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Exploring Counsellors’ Experiences of Working with Suicidal Clients, with Particular Focus on the Issue of Responsibility

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Dissertation submitted to the University of Chester for the Degree of Master of Arts (Counselling Studies) in part fulfilment of the Modular Programme in Counselling Studies

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Abstract

A qualitative study is presented revisiting the work of Reeves and Mintz (2001) in exploring the experiences of counsellors working with suicidal clients and extending the focus to the issue of locus of responsibility. Following a review of the literature, semi-structured interviews were undertaken with six experienced counsellors currently or recently working with suicidal clients. These were recorded, transcribed and the material analysed using the constant comparative method (Maykut & Morehouse, 1994) to yield twelve categories representing participants experience. Themes emerging included: the impact of training, experience and organisational context, issues of client autonomy and professional responsibility, contrasting thoughts and feelings of counsellors when clients disclose suicidal feelings, ways counsellors seek to work with suicidal clients whilst dealing with their own feelings and finally, the locus of responsibility for the suicidal client and young clients especially. These are placed in context of the literature and limitations; implications for practice and further research are discussed.
Declaration

The work is original and has not been submitted previously in support of any qualification and course.

Signed:

M. J. Whitfield
Acknowledgments

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<tr>
<td>BACP</td>
<td>British Association for Counselling and Psychotherapy</td>
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<td>BPS</td>
<td>British Psychological Society</td>
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<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
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<td>DBT</td>
<td>Dialectical Behaviour Therapy</td>
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<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<td>EAP</td>
<td>Employee Assistance Programme</td>
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Chapter One: Introduction

Some of the situations which counsellors encounter cause great anxiety. Working with clients who are seriously intent on suicide must be one of the most anxiety provoking because of the sense of imminent death, which makes any decisions and actions irreversible. The choice between life and death is a stark one. At a time when the counsellor’s therapeutic skills are being considerably tested, there are also major ethical issues to consider. The counsellor is faced with a choice between respecting the client’s autonomy or seeking to preserve life either because this is a fundamental ethical principle or because it is thought to be in the client’s best interests. (Bond, 2010, p. 101)

Client suicide has been described as an occupational hazard for psychologists and psychiatrists (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989) and is the ‘client crisis most frequently encountered by mental health clinicians’ (McAdams & Foster, 2000, p. 107) while Werth and Liddle (1994, p. 440) state that ‘The vast majority of practicing psychotherapists will have a client attempt and/or commit suicide some time in their careers’. Reeves writes that of over three thousand counsellors he has met delivering a training programme for working with suicidal clients that ‘Barely any… did not have some experience of working with suicide potential…’ (Reeves, 2010, p. 4) and, ‘…if we relate counselling agencies to suicide risk factors – bereavement, relationship breakdown, psychopathology, physical health problems… virtually all counsellors would have some profile of suicide potential…’ (Reeves, 2010, p. 3). While counselling has become increasingly available in primary and secondary care, multi-disciplinary mental health teams and in schools and colleges, it seems reasonable to assume that the more people who access it, the more counsellors will encounter clients with suicide potential.

However, the literature indicates that training on counselling courses around working with suicidal clients is inadequate and a cause of anxiety for counsellors (McAdams & Foster, 2000; Reeves, 2004; Reeves & Mintz, 2001) and one study indicates there is considerable variation in when counsellors chose to break confidentiality, implying individual factors play a major part in the decision making process, rather than training or context (Moyer & Sullivan, 2008). It would therefore seem appropriate to examine what these individual factors might be; what is the internal process for counsellors in these stressful situations, what influences might there be from their beliefs and experiences, their training and their organisation.
The one study focusing on this area is ‘Counsellors’ Experiences of Working with Suicidal Clients’ (Reeves & Mintz, 2001). As this was an exploratory study, conducted over ten years ago, and nothing like it appears to have been undertaken since, it seems appropriate to revisit this area, following the same qualitative methodology, without replicating in the way one would using a quantitative paradigm. It will be interesting to see what evolutionary development has occurred with the passage of a decade and to further shed light on an important and overlooked area. As Reeves himself notes, 'In research terms, very little attention has been given to the counsellor.' (2010, p. 135).

However, in reviewing the literature it became apparent that the issue of responsibility is of central importance in the relationship between the counsellor and the suicidal client. The extent to which the counsellor feels the need to take responsibility for the client affects the dynamics of the therapeutic relationship, the effectiveness of the therapy and the emotional impact upon the counsellor. The literature suggests practitioners may take on more responsibility than is efficacious, that this can be counterproductive in taking responsibility and control from the client and potentially damages the therapeutic alliance. Furthermore, this high level of responsibility can impact negatively upon the counsellor emotionally but is out of proportion to the influence the counsellor may have in determining the fate of the client. The counsellor’s beliefs toward suicide, and consequentially perhaps, their therapeutic orientation (Skovholt & Ronnestad, 1992) as well as fear of legal and ethical sanctions can determine the amount of responsibility the individual counsellor takes, up to and including breaching confidentiality, maybe against the wishes of the client. It is this issue, therefore, upon which this study will focus, within the experiences of counsellors working with suicidal clients.
Chapter Two: Literature Review

In addition to electronic databases I used textbooks on the subject and on methodology. A summary of the search strategy is in Appendix I.

Areas covered in the literature:

- Assessment of suicidal risk/ risk assessment generally
- Therapeutic process in working with suicidal clients/ therapeutic orientations
- Impact of client suicide upon the counsellor/ therapist
- Impact of suicidal clients generally: attitudes toward suicide and suicidal clients, experience, coping strategies, support, training or lack of training
- Client capacity for making informed decisions around suicide, the ‘rational suicide’ issue, counsellors’/ therapists’ views on this.
- Ethical, boundary and legal issues- especially relating to U.S. law in which there is more expectation of the professional to prevent suicide, the ‘duty to protect’.
- ‘No-suicide’ contracts, pros and cons, use and effectiveness of.
- Issues relating to suicide within specific client groups e.g. AIDS patients, or settings, e.g. schools, prisons

BACP Systematic Review

In 2009, the British Association for Counselling and Psychotherapy published ‘Counselling and Psychotherapy for the Prevention of Suicide: A systematic review of the evidence’ (Winter, Bradshaw, Bunn, & Wellsted, 2009). This considered the effectiveness of counselling and psychotherapy with suicidal people and the process. It demonstrates that the literature is dominated by studies of quantitative methodology and a focus on a narrow range of non-humanistic therapies. The fact that Winter et al felt it necessary to include more non-randomised and qualitative studies to balance out the weight of randomised controlled trials and shed more light on therapeutic process and facilitators and barriers to therapy, acknowledges the paucity of research in this area.
'Process': Therapist Variables

Gurrister and Kane (1978) found working with suicidal clients evoked anxiety, anger and frustration as well as concern and protectiveness. Neimeyer, Fortner, & Melby (2001) found an attitude which accepts death and a belief in the unacceptability of suicide were positively correlated to suicide intervention competency- although this is not well defined- and Winter et al (2009) suggest training needs to incorporate therapists’ attitudes toward death and suicide. Davidson et al (2004) found therapist competence - adherence to therapeutic model, skill level and interpersonal effectiveness - correlated with a reduction in depressive symptoms but unrelated to age, gender or professional qualifications. Winter et al, while acknowledging methodological issues with this study, suggest it implies appropriate training is sufficient for an effective intervention. In contrast, Winter et al cite Modestin, Schwarzenbach, & Wurmie (1992) as suggesting therapists’ experience correlates with lower rates of client suicide. These studies emphasise the importance of experience and training, especially incorporating the therapist’s own views on death and suicide, but the evidence is insufficient to draw definite conclusions.

Several studies focused on young people. Storey, Hurry, Jowitt, Owens, & House (2005) found young people resented therapists with their own priorities and agenda at the expense of the client’s concerns, though methodology is unclear. Paulson & Everall (2003) examined which aspects of therapy suicidal young people found helpful and found maintaining a strong therapeutic relationship based upon respect, understanding and acceptance to be most important along with treating the individual as a whole rather than concentrating on suicidal behaviour. The participants were 83% female and the recruitment process and therapeutic approach are unclear. These studies back the importance of the therapeutic relationship over adherence to theoretical model, or undue focus on specific issues, however, given their young and predominantly female participants, generalizability is limited.

In terms of important variables when treating suicidal people, Winter et al (2009) cite Kate Davidson, Livingstone, McArthur, Dickson, & Gumley (2007) and suggest this study may show therapists feel they have to work harder with clients who show little improvement to provide justification for the lack of progress and suggest therapists could be trying to alleviate guilt. This study focused on CBT and 85% of participants
were female, however, it emphasises the importance of understanding the therapist’s internal psychological processes and their impact.

**Qualitative Studies**

This section explores clients and therapists views on the process and effectiveness of therapy and also barriers and facilitators. Studies by Reeves and Mintz (2001) and Reeves, Bowl, Wheeler, & Guthrie (2004), although criticised methodologically and felt to make a small contribution overall, are cited as important for highlighting areas not addressed elsewhere, specifically lack of support and training.

Responsibility was seen as a barrier by counsellors but a facilitator for clients. Reeves and Mintz (2001) and Reeves et al (2004) found counsellors felt forced to conform to professional boundaries even though they conflicted with their personal beliefs on the right to suicide. This may impact upon therapeutic effectiveness and was not dealt with adequately in supervision. Clients, especially those in DBT, felt taking responsibility for making changes was important in therapy. ‘Counselling is only helpful if you actually want to change or get help’ (Craigen, cited in Winter et al., 2009, p. 50). One might speculate that the structured and institutional nature of DBT may make clients and therapists feel comfortable in the client taking on more responsibility as risk can be better managed.

Reeves and Mintz (2001) found lack of training and resources for dealing with suicidal clients caused anxiety for counsellors and this could lead to avoidance of the subject of suicide. Rubenstein (2003), in a study meeting six out of seven of Winter et al’s quality criteria, is cited as finding that for psychoanalysts, the threat of suicide can disrupt the therapeutic process and that the client may even hide their suicidal feelings to ‘protect' the therapist.

Winter et al (2009) identified support as a major facilitator of therapy. This was found lacking in suicidal clients’ lives and when this was apparent in therapy it was linked to the client's quality of life and a renewed sense of hope, which both Dahlsgaard, Beck, & Brown (1998) and Barbe, Bridge, Birhamer, Kolko, & Brent (2004) found to be positively correlated with reduced suicide potential. 75% of participants in the Barbe study were female, flagging up the possibility of gender bias.
Counsellors’ Experiences of Working with Suicidal Clients: Reeves and Mintz (2001)

The study which focuses most upon the research question is Reeves and Mintz (2001). They found counsellors experienced a range of distressing emotions when working with suicidal clients, such as anxiety, fear, panic and impotence. They felt ill prepared by their training, doubted their competence and ability to practice safely, and felt their work was dictated more by organisational policy and fear of litigation than by therapeutic judgement. This was a particular issue for those accepting of suicide, who felt coerced into breaking confidentiality against their beliefs, feeling they had ‘betrayed’ their clients in doing so. Yet there was also the need to break confidentiality in certain cases to protect clients from themselves. Risk assessment and contracting were carried out in an informal and ad hoc way.

A number of methodological issues regarding this study were raised by Winter et al (2009), which I have aimed to address in revisiting it. Specifically, they felt that the context of the study and nature and recruitment of the sample were only partially explained, methodology around the collection and analysis of data were unclear, no attempts had been made to establish the reliability and validity of the data analysis and there was insufficient original data included.

Richards (2000), working from a psychoanalytic perspective, also examined the effects on psychotherapists of working with suicidal clients and found ‘…feelings of hopelessness and helplessness; a sense of failure; feeling upset, distressed and sad; anxiety…’ The need for support and supervision were emphasized along with the dangers of inexperience. A finding also was the realisation that therapists are not omnipotent and that despite one’s best efforts, client suicide is still possible. Birtchnell (1983) notes similar emotional reactions in therapists and suggests this leads to dilemmas of dependency and responsibility for the therapist.

Training and Support

As Reeves and Mintz (2001) and Reeves et al (2004) noted, one cause of counsellors’ anxiety is lack of training and support. McAdams and Foster (2000) in an
extensive survey of U.S. counsellors, also emphasise the need for training around suicide as part of counsellor education.

**Personal Characteristics of the Counsellor/ Therapist**

It seems there is more here than a stressful situation for which the therapist feels unprepared and ill supported. Moyer and Sullivan (2008) in a study which acknowledges a poor response rate and an un piloted, non-validated instrument, found considerable individual variation in when counsellors chose to breach confidentiality. This implies the personal characteristics of the counsellors play a large part in decision-making as opposed to contextual factors and professional training and therefore underlines the importance of a qualitative approach to investigate the counsellor's process.

A number of studies show the importance of the counsellor's own attitude toward death, dying and suicide, e.g. Bernstein (2001), Lussier (2005), in their work with suicidal clients and their effectiveness (Roose, 2001). Barry (1984) believes it is important that therapists be aware of their attitudes and how they might impact upon client work, a view echoed by Rycroft (2004). Bernstein suggests these attitudes could be selfish, relating to the effect the other's death will have on us. Orbach also notes the potential for incapacitating anxiety arising from therapists’ own feelings:

> 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... (Orbach, 2001, p. 171)

Handin, Haas, Maltsberger, Koestner, & Szanto (2006, p. 67) talk of ‘...ineffective or coercive actions resulting from the therapist's anxieties...', while Roose (2001, p. 151) suggests ‘the fear of shame and failure’ can negatively impact upon the therapist’s ability.

Other therapist factors can influence working with suicidal clients. Gurrister & Kane (1978) found previous experience of client suicide can make therapists more protective and more directive in approach, while Cummings & Thompson (2009), writing about a prison population, highlight the danger of regarding the suicidal as
‘manipulative’ and thereby failing to treat someone research has demonstrated is at risk of suicide.

Those not accepting of suicide can have countertransference anger toward the client for rejecting life (Maltsberger & Buie, 1974) and their help (Milch, 1990) and these feelings prevent the development of empathy, which is counter productive (Orbach, 2001). However, Neimeyer et al (2001) found a history of suicidality and a belief in suicide as a right to be negatively correlated with suicide intervention competence, whereas ‘death acceptance’ was a positive, along with levels of training and experience. Interestingly, Brown & Range (2005) found trait anxiety in crisis helpline workers was facilitative to competence, although how this might operate is unclear.

**The Attitudes and Expectations of Society**

In the UK, a number of government documents, beginning with ‘Saving Lives: Our Healthier Nation’ (Department of Health, 1999b), continuing with the National Service Framework for Mental Health (Department of Health, 1999a) and the National Suicide Prevention Strategy for England (Department of Health, 2002), express the intention to prevent and reduce suicide. Reeves (2004, 2010) states this makes suicide prevention a priority for therapists regardless of work context. We can see therefore how the national legal and policy environment within which counsellors and other mental health professionals work, exerts pressure, via the vehicle of organisational policy, upon practitioners.

**The Effects of Pressure on the Therapeutic Relationship**

Ellis (2004) notes the heavy responsibility placed upon the therapist to succeed with suicidal clients and outlines how the therapist’s stress leads them to need to control client behaviour, leading to resistance and the loss of potential collaboration. Hendin (1981, p. 469) argues ‘Psychotherapy can be successful with suicidal patients if the therapist does not reduce therapy to management and control…’. An empathic, person-centred (Leenaars, 2004) accepting approach with suicidal clients appears to be more efficacious and preferred by clients (Thomas & Leitner, 2005) than one reliant on power and control (Streicher, 1995). Sharry, Darmody, & Madden (2002), writing from a solution-focused perspective, argue for a collaborative response, while Jobes, Moore, & O’Connor (2007) outline a collaborative and implicitly ‘client-centred’
model of working with suicidal clients and Plakun (2009) argues for the importance of the therapeutic alliance.

The Issue of Responsibility

Wildman (1995) found therapists of varying orientation were more likely to blame the ‘therapeutic failure’ of client suicide on the therapist than client factors (client suicide is defined as a ‘negative therapeutic outcome’, and it is unclear whether this is a prior opinion or merely a reporting of the findings), while Stern (1985) argues for recognising the limits of the role of psychotherapists in determining the client’s fate. Trimble, Jackson, & Harvey (2000), surveying over four hundred clinical and counselling psychologists, concluded successful coping with suicidal clients was realising client responsibility, while Olin (1976), writing on the chronically suicidal, regards the assumption of responsibility as a ‘therapeutic disaster’. Cummings, Cummings, & Pallak (1996) suggest taking responsibility is one of four ‘outmoded attitudes’ leading to therapeutic mismanagement. Whittinghill, Bordeau, Whittaker and Lusk (2008) elaborate the danger of assuming responsibility for one’s clients and the breach of professional boundaries by relating the tale of a counsellor who feels ‘solely and excessively responsible for his clients’ and allows them to phone him at home (Whittinghill et al., 2008, p. 77).

It seems possible therefore that assuming too much responsibility could be counterproductive to therapy and might result in the feelings of impotence and inadequacy felt by Reeves and Mintz’s (2001) counsellors - feelings which one study suggests may be misplaced. Tekavcic-Grad & Zasnikav (1987, p. 162) found counsellors on a Yugoslav telephone crisis line ‘were much more critical of themselves and less satisfied with the help they offered, feeling it was often insufficient and less effective than the callers perceived it.’ Uhlmann (2003), reporting case study material suggests even though treatment may appear to fail and suicide seem inevitable, the patient can in fact thrive.

Conclusion

Overall the literature appears to suggest negative emotional responses experienced by counsellors and therapists encountering suicidal clients stem from a number of
sources, the expectations placed on them by society via their professional standing and the fear of being held responsible for a ‘failure’; the lack of training and support in dealing with such difficult situations and the conflict with their own personal attitudes and beliefs. These feelings in the counsellor impact upon work with the suicidal individual, often with negative therapeutic consequences. The key concept that emerges is one of locus of responsibility. The role of counsellor seems to demand one takes on a degree of responsibility for a client who is, in being a client, vulnerable, especially so if suicidal, as the perception is one will be blamed if they kill themselves.

*If we suggest that suicide is preventable… we will be held potentially accountable for deaths that occur during our watch. It is an awesome responsibility we have accepted.* (Berman, 1998, p. 55)

However, it would appear that accepting too much responsibility can be counterproductive to therapy, compromise the trust and agency of the client, robbing them of the opportunity to engage in their own recovery, and that a strong therapeutic relationship based upon a client-centred and collaborative approach is not only more effective for the client, but less stressful for the counsellor.

Although there is much research that is pertinent to this area, they are often studies specific in their focus on client group, context, therapeutic orientation and professional role, sometimes with questionable methodology, and that the extent to which we can regard those findings as applicable outside their narrow focus, is limited. There is much literature which is tantalising in what it suggests but very little which concentrates on the area of the Reeves and Mintz (2001) study - the experiences of counsellors working with suicidal clients - and which uses a methodology capable of capturing the internal processes of those counsellors. It seems vital to understand these processes better as they appear to have such influence on work with suicidal clients and they impact not only on the outcome of therapy but take a toll on counsellors.

It is therefore justifiable to revisit the work of Reeves and Mintz after a decade, with little comparable research having taken place since, to see whether anything has changed, and focus additionally on the issue of responsibility which the literature has highlighted as important.
Chapter Three: Methodology

Design

A qualitative methodology was chosen as most suitable, in order to look in depth at the experiences of individual counsellors in therapeutic interactions with suicidal clients, in which they must grapple with complex issues involving their own personal beliefs, professional competence, risk assessment, client capacity for making judgements and possible legal and ethical sanction. Textbooks on the subject (Bond, 2010) admit there are few clear answers and decision making comes down to informed judgement. The scale, complexity and personal nature of the processes involved demand a phenomenological methodology which recognises the uniqueness of experience and meaning and seeks to explore and describe rather than quantify and generalise (Silverman, 2005).

The study to be revisited (Reeves & Mintz, 2001) employed a qualitative methodology for similar reasons, and it is logical to follow suit (Silverman, 2005). Also, as a person-centred trained counsellor, my core philosophy is phenomenological, based upon the uniqueness of experience and the suspension of objective truth to comprehend as far as possible the experiences of another (McLeod, 2003). This, combined with my ability as a counsellor to ‘bracket’ (Patton, 2002) my own attitudes and beliefs as far as possible should help minimise bias (Patton, 2002) - important given my personal and professional experience and opinions on the subject.

A qualitative framework allows the use of a flexible (Robson, 2002) or ‘emergent’ (Patton, 2002) design, responsive to the evolving research process and adaptable to take into account incoming data and the researcher’s experiences. I therefore kept a research journal (Maykut & Morehouse, 1994), (Robson, 2002) to make note of ideas, themes and experiences as I conducted the study. This informed the ‘Discovery’ phase of data analysis (Maykut & Morehouse, 1994).
Trustworthiness

Maykut and Morehouse (1994) suggest ways researchers can give confidence in the outcomes of their studies. The first is using multiple methods of data collection to demonstrate the phenomenon is being understood from different perspectives. Interview data have been used, backed up with a literature survey. Secondly, an audit trail allows anyone to follow the same path and understand how conclusions have been reached. This involved a documented, systematic review of the literature, the use of established methodology, standardised research materials, a research journal, a sufficient quantity of original data and a fully documented data analysis procedure. Thirdly, although not undertaken by a research team, the study has been overseen by an experienced, well-qualified supervisor who has provided advice and support. Fourthly, ‘Member Checks’ (Lincoln and Guba, cited in Maykut & Morehouse, 1994), were conducted, whereby participants’ feedback on the outcomes was sought and incorporated into the results.

Materials

A poster was designed (see Appendix II) to recruit participants. This contained details of the study, participant criteria and contact details. It was saved in PDF format so that it could be sent by email and printed off.

An Information Sheet (see Appendix III) was produced giving fuller details, the focus of the study, that participation was voluntary, that it was possible to drop out up until the work was submitted, what information would be taken in what form (questionnaire and audio recorded interview), that this information would be held securely, treated in confidence and that no identifying information about participants or their organisations would be included in the research or subsequent publications, and what would happen to written records and audio recordings (kept for five years by requirement of the University and destroyed upon completion of the research respectively). The Information Sheet was written with the ethical codes of both the researcher’s professional organisations in mind, BACP and BPS, in addition to that of the University of Chester, and in consultation with the supervisor.
A questionnaire (see Appendix IV) was designed to gather basic information about potential participants to inform the study and aid the purposive sampling process. This largely followed Reeves and Mintz (2001), in containing information about the study and contact details and took the following information: time working as a counsellor, working environment, professional qualification, current client load, theoretical approach, number of current suicidal clients, whether suicide or self harm are referred to in client contracts, confirmation of current supervision, which ethical code they work to, a space for additional comments and contact details and whether they would be prepared to participate in an interview. In consultation with the supervisor, demographics like age group, gender and ethnicity were added, the range of theoretical approaches was expanded to reflect current trends, as were the options for length of time working as a counsellor post-qualification. Options for working environment were expanded to include IAPT and EAP and the question ‘How would you define ‘suicide’ with respect to work with clients?’ was dropped as this did not gather quantitative demographic data about participants to enable purposive sampling, had not generated a great deal of information in the original study and would be covered in the interviews. The questionnaire was designed as hard copy and also electronic RTF format that could be emailed, filled in on screen and emailed back. This would reduce costs, make the process easier, and therefore increase the rate of return.

Interview materials were designed, firstly, an interview guide (see Appendix V). It is important to use an interview guide to keep interviews focused (Patton, 2002) and as a means of standardisation ensuring the same areas are covered for each participant, increasing reliability and trustworthiness (Silverman, 2005). However, this allows freedom to explore each participant’s own experiences, which a structured approach might stifle. The guide followed that of Reeves and Mintz (2001) with the addition of questions focusing on the issue of responsibility derived from issues raised by the literature: how much responsibility participants felt they took for clients generally, how this changed when clients said they were suicidal, how much responsibility they felt they should take for a suicidal client, how effective they felt this was, and what they felt would happen if they were to take more responsibility. A standardised interview introduction was written, to be read to all participants (see Appendix VI), following substantially that of Reeves and Mintz (2001). This restated the aims and purpose of the interview, the topic areas to be covered, asked
participants to confirm the number of suicidal clients currently worked with and that they were in on-going supervision. It restated the intention to audio record and transcribe interviews, how materials would be kept secure and treated as confidential, that no identifying information would be contained within the transcript, who would have access to the materials and that participants could withdraw up to the submission of the work. A consent form for audio recording was written (see Appendix VII), following that from the original study, restating the purposes the recording and transcript would be used for, who would have access and the levels of confidentiality and security used in handling and storage.

Recruitment

As with the original study and the requirements of the University Ethics Committee, participants were to be qualified counsellors with at least three years’ post qualification experience, in on-going supervision and currently or recently working with suicidal clients. To prevent ‘dual relationships’ biasing the data, the committee stipulated participants should not be from the researcher’s place of work. As it would be necessary to visit participants to interview them, the geographical area for recruitment was restricted. Two methods were employed, an advert in ‘Therapy Today’ magazine, and the researcher’s and supervisor’s contacts. These comprised counselling agencies and counselling departments at universities and colleges, including the University of Chester. The recruitment poster was emailed to named contacts where possible who were asked to forward it to others who might be interested.

