and to hold the client in their distress. The subtheme that follows looks at the interplay of experience and confidence in their work, what it looks like and what it means when working with a suicidal client. The last subtheme is about how support and external resources affect the participants' ability to manage and hold risk.

*This theme initially stood out to me as being about trust: building trust with their clients; trusting their own work; being trusted in their work. But as I continued deepening and widening the process of analysis, I found that elements of trust could be found across all the superordinate themes, while here, as this theme took shape, I began to discern overall frames, or structures that the participants had developed in different ways throughout this work. Some of these aspects were also more practical and external, such as for example lack of resources on a societal level impacting their work in therapy with these clients. However, I still find that trust, on all levels, micro to macro, seems to be the fabric that carries this work for the participants, throughout their diverse experiences.*

#### 3.4.1 The relationship

This theme took shape from various directions, which converged through the common denominator of the relationship in the work with suicidal clients. Their experiences of the relationship and the understanding of its role when working with risk were both shared and specific. All the participants viewed the relationship as an essential part of the work with suicidal clients.

Sam described his experience of how the complex interplay between the risk and his worry and overwhelming responsibility interfered with the relationship forming with his patient, thus impeding the work.

> "*I think therapeutic relationship is everything in, when you see a patient, whether suicidal or not! It's everything! /…/ but in that specific case, iiit, shifted, because befooore, I was empathising with him, I was trying to empathise with him and understand him, [inhale], but at the same time, my in-, sui-, like investigation into his thoughts, and, uhm, feelings, and suicidal thoughts, uhm, I realised that it's kind of, uhm, creating a distance between us, that therapeutic relationship, uhm, after a few sessions I realised it hasn't actually formed /…/*" (Sam, 508-519)

For Sam, the therapeutic relationship is key to his work with any patient. Yet, he tells of how his worry about the patient's suicidality initially prevented him from forming a meaningful relationship. "*Trying to empathise*" and "*understand*", but his fears formed a barrier to a real connection, his focus on the suicide "*investigation*" took him away from his usual attunement. Not being able to form that relationship seems to have meant not being able to work in a way that felt meaningful for Sam, hindering the process of knowing and understanding his patient, and through that his risk.

Another perspective of the role of the relationship came from Yvette and Susanna, who both expressed the essential part the relationship plays in disclosures of suicidal feelings.

> "*/…/ it's about relationship of course, to have that relationship that people are [inhale] speaking about it with you. And they know full well that you will have to, tell others, you know.*" (Yvette, 922-926)

For Yvette the relationship is the indisputable foundation to create the conditions where the clients speak about their suicidality. Even when the clients know that Yvette will have to tell someone else, and understanding that their therapy cannot continue, it appears her experience is that the disclosure comes out of the strength of the trust and care within the relationship, and that her taking action and involving other people is appreciated by the clients, as she goes on to explain:

> "*I find they respect when you, say, this is it, you know, I think it's more our fear, of suicide, that, puts the fear into the relationship.*" (Yvette, 938-942)

Yvette's words resonate of having created a caring and transparent relationship, where the client feels understood and also understands the premise of their therapeutic relationship. Susanna also spoke of how creating safe and trusting relationships has led to being able to deal with risk more openly.

> "*/…/ if people do feel safe and that they can open up to you, then you're more likely to experience more risk [dry chuckle] In a way. Because, if they feel that they're with someone, and they don't feel that they can really understand, erm, that shared experience, then they're not gonna open up /…/*" (Susanna, 1235-1242)

Like Yvette, Susanna's experience seems to be that suicide risk surfaces when there is a strong relationship. Her description of the client's suicidality as a "*shared experience*" appears to illustrate her view of this as a mutual process of trust, the suicidal thoughts disclosed when the client feels heard and held. Susanna's focus on the relationship in her work has meant that she frequently encounters risk. I believe her dry chuckle is an expression of frustration at regularly being told to spend less time on this and more on the therapy protocols. For Susanna, it is not only for the disclosure of risk that this matters to her, but also for the client to feel less alone with their distress, as she goes on to explain.

> "*And you know, being there, being steady with him, you know, and, and, holding that material, and not, you know, not, being distressed… /…/ but sort of being there. Being a presence*" (Susanna, 1250-1258)

Susanna is expressing the importance of the client not holding this on their own, feeling that she is fully present and there with and for him. The weight Susanna gives to "*being a presence*" resonates to me of something that Simon said about supporting suicidal clients in feeling that their experience can exist:

> "*/…/ I think in the end it's about somebody feeling like, their experience, <u>whatever</u> their experience is, can <u>exist</u> in the world, and their <u>therapist</u> can be someone who can <u>hold</u> their experience, and, say, this is a human experience, this is a relatable, valid, uhm, acceptable experience, and we can hold, I can, we can hold this together, I can hold this /…/*" (Simon, 467-472)

What I am hearing from both Simon and Susanna is a conviction that the experience of being heard, held and not alone with this existential pain and disconnection is therapeutic in and of itself – this relationship is an acknowledgment of a shared humanity. With Simon's pendulating between "*we can hold*" and "*I can hold*" encapsulating that reciprocity.

Lisa, too, reflects on the relationship as a vessel for the work, giving an insight into how the client's suicidality was played out in the therapeutic relationship and how hard this was to be part of.

> "*/…/ it's just about, sort of, you know, trying to contain someone. Contain her and contain myself, incredibly difficult. It was just, the whole relationship, I mean it was just so, it was so intense, and she was kind of <u>really</u>, uhm, locked into this kind of bullying/victim reciprocal roles /…/ and how she sort of tried to push me into the Abuser position /…/ I could be, the re-, the Rescuer or sometimes I felt like the Victim, /…/ you're kind of trying to contain that so that you can keep a clear head and keep thinking throughout the sessions and not just get pulled into what's happening, it's really hard, /…/.*" (Lisa, 1169-1186)

Lisa's acknowledgment that it is about containing the client's suicidality, but also herself, indicates how this is a relational process, she is part of the relationship and is impacted too. Lisa's description of the intensity of the relationship, of being 'pushed' and 'pulled', conjures up an image of a force field, being moved about as if almost out of her control, struggling to "*keep a clear head*". Lisa's description illustrates how difficult this relationship was to navigate, and how she was very much a part of this dyad, and not merely an empathic bystander of her client's suicidality. And, it was being able to jointly recognise and make sense of these relational dynamics, the reciprocal roles and the Drama triangle playing out between them, which helped the work, as Lisa explains.

> "*/…/ we stepped out of the battle and we could, could work together…and she could really make the links why she was feeling like this and what had contributed to where, you know, her ending up where she did.*" (Lisa, 446-449)

Lisa describes their shared process of formulation, of identifying how the client's difficulties played out between them and in her other relationships, and how doing this altered their "*battle*"

of her client wanting to die and Lisa fighting to keep her alive, moving more into a shared process of meaning-making and of responsibility.

The relationship as the means for the work is also expressed by Simon. He talks about how he gauges the level of risk through the relationship, contemplating on what this knowledge means and looks like.

> "*Uhm, it's almost like to confirm the feeling that I think I know, which is, this person isn't, imminently gonna kill themselves because in this moment they are in a room with me, telling me about it, and that counts, that's an expression of life, and, connection, and it's this kind of contradiction that can feel really hard to hold, in the moment*" (Simon, 317-323)

Simon talks about how asking 'risk questions' is often for his own peace of mind more than for the client. 'Confirming the feeling that he thinks he knows' resonates to me of a relational knowing that seems hard to describe and justify, but that feels real to Simon in the work with his clients. Simon's emphatic expression of how the "*person isn't imminently gonna kill themselves*" gives an insight into what is at stake for him in choosing to follow this relational knowing. Trusting the connection – the client's presence in the room with him in that moment – in the face of the client's suicidality, that 'contradiction so hard to hold', brings to my mind the idea of safe uncertainty. Daring to trust that intangible, yet real, relational understanding is something Simon seems to continuously revisit and reflect on, and appears to be key to his assessment and management of risk.

### 3.4.2 The role of experience

This theme addresses the role of experience in managing risk. As much as the participants' risk encounters, and perspectives, varied, there appeared to be something of a concordance of views regarding the part experience plays, and the impact it has when it comes to facing suicide risk. Learning by doing appears to have been essential when it comes to suicide risk. From naming it, to exploring it, to trusting oneself enough to know how and when to stay with the client and how and when to act, experience appears to have developed their knowledge, changed their outlook and made them less fearful and more confident, more able to know and trust their reasoning and their approaches.

Sam reflects on his early encounters with suicide risk, offering an insight into how unsettling, and frightening, this learning was, but also how inevitable and vital for his work.

> "*/…/ what went through my mind was, ok, I don't work with this one, what about the next one?, or the next after? So I have to be abl-, to learn how to work with that, I have to be, learn, to manage risk, I have to…[inhale] /…/ it's a challenge that presents itself with every patient, so, if I don't work with this patient, what about the next one? So I thought I'd better, accept the challenge, and seek, and seek help, from supervisors and…[fades out]*" (Sam, 344-358)

Sam explains how he could have asked to not work with this patient who had attempted suicide a few weeks prior to starting therapy, being relatively new in the profession at the time. But he felt he had no choice, reflecting on how working with severe suicidality was inevitable, 'if not this one, what about the next one?'. His emphatic repetition of "*I have to*", evokes a sense of pressured urgency – as if feeling the need to gain this experience immediately. Needing to "*accept the challenge*", like taking up a professional gauntlet, makes me think of how daunting this might have felt for Sam. He seems to have considered a steep learning curve unavoidable, and gaining this experience as soon as possible absolutely vital to his work, but acknowledging the imperative of doing this with experienced support.

Lisa and Yvette both voiced how their extensive face to face exposure to very high suicide risk has made them feel less fearful when confronting and talking about it with their clients. And both of them, in different ways, seemed to infer that this is not something they would encounter to this extent outside of this work, which is why this exposure has been so essential to acquire that knowledge and know-how about what is appropriate and needed in these high risk circumstances. Yvette captures how her experience of working with frequent high risk has shaped her profoundly:

> "/…/ *had I not had that, those years of, working with suicidal clients, I would feel fearful about it, and I wouldn't know how to mention it, and how to name it, and how to [deep inhale] be straightforward with it. Uhm, I guess, having had that experience has enabled me to do that, and to, uhm, yeah, to be, yeah, to, to, to just be more upfront, and, uhm…*" (Yvette, 942-948)

Yvette's description of "*those years*" resounds of a distinct and particularly formative period for her in working with suicide risk, highlighting the role of "*having had*" or "*not had*" this experience for her to develop confidence and not feel overwhelmed by fear in the encounter with very suicidal clients. With a deep breath – perhaps an embodied recollection – Yvette expresses in three different ways the struggle to address the suicide risk with the client ("*mention*", "*name*" and "*be straightforward*"), indicating just how hard this might be. Articulating, as she speaks, what this past experience has given her, Yvette searches for words through "*I guess*", "*uhm*", "*to be*", "*yeah*", possibly suggesting how integrated this is in her. The practical, experiential knowledge of being less fearful and "*more upfront*" is now implicit in her approach to risk, and yet, it could also perhaps indicate just how difficult this topic still is to contemplate and make sense of despite all of her experience.

Lisa echoes a similar sentiment, about how her extensive experience of risk has changed the way she understands and feels talking about suicidality with clients, no longer feeling discomfort, but confidence.