Participants/ Sample

The intention was to conduct four to eight interviews to keep the workload manageable and to draw participants from a pool of respondents in a ‘purposive’ (Maykut & Morehouse, 1994) manner using questionnaire data. In quantitative research, random sampling is used to ensure the sample is an accurate representation of its population so that the results are generalizable. In qualitative methodology, the aim is ‘gaining a deep understanding of some phenomenon experienced by a carefully selected group of people’ (Maykut & Morehouse, 1994, p.
Patton (2002) elaborates strategies aimed at increasing understanding versus generalizability of results. Extreme cases may be sampled as especially illuminating, typical cases sampled as it would be impractical to sample atypical ones, or critical cases sampled where they subsume the larger phenomena. However, Maykut and Morehouse suggest the most useful strategy is ‘maximum variation’ sampling, whereby participants are selected to represent the greatest differences in the phenomenon, and this was the intention in this study.

Participants would be a ‘carefully selected group of people’ in that they would be experienced counsellors currently or recently having worked with suicidal clients. Person centred counsellors had been advertised for, as all Reeves and Mintz participants had been this orientation and it had been felt wise not to introduce another variable. Given the person-centred philosophy places such emphasis on the individual as the primary reference point and stresses ‘the importance of rejecting the pursuit of control or authority over other persons’, Bozarth and Temaner Brodley cited in Mearns and Thorne (1999, p. 19 [italics in original]), counsellors schooled in this approach will struggle most with taking responsibility for clients and are likely to have the richest and most revealing experiences.

Seven emails expressing interest were received, resulting in six completed questionnaires. One respondent came from an institution contacted directly and only one via the ‘Therapy Today’ advert. The rest presumably came from emails forwarded by primary contacts.

Although sufficient participants had been recruited, there was a dilemma; choose four or five of the six using the questionnaire in a purposive manner, which would demonstrate that participants had been chosen to provide ‘maximum variation’ or interview all six, which would give more data but cease to be a purposive sample and become an opportunity or convenience one (Coolican, 1994) and of lower quality.

It was decided to interview all six as this was within the parameters set for numbers, the low response rate had reduced the representativeness of the pool of participants, and, as became apparent, there were reasons the majority of participants had self-selected themselves which could be built into the design.
Table 1 below shows participants’ questionnaire data:

<table>
<thead>
<tr>
<th>No</th>
<th>M/F</th>
<th>Age Group</th>
<th>Therapeutic Approach</th>
<th>How long since Qualification?</th>
<th>Working Environment</th>
<th>Predominant Client Group</th>
<th>Current clients</th>
<th>Suicidal Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>45 - 54</td>
<td>PCT</td>
<td>3 - 5yrs</td>
<td>LA (FE)</td>
<td>16 - 19yrs, some adults</td>
<td>20 p/w</td>
<td>Variable throughout the year</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>45 - 54</td>
<td>INT</td>
<td>9 - 10yrs</td>
<td>LA (FE/HE)</td>
<td>Student counselling, all ages, predominantly mature</td>
<td>16 current, 70 per year</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>45 - 54</td>
<td>INT</td>
<td>11 - 15yrs</td>
<td>FE</td>
<td>16 - 19yrs old</td>
<td>10 - 12 p/w</td>
<td>6 approx in last 3 months</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>45 - 54</td>
<td>PCT</td>
<td>9 - 10yrs</td>
<td>LA, VA, PP</td>
<td>Local Authority staff</td>
<td>2 current</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>45 - 54</td>
<td>INT</td>
<td>6 - 8yrs</td>
<td>LA (FE/HE), PP</td>
<td>Students from FE/HE college, 16yrs+, mixed ethnicity</td>
<td>25 current</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>35 - 44</td>
<td>INT</td>
<td>6 - 8yrs</td>
<td>NHS, IAPT, HE</td>
<td>Adults</td>
<td>25 current</td>
<td>1</td>
</tr>
</tbody>
</table>

All Participants described their ethnicity as white, white British or white UK and all stated that they followed the BACP Ethical Framework.

There were five females and one male, five fell into the 45 – 54 age group, with one in the 35 – 44. Four out of six described their therapeutic approach as Integrative (INT) and two as Person Centred (PCT). Average experience lay in the ranges 6 -10 years, the lowest being 3 – 5 and the highest 11 – 15. Five worked in several contexts, with Local Authority (LA) being the most common, although for all but one, this was further and/or higher education (FE, HE). Two also worked in private practice (PP), one in a voluntary agency (VA) and one within the NHS and an IAPT service. Four worked predominantly with students, an additional one having just started and three of these worked predominantly or exclusively with 16 -19 year olds. Current client load varied between two and twenty-five, with suicidal clients being between one and five, whilst those without current suicidal clients estimated numbers worked with recently or typically. All participants described their ethnicity as white, white British or white UK and followed the BACP ethical framework.

**Data Collection**

The primary means was in depth semi-structured interviews of participants as in the Reeves and Mintz study, utilising the same questions but with the additional focus of the issue of responsibility.
Pilot interview
The interview was first piloted with a colleague who fitted the criteria for participation but was unable to participate owing to ethical considerations. This allowed testing of the interview process, the Reeves and Mintz interview guide and the recording equipment. It would give sample material to transcribe and practice looking for ‘units of meaning’ (Maykut & Morehouse, 1994). This proved a useful experience in the feedback given, and the researcher’s feelings carrying out the interview. As a result, the Reeves and Mintz interview guide was changed. The first section ‘Working environment/ Context’ was expanded to ask whether the participant conducted assessments as well as counselling and the differences between these assessments and the first counselling session and asking how they went about risk assessment and how important they felt it was. This enabled a greater focus on the assessment process, specifically risk assessment, and refined the original guide rather than deviating from it. In the second section, ‘Counselling Agreements/ Contracts’, the order of the questions was changed into a more logical sequence. In the section ‘Own views and beliefs’ the final question on the impact of training was refined to ask whether suicide was dealt with in training as it had been a finding of Reeves and Mintz (2001) that counsellors felt training to be inadequate. The section ‘When a client says they are suicidal...’ was split into two distinct parts focusing on thoughts and feelings separately. Neither interviewee or researcher felt this allowed the interview to ‘flow’ at as it was difficult to separate out the experience into thoughts and feelings, so the two parts were amalgamated and the questions reordered into a more logical sequence. No other changes were made to the interview guide, other than adding the section on ‘The Issue of Responsibility’ prior to the pilot interview.

Interviews
Arrangements were made to interview the participants, all of which were carried out within a confidential space, usually their own counselling room at their place of work. It had become apparent that a high proportion of participants worked in the education sector, often with 16 – 19yr olds and it was important to see if this was an artefact of recruiting indirectly through educational institutions or something else. Participants were therefore asked prior to the interview questions proper, what their motivation had been for participating and these responses form part of the analysis.
Using a semi-structured format ensured a degree of consistency in that the same subject areas were explored with each participant and in the same order. However, there was sufficient flexibility to allow further exploration in response to the participants’ material. It was important here to bracket the researcher’s own experiences lest they inadvertently direct the questioning or colour the participants’ responses.

Interviews were recorded on a digital recorder using an external microphone. At the beginning of each recording the standard introduction was re-read and the participant asked if they were happy with these arrangements as an additional measure of informed consent. The date, time and location of the interview, researcher’s and participant’s names were recorded, in order that recordings would be identifiable, although all identifying information was removed in transcription. The audio files were then uploaded onto a computer for secure storage.

Analysis

A qualitative methodology was followed in line with the original study and the researcher’s philosophy and training. Reeves and Mintz used the ‘constant comparative method’, originated by Glaser and Strauss, cited in Maykut and Morehouse (1994), whose version of the method has been followed, as Reeves and Mintz did. In contrast to the positivistic scientific method which follows a deductive process, qualitative research operates on an inductive model where data are collected on a focus of enquiry and analysis allows themes or categories to emerge by a process of inductive reasoning. Following a defined methodology enhances the validity and trustworthiness of the findings of research as it allows others to see how conclusions are arrived at, and if desired the path can be traced back to the raw data whence they emerged (Maykut & Morehouse, 1994). Data must therefore be converted into an easily readable form and coded so as to remain identifiable throughout the analysis process.

Audio playback software was used to transcribe all six interviews into MS Word, identifying information removed and the initials ‘M’ used for researcher and ‘P’ for participant. Page and line numbers were added so that an audit trail (Lincoln and
Guba, cited in Maykut & Morehouse, 1994) could be used for purposes of replicability, ensuring once data analysis begins, any piece of data subsequently moved and re-categorised can be traced directly back to its source.

A decision was taken not to engage in formal data analysis until the interviews and transcription were complete, despite already being in the ‘discovery’ phase (Maykut & Morehouse, 1994), themes being noted in the research journal and Maykut and Morehouse suggesting data analysis begin whilst data collection is on-going. This was practical in that travelling to interviews and transcription were time consuming; however, it was also felt there was a danger of subconsciously biasing subsequent interviews as there would be an awareness of categories emerging from the analysis which would be difficult to ‘bracket’ (Patton, 2002).

The data was next divided into ‘chunks’ or ‘units’ of meaning (Marshall, and Lincoln and Guba respectively, cited in Maykut & Morehouse, 1994). Although following the method of constant comparison, paper copies of transcripts cut and pasted onto index cards were not used. In line with Robson (2002) and Silverman (2005), data analysis was conducted using word processing and spreadsheet packages, MS Word and MS Excel. This was less intensive in terms of labour and space and was more intuitive to the researcher, being more comfortable working on a computer.

Instead of drawing lines to demarcate units of meaning on photocopied transcripts, labelling them appropriately as to their origin in the transcript, then cutting them out and pasting them onto index cards with a word or phrase indicating the meaning, each transcript was gone through using the highlight tool to highlight text representing the unit of meaning identified. The relevant section was copied, including sufficient surrounding text to give context onto a separate spreadsheet, indicating the participant, page and line numbers in adjacent columns and then the word or phrase indicating the unit of meaning (See Appendix VIII).

The next stage was discovery and inductive category coding (Maykut & Morehouse, 1994). A second spreadsheet was created to hold recurring topics and phenomena in the data that were beginning to emerge from reading and unitising transcript data, informed by the research journal. As the process of ‘constant comparison’ was begun, each unit of meaning was examined in comparison to the others, and, in an
adjacent spreadsheet column, labelled with which category, or indeed categories, it
most looked or felt like it belonged to, (Lincoln and Guba, cited in Maykut &
Morehouse, 1994). If it appeared not to belong to any existing category, a new one
was created on the second spreadsheet and labelled with that. This process
continued, with categories being renamed, merged or removed as necessary as
more units of meaning were analysed.

Continuing to analyse units of meaning in this way, a list of eighty-one provisional
categories was reduced to twelve, which subsumed the provisional categories as
higher level or ‘meta’ categories. In analysing the units contained within them, ‘rules
of inclusion’ or propositional statements (Maykut & Morehouse, 1994) were created
summarising the meaning contained within. Remaining data were now categorised
using these ‘rules of inclusion’, rather than the more intuitive ‘look/feel-alike’ method
(See Appendix IX).

**Member Checks**

In line with Maykut and Morehouse (1994) as a further measure to increase validity
and trustworthiness, the list of twelve ‘meta categories’ and rules of inclusion was
emailed to the six participants, and feedback requested on how they felt their
experience was represented in them. Reeves and Mintz (2001) did not do this and
this was an improvement on their methodology.

Responses were received from five out of six participants (83.33%). On the whole
they were positive, however, two participants stated that one or more individual
categories were contrary to their experiences. This would seem to be inevitable given
the methodology rather than evidence of systematic bias or errors. By the nature of
the process of inductive category coding and assigning units of meaning, categories
will emerge more strongly the more participants produce units of meaning fitting
them. This would mean a theme could emerge from a majority or even proportion of
participants that did not fit the experiences of some of the others. One could not, nor
should not expect all the categories to reflect the experiences of each individual
participant but their experiences as a whole, what Maykut and Morehouse (1994) call
a ‘reasonable’ reconstruction of the data.
However, Silverman (2005) argues for ‘comprehensive data analysis’ where all data are incorporated into the analysis and that it is only in actively seeking out and addressing anomalies that this can be achieved and validity strengthened. The issues raised by these participants are addressed in the Discussion in an attempt to reconcile these ‘deviant cases’.

**Ethics**

Given the researcher’s status as a counsellor and member of BACP and also as a Trainee Counselling Psychologist and member of BPS, these ethical codes were followed in conducting research, around the issues of informed consent, confidentiality and data protection. Approval was gained to carry out this study from the University of Chester Department of Social and Communication Studies ethics committee, whose conditions were incorporated into the design.

As it was likely that participants may have personal experience of suicide, have lost clients to suicide or may disclose breaches of ethics codes or bad practice, there was a need for informed consent, confidentiality and anonymity, and adherence to data protection procedures but also a degree of sensitivity in approaching and interviewing participants.

In interviews, participants disclosed experience of suicidal feelings, losing relatives to suicide and in one case, losing a client to suicide. When this arose, the participant was asked whether they felt ok to continue. Having explored the issue, they felt that they were and the interview continued. Most participants felt that the interviews had raised issues for them around working with suicidal clients, which they were planning to take to supervision and copies of the transcript of their interview were offered to them.

The study has involved a considerable amount of work in addition to other work and personal commitments. This has at times caused me significant amounts of stress and I have had to take a break from the study at several points. I have been fortunate in having an understanding and supportive research supervisor who has enabled me to manage the process to the best of my ability, and I have also received support and
encouragement from my counselling supervisor and various colleagues which has sustained me throughout the work.

Reflective Statement

My interest in the issue of suicide stemmed from my own experience of depression and suicidal ideation and this led me to study psychology and counselling. I was interested in exploring not just counsellors’ experiences in working with suicidal clients but the dilemma around when or if the counsellor takes on a degree of responsibility for the suicidal client, and how much, especially the issue of whether to break confidentiality. It is this that has given me greatest difficulty personally, and one that gave rise to most intense and impassioned discussion with colleagues. I feel that this is an important topic to investigate, in terms of the magnitude of the professional, legal, ethical and philosophical issues, the complexity of the decision making process involved, and the potential consequences both for the life of the client and the professional and emotional state of the counsellor.

Conducting this study has taken two years and the work has had to be put on hold several times for personal and professional reasons. I have learned a great deal about working with suicidal clients from the literature and from the participants who so openly shared their experiences with me, and from my supervisor. I have also gained from having conducted the research process - especially from being able to change and adapt in response to circumstances - and in learning lessons for the future where things haven’t worked as well as expected. Although the work has proved extremely challenging at times, it has been a worthwhile experience and I hope that the findings will be of use to those working with the suicidal and stimulate more research in this area.
Chapter Four: Findings

The following are the twelve ‘meta categories’ or ‘outcome propositions’ derived from an analysis of the data, along with their ‘rules of inclusion’ (Maykut & Morehouse, 1994). These represent a distillation of the themes to emerge out of all six participant interviews.

<table>
<thead>
<tr>
<th>No.</th>
<th>Category Name and Rules of Inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A respect for autonomy, and an awareness of risk but it still may not be enough...: The impact and limitations of training and experience. Counsellors found it difficult to recall their core training with respect to suicide other than giving them a respect for clients' autonomy. Post qualification experience and training was felt to have had more influence but could still be felt to be inadequate when faced with a suicidal client.</td>
</tr>
<tr>
<td>2</td>
<td>Protective framework or restrictive constraint? The impact of organisational context, policy and procedure. Counsellors have to work within the context of organisations with their own needs and priorities. These impact directly on decisions counsellors have to make around breaching confidentiality when working with suicidal clients.</td>
</tr>
<tr>
<td>3</td>
<td>The Swan moment: Counsellors’ thoughts and feelings when a client says they're suicidal. Counsellors experienced a distinct cognitive/emotional split between feelings of panic, anxiety and helplessness and thoughts of what the situation demanded of them as a professional. This potentially threatened to disrupt their natural empathic connection to the client.</td>
</tr>
<tr>
<td>4</td>
<td>I respect your autonomy, I just don't want you to act on it: Counsellors' perceptions of suicidal ideation in clients. Despite believing strongly in their clients' autonomy, counsellors found it difficult to trust in, as they sometimes struggled to fully empathise with suicidal feelings even though accepting them as the client's reality. Their own personal and professional experiences can impact in this area.</td>
</tr>
<tr>
<td>5</td>
<td>Assessment: Informed, dialogic and continuous. Counsellors view assessment as a continuous, dialogic process, using their own skills and experience, sometimes informed by more formal tools.</td>
</tr>
<tr>
<td>6</td>
<td>I'm responsible to my clients, not for them- but when they're suicidal, I find myself feeling some responsibility: Responsibility for the suicidal client: where does it and should it lie? Counsellors believe that clients are responsible for their own lives and they, as professionals, are responsible to them. However, when the client was suicidal, counsellors found themselves feeling and sometimes taking a proportion of responsibility, which they found difficult to quantify, or evaluate in terms of therapeutic effectiveness.</td>
</tr>
<tr>
<td>7</td>
<td>It feels worse when they're young... The vulnerability of young clients. Counsellors feel young people are more vulnerable and less autonomous than adults, find them more challenging to work with because of this and</td>
</tr>
</tbody>
</table>
feel a greater degree of responsibility both toward and for them.

**Being a responsible professional**
Suicidal clients can make counsellors feel inadequate as a professional, that they need to do more in order to do enough and fear the emotional and professional consequences of feeling or being seen to have done less.

**What I can offer to suicidal clients: space, hope and alternative options.**
Counsellors feel that they can offer a safe space for clients to talk about suicidal thoughts, helping them explore options other than taking their lives and giving hope and empowerment.

**Holding the situation within the boundaries**
Counsellors can choose to continue to work with the suicidal client, sometimes contrary to organisational policy, on the grounds of their therapeutic approach and the ethical framework of their professional organisation but this feels risky to them.

**Putting on the brakes and putting up the safety nets: Counsellors’ actions when working with suicidal clients.**
Counsellors channel concern for the client and their own professional anxiety into a variety of means of managing the risks to the client and also to themselves.

**Sharing or dissipating the burden.**
Counsellors sought to dissipate the burden of responsibility they can feel in working with suicidal clients by seeking reassurance and guidance from supervisors and, where appropriate, sharing concerns with supportive superiors.

**Category One: A respect for autonomy, and an awareness of risk but it still may not be enough...: The impact and limitations of training and experience**

As none of the participants had been qualified less than three years and most for considerably longer, it wasn’t surprising they mostly had vague recollections of training with respect to suicide. Most felt this had been covered, although post qualification training and years of client work was felt to have had more impact.

<MW: Was suicide covered in your training as an issue, as a separate sort of topic?>
Erm, I think it was but it was quite a long time ago…
(Participant 3, p12)

…it’s more the workshops that I’ve done since because of the level of work that I do here… I don’t particularly remember, of course it did come up in our skills work, erm, but we didn’t specifically focus on working with the suicidal client
(Participant 1, p23)
The one thing training had given which was particularly relevant was a strong respect for client autonomy.

...I think it’s my person-centred training that’s given me that… ability and that understanding of autonomy… I’m going back to that word again… …so the client has the right to do as they wish…
(Participant 5, p23)

One participant expressed the view that no matter how good the training, it could never adequately prepare you.

...I don’t think anything can ever prepare you for… for working with a suicidal client, I think… nothing can take away the, the feelings that you have…
(Participant 6, p9)

**Category Two: Protective framework or restrictive constraint? The impact of organisational context, policy and procedure.**

Participants were largely working in organisations whose main purpose was not therapy, with their own needs and priorities, communicated in a number of formal and informal ways.

This category covers the impact of external frameworks on counsellors and their client work, specifically around contracting, managing risk and to some extent assessment. It is related to Category Ten, which describes situations where the counsellor decides to continue working with a suicidal client, potentially in conflict of organisational guidelines.

Organisations impact upon counsellors in three ways: directly via policy and procedure, in the relationship counsellors have with superiors and other staff, and in the culture of the organisation.

...there’s something about I guess, something coming back on the organisation and their corporate identity I guess and they want to make sure that their guidelines are quite strictly followed…
(Participant 4, p4)
...it’s quite hard working in an organisation like this because the main focus of this organisation is not... ...it’s not about therapy...

(Participant 5, p8)

How comfortable counsellors felt with their organisations was often dependent on the relationship they had with line managers and other key individuals.

...professionally I suppose I’m fortunate in this organisation that they respect that autonomy and that professionalism about that...

(Participant 3, p2)

Where this relationship was defined by mutual respect and co-operation, and allowed a degree of latitude within organisational policy, counsellors felt respected, understood and supported.

However, policies could conflict with the counsellor’s own professional judgement and beliefs, which could cause difficulties.

...there’s always that conflict because I, you know, I need to hang on to the ethical code... ...and that sense of autonomy. At the same time... I work in an organisation that wants different things... ...and is led in a different way...

(Participant 5, p17-18)

Most participants used formal, written contracts, which mentioned suicide or suicidal intent specifically, usually due to organisational guidelines but sometimes by their own choice. Producing a contract that protects the client, the counsellor and also the organisation was a difficult balance to strike:

... we’ve sort of tried to cover both er, sets really if you will, and find a contract that erm, both safeguards us and safeguards the client and meets the organisational erm... requirements... And it’s always a challenge! (laughs)

(Participant 1, p3)

This raised suicide at the contracting stage, which all but one counsellor was specific about, feeling it was important to be clear and precise even when contracting verbally in a crisis.
...I think it’s important when I’m contracting to use the word, to show that I’m not afraid to use the word, I’m not afraid to work with it.
(Participant 3, p9)

It was felt important, especially with young people, to make a clear distinction between self-harming and suicidal intent, for them not to be put off disclosing. One participant working in less prescriptive environments preferred a general form of words, feeling there was no need to be specific unless the issue arose with that client. Generally counsellors referred back to the contractual boundaries if suicide arose as an issue, making it clear that they were happy to explore those feelings but reminding them of the boundaries.

...just for you to be aware, don’t want you to stop sharing what you want to share but just be aware that within our original contract, this is what I said…
(Participant 4, p11)

Category Three: The Swan moment: Counsellors’ thoughts and feelings when a client says they’re suicidal

...a bit like an adrenaline burst isn’t it, you know- (sharp intake of breath) ‘Oh no, I wish they’d not said that!’
(Participant 1, p38)

...for me, there’s always a… a sinking feeling inside, ‘this is going to be hard’
(Participant 2, p18)

...it’s like I’m on red alert now…
(Participant 5, p27)

Two participants used the metaphor of ‘the swan’ to describe having to remain calm and professional on the surface whilst underneath, feeling panic, anxiety and helplessness but others talked of a similar cognitive/ emotional split.

Yes, it’s the swan moment isn’t it? You know, you’re calm and serene on the outside and your stomach’s churning up inside and… you know, you’re pedalling furiously in your mind trying to think ‘ok, so on a scale of nought to ten, where might this lie…
(Participant 4, p24)
I’m just thinking it’s almost like the... you know the swan... kind of on the surface appearing very serene to the client... but underneath, you know, kicking like crazy...

(Participant 6, p16)

The finality of a potential life and death situation was felt to be behind these emotions.

<MW: What is it that makes it feel different to any other issue?>
‘cause it’s life and death... ...there is something about that loss of life... something about the finality

(Participant 1, p27-28)

There was the possibility of a cognitive/emotional split around the contract; on a thinking level, it was clear and specific, however, counsellors felt they were betraying the client when they considered breaching confidentiality, which felt as though there could be some kind of ‘emotional contract’.

I think at a head level it’s very clear, at an emotional level I think it’s a lot harder [...] I felt I was erm... kind of betraying her in some way, letting her down, I was going against something...

(Participant 1, p31)

Anxiety could drive a proactive risk assessment and what counsellors felt they needed to do about it. They thought this through, and at the same time tried to maintain their empathic connection with the client, which could be difficult.

But the risk management brings in this little machine that starts ticking away, it’s a bit like this clock, ticking at the side, as soon as you notice it... ...tick tick tick, there it is... and you want to pull yourself back into empathy...

(Participant 2, p20-21)

Category Four: I respect your autonomy, I just don’t want you to act on it: Counsellors’ perceptions of suicidal ideation in clients.

Whilst unanimous in upholding client autonomy, counsellors found it difficult to empathise with suicidal feelings if they had not experienced them, even though they accepted the client’s feelings or that suicidal feelings were a part of life.
I think that suicidal thoughts are quite a normal part of a human being’s experience…
(Participant 2, p1)

…and although I as a counsellor and I as a human being might find that extremely difficult at times to understand why somebody might wish to do that… erm… at the end of the day it’s not my life it’s theirs and I haven’t had their experience in life that they have…
(Participant 4, p18)

I think because taking my own life would never feel the right decision… I think I would find it quite hard if someone I was working with took their own life… to fully accept that that was the right decision for them
(Participant 1, p22)

As we do not and cannot rely on having had similar experiences in order to empathise, this raises the question as to whether suicidal feelings could be a special case. The counsellor’s personal and professional experiences could impact here:

I understand why people commit suicide, I understand, I’ve had my own suicidal thoughts in my own life…
(Participant 2, p10)

I’ve had a family member that killed herself, I was quite young at the time but I guess you know, that’s probably had some impact on how I see it and how I deal with suicide… […] … I certainly wouldn’t convey it but I can’t sort of say that it’s not around…
(Participant 3, p10-11)

Some participants raised the issue of whether suicide could be rational, especially where it appeared to be an impulsive response to a crisis or temporary overwhelming pressure and there could be difficulty in trusting the client in this regard.

…that actually, to trust that you know, if they take their own life, that was the right decision for them… it feels as though it would be quite difficult to be with
(Participant 1, p22)

At least one participant felt the fact the client was speaking openly about suicide meant they wanted to be helped.

…they have the choice about what they tell you and I think that’s why they tell you quite often because they actually want, they want to help themselves through being helped…
(Participant 2, p24)
Category Five: Assessment: Informed, dialogic and continuous.

Although some participants used or would consider using tools to inform assessment, none relied on them completely, nor would they.

...I’m not using any paper-based system and I’m quite pleased that I don’t have to do that… (Participant 3, p4)

...so we do not use CORE as a risk assessment tool but if it’s on CORE then we’ll make sure that we address it. So what we use as risk assessment is dialogue… er, the CORE informs the dialogue… (Participant 2, p3)

In contrast, where information about the client was already available from referral or assessment, counsellors often preferred not to use it.

...I like a sort of blank canvas and not having my… the way in which I might work with this- tainted for want of a better word- by someone else’s perception of that person, so then I’ve nothing to judge them on ‘cause they just come to me fresh as it were… (Participant 4, p11)

Counsellors described assessment as a continuous and dialogic process, especially in the first session.

...when the session starts, then I guess I am assessing all the time… (Participant 1, p8)

They felt confident doing this, that it was integral to how they worked, and often had experiential knowledge of risk factors.

<MW: So you would, certain things would flag it up for you?>
Erm… yeah, I think things like helplessness, hopelessness… Things like social support, lack of, you know, isolation… (Participant 6, p5)
**Category Six: I'm responsible to my clients, not for them- but when they're suicidal, I find myself feeling some responsibility: Responsibility for the suicidal client: where does it and should it lie?**

Counsellors can feel and even sometimes take responsibility for suicidal clients, despite believing clients are responsible for themselves, and they as professionals are responsible to them.

…it feels like I’m probably the main key person that may be keeping that person going and keeping them alive

<MW: Mm, that feels like that could be quite a burden almost…[…]> It’s a weight, yeah, you could use bur- it’s a weight, a responsibility…

(Participant 3, p23)

…on a head level I’d like to think I’ve got my head round it’s their responsibility (smiling) … On a human emotional level… I think with certain maybe clients, certain times of year like that… erm… I can have… I feel that responsibility…

( Participant 3, p28)

The above quote again shows the cognitive/ emotional split.

…I don’t feel responsible for clients because ultimately they’re responsible for themselves but it’s interesting having just talked about suicidal clients that I feel much more responsible for them…

( Participant 6, p21)

<MW: …does it feel like this is something you’re taking [responsibility] or something that the client is giving you? …Or is it both?>

Probably I would say I think the client’s giving and I’m willing to take…

( Participant 6, p22)

It felt impossible to quantify the responsibility felt or to what degree it was effective.

Not all [responsibility], but I would say… I would say certainly some… I would find it hard to quantify really…

( Participant 6, p22)

I guess you know, the fact that she did what she did I guess that extra mile was, you know, never going to be long enough… […] …she’d find some other ways and means of doing what she wanted to do…

( Participant 4, p40)

Here it depends on whether effectiveness is seen as synonymous with prevention - although counsellors could accept that the logical consequence of facilitating client autonomy could be suicide, they felt their role was to help find alternative options.
**Category Seven: It feels worse when they're young… The vulnerability of young clients**

Five out of six participants felt young people were less autonomous and more vulnerable than adults, being less developed and having less support. Counsellors found them more challenging to work with and that they needed to take on greater responsibility toward and for them.

I guess I feel that responsibility… [...] …and possibly I take that responsibility as well, erm, I know that I work… harder in that counselling relationship because of the age of that client than I used to perhaps on placement or with adults
(Participant 1, p39)

…it can feel slightly different when you’re working with somebody who’s very young who’s suicidal… [...] …they’re developing who they are and an adult might have more of a sense of who they were to make that decision…
(Participant 3, p11-12)

...for those maybe that have just come from school and they’ve been used to being looked after… [...] …well is this person actually fully responsible for themselves…
(Participant 5, p41)

This data largely came from questioning participants about their motivation for participating. The majority work in the education sector primarily, mostly with 16 – 19 year olds and it was working with suicidal young people that had motivated several.

**Category Eight: Being a responsible professional**

Whilst acknowledging clients are responsible for their own lives, suicidal clients can make counsellors feel they need to do more, question whether they’ve done enough and worry about the emotional and professional consequences of client suicide.

*Have I done enough? That’s the helplessness. Have I done enough to offer that support?*
(Participant 1, p20)
<MW: […] What are you feeling, thinking about yourself as a counsellor when that client’s saying they’re suicidal?>
…am I… professional enough, am I competent enough, am I enough…
(Participant 6, p13)

Counsellors felt client suicide would be perceived a failure by their organisation but even possibly themselves.

…a number of people have said to me ‘the counselling service has never had a suicide’, and that feels a pressure in itself…
(Participant 1, p41)

I don’t know whether there would be that same understanding and support for us as counsellors. D’you know what I mean? It would be, it would presume more of our failing, or why has that happened rather than a supportive atmosphere…
(Participant 1, p42)

The possibility of vicarious trauma was raised along with the need for self-care.

…’cause I don’t want to feel everything, I don’t want to be traumatised by what I’m being exposed to…
(Participant 3, p14)

…I’ve had to learn to… to some degree to detach… from it, ‘cause if I took it all on board I wouldn’t be able to do the job I did
(Participant 3, p21)

The compulsion to do more could cause counsellors to stretch professional boundaries to protect the client.

I’d have done anything to be able to say ‘you can come to mine for Christmas’…
(Participant 3, p28)

…I made a judgement that I had an extra long session with her, it was about an extra fifteen minutes and I was so not unsure that she was actually going to get the bus to go home […] and I made a judgement call and I’m still not sure if it’s the right one that I offered her and did take her home…
(Participant 4, p38)

Included in this category are counsellors’ reflections on their own candour and their hopes others would be similarly honest.
I just sometimes wonder whether other counsellors would be as open about how vulnerable they feel sometimes…
(Participant 2, p33)

Category Nine: What I can offer to suicidal clients: space, hope and alternative options.

Counsellors almost universally felt they offered a safe space for clients to discuss suicide with the hope of exploring other options and giving hope and empowerment.

...that therapeutic hour that we have together with a client might be the only space in which they’re able to be open and honest with themselves to be able to explore those thoughts… [...] …because other people… don’t want to know…
(Participant 4, p22)

...if they’re saying they’re suicidal and they’re going to do stuff then that’s… that’s stuff you can work with in the room with them…
(Participant 5, p20)

I think it’s about accepting where they are now… but with the hope of… [...] …things changing in the future
(Participant 6, p18-19)

Category Ten: Holding the situation within the boundaries

This relates to Category Two and is perhaps its counterpart. Counsellors may, on the basis of professional judgement, continue to work with suicidal clients, even contrary to organisational policy. This feels risky, as responsibility lies with them and not the organisation, although in the example below, the principle became enshrined in policy.

And it’s me, perhaps taking that risk of holding that space, holding that student, trusting them in that…
(Participant 1, p26)

I guess in some ways I still follow my own judgement… [...] …at the end of the day… nobody knows the client better than I do… …and I guess it’s going to be my judgement as to… having known them over X number of sessions, whether it is truly their intention to do what they say they’re going to do or whether it’s not…
…I fought and fought and eventually it went through to the governing board that we could put that in that the counselling service was the only place where we could talk about suicide and child protection issues and it not necessarily go to the safeguarding officer…

Category Eleven: Putting on the brakes and putting up the safety nets: Counsellors’ actions when working with suicidal clients.

Several participants mentioned slowing things down, putting the brakes on, trying to contain the situation and manage risk, to give the client time and space to explore their situation, including the potential impact of suicide on others, and consider alternative options.

So being able to slow it down for them also helps with my anxiety to kind of slow things down.

…it’s almost as if I have to kind of help them put the brakes on to give them time to maybe obtain a different perspective on things…

One participant referred to Andrew Reeves’ term ‘safety nets’ meaning helping the client put supports in place.

I’ll explain to them how sometimes certain things can actually lead them to be more at risk… […] …so you know, I talk about how they can keep themselves safe as well, whilst they make a decision.

This felt driven by the counsellor’s need to protect the client and also themselves:

…I’m more aware that I need to be professional and cover my back, but I wouldn’t be putting that onto the client…
**Category Twelve: Sharing or dissipating the burden.**

This follows from feelings of responsibility counsellors can have for suicidal clients and relates to the need to dissipate or share that burden. The actions in Category Eleven also serve this purpose but are mostly confined within the session. Responsibility might be ‘passed back’ to the client at the end of the session:

...that stuff belongs to them it doesn’t belong to me… […] …my summing up of bringing this session to a close would be giving back what they shared with me…

(Participant 4, p33)

Beyond the session, counsellors seek reassurance and guidance from supervisors and, where appropriate, share concerns with supportive superiors.

...my first port of call would be my supervisors… […] …and I know I would get some good support from them, erm… and if I was, you know, er… unsure as to how to progress then I would seek their support being more knowledgeable in that area…

(Participant 4, p4)

‘Have I done everything’… yeah, ‘was I enough for this client’… yeah, so I’d definitely say it’s a kind of offload and a, and a reassure… you know try and get that reassurance…

(Participant 6, p19)
Figure 1: Schematic Representation of Categories
Chapter Five: Discussion

This study's purpose was to revisit that of Reeves and Mintz (2001), after the elapse of ten years, to see how much, in the authors' words “the maturity and accountability of counselling...” has continued to develop “...through a process of evolution” and to examine the issue of responsibility which emerged from the literature. To what extent, therefore, do the findings of this study coincide with those of Reeves and Mintz and where might they fit with the literature?

In Figure 1, the Schematic Representation of Categories, the twelve categories are positioned relative to each other, giving a sense of the relationships between them and how they might fit together. This is presented within a qualitative paradigm as one possible representation of the phenomena studied. Three concentric domains are posited: the External Environment of government, organisations, training institutions and society, the Internal Environment of the counsellor’s thoughts, feelings and perceptions, and in-between, the Organisational Context within which they work, its policies, procedures and structure.

The twelve categories divided into three groups: Inputs and Influences, Perceptions and Processes, and Actions and Outputs, the arrow indicating a sequential flow while acknowledging the inevitability of external inputs and feedback loops. These groups loosely correspond to Reeves’ category groupings from the dissertation research upon which Reeves and Mintz (2001) is based: Impact of the Organisation, The Counsellor’s Phenomenology, and Impact on Practice (Reeves, 1997).

Inputs and Influences

Category One found counsellors recalled little core training around suicide, save giving them a respect for autonomy, and relied mostly on post-qualification training and experience. This largely coincides with Reeves and Mintz' Category Nine ‘Counsellors do not feel their training has enabled them to work effectively with suicidal clients- both in terms of skills development and theoretical knowledge’, and with Reeves (2010; 2004) assessment of current counsellor training. Some diploma courses trainers did not believe students were competent to work with suicidal clients.
upon completion and Reeves cites Dryden and Thorne as stating a diploma qualification is a basic level requiring further training beyond. His conclusions that ‘Competence in this area is usually achieved through gaining day-to-day experience of working with clients, and processing that work in supervision;’ (Reeves, 2010, p. 54) were borne out by the majority of this study’s participants. However, Participant 3, when giving feedback in Member Checking, stated they did not feel inadequate when dealing with suicidal clients, and whilst this theme emerged strongly from the data, it is not necessarily universal.

So, little has changed in this regard with the elapse of a decade. Winter et al (2009) concluded lack of training and support was the main barrier to successful therapy with suicidal clients, tentatively suggesting appropriate training was sufficient for effective intervention and that experience might positively correlate with effectiveness; a finding corroborated by Neimeyer (2001). McAdams and Foster (2000, p. 107) go further, recommending that ‘Specific training in client suicide should be a routine component of the counselor educational process’. However, Carney and Hazler point out that:

Even if mental health counselor training could be extended by years, the needs of all the populations we must treat would not be addressed. It is, therefore, incumbent on counselors to take personal responsibility for increasing their competencies with high-risk populations through continuing education.
(Carney & Hazler, 1998, p. 29)

Category Two, that organisations impact directly on decisions counsellors make around breaching confidentiality is a direct correlate of Categories Two and Three in the Reeves and Mintz (2001) study: ‘Organisations influence counsellors’ decisions about when and how to break confidentiality when working with suicidal clients’ and ‘The organisations that counsellors work for expect interventions with suicidal clients which are often in conflict with the preferred personal choices of the counsellors themselves’. Little appears to have changed here also, perhaps not surprising given organisations are obliged to comply with the policy agenda set by government:

The task defined by UK and international mental health policy is for all mental health workers to recognise and assess suicide risk and to intervene and prevent suicide...
(Reeves, 2010, p. 51)
It seems this is an aspect of counselling unlikely to change without a radical policy shift and that will continue to ‘cause dissonance for those practitioners who view suicide in philosophically different ways, and who personally do not subscribe to the notion of prevention.’ (Reeves, 2010, p. 51). However, this study demonstrates successful compromises can be negotiated if there is communication and co-operation between counsellors and management.

There is considerable contradiction between this Category and three other Reeves and Mintz categories corresponding to it, specifically around contracting. Reeves and Mintz counsellors avoided formal contracts, allowed clients to set boundaries regarding what was discussed and did not specifically discuss issues around suicide. Counsellors in this study almost all used written contracts, specifically named suicide and made the distinction between it and self harm, and revisited the contract if the situation required. Whilst this may suggest a shift to more formal and explicit contracting, it could be that the overwhelming majority of the counsellors in this study work within the education sector, half of them with 16-19 year olds. This has an impact on the policy environment and risk management of these organisations and on the counsellors themselves, as evidenced by Category Seven. One counsellor working in less prescriptive environments preferred a more general form of words when explaining breaches of confidentiality. This is the only area of agreement with Reeves and Mintz’ Category Four ‘Counsellors encourage suicidal clients to set their own boundaries regarding what issues are discussed, so as to prevent further distress’.

**Perceptions and Processes**

Category Three reinforces Reeves and Mintz’ Category Thirteen, ‘Counsellors experience a range of distressing feelings when working with suicidal clients including, anxiety, fear, panic, impotence and doubts about their ability to practice’. ‘The Swan’ metaphor captures the split between counsellors’ thoughts and feelings and the professional role they are maintaining in action and appearance. The demands of the situation start a cognitive process which one participant likened to a machine, which can disrupt the empathic connection with the client. Reeves (2010) cites Leenaars as suggesting that feelings aroused in the counsellor by the suicidal
client can cause such a disconnection, as does Rubenstein (2003), however, these are unacknowledged feelings of negative counter-transference and not necessarily the same as those of this study’s counsellors. From a person-centred perspective, anything disrupting the empathic connection with the client might negatively affect the therapeutic alliance. If this is necessary to assessing and managing suicidal risk, it may be beneficial, however, this emphasises the importance of exploring any negative feelings aroused by the client thoroughly in supervision.

Reeves (2010) suggests negative feelings are a normal and necessary part of working with suicidal clients, providing a ‘viscerally important psychological connection’ (Reeves, 2010, p. 143) and ‘an understanding of risk unattainable by ‘tools”’. He questions whether counsellors claiming not to feel distress in these situations are sufficiently present in their work. Although this theme emerged quite strongly from the data, Participant 3 in their Member Check feedback stated categorically that they did not feel panic or anxiety working with suicidal clients, so this is not a universal experience in this study.

There was support for Reeves and Mintz’ Category Sixteen, ‘Counsellors feel they are letting down and betraying clients when they break confidentiality because they perceive the situation is then handled insensitively’, again represented by a cognitive/emotional split:

*I think at a head level it’s very clear, at an emotional level I think it’s a lot harder [...] I felt I was erm… kind of betraying her in some way, letting her down, I was going against something…*(Participant 1, p31)

The implication is that cognition and emotion are at odds. At a thinking level the counsellor knows they must breach confidentiality; on an emotional level, this feels like a betrayal. It seems there could exist an ‘emotional contract’ with the client with different rules to the formal one. Possibly this relates to the counsellor’s beliefs around client autonomy as found by Reeves and Mintz (2001) and Reeves, Wheeler, et al. (2004) and is an area where this might cause difficulty.

Category Four directly correlates with Reeves and Mintz’ Category Ten, ‘Counsellors’ own views and beliefs about suicide will influence their responses to suicidal clients’
and reaffirms the literature, including Winter et al.’s (2009) conclusion that this should form part of suicide intervention training:

*A counsellor’s views on suicide, influenced by their personal or family history, spiritual or religious views, experience of supporting family or friends… will have great significance in how they subsequently respond to suicidal clients…*

(Reeves, 2010, p. 127)

The findings of this study, that counsellors respected clients’ right to end their lives but did not want them to do it is an exact correlate of Hammond and Deluty, cited by Werth and Liddle (1994) and also of Lussier, who describes this as ‘suicide as an option (but not for my client)’ (2005, p. 4294) and explores this with Cognitive Dissonance theory. It appears there are different beliefs operating and dissonance between them.

Most intriguing was the finding that counsellors who had not felt suicidal struggled to empathise with suicidal clients. This is surprising as it would be impossible for a counsellor to rely on having similar experiences to clients in order to empathise, but it may be that suicidal ideation is such an extreme experience that it is difficult or impossible to empathise with. Widiger and Rinaldi (1983, p. 263) state that ‘acceptance of suicide entails an empathic understanding of the patient's tragic condition and a recognition of an inability to relieve the suffering’, implying that empathic understanding, the acceptance of suicide as an option for that client and the feeling the counsellor was powerless to help – as with Reeves and Mintz’ (2001) participants - were inextricably linked. If the counsellor is unaccepting of suicide, which Neimeyer et al. (2001) found positively correlated with intervention competence, it would seem they cannot feel both an empathic connection to the client’s suicidal feelings, and unable to relieve their suffering. This raises the possibility that empathy with suicidal feelings could negatively correlate with intervention competence as defined in by Neimeyer et al, if coupled with a sense of powerlessness to alleviate them.

Category Five partially agrees with Reeves and Mintz’ Category Eight, ‘Counsellors see risk assessment as an informal rather than formal process’. Although some participants in this study make use of or would use formal tools to inform assessment, none relied on them, nor would they; something they have in common.
with those from the original study, who highlighted a ‘lack of confidence in appropriate risk assessment approaches as significant causes for concern’ (Reeves & Mintz, 2001, p. 172). However, the process described in this study, although informal, was proactive, informed by knowledge of risk factors and is best termed ‘dialogic’ (Reeves, 2010, p. 12).

This study’s counsellors appear more aware of the necessity of risk assessment and engage more proactively in it than Reeves and Mintz counterparts, which could indicate this has developed over the past decade, or, again, might reflect the participants’ work contexts. Both samples have similar experience levels, all Reeves and Mintz’ counsellors having at least six years’ since qualification, whereas only one from this study was less (Participant 1, 3-5yrs) and a number considerably more. Therapeutic approach could be a factor, as all Reeves and Mintz’s counsellors were person-centred, whereas in this study, two thirds were integrative with one third person-centred. However, organisational context still feels the major difference between them as Reeves and Mintz were able to sample purposively and select a sample representative of different working environments, whereas, in this study, the sample is more a ‘self-selected extreme cases’ one focusing almost exclusively on the further and higher education sector, where it would appear there is more emphasis on assessing risk.

Overall, this emphasises the necessity of training around suicide risk. Without this, counsellors are not equipped with the skills, or the imperative to assess, despite working within policy frameworks implicitly requiring them to. However, we should note the danger of becoming so preoccupied with risk that actions become ‘…focused solely on risk assessment rather than therapeutic change’ (Sharry et al., 2002, p. 383).

Category Six has no parallel in the Reeves and Mintz study as it emerged from the literature. Counsellors found they took on a degree of responsibility for suicidal clients, despite believing overall they were responsible to their clients, not for them, and this appeared a cognitive/ emotional split. It was difficult to quantify how much responsibility they took and whether it facilitated therapy. Bond (2010) in proposing an ethical decision making model, suggests ascertaining whose dilemma it is, starting from the position that the counsellor is responsible for methods used, with
the client responsible for the outcome. However, he acknowledges counsellors may feel they hold more responsibility for clients who self harm, are young, or lack capacity to make rational judgements.

By assessing risk, counsellors take on a degree of responsibility for managing it, not only to the client but also to themselves and their organisation. To what extent this constitutes responsibility for rather than to the client is a moot point, as is the degree it aids the therapeutic process. The literature gives confusing messages here, for whilst there is emphasis on the importance of training in recognising and managing risk, there are a number of studies which question the effectiveness of taking responsibility for suicidal clients.

*All the precautions and all the management may result in encouraging one of the most lethal aspects of the suicidal individual, that is, his tendency to make someone else responsible for his staying alive.*  
(*Hendin, 1981, p. 469*)

One participant (Participant 6, p22) suggested this kind of exchange was taking place; that the client was giving responsibility and they were prepared to take it. Trimble et al. (2000) concluded successful coping with suicidal clients was the realisation of client responsibility, whilst Cummings et al. (1996) regard taking responsibility as one of four ‘outmoded attitudes’ leading to the mismanagement of suicidal patients, and Olin (1976) declares taking responsibility a ‘therapeutic disaster’. Richards (2000) found therapists needed to realise the limits of their powers and that despite their best efforts, clients may take their own lives. Interestingly, clients undergoing DBT cited by Winter et al (2009) felt taking responsibility was an important component of therapy.

It seems from categories two and eight, that as Reeves (2010) postulates, there is a downward transmission of societal discomfort about death, loss, grief and suicide via policy makers and organisations to the individual, ‘Ultimately that is where responsibility seems to be located; no-one wants to be holding the parcel when the music stops.’ (Reeves, 2010, p. 52). Responsibility for the suicidal may be given to the counsellor by society via institutions and by clients themselves. Counsellors then find themselves taking on an unquantifiable proportion of this, possibly contrary to
their beliefs and training, and as a number of studies suggest, with doubtful effectiveness.

This study has been exploratory, and as such, it perhaps raises more questions than it can answer, however, taken with the literature, responsibility seem to be the theme linking the others together.

If suicidal clients incline counsellors to take responsibility for them, Category Seven indicates young suicidal clients do so even more. Young people were felt less autonomous than adults, to have less decision-making capacity and be more in need of support. The literature would, again, sound a note of caution here:

A therapist’s own inclination to see himself as the saviour or rescuer of the suicidal patient can be responsible for perpetuating suicidal behaviour, particularly in young people… suicidal young people arouse rescue fantasies in therapists
Hendin (1981, pp. 472-473)

Whilst we cannot say how taking a greater degree of responsibility and working harder manifests itself in practice, the literature sheds light on what suicidal and self-harming young people find helpful. Storey et al (2005) found young people resented therapists with their own priorities and agenda and generally Winter et al (2009) found that a strong therapeutic relationship based upon respect, understanding and acceptance was preferred to one concentrating upon theory or self-injurious behaviour. As stated, this category is likely to reflect the self-selected nature of the sample, the majority of which work with young people, although it does highlight further the issue of responsibility. In the Member Checks, one participant stated that they had made no comments concerning young people but that their experience tallied with the findings.

Category Eight highlights responsibilities felt by counsellors as part of their role. Suicidal clients made them feel they needed to do more, worry about doing enough and fear the consequences should a client take their life. This relates to Reeves and Mintz’ (2001) Category Fourteen ‘When working with suicidal clients, counsellors doubt their own professional competence and their ability to work safely and appropriately’, and Category Twelve, ‘Counsellors feel that the threat of litigation and accusations of malpractice impacts upon their decision to intervene with suicidal
clients’. Again, responsibility is loaded onto the counsellor by society via its lawmakers and organisations, which have to work within those laws.

There is a clear expectation of counsellors in terms of actions and outcomes with suicidal clients. As Reeves (2010) says, this may cause dissonance for those with personal views not coinciding with prevention. Furthermore:

> How counsellors respond to their most vulnerable clients is one of the ways by which other professions and society as a whole make judgements about the integrity of the profession. (Reeves, 2010, p. 57)

Participants felt client suicide would be viewed as a failure by their organisation and even in some cases, themselves, echoing Richards (2000) and Wildman (1995). This fear might, as Reeves and Mintz (2001) participants felt, impact upon counsellors’ decisions to intervene and become an obstacle (Hendin et al., 2006), or, in fact, as found in this study, a pressure to stretch professional boundaries to prevent harm to clients.

One participant (3) described how they felt they needed to emotionally detach to work with suicidal clients so as not to be traumatised and incapacitated by the client’s material, and indeed, this participant noted in their Member Check feedback that they did not experience feelings of professional inadequacy. A delicate balance needs to be struck between feeling enough of a client’s pain to maintain an empathic connection, whilst retaining a degree of detachment sufficient to protect oneself.

Also in this category were comments from two participants indicating they had been honest in sharing their true feelings and hoping other counsellors would do the same, whilst having doubts about this. It could be there is a discrepancy between the way counsellors present themselves as professionals and the way in which they think and feel, which would echo ‘The Swan’ from Category Four and also the examples of cognitive and emotional splitting in this study.
**Actions and Outputs**

Category Nine, refers to what counsellors feel they offer suicidal clients and it is clear that despite practical and emotional difficulties, counsellors feel they have something valuable to offer, possibly unique; a position Reeves (2010) argues strongly:

> ...counselling is ultimately about giving voice to the client so that they can begin to make change... ...paradoxically we are helping clients to use the awareness of their suicidal potential to begin to move away from it.  
>(Reeves, 2010, p. 11)

This is backed by Winter et al (2009) who found that clients found respect, acceptance and an understanding, empathic and non-judgmental attitude to be of most help. There isn't a direct correlate in Reeves and Mintz (2001), however, Category Eleven, ‘Counsellors’ empathic responses to suicidal clients are aimed at trying to make contact with what they perceive to be the client’s isolation’ does echo one of this study’s participants statement that the therapeutic hour was the only time clients get to talk about suicidal feelings as ‘...other people... don't want to know’ (Participant 4, p22). However, accepting and exploring suicidal feelings with clients can be risky for counsellors as this may run contrary to organisational policy.