> "/…/ *that [*naming the suicidality*] was something that I would have found really difficult when I just started out, because it feels a bit intrusive, and, uhm…yeah, a bit nosey almost. But, that's, I'm fine with that now, I'm kind of used to asking really difficult questions of people.*" (Lisa, 907-910)

Lisa's description of how she used to feel talking about suicidality, and how that has changed through experience, might suggest how this is not something that most people do if not immediately faced by it and therefore it might be difficult to know what it really entails. It reminds me of Yvette's words, "*I think it's more our fear, of suicide, that, puts the fear into the relationship.*" (941-942). And as with Yvette, Lisa's experience also seems to have enabled her to be more upfront and less fearful of exploring risk.

Simon and Susanna illustrated how their experience with suicide risk has contributed to being able to trust their professional instinct and feel more confident even when there is uncertainty or disagreement, and how this enables them to stay present to a greater extent with their suicidal clients. This experience, with the knowledge and confidence that followed, seems to have rendered them a form of professional courage. Susanna, having years of experience and

trusting her approach, choses to go with what she knows to be helpful for her clients, even if that means not having her supervisor's support and thus standing alone with the responsibility.

> "*/…/ my supervisor is kind of, wanting me to, stay on the ball with the therapy, and stay with it. But I personally feel, it's actually really important for him to… have space, and an opportunity to discuss that suicide attempt – it's significant! /…/ So…[brief pause], I kind of laugh about it because, yes, she said that, but I won't, I won't take any notice of her [laughs again]. /…/ I would rather he had that space, because, you know, I can contain that with him.*" (Susanna, 282-302)

Susanna was describing a fundamental discrepancy between her own and her supervisor's approach to the work. The supervisor wanted her to keep to the therapy protocol – to "*stay on the ball*" – while for Susanna, enabling her client to talk about a previous suicide attempt, was a significant part of his therapeutic process. Susanna's laughter seems, once again, to be one of frustration, at not being allowed to do the work she believes in and knows is worthwhile. She had to trust herself to the extent that she dared to go against her supervisor's directives in the face of risk. Knowing that she could contain the client's experience, and knowing the value of doing so, seemed to be what gave her that confidence.

For Simon, similarly, a confidence turned to courage appears to be about being more able to stay in a safe uncertainty and to stay with the suicidal clients when he believes that to be possible.

> "*/…/ the longer I've worked, and the more <u>confident</u> I've got in my work, the more I understand that, being able to hold their experience, is maybe in the end, the best intervention there could ever be /…/ there comes a point where, <u>I</u> <u>am</u> the intervention, maybe, maybe it <u>has</u> to be <u>this</u>? You know, maybe this is the best way of holding someone, and helping someone, in, that experience…*" (Simon, 478-490)

What I hear from Simon's words is a sense of gained courage, through experience. The courage to stay with the clients' suicidal feelings, without referring them on thinking that someone else might do it better – trusting the connection. Saying how "*there comes a point where <u>I</u> <u>am</u> the intervention*", how "*it <u>has</u> to be*", Simon seems to choose not to pass on a metaphorical bucket of risk, so to speak, but offering a relational commitment to the client. He

explained how having experienced working with immediately suicidal clients, when he had to intervene, has enabled him to trust his way of working.

"*that taught me something /…/ like maybe to trust myself a little bit, trust that you'll really know about it when you have to do something. /…/ and that helps trust me when I, I don't feel, like I, perhaps need to do something, /…/*" [Simon, 1179-1183]

Simon's initially tentative and then continuously repeated use of the word "*trust*" seems to acknowledge how difficult this is to do when with a suicidal client, how it is not an exact science, but a confidence acquired from years of practical and reflective experience and knowledge.

**3.4.3 "I'm not on my own" – the role of support and resources**

This subtheme addressed the participants' views of the part support – or lack thereof – played in their experience of working with risk. Their accounts revealed how it entailed multidimensional functions and purposes, from emotional containment, through shared meaning-making, to shared responsibility, where not feeling supported became an additional strain. A common thread throughout seemed to be the importance of not holding the risk alone, as was expressed by Catherine, who works alone in private practice.

> "*/…/ I have supervision… That is a huge help, I've got a very good relationship with my supervisor. And, if anything happens like that, she's the first to hear about it. And I don't wait until my supervision session. I call her on the day. I say, this is what happened, this is what I've done, have I missed anything, do you feel I should do something else…*" [Catherine, 418-423]

I hear a great sense of trust, safety and reassurance in Catherine's description of her supervisory relationship. Catherine knows that, if she has any kind of risk concern, she can turn to her supervisor immediately. She knows that someone else is thinking about, and through, the risk with her, giving her a sense of security, that she is not on her own holding the risk, enabling her to feel safer in doing so.

Simon, too, describes the immense importance for him to collectively hold the risk with his colleagues, and how the debriefing also becomes an additional kind of safety check, jointly thinking through his response in the session.

> "*well, one of the best bits about working in a team is the feeling of shared responsibility, it's shared burden, it's like, ok, I'm not on my own in this. So, if…if I'm supported by someone in my team to connect with why it is, I have done or haven't done something in response to, somebody telling me they might kill themselves, I feel, supported in, my own rationale, for doing what I did /…/*" (Simon, 380-386)

Simon's appreciation of "*one of the best bits*" of a team, shines through his words, "*shared responsibility*", "*shared burden*", "*not on my own*", and conveys a strong sense of not being left alone with the weight of the client's suicidality. Simon's description of 'connecting' with his responses made me wonder if what he is describing is that in the session he partly acts on a level of intuition and relational knowing, while trying to stay present with the client's distress – reminding me of what Lisa said about "*trying to contain that so that you can keep a clear head and keep thinking throughout the sessions*" (Lisa, 1184-1185, in subtheme 3.1). Therefore, it appears that having that dialogue with colleagues afterwards enables Simon to make sense of- and articulate his rationale more explicitly.

Yvette further captures this experience, explaining how her team's shared thinking and responsibility is present with her in the therapy room, when she encounters risk.

> "*And I think, that's when, when you're then sitting with your client, you are, sitting there, you'll have the team, with you, you know?*" (Yvette, 650-653)

Yvette reflects on how she carried her team's support and strong dialectical thinking into her individual sessions with her clients. The teams' irreverent, empathically questioning outlook – facilitating a resourceful, open mindset – and knowing that they shared the work collectively, as well as being physically nearby, enabled her to have a less fearful, more present and flexible encounter with the client's suicidality.

Throughout my interview with Lisa, she continuously returned to the invaluable importance of the support from, and shared reflective space with, her weekly peer group supervision in the difficult work with a persistently suicidal client.

> "*/…/ I think, you know my feelings towards her, I think could have impacted more on the sessions if I hadn't had the good support network that I have, so I could bring things to peer supervision and kind of talk to my colleagues and have their feedback and sort of teasing out what was mine and what was her and what was going on and so I think, from* <u>*that*</u> *point of view I think I managed to keep what* <u>*I*</u> *was feeling to a minimum how much I was impacting on the therapy, I think if I'd been working in isolation without the support that I have, I think that could have been different…*" (Lisa, 395-404)

Lisa expressed the central role these sessions had for her ability to work with this very suicidal and complex client. Both for containment and disentangling of her own feelings in the work, and to make sense of the client's difficulties. Her assertion that her own emotions could have impacted more on the work without this level of support might suggest that she felt her colleagues' involvement in a way worked to safeguard both the client and her. Similar to Yvette feeling that her team was with her inside the sessions, Lisa's team were part of the work. She knew she was not alone. It was not all on her, as she also expresses elsewhere regarding working with other professionals supporting this client.

> "*/…/ so it wasn't just all down to me, you know a lot of the work that we do here is, multidisciplinary, so I think it sort of takes the pressure off the…therapeutic relationship a little bit*." (Lisa, 679-682)

Knowing that 'it wasn't all down to her' - not being the only person held accountable if something happened and not the only professional interacting with the client – was a release valve for Lisa. She explains how knowing this took some of the pressure off the therapeutic dyad, off her – even if just "*a little bit*", her words possibly reflecting the magnitude of the pressure and intensity she felt with this client and the vital importance of that support.

These insights into the importance and the manifold depths the support and supervision held for these participants and their work with risk, stand in stark contrast to Susanna's experience of no support and no acknowledgment of the impact of risk work.

> "*/…/ the intensity of that experience* [suicide risk] *for the psychotherapist, is, is very, sort of emotionally draining. /…/ but in the service I work in, the pace is very fast and hard, and, it just kind of gets absorbed. The, the impact of it just kind of gets absorbed into*

*your everyday work. It's not like people say, 'we'll go and have a cup of tea and a break for a while', it's like, you've now got to see your next patient, or you've got to get notes written up.*" (Susanna, 110-119)

This "*fast and hard*" pace evokes an image of a rushing car with no breaks. The contrast of someone suggesting "*a cup of tea and a break*" versus going straight onto the next patient or paperwork, seems to highlight a felt void of empathy, akin more to a production line. Susanna seems to experience no space, time or acknowledgment of how hard the work with a suicidal client is. Like a conveyor belt, she sees one client after another, not stopping for anything. The draining impact that she describes seems to come both from the direct work with the suicidal clients, and from the accelerated and isolated service environment. With no time or space to process the risk work, she absorbs it, and is left feeling drained. This lack of support was not exclusive to Susanna, most of the other participants having had similar experiences through their years practicing. The experiences of support here have been chosen because they show the relevance and function in working with suicidal clients. But the pressures experienced of uncontaining work environments were mentioned in different ways, such as Lisa, Martin and Sam spoke about the pressures put on their work by a lack of resources in mental health as well as in society at large. There were more examples of experiences of lack of support, some which have come across in other subthemes. The need for support came across most themes, one way or another.

# 4. Discussion

## 4.1 Overview

The aim of this study was to enhance the existing understandings of how Psychologists, Psychotherapists and Counsellors experience, and make sense of their work with suicidal clients in the context of mental health work in the UK today. In accordance with IPA's focus on the participant's experience and interpreting without a theoretical lens (Smith et al, 2009), the analysis was done while attempting to 'bracket off' the existing research to try to stay as close as possible to the participants' experiences in my interpretations, while acknowledging that it is not possible to not be coloured by my previous knowledge and experience. This analysis highlighted three supraordinate themes, which will now be discussed in relation to the existing literature.

Following that, I will reflect on the strengths and limitations of the study, as well as discussing personal reflexivity. And finally, I will conclude by discussing the possible implications for Counselling Psychology and the wider field of psychotherapy, followed by suggestions for future research.

The discussion will span across themes, as that is how the findings seem to relate and respond to the existing research but will be presented following the structure of the findings in the analysis for clarity.

*I found that in the process of beginning to join my interpretations in relation to the existing literature, it was far from clear-cut that certain themes would mirror or speak to a certain body of research. Rather, as is also the case in the therapeutic process, the interpretations and themes merged and moved organically between the research literature and existing theories that my study resounded with.*

## 4.2 Emotional labour

### 4.2.1 The emotional impact on self

The impact of working with a suicidal client seems to have moved beyond the space of therapy, and the participants' professional realm at times. In Sam's case, he described a loss of confidence in himself professionally, thus even if not going beyond his professional self, the fear

and uncertainty of the suicide risk made him question his entire professional being and competence. This experience resonates with existing literature that describes self-doubt (Moerman, 2012) and self-questioning (Rossouw et al, 2011) and doubt leading to a change in professional identity and outlook when working with suicidal clients (Moore and Donohue, 2016). Montgomery (2018) describes such doubt evoked in relation to the felt external pressures and expectations to be 'omnipotent' as a therapist, which was voiced by some of the participants here as well.

The participants expressed different perspectives of the experience of taking the work home, of carrying the worry with them in their own time. Lisa and Susanna, both explained how their worry for their clients' safety stayed with them and in different ways seemed to almost intrude on their personal lives. For Lisa, waking up in the middle of the night worrying about her client, and Susanna, feeling emptied of energy in her spare time, at times not wanting to talk to people. These experiences echo with Moore and Donohue's (2016) findings. They too, talk about how their participants describe waking up in the middle of the night wondering if their clients are safe; or finding they have no energy for their personal relationships. Moore and Donohue (2016) explain this within a frame of 'overworking' when working with suicide risk. A sense that the therapists feel they have to go outside the set-out therapy sessions to support the suicidal clients. Offering additional sessions and being preoccupied with their safety at all times. In an attempt to set boundaries to this all-consuming experience, their participants have different physical rituals to separate work from home, what they call a "*defrocking process*" and the "*participants spoke of showering as metaphorically disinfecting themselves form the work*" (Moore and Donohue, 2016, pp.27-28). In this study a similar process was described by Lisa, when she says "*I have sort of a half an hour walk every day from work to home and it's quite good, you just have that time to walk and kind of, getting out of psychology-mode, sort of processing what's been going on and going into sort of mum-mode [chuckles]*" (Lisa, 530-534), or Simon describing how he might choose to run home from work. There is a sense that this work can inundate the therapists' whole being, professional and personal.

An additional perspective on carrying the suicidal client in mind outside of work is offered by Simon's experience. Realising that he thinks about his suicidal clients outside work hours, but reflecting that he feels that to be necessary, a way for him to know that he is connected and attuned to the client. This seems to offer him some peace of mind when holding the uncertainty and worry of the risk. Moerman (2012) describes a similar perspective, of therapists feeling that

they could better hold their anxiety about their clients' safety outside of the sessions, when feeling connected with them in the work.

The participants' descriptions of deeply caring about their clients, being moved by their struggles and desperately wanting them to stay alive, sounds a human and empathic response. One that is also extensively explored in Mearns and Cooper (2005), even if not specifically in relation to suicide. They talk about the importance of the therapist being open to being impacted and even changed by the client (Mearns and Cooper, 2005). And in the work with a suicidal client this openness to a genuine relationship is more important than ever, a view that underlies the Aeschi approach to working with suicidal clients (Michel and Jobes, 2011). "*Failure to develop a collaborative relationship may result in an externalized locus of change, that is, expecting change from outside rather from within, which is a typical characteristic of traditional medical model interventions.*" (Michel and Jobes, 2011. p.23). Thus, a commitment to a real, reciprocal connection with the client is essential to decrease the power differential, enabling the client to hold their responsibility through a more mutual relationship, making way for a more internalised change. This is also something that Winter and colleagues (2014) describe how clients expressed that when they feel responsible for their own process and change in the therapy that enables growth.

However, how the therapists can engage in this work to this necessary depth without experiencing the intrusion and negative impact on their personal wellbeing, as illustrated above, with Lisa and Susanna's examples, will be explored throughout the coming themes, in particular looking at the role of support and experience.

One more perspective offered by this theme, is the existential aspect of this work, that Yvette describes. Something that was also found in Rossouw and colleague's (2011) study, as well as in Nicholl et al (2015). The therapists in these studies described how this work brought up reflections about their own existence and mortality. It is noteworthy that Yvette described having a personal interest in existentialism, and as such might possibly be more open to reflect on this aspect of the work and what it brings up in her. She speaks about this as something she appreciates with the work. The need to become aware of our personal thoughts and feelings about our own mortality, is highlighted by Orbach (2001) and also Yalom (2015) to make us more able to fully listen to our clients when they are struggling to live. Ensuring that our own possible emotional avoidance of these topics does not limit our listening to the clients. What

Yvette seems to add to this argument, is that being open to these personal reflections can offer a positive impact on the therapists' own professional and personal wellbeing as well.

### 4.2.2 An embodied experience

Embodied experiences of the work with suicidal clients was something voiced by most of the participants. Descriptions of a physical heaviness evoked by the felt responsibility. Or the intensity of emotion engendering physical responses in the therapists, such as feeling sick and all-consumed, mentally and physically, or a feeling of heaviness on them. But also, a kind of embodied alertness, as if the need and wish to connect and reach the client at this point of despair awakened all the senses. As if the therapeutic presence and attunement became heightened. Yvette described this saying "*it's very mindful of the present moment that you're in there*", as if in that moment is only the therapist and the client.

One way of understanding these embodied responses is as 'presence', as Geller and Greenberg's (2002) found in their research, presence goes beyond an emotional attunement and engages the therapist's whole being. "*Therapeutic presence involves bringing one's whole self into the encounter with the client, being completely in the moment on a multiplicity of levels, physically, emotionally, cognitively and spiritually.*" (Geller and Greenberg's, 2002, pp.82-83) And they go on, "*Therapeutic presence allows for a kinesthetic and emotional sensing of the others affect and experience through connecting to the client on a deep level.*" (Geller and Greenberg's, 2002, p.83)

A similar consideration is found in Carrick (2014), in her study of person-centred therapists working with clients in crisis. She talks about the therapists' experiences "*as polarised between danger and opportunity, necessitating metaphorically 'holding' their clients*" (Carrick, 2014, p.276). And her description of how the therapists hold their fear for the client's wellbeing alongside a sense of vitality, evoking "*a heightened quality of presence and a deeper quality of connection*" (Carrick, 2014, p.276) seems to mirror some of the participants narratives in this study, that mindful, attuned presence, here manifested as a 'vibrancy' or 'total calm'.

A few studies describe various embodied responses in the work with suicide risk. Moore and Donohue (2016) speak about the physical impact on the therapists in various ways, in some cases deep and enduring and even affecting their physical health. "*Suicide attacks the body of the client, and four participants expressed how suicide prevention impacted their body-self* " (Moore and Donohue, 2016, p.30), they make sense of these experiences as somatic

expressions of countertransference, but at times impacting the therapists beyond the work in therapy (Moore and Donohue, 2016). These findings resonate with what several of the participants express here, of the unpleasant physical experiences evoked through the work with suicidal clients. These expressions ought to be considered in relation to what is needed to safeguard therapists' wellbeing through this work, in particular in a situation like Susanna's, where the impact of the risk work seems to be exacerbated by the service pressures even more than by the interaction with the suicidal client. Again, this is something that will be explored more in relation to the subsequent themes.

Richards (2000) also reflects on the countertransferential responses when working with someone who is suicidal. She describes a therapist frequently feeling exhausted with one of her clients, to the extent of wanting to go to sleep, as if her body was responding to her clients wish to not be there (Richards, 2000). She emphasises the importance of exploring and understanding these responses in themselves and naming them with the clients as part of articulating and making sense of the clients' risk (Richards, 2000).

In a similar vein, Montgomery (2018) speaks of a 'bodily sense', the 'gut feeling' that helps the therapists assess the risk. Assessing for the risk in an embodied way is also described in other studies, a listening to a 'gut feeling' (Vail, et al, 2012; Godin, 2004), or 'instinct' (Moerman, 2012) as a means to pick up on the risk.

It seems clear that working with a suicidal client engages the therapist on all levels of their being and this needs to be recognised in the existing structures around this work, such as possibly the caseload, the time and space to process, acknowledging the various levels this work happens on and what is required to make sense and process this work.

#### 4.2.3 "*What if she dies?*" – the felt responsibility

All the participants voiced the significant presence of a felt responsibility, with slightly different experiences and meanings. For some participants it meant having the agency to respond as they believed appropriate. For others it was almost the opposite of that, an overwhelming feeling of being responsible for this human being's life, making it difficult to move past that into dialogue and connection with the client. The magnitude of the potential lethal outcome of a client's suicidality evoked a strong feeling of responsibility to save their life. This felt

responsibility seemed to hold both the immediate danger of the client's suicidality, as well as a personal and professional risk for the participants themselves.

As much as the participants described different experiences and ways of relating to the notion of responsibility, there seemed to be a commonality in instinctively wanting to ensure the clients stayed alive and safe. This may not be a ground-breaking statement in itself, as it is probably something that a majority of people would feel when faced with someone wanting to die. However, there are various aspects of specific interest to consider in this, in particular in relation to the work in therapy, and the changes we hope to enable for the clients, but also in relation to the therapists' wellbeing through this work.

First of all, considering the experiences of urgency and immediacy, in what the participants describe, that enormous sudden weight of responsibility to save a person's life who might otherwise leave and kill themselves. A felt sense of all or nothing, of feeling like they are literally holding a human being's life in their hands. Understanding the emotional impact this kind of experience might have on the therapist is essential to know how to prepare therapists as much as possible for this in training, but also, to know how to support the therapist to not hold such a situation alone, or to be able to process it afterwards, acknowledging it as deeply stressful and potentially even traumatic (Montgomery, 2018; Reeves, 2010; Fox and Cooper, 1998).

The existing literature tells us how within this experience, there is a fear of the person dying and having 'failed them' (Moore and Donohue, 2016; Rossouw et al, 2011), the possible worry about the impact on the client's family (Moore and Donohue, 2016), and the fear of litigations and possible accusations of malpractice (Montgomery, 2018; Moerman, 2012; Reeves and Mintz, 2001). All of these aspects are voiced here in the participants' narratives. And further, their descriptions suggest that this kind of responsibility is not conducive for doing therapeutic work. The work in therapy becomes 'compromised', to use Simon's word, or the therapist becomes professionally 'paralysed', as Sam put it, all of this indirectly (or directly) meaning that any growth or change for the client, becomes difficult to obtain. Going back to Reeves (2010) description of 'pot holing' in the light of these powerful and real fears, daring to take that risk to enter those difficult spaces with the client might feel too much of a personal risk. Thus, potentially turning the work with risk into a kind of catch 22 – feeling responsible to make sure the client stays safe, but not being able to engage with the process that might enable the necessary change, out of fear of how the client might respond.

Lisa's description of the therapist and client entering a 'battle' of living and dying instantiates what Jobes and Ballard (2011), describe as a key obstacle to meaningful therapeutic work with a person who feels suicidal:

"*The patient's capacity to complete suicide invariably injects issues of control, power, and vulnerability into the relational dynamics of the clinical dyad. In contrast to a medical model approach, in which patient and doctor join forces together to battle a disease such as cancer, within mental health the prospect of suicide tends to pit patient and doctor against each other.*" (Jobes and Ballard, 2011, p.53)

They go on to discuss how this is part of a wider social context of the expectation that the therapist undoubtedly/unquestionably has to save the clients.

"*For within contemporary culture there is both a societal expectation and legal statutes that assert that therapists must stop a patient from suicide; they are to keep them alive by all available means, no matter what the wishes of the patient are. Therefore, if the patient dies by suicide, it is widely seen as the fault of the therapist, rather than the fault of a disease (or, more pointedly, the fault of the patient).*" (Jobes and Ballard, 2011, p.53)

This chimes with the experiences expressed by several of the therapists in this study, mentioned above, of how that overwhelming responsibility is not helpful, nor realistic. However, several of the participants described in different ways what they considered to be helpful, understood here as a 'helpful responsibility'. One participant described the importance of a thorough collaborative formulation, to jointly understand the client's difficulties and that way to give the responsibility of their own growth and change to the client (e.g. Lisa section. 3.4.1).