Category Ten is the counterpart to Category Two, and describes how counsellors may choose to continue to work with suicidal clients against organisational policy. Reeves states:

> ...organizations never really ‘know’ of these decisions, because risk is ultimately safely contained within the relationship... The risk for counsellors is of client suicide, when suddenly it transpires that the counsellor has been working outside of the organizational policy....
>(Reeves, 2010, p. 77)

This echoes Category Six, with the counsellor taking on a degree of risk and responsibility, especially if organisational policy is black and white around actions to be taken. However, as Hendin states:
...therapy requires that the therapist be able to accept and live with some risk. As Schwartz, Flinn and Slawson point out “the only method of reducing the long term risk of suicide may be one that risks its short term commission.”
(Hendin, 1981, p. 479)

The question arises, how helpful is it to have strict policies protecting organisations if this pressures counsellors into flouting them and taking on increased risk and responsibility that could be counterproductive to therapy? As Reeves says:

*If counsellors can feel supported and contained by procedure, they are much more likely to be able to engage with suicidal clients in such a way that both will feel cared for.*
(Reeves, 2010, p. 88)

This category and Category Two correspond to Reeves and Mintz (2001) Categories Two, ‘Organisations influence counsellor’s decisions about when and how to break confidentiality when working with suicidal clients’ and Three, ‘The organisations that counsellors work for expect interventions with suicidal clients which are often in conflict with the preferred personal choices of the counsellors themselves’. This appears something else unchanged in ten years, as organisations followed government prevention policy. However, there remains the potential for compromise in the setting of policy and the nature of working relationships which could, as Reeves suggests, mean counsellors feel sufficiently supported to take on the short term risk Hendin believes necessary to negate the longer term one.

Category Eleven can be seen as an extension of Category Nine as it describes how counsellors try to work with suicidal clients. However, the focus here is more the short-term management of risk to the client and also the counsellor. Strategies are to slow things down to allow the client to explore feelings and options, sensitively making them aware of the possible consequences of taking their life and putting other forms of support in place whilst this is on-going.

The nearest correlate in Reeves and Mintz (2001) would be Category Twelve, ‘Counsellors feel that the threat of litigation and accusations of mal-practice impacts upon their decisions to intervene with suicidal clients’. In other words, counsellors’ actions may be driven by fear of the consequences of client suicide. Bernstein puts it starkly, ‘…we do not want them to die because of the effect their death will have on
Winter et al. (2009) in citing Davidson et al. (2007) suggest therapists feel they need to work harder with clients who appear not to be improving, possibly to alleviate guilt. There is a danger, as Hendin points out of ‘...ineffective or coercive actions resulting from the therapist's anxieties...’ (Hendin et al., 2006, p. 67), whilst both Ellis (2004) and Hendin (1981) point out that reducing therapy to management and control, in contrast to developing self-efficacy, can compromise the therapeutic alliance. However, Winter et al. (2009) found increased support facilitated therapy, gave clients increased hope, which positively correlated with reduced suicide potential (Barbe et al., 2004; Dahlsgaard et al., 1998). Overall, although there are dangers in ‘over-managing’ a client, the strategies described here, part motivated by concern for the consequences for the therapist seem practical and respectful, despite only general backing for ‘support’ in the literature.

Reeves and Mintz (2001) counsellors, whilst being aware of the possible consequences of client suicide, appear not to have specific strategies for helping the client manage suicidal risk. It could be this is an aspect of practice that has developed over the last decade, or it could reflect the sample in this study almost exclusively working with young people in the education sector.

Category Twelve relates to the sense of the responsibility felt working with suicidal clients and ways counsellors seek to share or dissipate this. It might be a companion to Category Eleven as it addresses support strategies, albeit for the counsellor. Reeves’ (2010) image of responsibility for the suicidal individual being passed down feels an apt one and we also have the possibility, discussed under Category Six, of the suicidal client attempting to pass responsibility to the counsellor and the counsellor maybe taking on a proportion. This might be dealt with by passing it back to the client at the end of the session as Participant 4 described, however, the main way counsellors avoid being left holding Reeves’ metaphorical parcel is by taking it to supervision to unwrap, share and defuse.

Counterparts in Reeves and Mintz (2001) are firstly Category Seven ‘Counsellors want their supervisors to empathise with them, to reaffirm their practice and interventions, and to reaffirm the counsellor’s sense of professional competence’. One counsellor in the present study (6) used supervision for reassurance this way, which can be seen as attempting to answer questions in Category Eight ‘Being a
Responsible Professional’, where counsellors queried whether they had done enough. However, in Reeves and Mintz (2001) Category Fifteen ‘When a client has expressed suicidal thought or intent during a session, counsellors have informal strategies for coping afterwards which are aimed at ‘distancing’ themselves emotionally from the session’, one gets a sense of counsellors being isolated immediately after seeing suicidal clients and coping with feelings raised largely alone to maintain confidentiality. These experiences do not relate directly to supervision, but rather to the period before supervision takes place and the counsellor is perhaps still ‘holding’ Reeves’ parcel. We can see an echo in this study in Participant 3’s comments in Category Eight, where they talk about not wanting to feel everything and learning to detach to avoid vicarious traumatisation.

Limitations

Though the self-selected extreme cases sample highlighted issues of responsibility especially regarding young people, it may lack representativeness and generalizability through concentrating on one client group and context. Also, the focus on responsibility, whilst providing exploratory insight has given no definitive answers and will need further investigation. Finally, the study has generated more material than was possible to include in a Masters dissertation and it is hoped that this can be put to use in other forms.

Implications for Practice

This study has backed the literature in finding a need to address working with suicide as part of basic counselling training, especially incorporating counsellors’ own attitudes and beliefs. However, this would not prevent individual counsellors from giving consideration to the issue and seeking further training where necessary. They might also reflect on the amount of responsibility they feel and take for suicidal clients and assess its effectiveness. Organisations and managers of counsellors should reflect carefully that policy, implementation and working relationships, not only protect the organisation but also support practitioners to enable them to better support suicidal clients. The study also emphasises the need for self-care and good
supervision when working with suicidal clients and supervisors might wish to reassess their monitoring and support of supervisees in this area.

Future Research

Given the lack of research in this area and the specific focus of this study’s sample, it would be useful to do comparison studies using other theoretical orientations, client groups and organisational contexts to ascertain any differences and similarities. For example, the study might be repeated using Samaritan volunteers of comparable age and experience instead of counsellors. This could highlight areas where differing training, ethical and legal boundaries and contact methods affect the internal processes involved.

Another issue worth further investigation would be why counsellors who had not been suicidal had difficulty in empathising with clients who were, whether this constitutes a special case of empathy failure and what the implications might be for therapeutic effectiveness.

However, it is the issue of locus of responsibility initially explored in this study which most demands further investigation as it is of central importance not only to the emotional impact of working with suicidal clients on counsellors but the effectiveness of therapy itself. This would need to take into account national and organisational policy, training, counsellors’ personal attitudes and beliefs and how these translate into practice.
Chapter Six: Conclusion

This study has reaffirmed much in the existing literature, highlighted important areas for further investigation and the author hopes it may make a small contribution to the pool of knowledge in this most vital of areas. It is not just of relevance to counselors, for as Reeves says, ‘…almost all of the factors that I discuss and explore about working with suicidal clients can be applied to most settings and helping professionals’ (Reeves, 2010, p. xii). Anything that better enables those helping professionals in working with the suicidal can only be of benefit to all.

*Since each of us is unique, we must come to terms with our own demons, our own fears, and the terms under which we can live out our days. It is always advantageous to be armed with as much information about ourselves as it is reasonably possible to acquire. On the topic of suicide, knowledge is powerfully preventive.*

(Shneidman, 1996, p. 156)

Shneidman applies this not just to therapists and clients but to everyone, as he puts it, ‘Suicide prevention can be everybody’s business’ (Shneidman, 1996, p. viii)
References


Appendix I: Search Strategy

Electronic Database Search

To give the most comprehensive search, I used both free text and thesaurus terms, in line with Winter, Bradshaw, Bunn, & Wellsted (2009). I first decided to use a broad search of the PsycINFO database, just on counselling, psychotherapy and suicide covering journal articles in English published in the last ten years since around the time of the Reeves and Mintz article (2000 - 2010) using the following search string with truncations on the Abstract field:

suicid* and (couns* or psychotherap*)

I kept 30 of the 485 hits and then used a more specific search string with the same criteria but without the date restriction:

(couns* or psychotherap*) and suicid* and (experience* or attitude* or belief* or train*)

This returned 361 hits, out of which I kept 7 not been found by the previous search.

I next conducted a Thesaurus search of PsycINFO, using subject terms decided by the particular database to produce a more accurate and relevant search. The string was:

(DE "Counselor Attitudes" or DE "Counselor Characteristics" or DE "Counselor Education" or DE "Therapist Attitudes" or DE "Therapist Characteristics" or DE "Psychotherapist Attitudes" or DE "Psychotherapeutic Processes") and (DE "Suicidal Ideation" or DE "Suicide" or DE "Suicide Prevention")

This returned 131 hits, of which I kept 23. Oddly, the Reeves and Mintz study was not found by this search, despite its obvious salience, so I ran a search using just the specific thesaurus subject terms from that article but only the Reeves and Mintz article was returned.
I then did a further thesaurus search for studies related to suicide and confidentiality. The search string was:

(DE "Privileged Communication") and (DE "Suicide" or DE "Suicidal Ideation" or DE "Attempted Suicide")

This returned 17 hits, of which I kept 4 that were in some way relevant.

I also decided to search the PubMed medical database using its equivalent of a thesaurus search on counselling, psychotherapy and suicide but this found nothing not already found on PsycINFO. A further ‘top up’ search of the most recent publications was carried out during the write up phase of the study but this yielded no new studies of any relevance.
Appendix II: Recruitment Poster

Counsellors:

Have you experience of working with suicidal clients?

Are you interested in participating in research into this vital area?

If so, then I'd like to hear from you.

My name's Mike Whitfield and I'm conducting research into counsellors' experiences of working with suicidal clients as part of an MA in Counselling Studies at the University of Chester and supervised by Dr Andrew Reeves. Initially I'd be asking you to complete a short questionnaire about your background, experience and current work, and then possibly take part in an in-depth interview at a later date.

Ideally you will have:

- At least a Diploma level qualification in the Person-Centred approach
- At least three years' post-qualification experience
- Regular supervision as per BACP guidelines
- Current or recent experience of working with suicidal clients

To discuss taking part, please email:
Appendix III: Information Sheet

Participant Information Sheet

Exploring Counsellors' Experiences of Working with Suicidal Clients, with Particular Focus on the Issue of Responsibility

Research for the degree of Master of Arts in Counselling Studies at the University of Chester

What do counsellors experience when a client says they're suicidal? What thoughts and feelings do they have and what impact does it have upon them? To what extent do they feel responsibility for the client? These are the areas I'm going to be exploring in this study.

You don't have to take part, and if you do, you are free to drop out at any time up until I submit my work for marking, in which case I'll destroy any records made of your contribution. Initially I'd like you to fill in a questionnaire about your background, experience and current work and then possibly take part in an in-depth interview at a later date. In the interview I would hope to explore what you mean by 'suicidal', your own beliefs about suicide, any policies and procedures you work to with respect to suicide and how you feel when a client tells you they want to die. In order to analyse the information I'll need to audio record the interview and make a transcript of it.

No identifying information about you or your organisation will be included in the research or any subsequent publications. Any record of what you tell me is confidential, will be used only for the purposes of this research and will be kept securely, accessible only to me, my supervisor, Dr. Andrew Reeves of the University of Chester and its examiners. The University requires that all written records be kept for five years and a final copy of the dissertation will be kept in the library, however audio recordings will be destroyed upon completion of the research.

If you have any questions or would like any further information about this research, then please contact me via email or phone:

Mike Whitfield

mike_ar_research@me.com

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Appendix IV: Questionnaire

Exploring Counsellors' Experiences of Working with Suicidal Clients, with Particular Focus on the Issue of Responsibility

Research for the degree of Master of Arts in Counselling Studies at the University of Chester

Questionnaire

Thanks for agreeing to complete this questionnaire, it shouldn't take you more than about five minutes.

I'm currently studying for an MA in Counselling Studies at the University of Chester and am carrying out research for my dissertation into what counsellors experience when working with clients who express suicidal ideas and/or intent.

The purpose of this questionnaire is to gather some general information from you about your training, experience, current work environment, the number of clients you're working with and how many have recently expressed suicidal thoughts.

No identifying information about you or your organisation will be included in the research or any subsequent publications. Any record of what you tell me is confidential, will be used only for the purposes of this research and will be kept securely, accessible only to me, my supervisor, Dr. Andrew Reeves of the University of Chester and its examiners. The University requires that all written records be kept for five years and a final copy of the dissertation will be kept in the library.

At the end of the questionnaire I'll ask you if you'd be willing to participate in a short audio-recorded interview. If you agree then I may get back in touch with you in a few weeks to arrange this. You are, of course, free to drop out at any time up until I submit my work for marking, in which case I'll destroy any record of your contribution.

Thank you once again, not only for helping me in my studies but also for contributing to what I hope will prove a valuable piece of research into this important area of our work.

Mike Whitfield
The sections for you to fill in are all coloured grey. For Yes/No type answers, just click the box to choose the answer you want. If you make a mistake, just click the box again to un-check it and click the one you want.

The longer boxes are for you to add text, just click in the box and type your response; the box will expand to fit what you type.

Please indicate your gender:

Female □
Male □
Other □

*Please describe if you wish:

Please indicate your age:

18 – 24 □
25 – 34 □
35 – 44 □
45 – 54 □
55 – 64 □
65 – 74 □
75 + □
Prefer not to say □

How would you describe your ethnic/cultural background?
(Leave blank if you prefer)

Please continue on next page...
Exploring Counsellors’ Experiences of Working with Suicidal Clients, with Particular Focus on the Issue of Responsibility

Do you have a Diploma in Counselling?

Yes ☐

No ☐

If not, do you hold a professional qualification in therapy?

Yes ☐

No ☐

*If yes, please indicate what it is:*

What would you describe as your main therapeutic approach?

*Please tick one only:*

Psychodynamic ☐

Cognitive-Behavioural ☐

Person Centred ☐

Other Humanistic (e.g. Gestalt, T.A.) ☐

Existential ☐

Integrative ☐

Don’t know ☐

Other ☐

*Please indicate:*

Page 3 of 6

Please continue on next page...
Exploring Counsellors' Experiences of Working with Suicidal Clients, with Particular Focus on the Issue of Responsibility

How long since qualifying have you been working as a counsellor?

- Less than 3 years  □
- 3 - 5 years  □
- 6 - 8 years  □
- 9 – 10 years  □
- 11 – 15 years  □
- 16 – 20 years  □
- Longer than 20 years  □

Do you currently receive specific ongoing supervision for your counselling work?

- Yes  □
- No  □

Do you work to any recognised therapeutic Code of Ethics and Practice?

- Yes  □
- No  □

*If yes, please give details of which organisation:*

Please describe the client group with which you predominantly work:

Page 4 of 6

*Please continue on next page...*
Exploring Counsellors’ Experiences of Working with Suicidal Clients, with Particular Focus on the Issue of Responsibility

In which environments are you currently working as a counsellor?

Please tick all that apply:

- Local Authority
- NHS Trust/ Local Health Board
- Increasing Access to Psychological Therapies (IAPT)
- Employee Assistance Programme
- Voluntary Agency
- Private Practice

How many clients are you currently working with in Counselling?

Of the clients you are currently working with, how many would you describe as ‘suicidal’, or have recently expressed suicidal thoughts?

Do you include any reference to ‘suicide’ or ‘self-harm’ in your therapeutic contracts, i.e. with regard to confidentiality?

Yes □
No □
At this stage, is there anything else you would like to add about yourself as a counsellor and your work with suicidal clients?

Would you be willing to participate in an individual, audio recorded interview to discuss your experiences of working with suicidal clients in more detail?

Yes ☐

No ☐

If so, please complete your details below:

Name:
Email:
Phone:
Address:

Thank you once again for filling in this questionnaire.

To return via email, in MS Word, choose ‘Send To’ from the ‘File’ menu and copy and paste my address below into the ‘To’ field. Or just save the file once completed and attach to an email as you would normally.

If you have any problems with this method then please email me and I’ll send you a hard copy to fill in along with a stamped addressed envelope.

Thanks again,

Mike
Appendix V: Interview Guide

Counsellors’ Experiences of Working with Suicidal Clients

Working environment/ Context

- Working policies/ procedures re: suicidal clients
- Employer expectations?
- Do you assess as well as counsel? Differences between assessment and first counselling session – will look at contracting next
- Referral processes - assessment criteria for therapy
- Risk assessment – how? Forms, documents? How important is this?

Counselling agreements/ Contracts

- Processes of making agreements with client
- References to suicide, re: confidentiality
- Reasons for breaking confidentiality
Own views and beliefs

• Own personal views and beliefs about suicide
• Role of counselling with suicidal clients
• Impact of training in counselling with respect to own beliefs – was suicide dealt with as an issue in training?

When a client says they are suicidal…
(Thoughts and Feelings)

• Thoughts and feelings about the client for saying it?
• Thoughts and feelings about yourself as a counsellor?
• Appropriate responses?
• Awareness of own feelings then - and now
• Relate back to agency policies / procedures
• Relate back to own views about suicide
What do you do when a client says they are suicidal?

- Your thoughts / feelings about how you worked with situation
- Does anything remain ‘unsaid’ to client?
- Use of supervision - how easy / difficult - response of supervisor

The Issue of Responsibility

- In your counselling practice as a whole, how much responsibility do you feel you take for your clients, as opposed to how much you feel they should take for themselves?
- How does this change when a client says they are suicidal?
- How much responsibility do you feel you should take for a suicidal client? Why? How effective do you feel this is in your work with them?
- What would happen if you did take more responsibility?
Anything else you wish to discuss?

- Comparing self to other counsellors - what is your guess about what they would say?
- Outstanding issues from this interview?

Thanks!
Transcript copy? Member checks?
Appendix VI: Introduction to Interview

MA Counselling Studies
Semi-structured Interview

Introduction

To be read to all interview participants

The purpose of this interview is to talk in more detail about your experiences of working with clients; specifically those who you have suggested in the questionnaire are suicidal.

In the questionnaire you stated that ______ of the clients you are currently working with are suicidal. Is this still correct?

You also said that you are in ongoing supervision, is that still the case?

The research I am doing is for an MA degree in Counselling Studies. I am looking at what the counsellor experiences, including their thoughts and feelings, when a client says that they are suicidal. I am hoping to learn more about the impact on counsellors of their clients talking about suicide. There is little research in this area and it is likely that most counsellors will experience this situation at sometime in their professional work. In the interview I hope to look at what you mean by
‘suicidal’, your own beliefs about suicide, any policies or procedures you work to with respect to suicide and how you feel when a client says that they want to die.

My research is being supervised by Dr Andrew Reeves from the University of Chester. I will be interviewing between four and eight people in total and will be covering the same topic areas. As a way of analysing the information it will be important for me to make a detailed, accurate record of this interview. To do this my intention is to make an audio recording.

Your identity and that of your organisation will remain absolutely confidential and information obtained will only be used for the purposes of this research and any subsequent publications based upon it.

I will make a written transcript of the audio recording and that transcript will not be associated with your name or organisation. In addition to myself, staff and examiners of the Department of Social and Communication studies may read material from this transcript for the purposes of assessment and moderation, all of whom are bound by the British Association of Counselling and Psychotherapy’s Ethical Framework with regard to confidentiality.
The University requires that all written records be kept for five years and that a final copy of the dissertation be kept in the library but audio recordings will be destroyed upon completion of the research. All records will be held securely.

You may choose to withdraw at any time up until the work is submitted for marking, in which case any records made of your contribution will be destroyed.

Are you happy with these arrangements?

The interview will last approximately one hour.

Do you have any questions before we start?

BEGIN RECORDING
“This is an interview for a research dissertation as part of an MA in Counselling studies at the University of Chester, between Mike Whitfield and ____________, taking place at ______________.

The date is ________ and the time is _____.

Your identity and that of your organisation will remain absolutely confidential and information obtained will only be used for the purposes of this research and any subsequent publications based upon it.

I will make a written transcript of the audio recording and that transcript will not be associated with your name or organisation. In addition to myself, staff and examiners of the Department of Social and Communication studies may read material from this transcript for the purposes of assessment and moderation, all of whom are bound by the British Association of Counselling and Psychotherapy’s Ethical Framework with regard to confidentiality.

The University requires that all written records be kept for five years and that a final copy of the dissertation be kept in the library but audio recordings will be destroyed upon completion.
of the research. All records will be held securely.

You may choose to withdraw at any time up until the work is submitted for marking, in which case any records made of your contribution will be destroyed.

Are you happy with these arrangements?”
Appendix VII: Audio Recording Consent Form

Audio Recording Consent Form

Exploring Counsellors' Experiences of Working with Suicidal Clients, with Particular Focus on the Issue of Responsibility

Research for the degree of Master of Arts in Counselling Studies at the University of Chester

I, ________________________, hereby give consent for the details of a written transcript, based on an audio recorded interview with me, to be used as preparation and part of a research dissertation for the MA in Counselling Studies at the University of Chester and any subsequent publications based upon it.

I understand that, without my further consent, the transcript material used in the dissertation, and possibly the full transcript, will be read by the student conducting the research and also Department of Social and Communication Studies staff and examiners for the purposes of assessment and moderation. I understand that all of the above are bound by the British Association for Counselling and Psychotherapy's Ethical Framework with regard to confidentiality. I understand the Department of Social and Communication Studies staff who are responsible for receipt, transmission and storage of dissertations are also bound by the BACP Ethical Framework with regard to confidentiality and agree to respect my right to confidentiality in their handling and storage of transcript material, and that no further use will be made of this material by them without my further consent and that of the student submitting the dissertation.

I understand that any record made of my contribution is confidential, will be used only for the purposes of this research and any subsequent publications based upon it and will be kept securely. I understand that no identifying information about me or my organisation will be included in the research or any subsequent publications. I understand that the University requires that all written records be kept for five years and that a final copy of the dissertation will be kept in the library but that audio recordings will be destroyed upon completion of the research. I further understand that I may choose to withdraw at any time up until the work is submitted for marking, in which case any records made of my contribution will be destroyed.

Interviewer:

Name: ________________________
(Please print)
Signed: ________________________
Date: ________________________

Interviewee:

Name: ________________________
(Please print)
Signed: ________________________
Date: ________________________
# Appendix VIII: Units of Meaning

<table>
<thead>
<tr>
<th>Point</th>
<th>Participant</th>
<th>Page, Line</th>
<th>Theme</th>
</tr>
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<tbody>
<tr>
<td>P</td>
<td></td>
<td>1, 8-14</td>
<td>Perceived vulnerability of young people</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td>1, 24-29</td>
<td>Perceived vulnerability of young people</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td>2, 4-5</td>
<td>Perceived vulnerability of young people</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td>2, 31-35</td>
<td>Specific written contract</td>
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<tr>
<td>P</td>
<td></td>
<td>3, 5-11</td>
<td>Organisational safeguarding policy</td>
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<td>P</td>
<td></td>
<td>3, 36-50</td>
<td>Conflicting policy demands</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td>4, 16-21</td>
<td>Holding the situation—breaching according to contract</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td>4, 27-33</td>
<td>Justifying working to BACP guidelines instead of organisational policy</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td>4, 37-41</td>
<td>Holding the situation—breaching according to contract</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td>5, 9-13</td>
<td>Holding the situation—breaching according to contract</td>
</tr>
</tbody>
</table>
Referral - no prior information

1 8, 3-16

Assessment, dialog and continues, clients 0-10 rating

1 8, 23-48

Referral - no prior information

1 10, 5-25

Verbal contracting in crisis situation, paperwork inappropriate

1 10, 46 - 11, 14
P: It’s a client who has presented in a session, even, or so, in the beginning of the session... they knew that they’d mentioned... they knew and I know that that was coming up, so it’s much easier to use the formal contract.

M: Oh

P: and, so, yeah, I take the time to outline... I draw the boundaries are about self-harm.

M: Yeah... and I think it helps, whatever it happens, it always... kind of brings it up when really it’s a serious... can get... there is a danger that it can get quite compliant with going through the boundaries of confidentiality.

P: The boyfriend that’s run off with their best friend and they’re not up with him, so we can’t hear about the content and, and to deny anything. So when somebody else says... what do you mean by... what do you mean you said...? "Their other, your, you know, I think, it’s always good to hear that, and I think it’s good for me to practice that confidentiality. It’s so important.

M: So yeah, it feels... I think that can impact on whether they feel comfortable working with you once you’ve stated those boundaries.

P: Mm

M: ...there’s a possibility of it going somehow else, I may not be able to work with you.

P: That’s right.

M: ...may not be able to work with you.

P: That’s right.