What Catherine expressed, "*Cos at the end of the day, I'm not going, I'm not here to be a saviour. I'm here to support them.*", it could be understood as realising the limits of her responsibility and power. Something also expressed by other participants as well. This echoes with what the family therapist Streicher (1995) writes about her learning from working with a suicidal client, "*I realized that, in order for him to regain some sense of control in his life, I had to relinquish my sense of control and power.*" (Streicher, 1995, p.93) and she goes on to describe what this meant in her work, "*This transformation allowed me to empower—rather than pathologize—in a blame-free context, to diffuse the resistance that Edward* [client pseudonym] *was prepared to present*" (Streicher, 1995, p.93)

The responsibility being "*to facilitate something that's helpful for someone*" (Simon – participant), rather than taking on the responsibility for the client's being, seemed to be expressed by them all in different ways, including the difficulty to do this with the weight of that overwhelming responsibility.

And finally, Yvette's experience adds to this with the perspective of how the felt responsibility differs if coming from within or without the therapist, in a sense. She exemplifies how the 'sense of self' in the professional role impacts the experience of responsibility, showing the importance of having professional agency and independence in one's work when encountering risk. This could be related back to Susanna's experience described in the previous subtheme, where the pressures put on her from her service and her lack of agency and independence in her job role, contribute to the 'hit' she takes when encountering suicide risk.

#### 4.2.4 Unrealistic expectations

One aspect of the participants' experience that seemed to be shared throughout, yet by most of them not named explicitly, was a sense of having encountered unrealistic expectations on them as professionals. It seems most of these expectations were, at least partially, external to the therapist, yet one participant also spoke about a level of internalisation of these expectations. Sam described this as a notion of being omnipotent, going on to explain this as being because of having all the responsibility, and all the power to "*save patients*". He particularly mentions the discrepancy of such a view against the reality of only seeing the clients short term and only one hour a week. This seems to offer support to Jobes and Ballard's (2011) view mentioned earlier, that therapists are held fully responsible for their clients' safety by their services, clients' families, authorities and a general societal view, and possibly also by the clients themselves in some cases, even if unconsciously.

Such expectations and pressures were described by most of the participants, even if not framed as 'omnipotence'. But rather the narratives involved being measured against criteria that did not reflect their work reality. Like Lisa said about the Coroner's expectations towards her colleague, "*in an ideal world, yes, we would have done all those things, but we just haven't got the resources...to do that*". Working in unsafe conditions due to lack of resources both within their services as well as outside, in the mental health care structures at large. Or being expected to hold a disproportionate amount of risk and responsibility on their own. From most of the participants there was a sense of vulnerability, of feeling isolated in the risk work and through

that exposed to professional vulnerability, but also having concerns about the limitations to how much they can help their clients. This sense of isolation was expressed both from an individual perspective within a service (lacking support and resources), but also beyond their own services, feeling isolated as teams or organisations in relation to external pressures, such as possible litigations or lack of external support for their clients, making their work very difficult on its own.

These experiences resonate with some existing literature. Montgomery (2018) talks about an 'expectation of omnipotence', which he describes as "*the pressure that the therapist feels from society (media, government, relatives, professional bodies) to be omnipotent when it comes to risk and the client's wellbeing.*" (Montgomery, 2018, p.32). He describes how his participants increasingly felt this, noticing "*an internalisation of persecution*" (Montgomery, 2018, p.32) manifesting itself through doubting themselves in their work with suicidal clients. Such an internalisation could be present in this study, in how the participants minimise certain difficulties, as if being meant to not be impacted, being meant to be 'fine' with it. But these forms of expression could mean other things as well, such as the therapists many years of experience making them more used to certain things, and/or finding that speaking about something in a less dramatic wording helps contain it. Therefore, understanding the level of internalisation of these expectations would require much more extensive research. Nevertheless, the pressures and the self-doubts as described by Montgomery (2018) following from these explicit unrealistic expectations were also expressed by the therapists in this study.

Hagen and colleagues (2017) also describe how some of their participants voiced that the society 'overrates' their ability to prevent suicide and also, that when someone does suicide, then there is the view that "*someone must have made a mistake*" (p.363), which brings my mind to the need for certainty even after death and how therapists hold this awareness that they can do their best but might still be 'accused' of malpractice. One of their participants voices this: "*So we have gotten a task that we are not able to fulfil 100%. But they [society] believe that about us then, that we can.*" (participant quote in Hagen et al, 2017, p.363). Hagen et al (2017) do not reflect on this from the perspective of unrealistic expectations, but from the perspective that the therapists feel they have to focus so much on the formal assessments that it prevents a real connection with their patients. I think, however, that it is also interesting from the perspective of unrealistic expectations, as well as drawing a link of sorts between how the unrealistic expectations, the weight of that responsibility can prevent the relationship from forming…

Similar expectations are also discussed by the Aeschi group, where Jobes and Ballard (2011), offer a critical reflection on what might underlie such expectations:

"*Society seems to imbue mental health practitioners with a kind of power, control, and level of influence that may not exist in objective reality. Suicide is usually a frightening prospect that we feel compelled to control or stop by any means. Perhaps what makes all of this so complicated is the fact that unlike medicine, surgery, or dentistry, the mental health clinician is the instrument of care—there is no equipment failure, no pathogen, no virus to otherwise blame. We are the instrument of care; it does not get any more personal than that.*" (Jobes and Ballard, 2011, p.54)

They go on to talk about how these expectations are present in the therapeutic encounter with a suicidal client and how they can impact the dynamics in the therapeutic relationship (Jobes and Ballard, 2011). Which can often lead to a kind of power struggle, as mentioned earlier, and potentially various different unhelpful responses from a therapist imbued with these expectations and pressures. Such as to "*overrespond clinically*" (Jobes and Ballard, 2011, p.55) by prematurely or unnecessarily admitting the client to hospital or referring them onto another service when that might make no difference (getting 'rid' of the client), or a struggle to empathise and collaborate with the client due to conflicting feelings of for example fear or anger towards the client and consequently disabling the therapeutic work.

Wider policy initiatives such as the Zero suicide alliance (**https://www.zerosuicidealliance.com**), possibly unintentionally, might contribute to this unhelpful cycle of unrealistic expectations adding to a fearful, less open/attuned approach to the client and thus less possibility for the client to move out of their suicidal state of mind. The idea of aiming for no suicides sounds ideal, and probably something that every therapist would wish for, but the suicide risk assessment tools are not yet proving effective enough to predict a suicide attempt (Large, Kaneson, Myles, Myles, Gunaratne, Ryan, 2016), and there is the mentioned risk of 'overresponding clinically' (Jobes and Ballard, 2011, p.55) and hospitalising clients when not needed nor helpful, potentially leading to iatrogenic impacts (Godin, 2004, Wand et al, 2015). But above all these aspects, the most important element is described by the suicidologist Edwin Shneidman (1998, p.6):

"*The most important question to a potentially suicidal person is not an inquiry about family history or laboratory tests of blood or spinal fluid, but "where do you hurt?" and "how can I help you?".*"

However, in the light of the heavy and frightening expectations the therapists have to hold and navigate, trying to do just that, to stay fully present and "*see the patient's suicidality through the patient's eyes*" (Jobes and Ballard, 2011, p.57) can be an overwhelming and very difficult ask.

In the subtheme about responsibility, Simon appears to be expressing the need for him to manage his own anxiety for the client's safety in an attempt to offer the client a real reflective and connective space – feeling seen and understood. He also voices the ambivalence in daring to do this, offering an insight into the heavy weight of responsibility he holds and tries to move away from, in offering the client that space.

I have described this first supraordinate theme of emotional labour as being about how the work with suicidal clients impacted the participants. From the above reflections it is clear that it is an interactive process; what impacts the therapist could also have an impact on the clients and in turn on the therapists again. Similar to the work in therapy, this can be an inter-relational process as well as intra-personal.

These themes, in particular the one about 'the felt responsibility' and 'unrealistic expectations', seems to echo with the existing theories about 'emotional labour', the personal emotions becoming a regulated, unpaid commodity of the work, an expectation on the employee within a capitalist, gendered economic model. The concept initially developed by Hochschild in 1983 (in Bolton, 2005) in relation to stewardesses, and more widely the business sector, but has also moved into the caring professions (see Smith, 2012).

Hearing the participants experiences in these themes, it stood out for me how 'emotional labour' is also manifested in the therapy professions. One could argue that emotional work is intrinsic to the therapy professions, that engaging in this work is emotional in its nature, and also at times expected to be very difficult. But my specific differentiation of this element of the profession and when it becomes 'emotional labour' is trough that individualised, unrealistic responsibility described above. The expectation that therapists ought to be able to save and prevent suicide no matter what, adds to this idea and pressure of omnipotence potentially limiting the actual work that could help the clients. I believe this comes into play when the weight on the therapist is not supported nor acknowledged, but rather, expected. When they are not part of a supervisory shared responsibility and reflection. I will return to this in the final theme about support.

### 4.3 Navigating the risk

#### 4.3.1 Facing the suicidality

The participants all shared the experience of having been face to face with someone seriously contemplating killing themselves. They described bewilderment and feeling at a loss as to what to do when faced by this frightening intent. Some participants expressed these feelings explicitly and others more implicitly, perhaps indicating how difficult the experience might have been, in that moment, to connect with these difficult emotions. Reeves (2010) talks about how when confronted with difficult emotional and relational processes there is a great temptation to disconnect. This is especially true when working with a suicidal client. Their death wish can be frightening for all the various reasons mentioned in the previous themes, also because it can touch our own death- wish or anxiety, which can be too difficult for us to contemplate (Orbach, 2001; Yalom, 2015). Reeves (2010) emphasises how this is not about a deliberate unethical response from the therapist, but one that is in many ways mirroring the wider discourse of risk assessment within an existing biomedical framework, which tries "*to objectify an essentially subjective process*" (Reeves, 2010, p.136), positioning the therapist as merely 'assessing' the risk, as an objective observer, not recognising the inter-relational dynamic of suicidality (Jobes and Ballard, 2011).

Orbach (2001) also speaks of the importance of engaging with our own feelings towards death in order to be able to truly meet the suicidal client.

"*One major difference between therapeutic work with suicidal and nonsuicidal individuals is the ability to contain and bear another person's death wish without being overwhelmed and incapacitated by anxiety. It is not only the sense of responsibility for another person's life that is incapacitating in this work, but mostly it is the therapist's "own suicidality", death anxiety, fear of hopelessness, and mental pain that hamper therapeutic work with suicidal patients.*" (Orbach, 2001, p.171)

A few of the participants' expressions resounded of this encounter touching their own humanity, perhaps their own mortality even, again, as suggested by Orbach (2001).
Further, some participants expressed a sense of deep empathy with their clients' existential pain, being present with their clients in their suffering to the extent that it was even difficult to hold hope for them. Fox and Cooper (1998) describe how therapists can experience vicarious traumatisation from hearing about clients' suicidal ideations and plans. Also found in Moore and

Donohue (2016). There is some indication of this being the case for a few participants in this study. Some of them said they were remembering this as if experiencing it now, and a few of

them described their experiences as being 'traumatic'. Which might lend support to Fox and Cooper's (1998) findings.

The participants described in various ways how certain situations set off 'alarm bells' for them. For most of them this kind of risk barometer had developed through years of experience working with suicidal clients, where most levels of suicidality they would engage with through an exploration in therapy, while others they felt there was no space for such an exploration, but only action. This, for the therapists, important inner compass of sorts, is in part discussed in the next subtheme. In light of what is discussed of the ease as a therapist to disconnect in different ways, I also mention this here, in the context of being faced by such frightening suicidal intent, to be considered as a possible area for more in depth research. To explicitly look at therapists' reasons and motivations behind different responses to risk.

### 4.3.2 Risk and/or Therapy?

The participants seem to have communicated a rather unanimous experience in this theme that working with clients who are 'too high risk' does not allow for the therapeutic work that could enable a change. Something that appears to decrease their professional sense of purpose to some extent. One participant, having chosen to move on to work with less immediate risk to be able to do in-depth work, which she experiences as more rewarding. However, as much as there is a commonality, they seem to make sense of this in varying ways, for instance one participant understood it as an interrupted relational connection, moving the work outside of the therapy and into taking measures to keep the client alive in the immediate moment. Other participants expressed a sense of therapeutic inertia, where all or most of the time in the sessions was dedicated to 'keeping the client alive', where this became the sole purpose of the sessions, either because the therapist were consumed by their worries about this, or because the client would continuously attempt suicide or expresses immediate intent; or because of service targets limiting a risk exploration to be part of therapy; and/or because the clients are too vulnerable internally but also externally – with no protective network – to engage in therapy.

All the participants that described the therapy as a containment of the risk rather than a growth-oriented process, a sense of therapeutic inertia, worked in services with time limited therapy, in organisational settings funded fully or partially by the NHS, where the resources were scarce.

And there seemed to be a shared experience of limited flexibility or agency in this work, coming both from the clients' situations as well as the service structures, policies and resources.

Returning to the Aeschi group (Michel and Jobes, 2011), they speak of the importance of staying with the client in a situation of high risk: "*This high-stakes stand-off is one of the most challenging situations that therapists and suffering patients can ever face in clinical practice. Yet, in the face of these circumstances, finding a way to connect and actually collaborate is crucial for mutual success.*" (Jobes and Ballard, 2011, p.57). However, hearing the participants narratives, they are closely tied to a wider context of a service or/and a lack of support and resources. Holding the responsibility for the clients primarily themselves. The Aeschi CAMS model has a strong therapeutic alliance and collaborative work client-therapist, but perhaps in order for therapists to be able to work in such a way with 'high-risk' clients there needs to also be a surrounding structure that enables this work by holding and supporting the therapist in taking such an important, but also potentially frightening, relational risk in the service of the client. Otherwise there is a risk of traumatising the therapist, as described by Yvette (in subtheme 3.1.4, Analysis) of her experience of having to hold a client alone, not calling an ambulance, when the client was seriously suicidal:

"*/.../ it worked, she didn't kill herself, you know [said quietly], but, I had a terrible time with it, and I didn't want to feel like that again.*" (Yvette)

#### 4.3.3 "*There's never certainty*" – the never-knowing

All participants described holding uncertainty in some form with their suicidal clients. They all also seemed to have different elements that they could hold on to give them just enough certainty, both between the session, as well as in the sessions feeling able to explore difficult things. Some participants described holding hope in the relationship – their knowing of the clients. Another participant made use of contracts where she talked to the clients about how they could not attempt suicide while in therapy, explaining how without that she could not help them, not being able to do in-depth exploratory work. And yet another participant described how her service ensured the therapists monitored risk very closely to safeguard for any possible change in the clients' risk.

There is a commonality of ambivalence amongst the participants, of both knowing – and to an extent accepting – that there is uncertainty, an uncertainty that holds fear and anxiety. While also trying to find ways to keep this unknown at bay, or to recognise the relational elements that

give them some level of peace of mind. Finding some level of certainty to help them hold the uncertainty.

The participant who described setting up a non-suicide contract with her clients before starting therapy described the need to feel safe in the work in order to be able to fully delve into the unknown of the work. In a way it seems that she is holding two unknowns that are both intertwined and also difficult to consolidate. One is the 'pot holing' (Reeves, 2010), the in-depth therapeutic exploration alongside the client, not knowing what they might come across. And the other is the unknown of the client's safety, which might be triggered by the therapy. This seems a very difficult line to tread.

Several other studies have described therapists struggle with the unsettling uncertainty of the clients' safety outside of the sessions (Reeves and Mintz, 2001; Moore and Donohue, 2016; Montgomery, 2018; Nicholl et al, 2015). Moerman (2012) describes this unknown as "*clients' hidden layers*" engendering fear and anxiety in the therapists (Moerman, 2012, p.217). This description also seems an acknowledgment of the complexity of a client, bringing my mind back to Sam's words how "*There's never certainty in working with the suicidal patient*" and how that is something he needs – and tries – to accept. This acceptance is also present in Moerman's (2012) study, where the therapists seem to recognise the limits of the extent that they could actually prevent the clients from harming themselves but described seeing their role as one of being a support for the client to reflect on their difficulties. This resonates with some of the participants in this study, who expressed holding the uncertainty week after week, expressing a sense of acceptance of holding this. As if them holding this worry between sessions is part of their commitment to their clients. Perhaps as if carrying them in mind is a way to hold some of the client's distress.

The findings in Thomas and Leitner's (2005) study of therapists and clients' views on the responses during a suicidal crisis shows how therapists mostly respond with a 'fight' response, by taking decisive action, while most of the clients' expressed that reaction as being unhelpful , preferring what they call the 'ideal' response, which entails the therapist remaining present and open to understanding and hearing the client's distress. As the authors suggest, "*most mental health professionals respond to suicidal clients in the best way they know how. The problematic 'fight' and 'flight' responses described in the literature are understandable responses to a very difficult situation*" (Thomas and Leitner, 2005, p.148). This is an empathic way to understand

how the uncertainty of risk work can lead to a need or urge to have- and take control. And it shows why it is so important for therapists to be supported in holding the uncertainty and understanding what it brings up emotionally (Reeves, 2010, Orbach, 2001).

The participant in this study who described her service's requirement to persistently monitor the risk every session, offers another perspective. As her service seems to suggest that by clinicians monitoring the risk closely, suicides ought not happen, the monitoring is "*to make sure that it doesn't then shift into...uhm, plans and possible actions*" (Susanna, participant). Yet Susanna expressed the existing unknown with risk, of how it can happen unexpectedly. There seems to be a gap between the service expectation to 'control' the risk and the uncertain reality held. This seems to be a way of not acknowledging the uncertainty, but leaving the therapists holding it alone. Which in turn feeds into the idea mentioned above, of the aspects of 'emotional labour' within therapeutic risk work.

## 4.4 What makes or breaks

### 4.4.1 The relationship

Relating to it through multiple layers, the therapeutic relationship was an intrinsic part of all the participants' work with suicidal clients. The relationship was both the vessel to naming, assessing, exploring, and also holding the suicidal pain. But also a possible indicator of any relational difficulty, like a traffic light signalling to the therapist that something is 'wrong', for instance, as was the case for one of the participants; that his fears of the suicide were getting in the way of the relationship forming and thus preventing the work.

This central role of the therapeutic relationship in the work with suicide risk was also found in Winter and colleagues' (2014) systematic review of the existing qualitative research on counselling and psychotherapy with suicidal clients, which encompasses research interviewing clients as well as therapists. They found "*a consensus that effective therapists are understanding, empathic and non-judgemental*" (Winter et al, 2014, p.76). A similar finding was reported by Dunster-Page, Haddock, Wainwright and Berry (2017) in their systematic review looking at the relationship between therapeutic alliance and patient's suicidal ideation, self-harm and suicide attempts, noting a positive impact of a strong therapeutic alliance on lowering suicidal thoughts.

The participant expressing the difficulty to form a therapeutic relationship as he felt all-consumed by the client's suicidality, his description of realising how his fears had created a distance seems to parallel existing research about the role of 'presence' and the importance to explore our own responses to the clients suicidal expression and how that might be impacting our ability to "*see the patient's suicidality through the patient's eyes*" (Jobes and Ballard, 2011 p.57).

Geller and Greenberg (2002) describe presence as an essential prerequisite for the therapeutic relationship forming. "*Therapists' presence can be viewed as the condition of being fully receptive in the moment, and in immediate contact with the other's inner experience, which then allows the relationship conditions to emerge and be expressed.*" (Geller and Greenberg, 2002, p.84) and they also found that presence can facilitate the therapist's attention to their own experiencing. Being present means being focused, attuned and open to receiving and meeting the client (Geller and Greenberg, 2002), which according to Maltsberger (2011), is the basic brick for building up the therapeutic relationship with the suicidal client, which in turn is the core tool and vessel for any therapeutic change. This might sound like a basic aspect of therapy which is superfluous to even mention, but Sam's experience illustrates how that is not the case. In describing how he was "*trying to empathise*" and "*understand*", and how that was not possible for him in that situation because of his fears.

Also, Maltsberger (2011) elucidates how this attuned presence and empathy is in fact often not expressed as "*with the rise of evidence-based medicine and the increasingly limited resources and consequent pressure on clinical settings, the art of seeing patients as full persons with a very individual history has in current clinical practice largely been lost. This is particularly true for suicidal patients who need good empathic care.*" (Maltsberger, 2011, p.30). In Sam's case, the aspect of limited resources was also present with this client, since he does brief therapy and he was acutely aware of the short time he had to work with this client with such complex needs and urgent distress.

The importance of the relationship as a space for the client to be heard, held and not alone with their suicidal pain was another experience expressed by the participant, that their feeling "*can exist in the world*", as Simon said, making a space for the contradiction of having – and needing – that relational connection while not knowing how to exist in the world. This resonates with Moerman's (2012) finding of the importance of seeing the whole person, following their narrative

and "*holding the tension between their reality and that place which does not hear reality*" (Moerman, 2012, p.221).

Trusting the relationship and what is held within it was part of the participants' narrative, and with that, one participant voiced the difficulty to stay with that relational knowing. Akin to a 'safe uncertainty' (Mason, 1993), that in and of itself being part of enabling the client to hold the conflict of how to exist. The relationship being the medium where the client's difficulties can be expressed and understood together, seemed to be a view shared by several participants. While also describing how difficult this can be to be part of, to contain and navigate. Being with the client's in their confusing and possibly chaotic emotional world, at times feeling 'pushed and pulled' and struggling to "*keep a clear head*", like Lisa expressed, can be hard. Yet this seemed to be considered necessary to begin the process of jointly understanding their difficulties, and the client being able to hold the responsibility for their change – "*we stepped out of the battle and we could work together*" (Lisa).

A good therapeutic relationship was also described as essential for risk to surface in therapy, for the clients to feel safe and able to voice this, one client expressing this as a "shared" process, acknowledging it as something they both contain, not simply a problem the client has. This echoes with Winter et al's (2014) systematic review, where they found that for the clients it was necessary to feel accepted and not judged in order to talk about their thoughts of suicide or self-harm.

The participants all expressed in different ways how they very much used themselves in the work with suicidal clients and seemed to consider that both inevitable and necessary. This resonates with existing literature on working with suicidal clients (Michel and Jobes, 2011; Moerman, 2012; Richards, 2000; Nicholl, et al, 2015; Rossouw et al, 2009), and the wider literature on therapeutic relationship (Means and Cooper, 2005).

### 4.4.2 The role of experience

Experiential learning appears to have been essential for all participants when it came to the work with suicidal clients. On all levels, from naming it, to exploring it, to trusting oneself enough to know how and when to stay with the client and how and when to act, experience appears to have developed their knowledge, changed their outlook and made them less fearful and more confident, more able to know and trust their reasoning and their approaches.