M: Erm, it’s very hard, erm... because, and I guess... I guess I’ve worked with a lot of different ways, because often they don’t want to disclose what’s happened. First of all, there’s two things really, I mean, first of all, I always worry that it’s not about self-harm, so they often times they have intent to suicide, suicide, harm to self, it can be about self-harm.

M: Yeah

P: and, so you know, we always work with... we work with a lot of students who self-harm.

M: Sure, so it’s important you’re able to make that distinction.

P: That’s right... that’s right, I think when a student is at risk of suicide or have very anxious about who may be informed, erm... sometimes we do a hypothetical scenario.

M: Mm

P: I’ll tell about a student who... well, let me give you an example of a situation and what might happen... and sometimes we cannot create more anxiety in this way, but still they may make that decision not to come back.

M: Mm

P: I’ll tell about a student who... well, let me give you an example of a situation and what might happen... and sometimes we cannot create more anxiety in this way, but still they may make that decision not to come back.

M: Mm

P: I’ll tell about a student... well, let me give you an example of a situation and what might happen... and sometimes we cannot create more anxiety in this way, but still they may make that decision not to come back.

M: Yeah

P: It can be hard because you are faced with a student who I know is carrying on holding something that is...
Perceived vulnerability of young people wanting to do more

1 15, 20 - 16, 10

Format contracting

1 16, 25 - 17, 23

M: Yeah
P: Obviously sort of quite distressing and quite difficult...
M: Yeah
P: Um... but it's tempting to sort of focus on how hard
M: So, it feels as though that could be difficult for you personally, or you can feel that the student has three issues then would seem with the difficulty they're having because that's less confusing for the boundaries you have to work with.
P: Mm
M: ...and they're going away again
P: Mm, that's hard
M: So if they were an adult making that informed decision... is... yeah, they may still be as vulnerable, but there's something about being an adult. It's easier, that being able to trust that they're able to make that decision...
M: Mm
P: ...and having more of a support network to deal with that...
M: Yeah
P: Because a lot of our young people come from very dysfunctional backgrounds, erm... where they haven't got a good support network...
M: Yeah
P: ... and that, that then is a hard thing to know that they're going to these... back out into their world...
M: That does feel especially hard then.
P: Yeah
M: Doesn't it? I can see what you mean...
M: ...carrying something that is quite heavy
M: Someone considering ending their life... is gone. kind of pull at you anymore...
P: Yeah
M: ...but when they're young and vulnerable, etc... that sounds like the move you feel you want, you are wanting...
P: Yeah
M: ...to do more maybe but not being able to...
P: Yeah... yeah

P: So... um... I take the student's information first... and then before
M: Yeah
P: talk to them about the boundaries of confidentiality and... because it's a very sensitive bit of our work, the exception to that would be confidentiality...
M: Yeah
P: ...I will be saying to them, suicidal thoughts or concerns or that intent to
M: Yeah
P: ...but I suppose all the time before that stage or at that stage there is
sometimes I've said it and they've just burst out crying...

M: Yeah
P: I think... because I think it really connects with where they're at. So it's quite a concise bit and then it's something that I do at the beginning
M: Yeah, so that kind of introduces... 
P: ... that introduces a point...
M: ... so you don't necessarily have to introduce...
P: Yeah
M: the subject straight...
P: No
M: the process is doing it
P: No, it's when I'm doing it, I'm just using similar wording as I guess that introduces it at that point

P: ... where things have been very difficult and quite dark for me. I've never reached that point where I felt suicidal myself.
M: Right
P: I mean, I say, I don't feel judgmental to somebody who does but I think it makes... I think I do struggle... struggle even not to sympathise... because I do empathise... but it... it's getting the connection... that full connection with something you've never reached that point
M: so it's something you've never felt yourself
P: something I've never felt myself, that's right

M: But at the same time, because it's something you've never felt or never considered
P: Yeah
M: it's perhaps harder for you to... to empathise exactly with where they're at.
P: Yeah
M: Because it's something that's alien to you?
P: Yeah, you think, that's more it

P: I think if I experience any difficulty I guess I may cry out... I guess it's... it's some of a battlefront... I don't really connect with what's going on hence. So I think when I'm working with somebody who is feeling suicidal or feels that, it's more that feeling of how can I help this person, how can I do enough...

M: and that's actually the next... the next subject area is really what you feel is the role of counselling therefore when somebody is perhaps having suicidal thoughts, do you feel counselling can do in that case. If you're perhaps feeling better as a counsellor, what do you feel counselling can do for them?
P: I think, I think the important thing is... to offer them... that space where they can express their thoughts.
M: Nm
P: "cause often... my experience has been that they haven't told anybody else and I think part by expressing them within that confidential space, within that safe space,
M: Nm
P: "cause... it seems to be... all my experience is it's a huge relief, and I think if I'm able to be... to offer that relationship that accompaniment, that will work with that, that doesn't panic around that...
M: Nm
82

1 20, 29-36

Worried about it being over the road, having to do more.

1 20, 40-50

Have I done enough? Trusting the client, difficulty of

1 21, 12-16

Perceived vulnerability of young people. Wanting to do more. What if? anxiety

1 21, 24-26

What if? anxiety

1 21, 43-45

Consequences of client suicide: professional and emotional

1 21, 49-22, 11

Trusting the client, difficulty of

1 22, 21-24

Hard to empathise with suicidal feelings if you've never had them

1 23, 4-6

Hard to empathise with suicidal feelings if you've never had them

1 23, 15-21

Post qualification training in suicide. Vague memories of training
The Swain: Anxiety-driven exploration of extent.

1 24, 13-21

Initial panic anxiety

1 24, 29-32

Anxiety-driven exploration of extent

Feeling some responsibility for the suicidal client

1 24, 29-25, 5

Putting the brakes on?

1 25, 9-17

Anxiety-driven exploration of extent

The grey area

1 25, 39-40

1 25, 39-26, 21
there is something about that kind of life... something about the finality

P: Yeah... and it's almost like, there's one chance...
M: That's right

P: Um and once they've done it, that's it. whereas they could always have the suicide prevention programs, even like this, I could be managed while they're in it possibly, em., but when they're dead they're dead.
M: Oh, that's right.
P: (laughs) it's done... actually, when you say it like that...
M: It does when you say it, once they're dead...

P: (laughs)... what do I feel about this client... If I'd be dead honest now... (sighs) I think... (laughs) it's awful isn't it, when you, usually that's what you think... I mean, I think there are times where I think I wish I hadn't said that...
M: Yeah
P: Is that awful to say that? Is it too honest?
M: So what makes you think that, what makes you feel...
P: I think for me that captures the kind of... the difficulty, not the difficulty... the pressure that I feel under-cause it's changed...

M: Once it's cut off, once they've said... and I'm experiencing suicide thoughts or just right now, that's you, that's almost like... oh, geez, I wish I hadn't done that...
M: So it's cut now...
P: It's cut there now... and it's cut and we have to work with it and we have to work with it, and I have to ensure your safety in a sense...
M: So it almost feels like they've kind of put it on you in some way, it's like now you've said that you're kind of... now you've been left with it in some way...
P: It feels like it feels like a huge responsibility...
M: Right.

P: ...I think it has a very responsible position that I find in anybody... working with young people, it's afraid that some things been disclosed, then it's as the auth... write into a different level.

P: ...I think sometimes... those policies and that contract that we've set up... case file are... and thank goodness it's in there...

M: So, are you saying that to some ways, it's important because it makes... it makes it seem as if that's... I believe that's the clear what I have to do.... and it's almost like, I don't... to make the judgement there, you've... some contract that that... would be... to consider with that, whereas it's a grey area, the responsibility two... I'm going to make the decision, which is about generally alone, somebody like, as we said, and that then feels like that's more reasonable...

P: No.

M: ...where it isn't actually clear. As I know the judgement down to you...

P: Yes, and that... I think even when student is expressing the intent, it can still be a hard call, it can still be quite difficult to have that confidentiality that's one particular student who hugged me and... and people at me not to inform anybody else and I had to go against that...

P: ...so that's all if that client is being told that... and I suppose that it may be different, as often they have shared that looking for your hugs and they're quite aware that other people are going to be involved or even going to give you that support... it's a different attitude is that sort of... it doesn't... it doesn't want you to...

M: So even when they've signed the contract...

P: That's right, that's right...

M: ...and that says will... they don't want you...

P: Yes...

M: ...and you have to... anyway...

P: ...and that look incredibly hard... and I can see at least two students that I've worked with so it doesn't happen... even where I had to go against the wishes and that was very difficult...

M: Mean... emotionally... So at head level, up here, you know, I won't and where your brain is that kind of sounds very... if you express sudden thoughts, that you've attempted suicide or you have that intent for yourself... I will have to do this... I think at a head level it's very... at an emotional level, I think it's just hard...

P: I think, personally, I feel I was... kind of betraying them in some way, taking him down. I was going against something... and I guess this is... being that if it's portrayed situation was very complex...

M: Yeah... and it's interesting, you're almost, when you describe that it already feels as though there are two different levels of things going on there's the sort of... this written contract against where, knowing very clearly, you know, I made this clear to you, you've agreed to it, you tell me this. I do that... where's the problem? But it almost feels as though an emotional level it's as though there's agreement... there's an emotional contract which actually has different boundaries...

P: Oh definitely.

M: ...almost as though, in actuality, I shouldn't be doing this...

P: I think emotionally... you know, it shouldn't have, but it does, and I think emotionally, because of that relationship, because of that... I mean, I think, in that sense, I think I have problems with this situation.
The Swan.
Value of offering space to speak about suicidal thoughts.

1 32, 49
33, 2

The Swan.
Value of offering space to speak about suicidal thoughts.

1 33, 20-27

The Swan.
Value of offering space to speak about suicidal thoughts.
‘Putting the brakes on’

1 33, 31-44

Congruent concern: ‘Putting up the safety nets’.

1 34, 1-9

Sharing or passing on the burden of responsibility.

1 35, 19-27

Sharing or passing on the burden of responsibility.
‘Have I done enough?’

1 35, 37-43

Sharing or passing on the burden of responsibility.
‘Have I done enough?’

1 36, 4-17

Importance of good relationships with superiors.
P: And sometimes I can get that from the EAP because I... I feel like I have worked together for a long time and I know that if I say to her I don't know anything more but I'm not steering you down here, I don't want anyone else involved from that her with that. She can check me but I feel like she's not enough to know that she will trust my judgment.

M: So the boundary of the relationship between you is important there.

P: Yeah.

P: And... my supervisor is very... I guess she offers me what I hope the one who I’m... I guess what happens there is she wants me to... very steady, explains fully the situation and implies anything that she feels I can’t have done you with or you can’t have put in place that she will do this. But suppose what she gives me is that safe space... means to explain that really.

P: Not fully emotionally acknowledged, you know, um... I think that probably part of the anxiety is that feeling of “oh no!” you know that kind of feeling of um... it’s that that can’t be there.

M: Is that kind of when they first express those feelings, that kind of “oh no?”

P: Yeah.

M: Sort of...

P: Oh no, we’ve got this!

M: Yeah.

P: Oh no, I wish they’d not said that.

M: Yes.

P: I’m that, it’s that, and I guess that’s part of the anxiety or what are they going to be working with here?

P: There’s a kind of probability, you know, I can never have feeling I guess that clear and I don’t know exactly what’s going on right now, I mean that being clear and everything or knowing about what we mean by that, you know, I can say there’s a lot like this and sometimes it’s hard to put in, you know, comprehensible or balanced. Oh no, I wish they did not say that.

M: Yeah.

P: I don’t know, what am I going to deal with? and slowly with measures of where they are, or what that means to them what supports they have, that can continue.

P: It’s interesting, as you were talking there, it’s interesting, the difference in decision making, the way everyone who’s saying that they’ve been in a domestic violence situation, it’s not that same powerful sense really, of somebody saying “this feeling suicidal”.

M: No.

P: I’ve thought about taking my own life, it has a very different kind of feel.

P: So I guess, um... yeah, I guess it’s because of the prominent age of the clients that I work with, I think I take more responsibility than I would with another clients. um... with adults.

M: You feel that you do too, a degree of responsibility and more than you would if they were adults.

P: I don’t know whether I take on is the same as that. I guess I feel that responsibility.

M: That’s an interesting...
and possibly I take that responsibility as well... even though I work harder in the counselling relationship because of the age of the clients, isn’t used to perhaps on placement or with adults.

So there’s something about being able to sit back more if I’m with an adult student than with somebody who is a younger student depending on the case... but I think that responsibility does.

So you feel more responsibility; you take more responsibility in the sense that you feel you are having to work harder.

Yeah.

And actually sort of do more.

Yeah, I do.

... with that particular client group and when that, when one of those clients says they’re suicidal, how does that then change?

Yeah, yeah, definitely. Use the anger. Er, yeah, I think the responsibility can be a bit higher.

So you then feel much more...

Yeah.

... and you feel it and take it.

... and feel it and take it, definitely.

Yeah, I think it’s necessary, even... and it’s felt to be important and I do feel, well, what’s effective, I guess. Even, if I feel what a client feels is... if they’re or if they’re feeling suicidal, would feel as though you’ve failed. I don’t know, I guess.

If I think that, because the organisation puts such a weighting on the safeguarding of the students and, so it would be hard to kind of view that as... that was that client’s responsibility and they should be allowed to decide for themselves whether they live or...

... I think that feels right, it’s very hard to know if that was... about you, you know, a number of people have said to me: ‘the counselling service has never had a suicide, and that feels a pressure in itself. It’s almost like...

Right.

... we have to maintain something here.

Yeah.

We’ve never had a suicide in this college, not of a client who’s being counselling; we have had a suicide in college ...

Yeah, you mentioned that.

... not of a client ...

So it feels like what’s being communicated by the organisation is basically suicide would be a failure of the service and if you are a...

Absolutely.

... and I think to some extent if something like that happened, there would be a lot of questions asked, so then, rather than I guess, let’s also... don’t know whether that’s some understanding and support for us as counsellors. (Doesn’t mean what it means?) I would be. It would presume more of our failing, or why has this happened rather than a supportive atmosphere of well, if that was the student’s choice, these things happen, better the student can choose.

Perceived vulnerability of young people: Feeding some responsibility for the suicidal client.

1 39, 46

Perceived vulnerability of young people: Feeding some responsibility for the suicidal client.

1 40, 14-

30

Client suicide as a professional failure.

1 41, 14-

17

Client suicide as a professional failure.

1 41, 26-

42, 5

Client suicide as a professional failure. Consequences of client suicide: professional and emotional.

1 42, 20-

27
I think, and you picked up on it, it’s not surprising I think, but I think it does make us realize how much I do feel that responsibility, and something about the vulnerability of the students that I work with, even that 18-19, 16-19 bracket, where they don’t have a lot of support...

M: So...

P: ...so therefore I think I feel as though I carry more than if I was working with younger adults...

P: ...Mr... and yet, you know, yeah, so is it difficult, or is it easier to manage that responsibility when it’s an adult? Is it easier to deal and kind of... you know, do you know what I’m saying? Do you have that pressure and weight where it’s somewhat older...

M: So is it in some ways, well they’re in an adult, they can deal with it better in some ways...

P: Yes, yes...

M: ...or do I... am I being parental towards them in some ways...

P: That’s right, I think that... they’re in some ways, but also because they’re older and more established they might have more people around them who might support them when might...

M: So if they’re older and more established they might have more people around them who might support them when might...

P: ...rather than...

M: So not just the role and developmental stage, they’re in in psychological terms but actually on in which they have more one of an established social network, family friends and therefore more support...

P: Right...

P: Most... my experience is that most people when they are struggling with... emotional psychological issues and difficulties in their lives will be thinking about what it is to be alive, what it is to be held... and I think that suicidal thoughts are quite a normal part of that experience... it’s just the nature of the nature and doesn’t necessarily mean they’re going to do anything with it, but I do think that I wish we weren’t able to access into... I wish I saw (self) and others on CORE term students and clients are recording themselves as at risk, even if they might not be, they are still having dialogue with themselves about wanting to be dead...

P: We use CORE to assess... when they come for the first session, so just before their first session, they fill in a CORE, even the counsellors here and myself and the other two colleagues and tomorrow are aware that there... but any process here would be that the student presents either verbally or with the CORE in any way describes suicidal ideation or want that they will be, that will be rigorously discussed with the client in terms of what they mean by that, whether they have intentions, they’ve made plans, and if they have, that we would be acting to or contact them to be held in a place where they don’t commit suicide while we actually engage in the therapeutic work with them, so what would be it would be, it would be for a duty of care really to disclose to the student that the student to disclose if they were actually intending... they do have any suicidal ideation...

P: Yeah, this is just the way that we work within our team, in terms of the university, I don’t think the university has any plans or awareness on... some, that’s aware of its own, in terms of what we should be doing, we work within the NICE guidelines framework, which doesn’t necessarily define that you have to break confidentiality, but what we do is we work very closely with the student, I have very many... do communications actually break confidentiality without consent, generally what happens is the student will disclose to the therapist that they’re thinking of it this way we’ll work with the student, and if they’re thinking, if they’re thinking about how they think about it, and we work together to work on it, and talking about it, and talking about it...
Although I don't think generally contacting their GP makes a huge difference, I think the counselling is where that change will happen, but there's something about making sure that we've decided on a measure and that we've made sure that clients have got, that clients have got an actual support system they can rely on, and you were saying before about CORE. If we don't use CORE as our risk assessment tool, we say it's because our risk assessment in the situation with the student, or CORE can sometimes... with a CORE form, and so... a client will, a young person will, the risk questions are zero which means they're not at risk, and yet the other questions will be very high, and then that can sometimes suggest that they're actually just not declaring that on the CORE form...

So we do not use CORE as a risk assessment tool but if it is on CORE then we'll make sure that we address it. So what we use as risk assessment is dialogue... or the CORE refers the dialogue...

Absolutely. It's a dialogue tool yeah, because I've worked with CORE for a long time, and I used to be in the teaching committee for CORE, from very early on in the university. I assessed people and I've always been one that didn't use CORE as a risk assessment tool, because if you often people will not tick the risk questions or they wouldn't declare them on so that we don't see a whole load of things that the whole form is telling you, and I've been a mum. I'm not really I'm not really sure that all of those questions we've asked about how distressed you are, you've got uncontrolled thoughts and feelings at the time, and yet you're also saying that you're not at any thought of suicide. And sometimes they'll say, well I just can't wait to tick them on the form...

Yeah. I think... I guess it did occur... individually we might have concerns about people's right to choose and make decisions about their own lives, and about that path death as well, but I think when you're working in a context... isn't working as a role therapist and you're working in an organisation, you need to be mindful of the organisational context as well, and in terms of the... the client's well-being at the centre... but also we need to be mindful of... checking that we've done everything that we need to do by ourselves as well. I guess, in terms of that, what we believe, in terms of our own, etc., etc., yeah, and kind of come up with our own beliefs as well.

My life feels miserable and... and it's really difficult because whilst I empathise with that, I also want... love his family, and at the same time going on with the whole thing is that... want... you don't manage and whole and with... whilst he perhaps looks at other options to see whether his life could be better and different... so...

So it's accouting for trying to sort of actually keep it in some way like you said, contained...

Yeah, and managed...

While you're working with him, yeah...

...and to see if we can find a way to keep him in a place where he can be with his family and... and not just them and we're not saying... but it's... you know... we're there and there's always the risk that things could be better and different... and... kind of managing and helping whilst he looks at other options and... you know, we're actually working with this person before three years ago when he was in his very... very similar place and he was able to get a good quality of life for a few years...

Holding the client, exploring options.
... Do it is really a very lovely place to be in a room with a person who you're working with. Because you care about our clients.

M: Yeah.

P: And I think it's a really really a very lovely place to be in a room with a person you're working with. Because you care about our clients.

M: Yeah.

P: Yeah, I don't strictly believe what we know, when we enter a student like a GP, I don't believe that necessarily makes any difference to them, I think it makes a difference to us in terms of legislation and our personal role, it makes a difference to the relationship in that they don't feel so alone.

M: And I think that in some way, that's the only person who's holding or helping or being with that person in their distress, and even if we end or just refer them to the GP and we feel that somebody else is there, maybe they're almost like a witness for us, just to accompany us.

P: Yes, I think that you don't feel so isolated with it and that there is another agency that is checking up on seeing that person.

M: We do a registration form which has just got basic generic information about them, their date of birth and all that, you know, what course they're on and we also ask them if they... that's the other thing that that we have done, and in the last three years on the back of a suicidal event that did not have a GP and refused to go and see the GP, we changed our procedure here so that we ask all students if they would like to see a GP, and we give them the number of our GP and suggest that they give them the number of the GP and decide for themselves what they want to do and we let them know that if we feel that they are at risk of suicide then we will be contacting their GP or that of all students if they will contact their GP or we will be contacting the GP on their behalf, so they're fully aware of the first session that has been done.

P: Yes, yeah we talk about risk and we talk about risk of suicide and all that, we ask them to just go to see if I've got one here, I haven't, it's in another office, and I can certainly show you one, you can have a copy, and we talk about the exceptions to that and the exceptions, we talk about the facts that they go and it states what the exceptions would be, which would be suicidal intent, it would be severe, it's in another office, and I can certainly show you one, you can have a copy, and we talk about the exceptions to that and the exceptions, we talk about the facts that they go and it states what the exceptions would be, which would be suicidal intent, it would be severe, it's in another office, and I can certainly show you one, you can have a copy, and we talk about the exceptions to that and the exceptions,
P. They do, and when we talk about clients, it makes clients feel like they really matter. The student that if they talk about suicidal intent and you’re telling them that you’re going to work on something, they have a choice about whether they tell you, or not, and I guess it is, you’re giving them the autonomy to decide whether... amen, whether they want to disclose it is given by the freedom to make that own decision on their own. What we’re saying so we’re not saying that clients cannot engage in suicidal thinking or suicidal behavior, when we’re saying it if we know they are then will need to work with that.

M. Yeah.

P. I think that is good, that is something that people do when they are at their most despairing, and that I understand why people would want to be alone, I think I understand, no, I think my own suicidal thoughts in my own life...

M. Amen.

P. And at times where things have been very difficult and I’m interested in thought, and I think I understand... I don’t mean that clearly I’ve never acted on it. No, I mean, it’s tied in with a sort of... like, you know, an argument with a young one, which can turn things around. I’m aware that there are times when things are not okay, like, the times where things are really tough, I think that people should be enabled to be safe and during that period, my personal feeling is during that period, because actually there are so many... even when you are working with suicidal clients, for many they do come through that. In most of the cases, it doesn’t exist as it is... and that’s been embedded in many sessions with clients, I’ve worked with in the past, where they’ve said ‘I’m so pleased I’ve been able to say that think, my personal belief is as well as my professional belief is that people have a choice, absolutely have a choice about whether they live or die, but that something about... about making some sort of decision to make sure that it’s the right decision for them and for it not to be something that comes out of despair or because of a particularly difficult world.

M. I think it is... I think if we’re asking about whether it’s going to be another... or another compelling pressures.

M. Amen.

P. I think that something about... yeah and they may be very creative at the time and they are there just was no other option, but I think that once you’re kind of faced with the possibility of options and after they might be able to no, if they still believe that that is all of this, then you know, I think he would do well, do I have the right to decide for someone else, what they do? Quite often, myself, the student is working with at the moment... because he’s isolated and he is, so you know, he’s not put any family that he’s in touch with, even if he is alone, it’s not that he doesn’t have any family that he is, so you know, it’s not that he’s not seen, nor he is, it’s not that he’s not seen, but basically he doesn’t think that his death would matter to anybody... and so...

P. He thinks that he has no, he will not, and nobody will notice, and what I think is that when one is in so-called challenge that will actually somebody will notice, as well. I think that is the case, and I think it is the case in so-called challenge that will actually somebody will notice, as well. For example, I’ll notice, if that doesn’t seem to be quite so, and you notice, all, I’ll notice something about what this will feel very sad about that and also, even though he’s not in touch with his family at the moment, he’s family are going to notice, so something about helping people to be accountable as well.

M. So, so you feel part of your role in working with... with suicidal clients is to avoid minimizing some of those feelings and... and, are leading them in that direction?

P. Yeah, and in order to be congruent with my own way, because I do think that they are in a relationship, they might be in a relationship with other people but they’re chosen to come to a relationship with one, and there’s something about, you know, this feeling, the feeling about that relationship, you know, and I think I used this to my started the other week, you know, I’m really hearing that you feel isolated and that you feel that nobody would notice, and what I need to say is that, that’s what I would notice, you don’t have to have this week I would notice and if you don’t have this week I would notice... and you’re not there and I heard that you’ve done this, then it would feel something, I would feel bad.

M. Amen.

P. And I feel that’s... the only worked with you for so many weeks, now my guess is that people who know you, who’ve been on the course with you, and people who are are still trying to get in touch with you will feel that too... because of something about not seeing you, not writing, that’s saying... actually...
Challenging with the ripple effect

12, 47 - 13, 6

Challenging with the ripple effect

13, 29 - 31

Challenging with the ripple effect

13, 35 - 47

Challenging with the ripple effect

14, 10 - 19

Challenging with the ripple effect

15, 1 - 16

Practical risk management

15, 20 - 36
M: Oh, erm., was suicide dealt with as an issue in your own training?

P: Yeah, we did have, erm., we did have a session on Andrew Rees in our, on our course. I think it was, 2014, postgraduate at Chester, yeah, it’s a long time ago, I’ve never seen it covered.

M: Right.

P: Yeah. Well, I think the emotional impact of the suicide will be much more pressing than the intellect. I think there will have been many times in your work where you’ve felt like this is something incredibly distressing and in your own professional life and in your own life, it’s the longer term, it’s the aftereffects of it that I think are more pressing. I think it’s much more pressing for the families and the friends and the people who are left behind.

M: Do you feel like that’s maybe made it more important for you to perhaps be more proactive in the way you manage it?

P: Yeah, to be more proactive and just to give people space and the opportunity to talk. I think the other thing that’s really important, if you’re going to be proactive, you must risk your own space to those thoughts.

P: Because they aren’t ready to go into the pit with those thoughts. They need to be able to move on from those and to come out on the other side. I think that’s crucial. If they just walk around the edge of the pit and aren’t ready to go off, it’s not going to help them.

P: No, not at all. I mean, I think I just realized we were saying that it was talking so much about how you manage the risk. I think it’s really important about the therapeutic side of it, not just the risk management side. To support the work, then, to go into those feelings, is about 6 hours, perhaps... the risk management, but it’s not the whole process.

M: Vague memories of training.

Impact of own experience of suicide and of working with clients.

Impact of own experience of suicide and of working with clients.

Value of offering space to speak about suicidal thoughts.

Value of offering space to speak about suicidal thoughts.

Value of offering space to speak about suicidal thoughts.

Value of offering space to speak about suicidal thoughts.
This is going to be hard work...

Empathic response...

Empathic response...

Empathic response...

The Swan
P. But the risk management brings in this little machine that starts flashing black, it's all bit like this clock, ticking all the time, as soon as you notice.

M. Yeah

P. Yeah, it means you lot of empathy and that the rules and what I need and accept and would do now...

M. Yeah

P. So, there's this I think it's a skill that you develop or that I feel that I've developed over the years that I've worked as a counsellor, which is, I'm probably about ten years old, I'm not sure how long it is... it's a skill I've developed which is like, the way you talk, your tone, your way of speaking, it's coming back into empathy but also knowing that you need to pay attention to that ticking at some point in the session.

P. Yeah, yeah. I mean, I think it's a skill that you develop. I think that it would be useful, it would be important to pass on to students, it seems like a skill to make an appointment, sometimes things go wrong in the room and it's their own appointment, sometimes they've got a wait, can you move the appointment for me? And sometimes, I'll write in the GP's office, if it's not, I'll write in the GP's office, if it's not, I'll write to the GP. I think it would be useful for you if you write to your GP to give them an outline of what we've talked about today and they may say yes, and I write a brief comments on it and I'll then make sure that I've booked it up the information on the sheet when they go to the GP, the student has come and talked about feeling and worried about their health.

P. Yeah, and also, if they come and they're sad, and they're feeling bad, they feel bad, the feelings, and if they really feel that they are actually at risk that they actually might do something about it, they might want to talk about it, they might want to talk about it, they want to talk about the things that are worrying them, and the things that they want to talk about.

P. Yeah, and I think that's why, when I said before, they have the sense that they are worried about what they say and they talk about it, but then they feel quite safe because they actually want to talk about it, they want to talk about it, they want to talk about it.

P. Yeah, I really care about them in the moment. I care about them when I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it, I'm doing it.
I think the other thing that he says is that sometimes when clients have talked about suicide and how they might commit suicide, he does have a way of going into an imaginary fantasy about if he were to do something like that and imagine that he actually did it. I think that’s a very strong image of that in his head.

Yeah. I see what you mean.

And I kind of noticed that image and I’ve sort of thought, you know, that I’ve imagined a phone call where I’ve heard that someone’s killed themselves, and, in fact, I don’t think too long really, I mean something will come up and then I’ll notice it and I’ll acknowledge it and then I’ll say, you know, that’s quite a natural response to that.

Yeah, I guess it doesn’t dominate my life.

Yeah, absolutely. My supervisor’s brilliant and she was very good as well with noticing and, I am too, so I was talking about a client in supervision. I was feeling some, I suddenly felt quite upset about a client, and I can suddenly went and gave him some space, and then I felt quite unsettled. I thought, I can’t just do this, I’ll have to do something. I don’t know what the answer is. I just have this image of what I think something might be, and I’m really scared, you know, I don’t want that to happen, and yet also I know that it’s their kind of choice, so I’ll talk about the emotional impact, and if that happens in supervision, it’s really good, what they do to stop the supervision session and let me, you know, go with whatever it is, and what I’m feeling, and then look into that, you know, I think that happened, you know, a few times with clients, and I think that is where the difficulty lies for me, and I think probably for many therapists, is the fear of the fear of a client, killing themselves.

So where’s that fear from? Where’s that fear of?

Yeah, I see.

Yeah, that’s, you know, I’m trying to work on it, and I’ve been working for something, and they were talking about wanting to be dead and wanting to commit suicide and feeling a choice that actually even, this is the course I would make, I might feel different, but I think it might, but generally speaking, all the clients I’ve worked with have actually not been wanting to be dead, they’re just been in distress.

Yeah.

Yeah, that’s the bit that I think makes it hard. The fear that you might have not enabled them to want to go through that, or to find a place where they can be free of that activity, which I don’t...

Yeah.

I’m not sure that that’s the answer to... just and trying and doing that might, you know, just taking that into consideration.

Yeah, yeah.

And getting them through that somehow.

Yeah. Yeah, I don’t think that's enough to enable them, then there to have that space because...
Client autonomy. Being a responsible professional.

Client autonomy. Being a responsible professional.

I've got to work harder. The Swan.

Initial panic anxiety. Life and death, finally.

Feeling some responsibility for the suicidal client

Consequences of client suicide.

Professional and emotional.

98
P: ... and she said I can’t work with you if you’re dead... And it’s a really odd point, sounds like it’s being the breathing obvious but actually there’s something else you know we can only speak with our clients if they’re time to leave with them, and so it feels like my role is a connector to some form of thinking with them... Am I right... they need to stop also to do that, but also as a human being... it’s quite frightening to think that somebody might take your hand and see that...

M: Horrified

P: So is this the potential consequences seem to raise the stakes...

M: Yeah, and the notion of that in terms of anything they’ve shared with you about their life, that you then know... as in their family, their friends...

P: ... and it’s that, the wider impact again...

M: Yeah

P: ... I had a bit come on the back of a dinner and I think it mentioned to you, he didn’t give me the DCP because he refused to have a DCP, he said there’s no point having a DCP so every time he spoke to a DCP, he said they had no value in the... it was a man in his 50s and he said they’ve never seen nothing to help him so far, if anything they’ve just medicated him...

M: So it was in a position as a contributor where I didn’t really have a fallback... I didn’t have the time to go to... didn’t have a doctor... I just find... musical stuff... where you can get someone on the phone and be hit by a train, which is quite a common way...

P: Yeah

M: ... and actually was what he said was, because I couldn’t talk to him and... because I couldn’t come to him, I thought about the people I’ve worked with that just made them... I just find empathy... well there’s nothing (I can do)... I just stick to the assistance that I made and he said to me, for the first time he had some five years and he had leads of psychosis, leads of psychosis, it was the first time that actually been able to... and that was...

M: ... and that’s until because you had nowhere else to go with it but to work with what was...

P: Yes

M: ... and that’s until because you had nowhere else to go with it but to work with what was...

P: He said that it was the first time he went into it without being persuaded through drugs or through treatment, and he then said that he was able to go into it, because it’s come out of itself... and he said it was the first time he actually felt that he didn’t want to die... because he went into exploring what that was about...

M: Which goes back to what you were saying before about the importance of being able to do that...

P: Yes... And for the actually intrusion that you was... not to... dominate or change... the hierarchy...

M: Yeah...

P: ... and empathy...

M: ... it’s the importance of actually having that therapeutic process there... whatever else you feel... you have to do... either for you or the organisation...

P: ... that’s still in my mind and that’s still part of how I work with suicidal clients because he taught me that whilst it is important to have that ultimately, it is important to have that, but also that it is important to have that, but also that there’s a role as a connector and you’re still interacting with the client in a making sense of the meaning behind the desire to die...

P: ... I don’t know, I mean... I’m very much a very cogent, honest, real person, I want... I don’t even... I wonder whether people want to say how they feel about things... sometimes... I think it’s the whole... the other people who are just sometimes wonder whether other people care so much as open about how vulnerable they feel... sometimes... I don’t know how said they feel...
P: Yeah, and I've not yet had a suicide and I have the sense that one day I may, and that's why my reflection is that I've worked far too hard, and part of me feels really damaged about that, and I happen to be in a role where I don't want to have a client commit suicide.

M: It's almost like a wall... you've got to kind of keep that 100% record, that sounds a flippancy way of putting it but...

P: But you know, you know, just... I guess it's about not wanting something to slip...

M: So do you actually have any sort of, does the college give you training in that case, under those safeguarding rules any guidance on how you know, how you then to deal with issues around suicide...

P: They don't give the counselling leave any guidance

M: They would have noticed there for... very generic but not specific around suicide, it would come under child protection issues or something like.

P: Yeah, so if they knew that then where you had all as a counselling service kind of, you're dealing with this issue or boundaries are on that and how to work with them...

M: Yeah, I would begin, I would begin this professional boundaries, BACP and their professional guidelines and working within that, so some of this that can be in conflict with what a college policy might say around confidentiality...

P: Yeah

M: But, professionally I suppose I'm fortunate in this organisation that they regard that autonomy and they professionals about that...

M: Yeah, so I would, what you're looking at, the professional capacity is also to an extent allowed to be able to work within your professional...

P: Yeah

M: and professional boundaries determined by your professional organisation...

P: Yeah... anyway, although saying that, I would I was there, obviously if somebody was and I'd had that assessment that they were suicidal, I would be putting things in place or putting referral in place so there's no policy saying I have to do that but it would be taking that within the organisation...

P: And that type of referral would come from her, if she's discussed it with the patient's risk, if somebody's disclosed. The assessment role... erm, I suppose for a number of years, I suppose I have started this particular role, you know, over the years, obviously I've not opened up for this type of interview, so I'm quite, erm, I'm quite familiar with the idea of what mental health issues are, but I don't use those, though I'm aware of them. So my professional assessment isn't a paper exercise, it's to me, it's more based on my experience and where I've worked with clients, my experience of how I've assessed someone's risk, depending on what I'm feeling and what's going on for them and looking at that referral system, I must not, I wouldn't say I would, use the word assess to a formal way to other people, but I've assessed you and you're not at risk or you are...

M: Ah
P: ...but I would make a professional judgment: does this person need mental health care and the majority of the time it would be you. I'd expect more than to go to the GP to be formally assessed... if that makes sense?

P: I'm rat. no. I'm not using any paper-based system and I'm quite pleased that I don't have to do that.

P: Well, my assessment wouldn't done the same thing. They came in. I was asking about the nature of the event and what course they're doing and things that might flag up, so I think it's harmless. It's going to be a serious warning signal. Do you even have a pattern of abuse? You know, there's a certain level of risk that's there when they first come, and form that's a lot of questions but even just about their life at school, how things are going, you know. If somebody is and started at school how did they get on at school. If they're feeling nervous about how they are then, and I'm building up a picture of before they've actually started.

P: Yeah, but... I would do it and then they have a written one that I'll go through as well. So, I think if... I think you've recognized it they understand it, but it's not out, you know, who, and... what's the assessment service is really important but the majority of the time it would be you. I'd expect you would need to go on as before and I would justify the reason of suicide. I might have to hear that and then I would explain who might be involved.

M: So for you actually mean the specific?

P: I mean the mentioning yes, if they're suicidal or intent or get the intention of suicide. I might. I would have to hear that and then I would explain who might be involved.

P: So I might say... for self harm as well. You know, if you're suicidal or don't. Cause you know. You get a lot of young people are suicidal...

M: Yeah

P: ...and I actually explicitly mention that if I wouldn't have to hear.

M: Right, so it's actually the wording it's important, yeah... or

P: We used to have it as suicidal but I think we put the intent in to deliberate.

M: Well, so that's more a sort of a... perhaps a more... wouldn't necessarily poor behaviour or thinking of it, but it's more a serious... you know, a plan or something like that.

P: Well, I think that was following a discussion with the other counselors. That's what we came and wanted to do. Because we work with a lot of people who say that they're suicidal and they are actually... they're actually just having a bad day. (laughs) may be that's I'm saying? So... it's what words we use talk.

M: Yeah

P: I sometimes just probably had suicidal but in agreement with the other counselors we decided to go with suicidal intent. That they intend to do something.

M: So it... so that's quite specific then.

P: I would think. If somebody's planning an intending was feeling quite different than somebody just thinking it right and things using that term you know.
Rational / irrational suicide

7, 47 - 8, 4

Normality of suicidal ideation

8, 13 - 23

Value of offering space to speak about suicidal thoughts

8, 34 - 9, 14

Formal contracting, Not avoiding the term, Being specific

9, 18 - 21

Value of offering space to speak about suicidal thoughts

9, 25 - 34
P So in that sense... I know that there's something about the idea that it's somebody else's... So I think what I can have been behind... and then... I don't know, until the work would be... and you never really... because you can talk to a lot of people.

M So you're kind of quite aware of the effects that this person's death may have on the other people around them?

P Yeah, yeah... and yeah, I've had, I mean, a client but we have... you know... clients... students who have been there at an early age...

M Yeah

P ...if you know what I mean, that ripple effect that's gone through the school, the college, the family, you know. It's... it's... it's... it's... it's... it's transformative when it can happen.

M So you can look at it as an issue that it's not only about this client, there is a much wider effect that that suicide could have?

P I mean, wouldn't that be the client, you know, but...

P Yeah, and then the idea is that the family that this sort of thing happens to, it was quite young at the time, but I guess you know, that probably had some impact on how I see if and how I deal with suicide

M You've seen the effects that it can have on other people...

P Yeah

M ...it feels like that... that... that sort of effect... how you might sort of... a person expressing those...?

P No, I don't, because I don't particularly have that and I certainly wouldn't deny it but I couldn't sort of say that it's not around; when I'm with that person that's suicide, that's not where I am, but...

P I think for me, think... the number of people I work with who are suicidal and the number that I think I'm very, think with those that are very, that's probably does come in...

M It does...

M... because I think that I could happen, you know what I mean?

M It does...

P That eventually they might meet that decision and I suppose it's just being aware that that's going to have a massive ripple effect... it would have an effect on me if one of my clients killed themselves...

P It is a way it's one, it's a matter of time till that could happen and it will happen... you know, and how that would affect me, that would have a massive effect on me... but that's not... but I don't think it would be... that I was working with them, you know. In allowing them to be where they are... I think sometimes I can feel slightly different when you're working with somebody who's very young who's suicidal...

M Right, in what way, what would be different about it?

P I think usually in the sense, they're, they're very confused or they don't understand or their resilience and the background to that and put the right measures in and they can turn it around and... I don't know, the impact would be as big as if it was somebody that's older... I don't know; just something that I haven't felt quite... I suppose it feels quite... they're developing... so they are and it's sort of... how you... of who they were to make that decision... does that make sense?

M So I guess it's kind of an... paraphrase, you perhaps feel that they're... at a stage in their life where they're not as able to make the safe and a rational decision around whether or not their life might... have they actually get that capacity to do that?

P Possibility, cause sometimes they could be like that one week and then the next they might be... you know. It's... if you know what I mean? It can be quite transient as well, you know and I... I know when I've worked with young people who have attempted it, you know, the... how difficult...

M Right...

P ...and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and sometimes just... and 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Vague memories of training

3 12, 35 - 13, 2

Value of training in recognising we can't know how others feel. The grey area: client autonomy. Holding the client, exploring options.

3 13, 17, 37

Hard to empathise with suicidal feelings if you've never had them:

3 13, 48, 14, 7

Empathic response:

3 14, 12-16

3 14, 20-31
I'm not tired by it and if anything, doing something new to become more in touch with how it does impact on me and try to get more sensitised to it.

I think that when I was training that was there, I think it's a feeling of the loss of my own sense of identity, but sometimes my work feels a very heavy. I can almost feel that concentration being coming back when I'm not feeling everything, or, I don't want to feel everything. I don't want to be overwhelmed by what I'm being exposed to.

Yeah, yeah.

It's almost like a therapist, with experience and time about therapeutic trauma and the looking after me. It's a bit of the other way, not being fully in touch with how things affect me internally. I feel going through all the things and being able to be more transparent to show learning to the bit more explicitly and not just everything, I think it was a therapist.

That's usually... I've been asked to be embraced and all that, so I usually have picked something up within what they've said.

Right, so has...

or how they've said it...

or not going to have a big "Oh!" and all that stuff for you?

No, it's unusual.

Right.

I think saying it never cleans itself (unusual)

Some do,..., I think there. I don't know, there is probably a couple of things that go on. I think what the client probably experiences is me being flippant about it, but very,..., we need to talk about this and understand it and look at it. I haven't used the words 'exposed' but look at what's going on, what that's about... but I think for me, I'm very sensitive.

Um...

and then that brings to get all my information that I might need if I have to take any action, and I think because I tend not to have the big phone calls because I have a lot of other things to do.

... that, you know, I'm aware that sometimes I can be probably less of the act that's going on about it (laughs) but very... I mean, counseling, you get into a bit of a different level, because I tend to put things in mind... there is a plan or an intention there. What services are they getting already, have they been to their GP, what they do to their GP?... and then I'm just sort of leading towards professional counseling, but there's still... really working with... you know what I mean, I'm working as a counselor. I'm aware of the college and I'm required to what I can do to get to work with them, because I can't work full time.

so I would be just looking at what resources I can link them up to or
got there in touch with, so they can get the help. If I have to, you know... I'm trying to, I mean, I was at the college, I was at another college, you know, I went to have to get to cognitive... and there's people there who have a few things with... you know, you know and that creates a different role for a counselor, that's as hard to be part of that process.

Yeah, yeah... I think that sort of comes up, not on every case, cases are very different isn't it, but I think it's trying to reflect on my practice and how it's affected the impact. It's very heavy, I'm very aware of what's efficient in the sense of looking at what needs to be put in place, then I can even if it is to still work with them... I'm like, I feel, the majority of the time, I don't have this immediate reaction because I know that case, they've seen it, and, I'm not going to be ok.

But you know, there are clients I've worked with... maybe I might only be dealing with them in a year when I'm working, I'm seriously worried about them because of what they're presenting with, cause the... for me a lot of it, mental health, what's going on is they need treatment and attention very quickly. That looks very different when I'm working with an adult because I felt relieved that this person is a high risk and if they're not getting the services they need or they're...
out in courses and you know, they're struggling, I need to know if they came in the next day, so normally I would chase the plans up the next day but if someone was in, it would go... I could want to know if they were in or if they left college or, usually, it would come under safeguarding, there's another team within college that would be alerted around that. That feels very different from somebody who just says they've just suicidal...

M: Right

P: It is the case that my experience is it's the case who are not saying it, they're actually being quite clear and open about who are not saying it, that could be high risk, and the ones that I'm probably most concerned, may not... but I am showing symptoms.

M: Yeah

P: They might not say I'm suicidal but they might say I found myself or I had a... give up on life and I'm wanting and I want to lose...

M: Yeah

P: Or I know what I'm saying, that feels very different...

M: A more sort of impulsive kind of thing possibly...

P: Yeah, yeah.

P: Yeah, I'm not saying, I consider myself to be quite strong, but it's a two-part. I feel out of time and I'm not, that there's happening in their lives and another part is, I'm really pleased that they've told me.

M: Right

P: I'm really, I feel quitei nourished.

M: Yeah

P: That they've been able to name it. Even if they don't use the words suicide, whatever they've said, I feel really important that they are either finding me or they're finding someone and the fact that they've said it is like a massive sort of stepping of hopefully potential to get some help and to make some change.

M: Yeah, you know, I feel like... that they're trained enough to be able to handle it.

P: Yeah.

P: That's a good thing. That they've trained me to do that, still... I am think it's quite a... sort of sort of thing, you know, I think... I think I'm not aware of the situation in what I'm in, so I am that the situation is, you know, there's that step up of, I can offer therapeutic help and support.

M: Yeah

P: But often, they might be accessing someone somewhere, it's trying to negotiate who I am within that, what's going on with what's, is it the right thing for that person, sorry, I forget the question.

P: Yeah, some things I need to clarify and they might get, oh no, I'm not suicide now, I looked at the weekend and you know...

M: Yeah

P: You know, you're just moving on and it's not a... it's... it's not a problem and I might have to, I hope what they've said, I might choose to tell my line manager and just flag it for the safeguarding issue.

M: Yeah

P: Whichever somebody's coming in that I'm really worried about that could take a whole day to sort out.

P: I wouldn't put myself to it. There's just that I've assessed them in the sense of what I'm qualified to do, in my judgment, in professional judgement. Both of the conditions here, moved and the other one, you know, we don't want to get into that scenario...

M: It's good.
Covering the counsellor's organisation, getting support for the client, even if not effective

1. 20, 25, 32

2. 21, 14, 18

3. 21, 29, 41

Trusting the client, difficulty of. A kind of vicarious trauma

1. 22, 14, 19

2. 22, 28, 30

Not avoiding the term, being specific

1. 22, 14, 19

2. 22, 28, 30

3. 22, 42, 23, 18

Value of offering space to speak about suicidal thoughts. Feeling some responsibility for suicidal client

1. 22, 14, 19

2. 22, 28, 30

3. 22, 42, 23, 18
P: Yeah, yeah. I mean, I have good supervision and I have a great relationship with the other counsellors and we supervise each other. I've got a support manager, I've got everything, it's just it's like, we have to have the knowledge of the system, of what's going on and we have to know that it's going to be as deep as possible, the more knowledge you have, the more you'll know.

M: Yeah, I think.

P: And I don't feel that at the time, I'm glad you have shared it now. I think it's important to share it now. It's something that's really difficult to express and it's something that's really hard to talk about, but it's something that's really important to talk about. I think it's really important to talk about.

M: Yeah, I think.

P: I suppose I thought about the person that I'm talking to a lot. Usually, I think it's taking a lot of energy, to keep up with what's been going on in the organisation, who needs to be involved, what needs to be done, who needs to know.

M: Yes.

P: The only thing that's different now is that there's a different feel. I think I'm around to this thing where there's a different feel. I think there's a different feel. There's a different feel. I think there's a different feel.

M: Yeah.

P: Yeah, and I think it's important to assess, cause they might be seeing people in the community who are looking up to me.

M: Yes.

P: And I don't want to betray the people's trust. I want to make sure that the trust is not broken. And I want to make sure that the trust is not broken. And I want to make sure that the trust is not broken.

M: Yes.

P: Yeah, so you know, I know through experience, if a young person has been in hospital, and is linked up with a crisis intervention team, that there's a real need for crisis intervention teams, but they need to be there. They need to be there, and they need to be able to access services and if they don't, they are going to get support. I've not heard good stuff, and I don't give you confidence. In a sense, everything was in place that would give me confidence, but it wasn't, it doesn't happen.

M: Sometimes, sometimes, it's not a good GP and that's fine. When they've got good support, it's brilliant, but if they haven't, especially when they're using their networks or they're not using their networks, you know, and then they're not getting that through the GP or mental health services, yeah. So, I think it's really hard to do, but it goes with the system and that system is very carry.

P: Yes, I'm not going to disagree that sense of responsibility, I know you don't need to justify it and I don't want them to see me in that sense, I don't want to be put into that, but I don't know if reasonably, you know.

3 23, 22-27 24, 16-20 24, 24-35

3 24, 46-48 25, 15-33

3 25, 47 26, 6

3 24, 19-24 27, 13-18

Feeling some responsibility for the suicidal client

Other support involved can make the situation complex. Sharing or passing on the burden of responsibility

Other support involved can make the situation complex.

Other support involved can make the situation complex.

Other support involved can make the situation complex.

Value of offering space to speak about suicidal thoughts

Feeling some responsibility for the suicidal client

Feeling some responsibility for the suicidal client. Covering the counselling organisation, getting support for the client, even if not effective
...and you've got to carry that. Everything's coming on the same before Christmas, you might have told them about all those other stresses but I don't have confidence in all of them.

M: Sure.

P: One that I really have worried about, well... I wasn't at this college, I was nowhere else you know, I had to really be open about that and it was quite heart-wrenching stuff really...

P: it's about that, it feels like I'm abandoning that person.

M: Right.

P: over that period of time and she was very suicidal, she was very, very suicidal and as I... really pushed in counselling, I needed.

M: Yeah?

P: I understand I did, it doesn't feel like it, it can't really be in this because... you know, I'd have done anything to be able to save you, you can come to see me for Christmas.

M: You.

P: wouldn't be appropriate. I'm not professional, I didn't do it, but on a human level...

M: That's what you felt you wanted to...

P: this kid had nobody.

M: Yeah

P: I don't know, it's hard to measure that... even... at a human level I think to them, I've got my head round it that responsibility coming... On a human emotional level, I think with whether maybe a chance, below them are more like that, even... I don't know... I think that responsibility I have done, there's bits of stress when it's own overwhelming but as I say, it wasn't in this organisation, it was another organisation where I wasn't being pushed up, it wasn't supported, you know, there was a lot of other things in place that made that... weight heavier

M: I'm going to feel like I didn't want to do more than the boundaries of my role allow me to do.

P: I feel like I haven't done enough, but yeah

P: I'm not taking responsibility whether they go to live or die.

M: Right.

P: but I might have an impact on that... I don't know, I don't think that it's likely, I suppose my intentions are to live.

M: Right.

P: even rather than facilitating their death.