Two participants voiced the importance of experience regarding the aspect of naming the suicidality and talking about it with the clients. Expressing how extensive experience of working with high suicide risk made them feel less fearful when bringing it up with their clients. And both of them, in different ways, seemed to infer that these kinds of conversations are not something they would encounter to this extent outside of this work, which is why this exposure has been so essential to acquiring that knowledge and know-how about what is appropriate and needed in these high risk circumstances.

The difficulty of naming the suicidality with clients has been discussed in other studies. Reeves, Bow, Wheeler and Guthrie (2004) especially looked at this and found that the counsellors struggled to directly name the suicide risk when in a session with a client that was implicitly talking about it. Instead they offered a reflective response, which did not enable a full exploration of the clients' experience, and, according to the authors "*failed to engage with a redefining process*" (p.68, Reeves et al, 2004).

Vail, Adams, Gilbert, Nettleingham and Buckingham (2012) found a similar difficulty, namely that the clinicians, especially those less experienced, had difficulties in explicitly naming risk with the client. They found that for these less experienced clinicians, having a formal assessment could be of help, as a tool to be able to name the risks, while those with more experience can make this a part of the therapeutic conversation.

A few participants illustrated how their experience with suicide risk had meant they felt more able to trust their professional instinct and more confident even when there was uncertainty or disagreement (e.g. with supervisor or service), and how this enabled them to stay present to a greater extent with their suicidal clients. Thus, experience, with the knowledge and confidence that followed from it, seems to have rendered them a kind of professional courage.

This could be linked back to what was discussed earlier, about Andrew Reeves' (2010) description of how being able to work with a suicidal client in a meaningful way, engaging with them with openness, empathy and flexibility, and sharing their difficult journey of sense-making, how this requires courage. The participants in this study, seem to have gained that courage, at least in part, through experience. Sam's description of taking the step to work with a suicidal client without having that experience showed how frightening this can be and, again, how much

courage it takes to engage with suicidality. Doing this work is emotionally intense and uncertain and holds risks also for the therapist. Yet, what seems to be expressed here is that experience gives a certain level of knowledge, know-how and confidence. One participant describes this as having enabled him to 'trust' his work, having come to a place of feeling safer in holding that uncertainty. As a result, he was able to stay with the client, 'to be the intervention' (Simon), instead of referring the client on because they are seriously suicidal.

Jobes and Ballard (2011), especially speak about how 'referring on' is often part of a fear to fully engage with and commit to the work with a suicidal client, a fear fuelled by the current societal culture of expecting the therapists to stop the clients from suicide. "*However difficult, when a patient is suicidal, collaboration and empathy within the dyad may be even more essential than usual.*" (Jobes and Ballard, 2011, p.55) It seems from some of the participants' narratives expressed here, that the confidence brought by experience, can in part help to engage in such a process with the suicidal clients. Another important part of being able to do this, is support, which is discussed under the succeeding theme.

#### 4.4.3 "*I'm not on my own*" – the role of support and resources

The participants accounts revealed how for them 'support' entailed multidimensional functions and purposes, from emotional containment, through shared meaning-making, to shared responsibility, where not feeling supported became an additional strain. A common thread throughout seemed to be the importance of not holding the risk alone, but with a supervisor, or even, collectively with a team.

One participant seemed to express the difference in how the risk is processed in the session, where it is partly a reaction based on intuition and relational knowing, trying to stay present with the client's distress. Therefore, having that dialogue with colleagues afterwards allows for a more explicit understanding and formulation of the rationale underlying the response to the risk.

The participants expressed the central role the frequent and regular discussions within their teams had for their ability to work with their complex and highly suicidal clients. This was important for various reasons. As an aid in the sessions with the clients, feeling contained and that they were not alone with this weight of responsibility, and also having their perspectives on the work with them. Also, it was a crucial aspect of disentangling their own feelings brought up by this difficult and emotionally intense work, alongside making sense of the client's difficulties.

Further, articulating with colleagues how they reasoned around this, was central in their sense of clarity on how to manage the risk, whether feeling more confident in their work or realising that they needed to take further action. Either way, it enabled them to feel safer within their work with suicide risk. It appears that in many ways the support of their teams offered confidence, containment, support, new perspectives and it seemed to work to safeguard both their clients and them.

Discussing with colleagues helped to take some of the pressure off them, or like Lisa expressed it, "*it wasn't just all down to me*". Not being alone if something was to happen, and not being alone in holding the intensity and complexity of the work seems to have been key to coping with this work and to feel able to fully engage with it.

The importance of support has been discussed in the existing literature. Winter et al (2014) highlighted the importance of specialised training for therapists working with suicide risk, which would support the findings here of how frightening and difficult this work is for therapists new to it. Moerman (2012) describes, similar to the participants here, how supervision and peer support were invaluable both for the therapists to reflect on what came up for them in the work, as well as to share the weight of the responsibility.

Reeves (2015) offers an extensive list of possible risks within therapy with a client that presents with suicide risk and emphasises the role of supervision to prevent and/or work through these dangers. In the present study, the majority of the participants found their supervision helpful, but it would seem that for most of them it was mainly the peer supervision or peer support that was emphasised. This was in part because several of the participants were experienced practitioners with additional responsibilities to seeing clients in therapy. This seems to have entailed the combination of having less frequent supervision and talking a lot about practical, not clinical, things in supervision. The peer supervision was more frequent and completely focused on the clinical work. All participants expressed the need to not feel alone in this work, yet for some participants they held the work completely alone, even when working within a service.

## 4.5 Reflections on the limitations and possible contributions of the study

### 4.5.1 Methodological reflexivity

As explained in the methodology chapter, this study used a qualitative approach as a means to

accessing understanding of the therapists' experience. However, there are limitations to how much this experience can be accessed, which I will now discuss.

Willig (2008) offers a pertinent critique of the seemingly unproblematised use of language as the main tool to access the participants' experience in IPA, considering the various different perspectives to language, such as understanding it as a construct, where it can pose possible obstacles to accessing the direct experience as the words to describe said experience could be understood to add or create yet another layer of meaning as they are expressed. This is in part why the interpretations extensively involved nonverbal communications and prosody, which offered insights into their experiences which were less directly dependent on language.

Willig (2008) also discusses the difficulty in ensuring the 'suitability of accounts' asking questions of the extent to which the participants are actually able to express their experiences through words, and also if their specific experience is appropriate for a phenomenological analysis. Regarding these aspects, the participants in this study, being therapists and using language as their main tool in their work in which this experience takes place, I believe they did have the necessary use of the language to be able to express their experiences.

For five of the participants, English was not their first language. However, they were all fluent English speakers and I reasoned that as they worked as therapists in English, they would be sufficiently proficient to take part in the research.

Further, as language is the means through which they communicate with their clients I reasoned that using a similar way to access their experience, it could add a level of proximity to the work. But these limitations also possibly suggest that an additional future perspective where the use of language when talking about this experience of suicide risk, might be of interest. As well as possibly a more narrative analysis, where the use of language as a construct is considered and explored. Although, saying that, what came across strongly in this study was the level to which their work with suicidal clients is an embodied experience, in spite of the limitation of language.

Willig (2008) continues to discuss how IPA accesses a descriptive insight into how the experience might be perceived, but that it does not attempt to offer any explanations as to why a certain way of experiencing, possibly offering a lesser level of understanding of the phenomenon. I see this in two slightly conflicting ways. On the one hand, as much as I do think that understanding the underlying mechanisms of a phenomenon is important, I think there is a

strength in being able to focus on the ‘what’ and ‘how’, rather than the ‘why’ of an experience, as that can often be a way to train ourselves to see and hear, without jumping into conclusions and assumptions about the world. A kind of prerequisite to be able to then possibly reach a more in depth understanding of the ‘why’. But my somewhat contrasting view of this, is that we will inevitably interpret, and thus, a ‘description’ will always contain an interpretation, thus possibly adding a ‘why’ without a conscious intention of doing so, which is more problematic. As I believe that we cannot separate our observing eyes and ears from our being and our lifeworld, I have, during this process, rather than ‘bracket off’ my assumption, I have tried to be attuned to them and make notes of them. Saying that, I have also, when doing the initial encoding in particular, tried to employ Smith et al’s (2009) concept of the ‘naïve listener’. But in order to do that, I have needed tools, as I describe in my methodology.

Willig (2008) makes a point about the role of cognition, as something that is accessed specifically in IPA, risking creating a Cartesian separation of different aspects of our being interacting with the world. This is an aspect that I tried to move away from in my research to an extent, in trying to focus on their full embodied experience as mentioned already. Further, my interview schedule purposefully started with questions focused on bringing back the sensory immediacy of their experience rather than an intellectualisation of the work or their views on suicide. However, as mentioned already, one of my participants did not appreciate this approach, thinking it was too abrupt. Thus, I would need to give this more consideration when trying to access the felt experience in future research.

Further, I had a concern regarding the temporality of my research, in that the participants would be talking about their experiences in the past, which, again, brings up the question of the access to the actual experience through a memory. But while acknowledging that it may not capture the immediacy of the experience, it seeks an insight into how the participants made sense of their experiences, recognising how sense-making changes, and can change the moment after an experience and many times after that, with the phenomenological perspective of intentionality relating not just to the present, but to the past and future (Krell, 1982). Merleau Ponty (1962, quoted in Krell, 1982, p.503) described this when saying “*Time is not a line but a network of intentionalities*”. Furthermore, in phenomenological terms (e.g. Merleau-Ponty, 2008), intentionality can be understood as an embodied act, where the “*lived body is the proper source of that "sedimentation" of time.*” (Krell, 1982, p.503), and as such, this research focused greatly on capturing any expressions of embodied experience, and through that, in some ways got an accentuated insight into this experience, as the participants’ embodied responses, even in some

cases of recollections from years back, were brought back in intensity and affect in embodied ways.

Trimble, Jackson and Harvey (2000) emphasise the difference made by the therapists' awareness of their own views on suicidality in how the work with suicidal clients is experienced. This is something that I did not explore enough and is a definite limitation of the study. I did not explore this initially as I wanted an experiential narrative. However, after a few interviews I realised how this would have been interesting to know and some participants did talk about it, but not enough to bring it into the analysis.

In a similar vein, I have come to realise that it would have been of interest and relevant to ask about the participants own reflections on their own mortality. However, I find that this might have been moving away from the experiential focus of phenomenology and into being more directed by the existing literature. Also, I could not assume that this would be something the participants had reflected on previously and I would need to be mindful of what this could bring up for them. Thus, this could be more an area to consider in future research, perhaps through a different methodological lens.

### 4.5.2 Reflections on the design and methods

The participants coming from different therapeutic orientations could be seen as a weakness in the homogeneity of the study and thus possibly lending the findings less strength in offering an insight into the shared experiences. However, similar to Hendin et al (2006) who found that despite the wide range of therapists in their study still had a "widespread applicability" (Hendin et al, 2006). I have found that the differences in this study were not based on the sociodemographic elements, but rather on a combination of aspects relating to context, experience and possible values, which could be something to explore in future research.

Because all the participants volunteered to take part in the study, there is the possibility that they chose to do this because they experienced this work in a particularly demarcated way. However, this was asked about in the beginning of the study, why they chose to take part, where all of them spoke of the importance of understanding the therapists' experience of this difficult work. Four of the participants also said how they usually try to take part in research studies when they can, as a way to contribute to the field and to help researchers who can find it difficult to find participants.

There is also the possibility that the people who chose to take part did not find this too difficult to talk about, with potentially other therapists struggling more and not coming forward for an interview. However, from the participants' narratives it would seem that there is a range of experience and intensity of the impact of the work still represented in this research. Also, as this study does not seek to offer generalisability, but an increased and in-depth insight into the experience of this work, the representativeness of the sample is not a priority. The priority being to have had this experience and be willing to reflect on it, which applies to all the participants that took part.