P: Working with young people, yes, definitely, even if I might understand why they don't want to live and why their life is so and... I can understand why they would want to do that and if they did it I would have that level of respect... but yeah, probably I would have that level that you know, things can be different, they also can't... they haven't got any life experiences to actually feel any up or changes... etc.
M: Yeah, I see you want to take more responsibility for... for young suicide clients.

P: Perfect, yeah... yeah... yeah.

M: Yeah.

P: And I know it has to be done if... if somebody did you know... with... with things like that.

M: Yeah, so it would be somebody who... yes, those who hadn't got a good relationship with their GP, they're my family ok, all, they're multiple trauma, you know, very complex cases but very vulnerable.

M: And the less other support out there...

P: The less other support, that's... but that's when I... I do feel that responsibility. Whether I there... have it... does it have an impact on me. Determine what I'm going to do, you know. I don't know, maybe it would... I don't know. I... oh... I think all the time, it's hard to employ it in this way.

P: ...you know what I mean? So I'm... doing a lot, it's, but I really need to look after myself. It might not always be immediate, you know, but I have lots of holidays, lots of breaks and lots of time and need to keep the balance in...

M: Sure.

P: ...if the balance wasn't... if don't think you could survive doing this.

M: No.

P: Type of work that sort of intensity really...

M: How effective do you feel that is for your work with them?

P: Now, how do I measure that effectiveness? You know, do they leave, do they do, you know, new appointments, how we don't measure it in that way.

M: Yeah.

P: There's a real challenge. So I don't say how effective. I think I think that what I would say, until him, that measure of responsibility in, I don't know whether it would be exactly the same. So I don't have any responsibility.

P: ...so it's effective? I've had no delays that have been identified here, in that way. Is it any intervention, right?

M: But it's difficult for you to say whether... feeling that greater degree of responsibility, is actually going to be effective in your work with the client.

P: Yeah... yeah.

M: Any more or less than normally.

P: I'd like to say it doesn't affect but realistically, I'm sure there's some effect in there. Ones that make sense, you know, that.

M: You'd like to feel that...

P: As a reflective practitioner, I'd like to say, it doesn't make any difference, but I'm aware realistically over having that sense is going to have an impact.

M: Sure.

P: I mean, I do think, there has been a couple of occasions where starting how... one was around... it protection, another was suicide where they didn't want me in the building.
M: Yeah
P: ... you know, and I don't remember all the detail but it was he said something within my professional capacity I couldn't do that... but that felt like a lot of weight on us...
M: Yeah...
P: But he felt by giving it to the client to manage risk - you know, and that was a very difficult scenario than the other examples that I've given...
M: You mean by... by taking it all on yourself?...
P: Not taking it all on but by honouring that they don't want that disclosure etc.

P: I don't think so... I don't think so. We go on to the next question I think.

M: Yeah
P: ... a bit more... at this moment but, when I start having clients... about that responsibility and doing it... but no... I think any of those sort of... questions or thoughts and feelings about the subject area...

M: If you ask me about conundrum to people that I know, in mental health issues, and I did a course recently, really with mental health, I think they've got their hands tied behind their back, you know, with abovement and what they can do and can't do.

P: No
M: I'm not saying that they're not doing what they should do, because I know that the constraints that are on them.

P: Yeah
M: ... so I think, you know, if I was to make a comment... I think it would be really... and sometimes working in GP practice... you know, I think their probably would answer the very differently...

P: ... really shifting out... this... it was hard just to get into gear and... so even though it worked with some quite suicidal people here, from taking... because that's when I started, I was aware of how much of my previous work was coming in and four back... now I didn't have the support and here that really, really had massive, completely different feel to it.

P: ... and they have different sorts of problems, the voluntary organisation is really... it's a form of self and others... is an exception so qualitatively and I always made sure that clients and I was outside of one of those that is... it seems there... but it can be a very great one,

M: Right
P: depending on why the role, the minute I say, for word of a better expression at the moment, how this client is feeling at that moment...

M: No
P: ... it's whether they just something that they bring out an... an offensive remark because they're feeling and usually pleased or tease...

M: Yeah
P: ... or annoyed or whatever in the situation

M: No

Feeling some responsibility for the suicidal client is taking responsibility effective?

Working context, the effects of...

Sharing or passing on the burden of responsibility

The grey area: Rational/irrational suicide. Not avoiding that term, being specific.
The grey area

4 3, 27-38

Working within own professional boundaries and ethical code

4 3, 45-4

Client suicide as a professional failure: organisational safeguarding policy

4 4, 13-16

Sharing or passing on the burden of responsibility

4 4, 32-40

Sharing or passing on the burden of responsibility

5 5, 11-18

Working within own professional boundaries and ethical code

4 5, 26-39
M: Yeah
P: Yeah and for almost me to see if they're suitable for what they want to
M: Yeah
P: come on counseling for. What further makes the unique is that with the volunteer organization I get an unlimited time with that client.

P: ...and erm... It's lying to remember sometimes which had I was... wearing... erm... again, I even I could always go to her although she want my supervisor I would always go back and look at her notes that would show about the pattern of the sessions to me.
M: Me
P: ...which were quite detailed. She took a... detailed notes of the family history.
M: Yeah
P: ...whereas most others than me I've been used to having little or nothing regarding that person, and in some ways I liked that, being a non judgemental counsellor. I like a lot of blank canvas and not having any... the way in which I might work with have limited the view of a better word by someone shows a perception of that person then I'm nothing to judge them on because they just come to me with no frame.

P: Me... and in between you know. I'll say things like erm... situation regarding the one from the Homelessness Agency, erm... the fact that she had able to share that she had attempted suicide before. I think some were quite new on her part. She didn't have to keep that information prior to assessing the person that she later came just as it is a session, so... it gets... in that... it don't tend to contrived so but it did make me feel a bit more... careful on the way that I worked with her, erm... especially as things developed as well. I think that was... if I find whatever possible to maintain that's empowerment but... I don't think she wanted it.

P: Yeah, in families, all these agencies, erm... had no contracts, for the... it was already set out which was useful, erm... boundaries were pretty much the same, some things were just operational for some organizations that they broke things but you knew, really was about everything we share is going to be confidential except if you receive harm to yourself, others, and yourself, just going to mention something about breaking the law as well, might need to know that further with other my supervisor or somebody else but I would talk to you about it before. So that so it is... is clearly and especially if someone brought it up within a session I would refer back to that as well so that before they continued anything.Anyway.

M: Me
P: I said that, just for you to be aware. Don't want you to stop sharing what you want to share but be aware that within our context, this is what said and... then.

P: ...and sometimes I've that it's tough to stretch these boundaries highly just because... you've got some notion that something isn't quite as it should be.
M: Yeah.

P: Yeah and I would say to you know I usually let my clients about ten minutes to go and then minutes and I'd done that with her and I said I would talk all the way to the end of our time but I'm like aware of when you're at risk herself.

M: Yeah.

P: And then I want to give you an extra quarter of an hour but we're going to have to finish at the end of that quarter of an hour because I get to be elsewhere and I guess I was giving that opportunity to further this session but putting some ending to it.

M: Yes. I can understand that. So, does the contact itself bring up the issue of suicide or do you raise that, do you have a way of raising that yourself?

P: Not necessarily no, just harm to yourself, others...

M: Yeah.

P: ...and just leave it at that. W... I don't like to emphasise anything in particular, you know because I might be something that I think doesn't need to be emphasised.

P: Yeah, yeah. I think that's true. No, we don't know. I can think of a reason I wouldn't want to mention it in general terms because, you know, do you... I have a hundred clients in a year it might only be one client in the year, so the question is who we should talk to if it's not even on their mind?... So no, I don't think it's as something specific and I wanted input on an exception to confidentiality...

P: And you know, it's a general catch-all, harm to self but you know, clients who kill themselves, for example, you can go into quite some detail, so I'm going to mention suicide, I'm going to mention self harm, I'm going to mention that generally as the role of the role of which clients may try to take their lives, self harm and we could say this same for drugs and alcohol to some extent.

P: And it is well and indeed not just us will come and work our way through the what they talk him with and it rarely looks him by and how and isn't... He don't think that it's... The shallower aren't very appropriate of his and he wants, you know, it was the thought process and... really isn't... during my time into a kind but...

M: Yeah.

P: And then thought. Um, that's interesting. As we went. You know, I said... He then refer you back to our original contact about them to yourself you know and you're looking at an possible suicidal tendencies. I'm just wondering how real that with you.

P: Em... I didn't change much but his way of looking at that did change...

M: So I would love his thoughts, having thought it and being able to discuss it had actually changed her perspective in some way?

P: Yeah, cause they weren't bothered about how he felt about it...

M: No.

P: So it's not going to change their attitude towards...

M: No.

P: And therefore you know, the consultation therefore that it was done to him to change his attitude about himself and the way he looked at it and experienced it...

P: Hmm... and I became a connector I don't know if I really... thought much about at suicide to....
P: ...now it is you know, as individuals in this room, you know, what we do or don’t do with our own bodies is entirely up to us.
M: Yeah
P: ...and although I am a counsellor and I am a human being might find that extremely difficult at times to understand any somebody might want to do that... even at the end of the day it’s still my life its theirs and I haven’t had any experience in life that they have...

P: ...and that might be more difficult to square the circle when you’re thinking about somebody, somebody young at the time, we opposed to somebody who’s a bit older...
M: Yeah
P: But, I think if we can do is educate people to some extent and try to find the solutions for them if they want those solutions but at the end of the day if we’re going to take away the autonomy and empowerment of getting on with your own life then they’re not going to do and it’s like they would have to do it themselves...
M: Yeah
P: ...that the number that have made some changes in their own private lives... regards relationships, and work related issues, and things like that that have had quite a profound effect upon them and therefore if you take some of that as they have found themselves previously throughout their lives, then... erm... we’re just perpetuating what’s already happening... and cause that’s what we’re training to regard suicide... by directing people what they should be doing about keeping alive...
M: Yeah
P: Whereby if all else is darkness around them and that’s all they see, they’ve got to look forward to...
M: Yeah

4 18, 39-47  Client autonomy. Hard to empathise with suicidal feelings if you’ve never had them

4 4 19, 1-3  Perceived vulnerability of young people

4 19, 19-23  Value of offering space to speak about suicide thoughts. Client autonomy.

4 19, 43- 20, 22  Value of offering space to speak about suicidal thoughts. Client autonomy.

4 21, 25-26  Being a responsible professional. Consequences of client suicide attempt professional and emotional.

4 22, 1-27  Value of offering space to speak about suicidal thoughts. Client autonomy.
M. Yeah
P. Yeah, cause that comes from my frame of reference and so from
there and there's always the temptation that you might want to do so...
M. Yeah
P. And not all but at the end of the day, you know, as you know, those things
that we say to lighten, those people up but in a covertly way, you know,
it's like being a professional - like professional you're not going to
ask a client, might be the only space in which they're able to be open
and honest with themselves to be able to explore these thoughts...
M. Yeah
P. Because other people don't want to know, it's too frightening for
them, or maybe they are not open and honest enough with other people
either.
M. No
P. Because they may be frightening them away...
M. Yeah, so that's what we can offer them in that case.
P. Yeah.

M. So was it covered specifically in training or did it just come out?
P. No, I think it comes out in the training as an exploration of...
M. Right
P. So you know, what we are, we're on the diploma now, certainly on the
diploma course now and that would you do? You're looking at this in Level
Five, you're coming to in Level Three but now you're at a stage now where
you're training to put it in serious practice and being out there with live clients
and so and therefore if you're going to do these then you need to explore
those sort of issues and you would do it, what would you do with it, how would you handle it?
P. Er, yeah, you know, black and white would say this is what you need to
do but in fact when you're just in the mix with the client, is it going to seem more grey than it should be?
M. Yeah... that's it...
P. And you know, there was some really good discussion and support.

P. Yes, it's the open moment isn't it? You know, you're calm and serene on
the outside and your demeanour showing up inside and... you know,
you're probably thinking in your head trying to think, oh, on a scale of
thought to ten, where might this be...
M. Yeah
P. The key moment, so let's work through the process with them
so where they think they are in this just setting that's come up, like my
client, they're off moment, well, I guess if he hasn't got a family, if he hadn't
get a good strong bond with the wife, he may have just actually driven into that
wall that day.
P: I think being aware that the last thing I want to do is for me. Oh my God! you know...

M: Yeah.

P: ...they're going to commit suicide (laughs) I have seen students give that reaction actually on what they've said. it's not...you know...it's not...and you know. I see myself as reasonably experienced now after nine years.

M: Yeah.

P: ...and that's a real fear. It's one of the cases and therefore I am not particularly to do with suicide trying to remain calm and trying to work through with the client just when they are going through this...

M: Yeah.

P: ...is it just a fear of the moment thing. It is something they're planning is it something they're contemplating. Is it something they've heard of other people doing and it's no...a way out of the situation...

M: Yeah.

P: Em... for my male client. I was quite... I felt that I was quite strong of him. He didn't have to say that he's contemplated that cause I can't see what...now that I would have changed my outcome unless he was thinking of following it through in a similar kind...

M: Same.

P: ...but he was quite open and as I said, you know, it was just a fleeting thought while I was at the thinking about before I drove home, and with the other one I guess, having someone who had a history of attempts suicide then em...and the way that he was thinking...he wasn’t turning out as he expected.

M: Yeah...

P: Em... what do you feel about yourself as a counsellor in those moments?

M: The same...

P: Abstinence. I would be too easy to be drawn into trying to rescue and save the client and I was absolutely having to do that...and I was also aware that that was so easy to get sucked into that...she I think I allowed that you’re looking for a knight in shining armour and he’s not coming and she acknowledged that that’s how she saw it...

M: Yeah.

P: ...and I think I even said “I hope you can...” I mean I saw the thought in shining armour saves you until I can’t...

M: Yeah.

P: ...which are...which...she sort of looked at me strangely initially.

M: Yeah.

P: ...and I sat, you know. This is not the kind of relationship that we’ve got. This is my relationship with you as a counsellor and you are a client and I’m not here to rescue you, you knew from the duration we’ve had...

P: Yeah, yes... and you know that being, getting drawn in and drawn and drawn from the client as they did have seen focus of how desperate the life...

M: Um.

P: ...and trying to remain that... professional distance between you and...
I try not consciously to... but I think... and take a deep breath. I always do that; it makes me think. I try to look at what they're doing, pick up the nuances, sense the body language. I mean: I sense the arm, the body, the face, the body language. I mean, I think it's very strange, seeing that person as a whole person anyway, rather than just the words they say, and the way they move.

M: Yeah.

P: ... to where they are.

M: Yeah.

P: ... and then where you're going to. You need to be put on the back burner, and later as soon as possible to experience, and...

M: Yeah.

P: But at this moment in time it's the least that needs my attention. You know, it's not a big deal, it is a... it is a big deal, you know. It's almost as if the magnitude of the issue is perhaps the thing that I think would detract you from being dealt with at the moment.

M: That's exactly it.

P: ... and therefore you're having to put off... I mean, I mean, I mean.

M: Yeah.

P: ... and therefore you're having to put things off.

M: Yes.

P: ... I'm sort of putting... keeping that to one side.

M: Yeah, that's exactly it.

P: ... and realising you know, I needed just... I needed to hold this and put it to the back of my mind and not think about it.

M: Yeah.

P: ... and just... really put it aside. Any... be aware that I don't mean something that could be quite quick at that moment, especially with the body... I think more so than the gentleman because of the previous history.

M: Sure.

P: ... because you know, the way... a dream for the way you were quite quick, and that... as I said, is it was quite quick that she was doing...
P: ... but just saying that I was having it and that it was an issue, that I also needed to make a decision so to what I was going to do with that information...

M: Mm.

P: ... and then I realized that our way of dealing with that was very straightforward. That within our sessions the client had the opportunity to work with me whatever they wanted, of course, or whatever you know; that stuff belongs to them it doesn't belong to me...

M: Yeah.

P: ... although I don't mean it literally. I say something to the extent that, you know, the session is a safe space and if they need to vent or if they need to talk about something then I'd be actively listening to what they're saying and I would respond to it...

M: Yeah.

P: Empathic in what they're sharing or regards thoughts, feelings and meanings regarding the issue but that was my way of hopefully giving it back to them rather than me keeping it from me...

P: Because otherwise how could I be empathic with the client if I'm keeping it in touch with them in that way. I'm not going to be able to react in any depth with them if I'm not going to be understanding if there's point of view you know.

M: Yeah.

P: ... so therefore I guess it's always... I always does trouble me that I know what something is that's bubble round in my head, there's something I need to write down and take to my supervisor and wonder why is it still sitting unspoken in my head...

... and at the end of the day when I'm out of the session maybe... I know I was talking about the session but I'd like to do it somehow...

M: Mm.

P: so as long as I feel that I've saved all you can do as a professional counsellor is facilitating when they're brought within that session, whether it's something to do with... whether it's to do with suicidal thoughts...

M: Mm.

P: and that's all I can do; even that means that after the session I have some phone calls or contact certain clients...

M: So how much responsibility do you take for suicidal clients? Or, is it still the same way though you may take it in the moment to the session...

P: Yeah...

M: ... and then you seek sort of then... dispose of whatever it is, whatever it is at the moment to the session...

P: I think that's also a good way of putting it. Yes, I think that's how I would... from time to time, you know, or another issue, I would be talking about it. If you're talking about issues, it seems like it's there, you're talking about it, localizing it, expressing it and... you know, you're much more as the client and feeling as well...

M: Right, ok. So it feels as though you might be taking on responsibility when they touch that issue as you would, there's the issue of the session and then there's the issue of the client, you're not working harder. You're working harder, you're then either you're... handing things back to the client or you're passing things on to other people...

P: Yeah.

M: you're dealing with things and then once you've done that, that burden is then gone from you and then responsibility isn't there...

P: It would be nice to think that, that happens 100% of the time...
What if? anxiety

4 36, 24-47

What if? anxiety

4 37, 26-29

Client autonomy. Hard to empathise with suicidal feelings if you've never had them

4 37, 33-39

Wanting to do more, is taking responsibility effective?

4 38, 1-11

Wanting to do more, is taking responsibility effective?

4 38, 41-39, 21
M: ... I feel perhaps, prevented that at the time and I think, you know, had the outcome but it didn't necessarily prevent if happening now to those women.

P: No.

M: Yeah, so even though you can still go that little extra.

P: Yeah.

M: It may not be for everyone. Yeah. That extra mile might not be far enough. Because with... I don't know why she did that and decided to give them to me but it was a huge sense of relief for me that she did.

P: ... try to keep in touch with what I'm seeing, what I'm feeling throughout this whole process and I just knew the fact that she did it what she did I guess that suited me was, you know, I never going to be long enough.

M: Right, yeah.

P: ... and that was my... I should find some other ways and means of doing what she wanted to do...

M: How do you think other counselors may have answered these questions?

P: And I would hope to learn more about that experience.

P: ... and I would expect them to... so on... to respond with similar candor about... like... one.

M: Right.

P: ... and some people might have taken it to the nth degree or method, then going to the office. You know, I don't know... um...

P: Yes, I'm interested in the idea of suicide and how does that affect me and... in my private work and... and... and... it's deal with it differently in my private work than I do in my workplace.

P: Em, yeah, um... I do... I do... we don't call them patients but we do call them guidelines. There's things I've written there and he's maybe slightly different around them. Then we make general... there's only one but... or private students coming in and working as well...

M: Yeah.

P: ... it's important they're clear about what to do. So yes, we do have some guidelines that we have set out on... and that is... I mean from my own point of view I would talk to my superiors. It was only sure that there was communication. Then, you know... maybe I should say, um, for the client to take them into lives... there's also, we have to... in the criteria where I... it's either based to the criteria for a case...

4  40, 3-11

Is taking responsibility effective?

What if anxiety?

4  40, 17-20

I've given honest responses, would others?

4  40, 29-30

I've given honest responses, would others?

4  40, 38-45

Working within own professional boundaries and ethical code

5  2, 1-3

Working context, the effects of.

5  2, 13-33

Conflicting policy demands
122

organizational safeguarding policy

Assessment, dialogic and continuous, clients 0-10 rating

Assessment, dialogic and continuous, clients 0-10 rating

Assessment, dialogic and continuous, clients 0-10 rating

Referral - no prior information

5 3, 9-15

5 3, 38-46

5 3, 50 - 4, 13

5 4, 15 - 27

5 4, 29 - 41

5 4, 47 - 5, 8
P...although I thought it was only because I would explain the decision and discuss it with them, I think I still think it's very useful in my guidance role. I would think of it as being part of that team. I would think of it as being what's on the minds of the people who come into the service...and I think it's a bit more...it's a bit more...coping...it's a bit more...there's a lot of stress in that...I think it's a lot of that is down to your judgment...!
M...whether it's the college or that you've set up yourselves...so then it feels like a lot of that is down to your judgment...!
P...it's really and I suppose it...it's based on that person...it's sort of that kind of thing...I have to come to a conclusion on that person...so then it feels to me that...where they are in their...!
M...Yeah
P...at that point...
M...Sure
P...and are we at that point...
M...at another level...so we...we need to have a safeguarding procedure and we have a safeguarding officer in the college...
M...Ok
P...and there is a protection of children policy, vulnerable adults and young people policy in place as well, so I was wanted to and that is...

P...it does and it doesn't...cause there are so many emotions in the policy that says the procedures in the college do it differently...or otherwise...
M...so you've got your own...there's sort of an evaluation...
P...and thought really hard for that...
M...Right, that is interesting...right...
P...I thought really hard, because originally the policy wasn't written like that and when it was being reviewed five years ago I thought and thought and eventually I went through to the governing board that we could see that in that the counselling service was the only place where we could talk about suicide and child protection issues and it not necessarily go to the safeguarding officer...

P...Well, essentially...I'm not sure because I think the BACP ethical code...
M...but...I'm not sure whether there's a misperception that I thought that there's a...an area where they've got to talk about...or otherwise...
P...I'm not sure whether...or otherwise...to make it viable and to be able to relate the policies like that, I wanted to have to do it...
M...No
P...and interestingly enough, when all of that was coming about...I contacted my professional indemnity insurance people...
M...Right
P...and asked them how they support me...well...I didn't disclose before the policy and changing them...!
M...Right
P...I knew what they support me...I knew that they supported me...and they said they would...they would support me...!

P...In defence of the employer I would say that once I've been able to sit down and explain the dilemma and the ethical issues that are around that type of staff...
M...Ok
P...they have actually been able to say...!

Working within own professional boundaries and ethical code

Working within own professional boundaries and ethical code

organisational safeguarding policy

Seeking policy demands

Working within own professional boundaries and ethical code

Working within own professional boundaries and ethical code

Justifying working to BACP guidelines instead of organisational policy

Working within own professional boundaries and ethical code

Working within own professional boundaries and ethical code

Justifying working to BACP guidelines instead of organisational policy
P ... so they do actually listen but it's because I mean I always ... It's quite hard working in an organisation like this because the main focus of the organisation is not ... it's sound education.

M Sure

P ... it's not about theory and in here ... hopefully they see it like this anyway, the management, that I'm here to help the process of education.

M Yeah

P ... I am ... the only person who understands my profession and I'm a very different professional.

M Me

P ... in this organisation ... there is apart from the fact we have the training we have in another building from where I ... although I do came the whole college, we do teach counselling here.

P ... but apart from that there is nobody here who actually understands the profession cause they're all teachers and administrators and managers and I'm a little on my own here.

M I guess that would make you quite isolated, particularly if they weren't prepared to back you, that could be quite a...

P ... is you ... and I do things to work with that I have a lot of friends who are counselors. I'm on a panel and they call it for mental service, a peer information service so I can send an email, you know, if I've got a dilemma or I'm not sure what to do with something I can send that email and it goes out to a huge group, a network of all college and university counselors and they can come back to me and give me ideas.

P ... I make quite clear in the contracting ... so they know there are these exceptions to the confidentiality issue, she is around even if they're feeling suicidal then I would need to tell him about that and that sort of thing, and I saw the next step is if I MAY want to discuss that with their GP or another medical professional just to get some more support on their side and I'd like them to read it to you ..., if...

P ... let me read it to you ..., it says that the counselors in the counseling and wellbeing service will not tell you in what you tell them to anyone else unless they have your written permission to do so or in exceptional circumstances as detailed below. In cases of imminent danger to yourself or other people, including suicide and serious self-harm...

Yeah, ok ... so it feels like it's still okay though that's a specific occupational role something that you've done on largely ... this and something that is generally imposed upon you and you've chosen to do...

P ... Yes, yes

M ... and it leaves it up to your judgement...

P ... Indeed

M ... it feels like

P ... I know...

M Yeah

P ... Which I do...

M Yeah?

P ... because it gives me that ability to work with the relationship I have with the client...

M Isn't

P ... and I think it has that element of true...

M Yeah
P: ...and he might make recommendations... and I was very lucky to have this boss, and I knew very well how it will be when we get a new person which we were appointed yet...
M: Umm
P: ...because he would... if I said... ok I listen to what you’ve said, I need to go and talk to my supervisor, so I took back and told a very basically, my supervisor says different to you then he would work with that, so I was given lot of my own space really to work it...

P: But this is... we always have in mind, you know, the autonomy, in those things of the client as well...