### 4.5.3 Personal reflexivity

Reflexivity in the process of qualitative research, as discussed earlier, is an essential part of the ensuring the rigour and transparency of the study. I have included my reflexivity throughout the whole study in italics, but I will also make some final reflections on my research journey.

My main struggle through this process has been that of interpretation, as I have already described, I was concerned that I would make my own voice heard over the participants'. My own reflective notes and discussions in supervision and with peers, helped with this. But I have inevitably had to choose some quotes over others, and I am certain that another person going through this work would find other themes and quotes of relevance. Or even I might if I were to go back to the text now or in a few years' time. But I have come to accept that this is part of the process of research, in particular qualitative research. Where my study offers an insight into some aspects of the participants' experience, which are important to understand.

I also believe that I have slightly re-evaluated my idea of what a 'phenomenological' enquiry might entail. Where initially I was determined to focus on the moment and what impacted them then and there, something I still believe is a core aspect of such an enquiry. However, as I have come to hear about the participants external pressures, and professional identities, I realised that I ought to have asked more about their beliefs, values and ideas as well, as they contribute to shaping their experience in the moment.

### 4.5.4 Possible implications for counselling psychology and the wider field of psychotherapy

As my research explored the experience of Psychologists, Counsellors and Psychotherapists alike, I will also reflect on the possible implications for the professions jointly.

Throughout the interviews the participants indicated in different ways how they were having insights during the interview as well as expressing their views of the importance of understanding therapists' experience of this difficult work. This was also illustrated through the themes, showing how the therapists hold so much on their own and often with an expectation that they are meant to hold this alone. Creating spaces for talking and reflecting about suicide risk and suicide therefore seems important, both to process the work with everything it brings up for the therapist, but also to articulate and note the experiential knowing of this work.

Continuing from this, a possible implication for training, would be to create more spaces to talk about suicide risk not just from a risk assessment perspective, but as 'risk exploration' (Reeves, 2010). This would include creating a space to reflect on one's own thoughts and feelings about suicide and death, noticing what it might bring up in ourselves.

Another reflection for training comes from how some of the therapists talked about how hard they felt it was to explore suicidality with clients in the beginning of their career, resonating with other studies (e.g. Reeves et al, 2004). I wonder if as part of the training it would be useful to explicitly ask trainees how they feel asking and talking about risk. What the meaning of asking these questions is to them and how it makes them feel?

A few participants expressed the pressure they had felt to learn to work with suicidality, as well as the self-doubts and lack of confidence this work could evoke (also with more experience). This brought my mind to thinking of training again. I believe it is important to actively reflect on how this experience is gained, knowing that there might be a pressure felt by trainees and newly qualified therapists to know how to work with suicidality. Therefore, recognising the possible vulnerability felt by the new therapist and ensure that this learning is facilitated and supported by teachers and services alike. Thus, creating a safe space to learn how to explore any countertransferential responses early on, making it as much a part of the risk exploration as are the explicit risk questions asked to the client.

The impact of the felt responsibility seems to have had an influence both on the therapists' wellbeing, as well as on their ability to fully engage with their clients and meet their needs. But some of them expressed aspects that were helpful in holding this responsibility. Such as, feeling trusted to do their job; having a space to discuss concerns and doubts – as a way of both sharing the responsibility as well as clarifying own reasoning. Also, being able to relinquish power and control – moving away from the 'power struggle' and into a mutual, collaborative

relationship where the client can make sense of their suicidality, giving back – or sharing – the responsibility to/with the client. These things were expressed by the therapists as things that enabled what I have called a 'helpful responsibility'.

Jobes and Ballard (2011) speak of how even when having to admit a client to hospital, this can be talked of in a way that is collaborative, relational, and ultimately – and vitally – therapeutic. But crucially, the weight felt by the therapist of the responsibility to keep the client alive needs to be acknowledged. There needs to be an active, conscious formulation of a more helpful responsibility, one that becomes shared with the client and enables therapy to happen. Most of the participants voiced the vital role that support had in doing this.

Yvette described how she would feel that she had her colleagues with her in the therapy room, because of the extent the work was shared between them as a team. Everyone knowing of all the clients in depth and contributing frequently and actively to the reflections about them. Simon expressed a similar experience. This is the way the work is approached both in the consultations of dialectic behavioural therapy (DBT) services as well as in mentalization-based therapy (MBT), two approaches which are generally found in the work with people with very high suicide risk (Walsh, Ryan and Flynn, 2018; Bateman and Fonagy, 2006), which adds strength to the argument of the importance of this collaborative way of working with suicidal clients.

However, I am aware that the lack of resources in most mental health services today can make this hard. Nevertheless, the essential role of support needs to be highlighted, both for the therapists to process the work and feel 'less alone' holding it, as well as to enable a more attuned way of meeting the suicidal client and hearing their experience. In many services today, therapists have one hour of supervision once a month at the most. It seems that when working with suicidal clients, having frequent support is essential. Lisa expressed how she could not have managed without the weekly peer supervisions, and Simon described the essential role of being able to debrief with a colleague whenever he needed to. These are just two examples of several. The informal support of colleagues is clearly vital, but there also ought to be structures set in place that are real reflective spaces where the work is thought of and held jointly.

In addition to that, an attempt from services to not have too big workloads. This would make space for real breaks. This would be an acknowledgment of both the emotional impact as well as allow a space for the body to recover. To rest, notice and release tensions accumulated in

the work. The difficulty with this if working in the public or third sector is that lack of resources often set the tone for the workload and recovery spaces.

Lisa's description of "*walking a very dangerous tightrope*" in relation to the lack of resources in her and other services, highlights the difficulty of doing this work safely when so under-resourced. The participants spoke of the stress of time-limited therapies with suicidal clients and of the many people on waiting lists. They all talked about there not being enough helpful and meaningful resources for people in distress. Seeing their clients in therapy and being able to safely and meaningfully explore their suicidality, thus becomes a matter of resources as well, of balancing the tensions of service targets and needs, with the client's needs.

"*Do we value people for the added value they can provide for our economics or do we value our economics for the added value it can provide for our people?*" (Mearns, 2004, p.1)

An intrinsic part of being a therapist is exploring one's own internal world and one's ways of relating to others. But I believe there is a need to also, more actively engage with matters of social injustice as part of how it impacts our profession.

The link I draw between my findings in the theme about Emotional Labour, in particular 'The felt responsibility' and 'Unrealistic expectations', with the sociological theory of 'Emotional Labour' (Hochschild, 1983 in Bolton 2005) is, I believe, important to consider in our professions. Positioning our work beyond the immediate interaction with our clients is increasingly necessary in order to safeguard our clients and ourselves from political and economic values that go counter our work and responsibility to "*to facilitate something that's helpful for someone*" (Simon – participant).

This development of neoliberal top-down agendas and targets, which are increasingly found in social work, healthcare and education (see e.g. de St Croix; Smith; 2012, Kulz, 2017) is also being observed in much of the psychotherapy professions (Mearns, 2004). In my study, this was especially voiced by the therapists working in the public and third sector.

Bringing our working conditions with suicidal clients (and all clients) to a broader discussion about socio-political values and conditions can be another aspect of finding resilience in the work. Resisting an internalisation of the professional stressors of lack of resources and

medicalised models of care. Redefining the stress and sense of isolation voiced by the participants, from an 'individual' weight, to a shared experience of particular systemic injustices.

In the same vein, it seems especially important to be actively aware of our own ontological and epistemological positions for our practice (Willig, 2019). Doing this as a way to be more explicitly aware of how the possible ontological and epistemological tensions in the professional contexts might be influencing our approach to risk work (Reeves, 2017). Such an awareness might serve as an aid to navigate through the difficult decisions of this work. That way possibly offering tools to highlight the contradictions and be guided by an awareness of what is the client's needs and what might be external demands. Again, discussing this in training courses as an essential part of understanding one's own therapeutic approach would be a way to prepare therapists for these professional tensions.

### 4.6 Future research

Possible areas of future research are closely linked with the preceding sections. Coming back to the point made in the methodology reflexivity (4.5.1), about seeking to explain this experience rather than simply describe it (Willig, 2008), in view of my findings, of the importance for the therapists to not hold this work alone, and the prominent role that external pressures and expectations seem to have on the therapists and their work with suicidal clients, it seems important to explicitly understand this underlying pressures and how they might impact the work and the therapeutic dyad.

Another aspect to explore would be the possible internalisation of the unrealistic expectations described in this study and others (e.g. Montgomery, 2018). In this study there were indications that this internalisation might be present, but this would need further research, possibly with a more explicit focus, perhaps a narrative analysis or discourse analysis to notice the use of the language, as here, the main indications of such internalisation, was noted through implicit uses of language, in contradictory comments and expressing very difficult experiences in downplaying, understating ways.

Another possible aspect of interest would be to explore that experienced difference between when it is possible to work therapeutically and when the risk takes over, as it seemed that participants had different cut-off points and reasons for this. Further research to understand what underlies this difference seems necessary to understand if there are structures and supports that can be put in place to be able to pursue the work.

The last point I would like to make regards the role of experience and training. Doing further research into how training programs prepare trainees for this work, to understand what would be relevant to include and how, given the seemingly very important role of actual clinical experience of this work as well. I am aware that there is a small body of research looking at this, but it might be relevant to incorporate the aspects such as not only talking about the risk assessment, but also of what it brings up for the trainees and what they feel are the expectations held on them, both externally and internally.

### 4.7 Conclusion

This study was an exploration of how eight psychotherapists experience and understand their work with suicidal clients. It has contributed to a further insight into this work and has implications for training, therapeutic practice, research and policy.

Initially, I found it difficult to articulate the specific original contributions of my study. Not because I felt it had nothing to contribute, because I know it does, but because I know it is an area that so many therapists and clients have inhabited for a long time already through their practice.

Nevertheless, precisely that is very indicative of where our professional expertise and voices often go as psychotherapists of varying schools of thought. To the individual work with the clients, not to research or policy. This is understandable and perhaps as it should, in many ways. But it seems increasingly clear that our expertise needs to be made explicit also to policy makers, as we are often practicing within policies that go counter our professional expertise and practice. Something that can have negative consequences both for ourselves as well as our clients.

This I believe is the most overarching message for me from my study. Like a conductive thread throughout the in-depth experiences heard here are the narratives of unrealistic expectations. As therapists we expect to use ourselves in the work, but it is not meant to be to the detriment of our personal and professional wellbeing.

This profession sits in a slightly tricky place in society, by being part of the healthcare professions, under a positivist biomedical umbrella, while trying to acknowledge a subjective,

multi-faceted view of the world in our practice. Somehow having to respond to demands of 'curing', while trying to maintain an open position of 'not knowing'.

I hope to continue disseminating these findings and to take part in conversations that make space for the many things that are involved in this work, for the therapist as well as the client.

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[This position statement has been published by the various different stake holders. I am referencing it to the BPS site, being a psychologist trainee and because I first heard of it through a talk at the BPS, 04.06.2019.]

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## Appendices

### Appendix A: Recruitment advert

**Department of Psychology**
**City, University London**

# PARTICIPANTS NEEDED FOR RESEARCH IN WORKING WITH SUICIDE RISK

We are looking for volunteers to take part in a study on how psychotherapists experience working with suicidal clients/patients.

In order to take part you need to:

- Be an accredited psychotherapist: Counselling or Clinical Psychologist, Counsellor, or Psychotherapist; registered with the HCPC, BACP, BABCP, BCP or UKCP respectively.
- Have been working in this role post-registration for at least two years.
- Have worked with adult suicidal clients/patients post-registration and be interested in talking about this experience.

You would be asked to: take part in a one-to-one interview to talk about your experiences of working with suicidal clients/patients.

Your participation would involve *one* interview, which will be approximately 1-1.5 hours.

In appreciation for your time, you will receive a £20 voucher for Waterstones bookshops.

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

Researcher: Julia Betancour-Roth

Psychology Department at City, University of London

Supervisor: [redacted]

This study has been reviewed by, and received ethics clearance through the Psychology Department Research Ethics Committee, City, University of London PSYETH (P/L) 16/17 164.

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee

## Appendix B: Participant information sheet

**Title of study:** *An exploration of psychotherapists' experience of working with suicide risk*

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 the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

**What is the purpose of the study?**
The aim of this research is to explore how working with clients/patients presenting with a risk of suicide is experienced by psychotherapists (Counsellors, Psychologists and Psychotherapists) in the UK and carries a further interest in seeing how they perceive how this impacts on the therapeutic interaction.

The study is for a Professional Doctorate in Counselling Psychology (DPsych). The study objective is to gain a deeper and more nuanced understanding of the experience of working with suicide risk to potentially inform how this complex area is approached in a therapeutic setting.

**Why have I been invited?**
You have been invited to take part because you are:

- An accredited psychotherapist: a Counselling or Clinical Psychologist (registered with the HCPC), or a Counsellor (registered with the BACP) or Psychotherapist (registered with the BACP, UKCP, BPC or BABCP).

- Have been working in this role post-registration for at least two years.

- Have worked with adult suicidal clients/patients in this professional role and are interested in talking about this experience.

**Do I have to take part?**
Participation in this study is voluntary, and you can choose not to participate in part or all of the project. You do not have to answer any questions that you do not feel comfortable with. You have the right to withdraw from the study until one month after the interview when the stage of data analysis will begin, without being penalised or disadvantaged in any way.

It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason until one month after the interview when the stage of data analysis will begin.

**What will happen if I take part?**
- You will meet with the researcher on one occasion only for an individual interview.
- The interview will take between 1-1.5 hours and will be audio recorded.
- The interview procedure is: we first go through what is entailed by consenting to take part. Then I will ask you a few questions about your experience of working with suicidal clients/patients.
- The interviews will take place in a quiet, private space of your choice. This can be your home, therapy practice, or a similar space, or at City, University of London (closest tube station: Angel, further travel instructions will be given if this venue is the one being attended). It is important that the space is private, to ensure confidentiality.
- The methodology underpinning this study is Interpretative Phenomenological Analysis. This entails the researcher interpreting the participants' meaning-making of their experience.
- The research study is due to be finished in March 2019 (the written work to be presented and evaluated by an examination board).

- The final thesis will be accessible to the public through City, University Library after March 2019, and subsequently the study may be published as a journal article and presented at conferences.

**Expenses and Payments**

- Where possible, maintaining confidentiality of the interview (see above), the researcher will travel to the participant's location. If, however, the interview will be held at City, University of London, the participant will be reimbursed for their travels within London to the location of the interview. Receipt required.
- Each participant will be given a £20 voucher to Waterstones bookshops.

**What do I have to do?**

- You will take part in an audio-recorded interview about your experiences of working with suicidal clients/patients. The interview will take about 1-1.5 hours.

**What are the possible disadvantages and risks of taking part?**

The main potential risk of taking part is feeling distressed if bringing up painful memories and emotions. If this happens, you can take a break or terminate the interview at any point with the option of rescheduling another session if you wish to do so or to withdraw entirely form the study. There will also be a space and time to debrief at the end of the interview.

**What are the possible benefits of taking part?**

- Contributing to further understanding of the work with suicidal clients and potentially contributing to a more nuanced discussion around this work.
- A space to reflect in depth on your experiences with this difficult client group
- Taking part in generating research knowledge
- Receiving a £20 voucher to Waterstones bookshops

**What will happen when the research study stops?**

The interview-recordings and transcripts will be stored with password protection. The data will be kept for five years following publication, as stipulated by the British Psychological Society's Code of Human Research Ethics. After that period all data will be destroyed.

**Will my taking part in the study be kept confidential?**

- All names and personal details will be changed by the researcher, so that they cannot be identified. The researcher will be the only person to have access to the data before this stage of de-identification.
- The recordings and transcripts will only be accessed by the researchers.
- All the interviews will be confidential. The only exception to this is if there are any concerns regarding violence, abuse, self-inflicted harm, harm to others or criminal activity in which case the confidentiality will be breached.
- All audio files and transcripts will be stored with password-protection. All audio files and any identifiable data will be destroyed five years after publication.
- There will be no future use of personal information.

**What will happen to the results of the research study?**

The results of the study will firstly be presented through a Doctoral thesis at City, University of London and will as such be accessible at City, University of London Library. Subsequently, there may be further dissemination of the study through possible journal publications or presented at conferences, available to the general public. Your anonymity will be maintained throughout the research process, including dissemination. If you wish to receive a summary of the findings, you can contact me, by email at any time, or alternatively let me know at the interview.

**What will happen if I don't want to carry on with the study?**

You can choose to withdraw at any time before and during the interview, and after until the stage of data analysis, which will commence one month after the interview has taken place. If you wish to withdraw please let the researcher know via email.

**What if there is a problem?**
If you cannot attend the planned interview but still wish to take part in the research, we will try to accommodate for this as far as possible within the time constraints of the study.

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 [redacted]. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: 'An exploration of psychotherapists' experience of working with suicide risk'

You could also write to the Secretary at: [redacted]
Secretary to Senate Research Ethics Committee

City, University of London holds insurance policies which apply to this study. If you feel 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 approved by City, University of London Psychology Department Research Ethics Committee, PSYETH (P/L) 16/17 164.

**Further information and contact details**
Researcher: Julia Betancour-Roth, Trainee Counselling Psychologist

Supervisor: [redacted]

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

**Appendix C: Interview schedule**

## Interview Questions

Note: regarding the use of the words 'client' and 'patient'. Which one I will use depends on the therapist I am interviewing and the term they use.

**Research title:** 'An exploration of psychotherapists' experience of working with suicide risk'
**Research question**: *How do therapists' experience working with suicide risk?*

1. What made you take part in this study?

2. Can you tell me about a time when you worked with a client/patient that was suicidal? PROMPTS: How did you become aware that they were suicidal? What was your initial reaction?

3. What things can you recall?

4. What kinds of feelings comes up for you recalling that?

5. What kinds of thoughts go through your mind when recalling/thinking of that?

6. Can you tell me about how you know/become aware of when a client you are working with is suicidal? [If has not come up in question 1]

7. Can you tell me a bit about how this risk was communicated in the therapy? PROMPTS: How do you feel it was manifested in the therapeutic relationship? What was the role of the therapeutic relationship working with this client/patient?

8. Can you think of ways in which working with suicidal clients/patients is different from clients/patients who are not suicidal?

9. Can you tell me about what you found was helpful/unhelpful when working with this/these client/patient/s?
   PROMPTS: What kind of support did you receive? What kind of support would you have liked to have had?

10. Can you tell me a bit about what this risk meant to you?
    PROMPTS: On a personal level? As a professional?

11. What was/is the attitude of your organisation in regards to this kind of risk?

12 ADDED QUESTION DEC-2017: If they speak of having had to disclose their client/patient's suicidality, ask the following: how would you describe your relationship after that disclosure?

13 We are approaching the end of the interview, how have you found it?

14 Is there anything else you would like to say that we have not talked about?

## Appendix D: Consent form

Title of Study: **An exploration of psychotherapists' experience of working with suicide risk**
Ethics approval code: [*Insert code here*]

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 I have read the participant information sheet, which I may keep for my records.<br><br>I understand this will involve:<br>• being interviewed by the researcher<br>• allowing the interview to be audiotaped<br>• allowing the use of direct verbatim quotes (de-identified) from the interview<br>• the final piece being disseminated through different medium | |
| 2. | This information will be held and processed for the following purpose(s):To answer the research questions<br><br>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 project, and that I can withdraw at any point of the project until the stage of data analysis, without being penalised or disadvantaged in any way. | |
| *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(s) 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 |

When completed, 1 copy for participant; 1 copy for researcher file.

Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

**Appendix E: Debrief sheet**

## An exploration of psychotherapists' experience of working with suicide risk

### DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it's finished we would like to tell you a bit more about it.

This research aims to explore how working with clients/patients presenting with a risk of suicide is experienced by psychotherapists (Counsellors, Psychologists or Psychotherapists) in the UK and carries a further interest in seeing how they perceive how this impacts on therapeutic interaction.

The background of the present study comes from a body of research that looks at how working with suicidal clients/patients can be highly emotionally charged, and is perceived and approached in very different ways depending on therapeutic modality, institutional/organisational culture, years of experience, and personal values and experiences. Furthermore, some authors argue that since the 1990's shift towards a clinical governance and an increased focus on risk in mental health, the responsibility for the risk is less collective (e.g. multidisciplinary mental health teams) and more individualised, putting more strain and responsibility on the individual practitioner.
Thus, how clinicians experience, negotiate and cope with this complex professional reality is the focal interest of this study.

In accordance with the methodology, Interpretative Phenomenological Analysis (IPA), which emphasises the importance of staying as open as possible to the participant's meaning-making, there are no expectations of results. However, whatever the findings, the expectation is that it will contribute to a deeper understanding of this difficult aspect of therapeutic work and through that a more nuanced way of approaching risk.

If the interview brought up any concerns or distress, and you feel that you would like some support, there are a few numbers below that you can contact.

Mind
Webpage: http://www.mind.org.uk/

Samaritans (national helpline):
Phone:116 123

Survivors of bereavement by suicide
Webpage: http://uk-sobs.org.uk/
National Helpline: 0300 111 5065 (9am to 9pm every day)

BACP Register
Webpage: http://www.bacpregister.org.uk/check_register/

BPS Directory of Chartered Psychologists
Webpage: http://www.bps.org.uk/bpslegacy/dcp

UKCP, 'Find a therapist'
Webpage: https://www.psychotherapy.org.uk/find-a-therapist/

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:

Main researcher: Julia Betancour-Roth, Trainee Counselling Psychologist City, University of London.

Research supervisor: [redacted]

Ethics approval code: *[Insert ethics approval code here.]*

**Appendix F: Examples of encoded transcripts with emergent themes**
**[This appendix has been redacted for reasons of confidentiality]**

**Simon**

**Lisa**

**Sam**

## Appendix G: Example of clustering process in step four of the analysis process

**[This appendix has been redacted for reasons of confidentiality]**

## Appendix H: Updated ethical approval from City University of London Ethics Committee

Psychology Research Ethics Committee
School of Arts and Social Sciences
City University London
London EC1R 0JD

07 June 2017

Dear Julia Betancour-Roth and [redacted]

**Reference:** PSYETH (P/L) 16/17 164

**Project title:** An exploration of psychotherapists' experience of working with suicide risk

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 (), 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

Co-Chair [redacted] Chair [redacted]

# PART TWO: PUBLISHABLE PAPER

**[This part has been redacted for copyright reasons]**

# PART THREE: COMBINED CASE STUDY AND PROCESS REPORT

**[This part has been redacted for reasons of confidentiality]**