P: I’m not saying that I wouldn’t want to contact the GP or someone else... if a private client was... you know, suicidal... but... I believe that a human being has a right to take their own life if that’s really what they want...
M: Yeah
P: Umm... I know that puts me in the plant... but I believe that that gives the client... you know, the right to... the self governing and take that autonomy, which is so important to me...
P: ...and... and thinking back to my previous practice and I can... I can never really think that I’ve, you know, had someone that was planning to that point of going to do it, but there was... there were people in here who I’ve had allowed them to have that autonomy...
M: Yeah
P: ...and they have not committed suicide...
M: Umm
P: So... and I’ve given them a lot of support... and... but they haven’t gone and done it... so... I know that... you know, a human being has the right to take their own life if that’s what they want to do...

P: for all sorts of different reasons, but ultimately I just don’t know what it would be like. I’ve known there was a private client saying that well, I’m going to go home today...
M: Urm
P: ...and I’m going to do it, I’m not so sure that I would feel that, so...

M: Yeah. Oh, well we’ve got onto that little bit... I mean... we mentioned... I think it was about... I mean... what do you see of the role of counseling with clients who may be having suicide, what do you feel counselling can give them?

P: To allow them to start to make that decision if that’s what they need to do, if that’s what they want to do...
M: But if that means making the decision to die...?

P: You, I mean, it's difficult because I work in a college and this organization works quite unethically, quite rightly want me to stop them from happening...

P: ...and it's an awful thing to say but I know exactly the reason why it's because they don't want their name all over the front page...

M: Hmm.

P: But the local and national newspapers, you know, silent at college commits suicide...

M: Yeah.

P: ...even though they've been seeing the counsellor, you know, they don't want that...?

M: No.

P: ...and that's really hard line but it's true.

Client suicide as a professional failure

5 17, 22-37

Conflicting policy demands: Holding the situation - not breaching according to contrast. Client autonomy.

5 17, 45 - 18, 10

"Putting up the safety nets".

5 18, 34-41

Value of offering space to speak about suicide thoughts. Glad they've shared suicidal feelings.

5 19, 1-18
P: I know she would do as I know you there... I have got support around me actually. I do the same, it makes me realise that more often... well... but it's always given me that space to allow me to deal with the client.

M: I'm not saying that it's a recipe for success but my experience has been that it's always worked... So yes, you can do it... but in your case, I'm not sure if that's the going to be the case... I'm not sure if that's going to be the case for you. You know, here's going to be the case.

M: That's actually kind of saying 'Well, now you've met that...

P: I'm the door and I'm just going to... I'm just going to do something.

M: That's actually kind of yes, yeah, let's work with that.

P: That's what I'm saying. It's work to work with. I mean is a work with that's what I want.

P: That's probably a bit of a generalisation but... yes, there's that level then there becomes a discussion about what happens when you die and what's your latest system.

M: So you're getting into some quite deep stuff.

P: Very much, yes... and actually that then, I mean, I'm thinking back to how experiência and how clients where that's happens, the death of a relationship is ended, you know, and it's quite hard when they say goodbye then for me and then, cause you have shared at that level.

M: Talking about that sort of fundamentally deep stuff about the fundamental meaning and nature of life going on...

P: Yeah

M: That actually refers to death.

P: Me

M: Bond is a way... and I allow them to explore... that's right.

P: and I value that highly but I'm glad that I work integrative and I have other ways to... you know other things to throw in the pool... and think it's my personal mental training that's given me that... so you want that understanding of autonomy... I'm going back to that word again...

M: Yeah

P: so the client has the right to choose they wish.

P: Yeah, yes... and yes... and yes. I mean there was always difficulties of opinion but the ethos were good because they never said you must do this, you must do that and said we produce closed counselors...

M: Yeah

P: of themselves, they allowed us the space to explore how we feel in individuals about it... and to discuss it in an open forum with other students, yes... it was like a sort of learning stage of thing, you know, where you could discuss it and maybe go away and change some of your thoughts and your thinking processes about it but it helped me to formulate some of my ideas...

M: Yeah

P: The most important for me, I think it's that and for me...

C: 

Supervision as a safe space

Value of offering space to speak about suicide thoughts. Client suicide as a professional failure

Value of offering space to speak about suicide thoughts

Client autonomy. Value of training in recognising we can't know how others feel. Training facilitated exploration of issues without being directive.

Value of training in recognising we can't know how others feel. Training facilitated exploration of issues without being directive.
M: Ok. erm... I’m going to have an one on one. Actually that moment when... I told you a client disclosed that they are suicide... and what kind of things... and going through your mind, what do you think, what do you feel?
P: I suppose a sense of... erm... it’s a gut reaction. An initial sort of knee-jerk emotional response there is... Oh God, has Failed
M: You’ve failed?
P: I’ve failed, because they’ve not got better; not... erm... it sounds away from... they’re not cured but I have to take responsibility for that thought. So, it’s like... well hanging on to a straw, so that what I learned to...
M: Yeah
P: You know, so I have to do that bit of logic that bit out.

P: ... and then I suppose a sense of... I might have a sense of guilt, a sense of guilt, a sense of guilt... and... one of our... I do my supervision a while ago and my supervision qualifications and the idea of the roles used to say when you felt the panic rise up in your head... what the was sense of saying was back it down and just went and that sort of... and later back to your client.
M: No.
P: So I’m aware that I can sometimes go into. Uh, what’s going on, what am I going to have to do?
M: Right
P: So I suppose this is not going to tell client truth...
M: Yeah
P: I’m becoming very aware now, isn’t it. I need to be really, really careful what’s going on here. I really need to listen exactly where they’re going to... and I may at that point happen more direct rather than non-directive so I’ll start to ask a few questions, to elicit... the ideas of their client and where are we with it. If this is to understand... I am going to do something about this so it’s about putting all of that...

P: Yeah I would need next week from it.
M: Yes, we...
P: ..even very next week from it...
M: Right, she’s with us now. I need to... I guess the sense I’m getting from you, as I need to explore the extent of this...
P: Yeah
M: ...the serious is yes, what are they actually dealing with?
P: Yeah, yeah... so right... so when I say I am trying to talk about... I am not talking about... and whatever but I may become a bit more asking about it...
M: No.
P: what’s the time frame you came to that decision... that’s what’s the thought that you’re having about it...
M: No
P: ...and looking... have they got a plan, where are they in the process of the suicide... also...

P: How do you think you know, what do you know, where and what shall we do? Congruent concern, now what shall we do about this? Can... what do you think I should do about this? And that I would tell them now I was having...
M: Yeah

Initial panic anxiety. Client suicide as a professional failure.

Initial panic anxiety. The Swan’s Anxiety driven exploration of extent. I’ve got to work harder.

Not avoiding the term, being specific. Anxiety driven exploration of extent.

Congruent concern.
P: Yeah, really unpack it, so I do focus a lot on it. I would never run away from that.

P: ...It’s like a flip ... It’s a sudden thing of the... What I have to be

P: No, I really have to work hard at that... So it’s like... I don’t know how to... in a literal sense... I said it’s like I’m in a literal sense.

M: So you would use your own experience.

P: Yeah, absolutely.

P: You know, I may be feeling let down at the moment or I’m let you down or I... you know I’m sad that you feel like that, I’m sad that you’ve come to that point.

M: And then... how it might impact on me if you do go away and do this?

M: So...

P: Oh, I don’t know whether that... I don’t know whether that’s a bit manipulative.

M: That’s where I’m just getting to... It’s like... That’s all stemming... because... I’m going... I mean I will explore how it’s going to affect other people in their lives, so I’m sort of... I’m showing you that there are consequences to their actions even if they’re not alive anymore.

M: So...

P: ...and those consequences will ripple out to all parts of their lives, including... 

P: ...and me, and do they have anything to do with what you feel about it? And how do they feel about this? If it’s not a really substantial idea, you shouldn’t go for this because it will have an impact on my life, do you know that I could get like this, how that feels?

M: Yeah

P: ...I can tell that it’s more... you know, how would you feel knowing that this is how I feel if you did this?

P: Because it is a relationship. I have a relationship with this client and I... my interest is always to have an equal relationship.

M: So...

P: so ultimately, you know, I have a right to feel the way I do, if they have a right to feel the way they do, then I also have a right to feel the way I do about their actions.

M: Yeah, yeah.

P: ...and I need to be able to share that with them because... ultimately I see them, hopefully they’re getting through that satisfactorily, that will bring us the relationship back on, the level of trust is there, it’s green...
M: Yeah
P: ...and the depth is these and greater in the relationship...
M: Yeah
P: ...and the relationship's key isn't it?
M: Yeah
P: Now ultimately the relationship is key and I always have to remind myself that your hope in this case is that one point in the relationship... and the relationship will continue after that point...
M: Yeah
P: ...and it is... it's a way of them understanding that you're both in this together...
M: So let's perhaps go back to your feeling of the sort of your first feeling if you're sort of stuck is you know, the false narrative I wasn't... I mean have failed in some way if they're feeling that way...
M: Yeah, it's my own stuff that...
M: Yeah
P: ...that's what that is.
M: Yeah
P: I hate to tell...
M: Right, so it feels like it's a failure if they're feeling this bad...
P: Yeah, yeah

P: On my part, yeah, I've reflected about... among and have come to the legal... there's a minute now, there's not why you've been... and... and... you know... maybe this is part of the healing process... they need to go to that low to come back up...
M: Yeah
P: ...and I had the process of education to him...
M: His
P: ...you know, it was an honour... it really, we know that we use that term a lot but I really mean that, it was an absolute honour to work with him and know the strength of his truth...
P: It was amazing actually... but my gut feeling at the beginning of my last session was that sense of depth sadness, you know... am I answering the question?
M: Yeah, yeah... yeah... I was... I was so good, so for him...
M: Yeah
P: He was very sad.
M: N
P: ...and I felt that sadness.
M: Yeah
P: ...and em... I knew there to time I was... you know I was... you know... I felt my emotion wasn't, you know...
M: N
P: ...I might become... not saying I went openly... but you know I would...
M: N
...I'd feel that sense of the tears and, and yeah...

...and occasionally I have cried with this client.

Yeah

...the absolute devastation.

Well, I would... before the end of every session, whether a client's suicidal, always say 'how are you all right?' What have you got from this session, so I would probably home in a little bit more about, you know, how am you feeling right now? Do I want to do something, I'm checking out with this client, do I need to do something? How do you want me to react, what do you want me to do, what are we doing about making another appointment and if a suicidal client tells me what's happening now, where are you going now, what have you got on till the next appointment, do you want me to see me later in the week, etc... how are you going to cope with the weekend, the lonely evenings, you know where college isn't even...

...but I will make sure that they know that there is a lot of support around them. If I'm really concerned that there isn't a lot of support around them then I guess that claim tests start crying then.

Right, and in which case... who will you do them?

Well, I think at that point it would have to do something. It would have to go out of this door, I would have to say, look, I'm really concerned about you...

...I really think that I've listened to your plan, I know where you are with it, I'm really unsure that's where you are with it and I refer back to the contact, you know, the boundaries, I have to do something with this...

...and I wouldn't let them go, I would wait them to say until they got the received, I'm not saying I would have them sit in that chair but I might ask them to stay in student services or I might ask somebody to just be with them...

...set as we're received...

Yeah

Well, and so to the bottom of this, I'm for me, you know, it feel other other other, I might have to say... you know, I might have to do something about that.

Is there anything that would remain unpaid to the client, anything that would be going on for you that you wouldn't be congruent with?

I guess my sense of panic...

Yeah

...cause that would be there, course it would...

But you wouldn't want to show that to the client?

I'd have to think about it... I think I might do actually... That you might actually share...

Actually I'm really feeling uncomfortable about all of this...

That is how...

I'm really hard for me...

Yeah
P: ...for me too.
M: Hm.
P: Yes, I think I might as.
M: Hmm... Yeah, because, I mean, there's two people coming up for me and now, usually, you know, I have feelings too.

P: ...and they need to know that... and sometimes they can put... you know... that is an example of now that... they may put other people into places that that person feels uncomfortable with, so there's that learning for them... and... and the other... well, that's actually it, but I'm a human being too and I react which is the same thing actually.
M: Yeah.
P: ...I need to protect... and you need to know how I react to your actions.

P: So in a way then, isn't that... well, very...ility saying to the point that they... I still think there's hope for me yet... to carry on from this place onwards and to grow and develop and learn.

P: ...I've always felt more towards you and you know, as with that client, but I know what you mean the like, it's... the self-determination itself, like I'm saying this passing by someone: yeah, you can take your own life if you like, that's fine... but actually, really don't want you to.
M: Yeah.
P: Yeah, it's like a battle as opposed to... my own personal choice.
M: Can you perhaps explain that a little bit more?
P: ...if I read about somebody who commit suicide in the paper... I suppose I wouldn't know this person.
M: Yeah.
P: ...and so I could say that was their choice.
M: Hm.

P: ...but maybe as I grow up... and I see the term 'do it' very closely.
M: Hm.
P: ...and grow to understand them better.
M: Yeah.
P: Then maybe I become more self, I guess.
M: So you're saying it's because we've actually formed some... perhaps it shouldn't be a term attachment but... but you have a feeling towards this client... you have a relationship with them.
P: Yeah.
M: And it's almost... are you feeling selfish, will actually don't go because it's... it's the other me.
P: Yeah (laughs)
M: Don't do because I'm going to feel bad...

P: Yeah (laughs). Cause it's all the consequences from it (laughs).
M: I believe you've got the right to do that, but don't do that because I'm going to feel bad.
P ...and then, you know, particularly for those people that have just come from school and they've been used to being talked about and...

M Right

P ...and controlled, there's a fine line then I'm breaching, we're not talking about someone who's lost their own freedom and... I think...

M Yes

P ...and so, there's a sense of like, particularly if I know the client already, erm, you know, I might be sort of, well is this person actually fully responsible for themselves and what input do I, I'm making a judgment call all the time, with each and every one. I also deal with students with special needs...

P ...so for example, you know, I may have a client who, who's got a history of this or her learning disability may well be affecting memory loss, so you know, should I send them a test maybe an hour before that session starts...

M Yes

P ...to test their memory, you know, 'you see, I've got this [X] today or [Y] today, or [Z] today, and if a student were to do that, I go down the route of why? What would we, why do we need to do that is there any reason that we can get you to do that for yourself, because I don't really necessarily want to have to do the it's not, it's not going to happen...

P Right, Yeah. I think it's clear that this is a suicidal client with significant grief and... client and then, I have to give that responsibility over there in the organisation because my contract is clear about that...

M Yes

P ...and I'm clear where I am in my empowerment, you know...

P ...cause I'll already been in touch with her COP and well you know, I'm really concerned about this person, you patient area... and he arranged to see her the following day and then I went back and... she wasn't really confident about how the doctor had dealt with her, that's when I started up speaking to her... I think I'm actually talked about... I think I think I think...

M Right

P ...and what she did in again instead of jumping up and doing something I sat back and said... ok, what are you going to do about it...

M Right

P ...and that changed the context...

M Right. Cause my next question was actually going to be how effective do you feel it is to take that responsibility...

P It's not, that's... those are... now in that experience that wasn't...

M Yes

P ...and I know probably the reason that I responded like that is with that client was because of her youth...

M Yes

P ...and her vulnerability...

M So you felt more drawn to take that responsibility...

P Yes

M ...you didn't feel that she had the responsibility or was able to take it for herself and yet after the third sort of time.
Responsibility transfer: Trusting the client, difficulty of

Client autonomy: Consequences of client suicide: professional and emotional

Organisational safeguarding policy

5 46, 20 - 47, 7
5 48, 18 - 20
5 48, 39 - 49, 13
6 3, 22 - 31

P: I have to do it instead of moving forward in my chair.
M: Hmm.
P: I hardly remember thinking I was at this point again... and I'm going to be different.
M: Hmm.
P: I literally sat back in my chair and I did that once, back then arms in ... I've been doing that.
M: Hmm.
P: So I just literally just pushed it back on her but it... it took me a while to realise I needed to do that.
M: Yeah.
P: To get her back into taking responsibility... and I have since then, but actually, she's still she's still working with her, she's still doing what she's doing now and she's still working with her and she is change in the dynamics and in the relationship and she's much more well now, much more well and she's coming up to this end of her work.
M: So you're saying it feels like to you actually, actually, throwing that responsibility back on her... I'm almost getting the sense of actually REGRESSING her.

P: Yeah, yes.
M: And her autonomy.

P: Yes, yes.
M: You feel that actually that has actually worked in that sense?
P: Yeah, yeah.

M: No, it's quite interesting that... like that idea of not... being interested in the public debate, you, the client has the choice to take their own life no how, at a minute, there's that going to impact on me.

M: How do you think, sort of... your responses to this would compare to others that other counsellors... what do you think they might say, might have said? Should they have gone much the same or do you think they would have differed?

P: Well I guess, I guess if... it depends on their training, is what I'm going to say now.
M: Right.
P: Ehm...
M: Different therapeutic approach?

P: Yeah, possibly different and also that organisations that their work will make them work very differently. One of my close friends is a counsellor in a very different type of organisation and it's within the NHS and they're very more client and less flexible in their way that they work and that pressure is much more tight.

M: Hmm.
P: Because you know those procedures are probably not driven by counselling professionals but more general health professionals and they're based perhaps within that environment.

P: and the clients that I see, have already been screened and assessed as suitable for weariness.
M: Right.
P: And the policy preceding... sort of... Oh, that... if I were to think of being... I mean, think of being... I think of being... I would... I think of being responsible...
em uh uh uh um um if you were one of these clients what would you need to improve

M: I suppose what I do in practice is that I ask what is it? Make a risk assessment. I look at whether clients are presenting with suicidal thoughts, where there's no idea of it, it's just a kind of method of, a fantasy of escaping whatever difficulties they're in...

P: Yeah.

M: ...or else just check out whether there's any intention to act upon those thoughts and if that point if I think there is then I would either revert back to the mental health team or to the clients' GP, whoever is available.

P: And is that kind of way doing that on your judgement or is it that the policy makes that you do?

M: Yeah, being brutally honest, I don't know what the policy states, I think there is a policy to refer back to, whether the mental health team or the GP, even if what you're saying is that kind of, erm based on whether I think somebody is having suicidal thoughts or is or there is some intent to commit suicide, I don't know what. I don't know if there's a distinction going on.

M: I suppose what I'm wondering is, erm, you know, is it the case that the policy says you, know, if the client says this, you do this and therefore, you know, there's almost kind of out of your hands, you have to follow what the policy dictates or whether it's left up to your judgement to decide whether you breach that confidentiality.

P: No, if there's risk there, then I have to breach the confidentiality.

M: And that's a risk of intend rather than a decision?

P: Yes.

M: Oh, that's far enough. So you, um, were saying sort of is the primary care service you're getting, you're getting people referred through who've already been screened assessed?

M: Yes.

P: And then, from what you're saying you kind of, you already are assessing yourself?

M: Yes, I do.

M: After that.

M: I do, always assess at the first session and ongoing if somebody's sort of presenting at being kind of hopeless or hopeless or, you know, yeah, I do. I think we.

M: So how do you go about that, what sort of process do you use?

P: ...I would sort in the first session if whether there was any suicidal thoughts, whether they're, whether there was any risk of them harming themselves, I would put that as a question...

M: Yeah, so you would actually, you would breach the subject?

M: ...Not always, I think it would depend on the client and how they're presenting but it did have a general sense of some kind of...

M: So you would, certain things would bring it up for you?

P: ...Yes, yeah, things like hopelessness, helplessness.

M: Yes.

P: Things like social support, lost of, you know, isolation, etc. I guess there would be a number of things that might...

P: Yeah, I'm, I'm, under the IAPT...

M: Yeah.

P: ...stuff, we... are obliged to ask at every session, clients to fill in sort of, empty, general health questionnaires, etc.

Assessment, dialogic and continuos, clients 0-10 rating, likely awareness of possible risk factors in assessing.
P: One of the questions is: whether there’s whether they’ve thought that they would be better off dead.
M: Yeah, so that’s a fairly regular thing under the SFT?
P: Yeah, every session.

M: My contract working in the SFT is a verbal contract.
P: Yeah, I contract with them usually at the beginning of the first session.
M: And... it’s a sort of... I think of it as sort of confidentiality. I made explicit that if they were wanting to... nor... and I felt that they saw it as a risk of serious harm, then I would be something that I would share with the medical team.

P: So you put it in these terms, sort of, risk of serious harm?
M: Of course.

P: What’s your name?
M: Yeah, I say suicide, yeah... yeah.

P: And so you say that you will you will share it or that you may or

M: I will share it. Information and... and I would hope to get their consent to share that information, err... but there may be times when I might have to share that information without their consent.

P: Yeah. I think it’s a... it’s a really difficult... thing to know when... I think sometimes... (laughs) without consent.

M: Yeah.

P: ... and, you know, in human beings we have a choice, we have... there is... to that extent I think.

M: Yeah.

P: Because I think... you know, I think (laughs) these people can make their choices and I think that people can know but that their needs and feelings can change... that somebody choosing to commit suicide at a certain point when their life feels too difficult to handle... there might change for them later and having committed suicide for the moment and something can change then... yeah, so...

M: What do you feel the role of counseling with suicidal clients is? What do you feel counseling can offer them?

P: ... and hoping to... I think... and hope and encouragement to... for them to see... hope and see the choices for change.

M: Yeah.

P: ... but I think (laughs) I would advocate, when someone’s away from that choice... but I think implicit in all the work I do, would be to explore whether that was the only choice that they had...
<table>
<thead>
<tr>
<th>Time</th>
<th>Transcript</th>
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</thead>
<tbody>
<tr>
<td>9:20-42</td>
<td>Vague memories of training</td>
</tr>
<tr>
<td>9:46-49</td>
<td>Nothing can adequately prepare you for a suicidal client</td>
</tr>
<tr>
<td>10:14-22</td>
<td>Initial panic/ anxiety</td>
</tr>
<tr>
<td>10:40-48</td>
<td>Feeling hopeless. What do I do now? Empathic response</td>
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</table>
P: It's hard to say... I guess it's difficult... I suppose possibly anger... unless it's... I mean... not that I don't know that suicide or don't... em...

M: So where's that anger coming from?

P: I don't know. I just... I don't know... Something that came up as you were... 4...

M: Don't you dare...

P: ...I think probably that... you know... you don't... you're... I don't know, probably... I don't know, probably...

M: Because...? If you do it when you're in therapy, isn't that...

P: I'm going to feel... guilty... responsible... that...

M: Yeah. So it almost feels like their death was your responsibility?

P: I guess... yeah... Yeah, um... that I wasn't... good enough to... help them, that I wasn't... I wasn't... I wasn't... I wasn't...

M: ...if I don't actually prevent you from doing this... it's going to feel like a failure for me...

P: Yes, you're... you're... you can... you can... you know... I can think that and at the same time hold onto the idea that the... that their choice to do something isn't my responsibility...

M: Em...

P: Em... I guess ultimately it's about me... I don't know... I don't know with my experience...

M: Me

P: ...with a client... em... ending his life... even though I know cognitively that... I did everything that I could...

M: Yeah

P: ...and if you know, I adopted the normal procedures and...

M: Em...

P: ...and actually you know, he'd take kind of referred visits and seen his GP... and... you know, that was that... I still felt some responsibility... I still felt... should have been something else in the session... or... could I have said anything else in the sessions... that was... um... ultimately, don't think... I couldn't think...

M: Em...

P: ...you know and... I don't think... I don't think... if it happened again today... I don't think I would do anything differently...

M: I almost get the sense of there being two different levels, it's on the one hand it's the client's choice, it's their responsibility, they're everything they... and... you can sort of summarise that... or... it's through you and it's the responsibility... I guess it's the supervisor... and... on the other hand, the feelings seem to suggest that you still feel... I don't know if responsibility is the right word but it still feels as if...

P: Yeah

M: ...maybe I could have, should have...

P: Yeah

M: ...done something else...

P: And...
P: Yeah. Maybe not literally stop them from doing it... in fact I actually had those thoughts about that before. I think... that... there's... for me if I can... it's almost like... it feels like I need to... help them put the brakes on if you like. If they're on this journey...

M: Yeah

P: ... towards ending their own life...

M: Yeah

P: ... it's almost as if I have to kind of help them put the brakes on to give them time to maybe obtain a different perspective on things...

M: So it's not necessarily stopping it but... actually what's slowing things down enough for them and... an opportunity to reflect on what they're doing...

P: Yes. Sort of... yeah... I think that would... that would explain it... yeah... kind of putting the brakes on and slowing them down... to explore other avenues... to think about... often... in perhaps just a different perspective...

M: Acknowledging those things. I think that would make sense...

P: Yeah... I think the client... exploring options... Value of counseling in exploring options other than suicide...

M: Initial panic anxiety. The Swan...

P: ... that would make sense... and I think that's something that they're... pulling into... because it could be a client... itself... in front of you... that's not seen of himself... you know... of other and maybe the thinking you know... is something that been there for a long time for them but again... it might be upon them or been stuck with... yeah... having to sort of work on that... and it's about allowing them... to do that... but that's how... that's how you... perception is... to sort of... that anxiety...

M: Yeah...

P: And... I think that's one of the tough things I have... I think that I need... with empathy and... compassion... you know... I... I... you know... having what the client's saying and... I'm not saying that I'm reflecting that back that I'm with them. I'm acknowledging that...

M: Yeah

P: And... yeah...

M: It feels like that could be quite a struggle though... from what you're saying... because there's... or going on for you... there's... it's stuck on for you... that... how might I want to be responding to that client... the client is... they're stuck in... when they've said that... you've suddenly become distressed... maybe by all the stuff that's going on for you and then you're having to sort of... to sort of... to sort of... to sort of... to sort of... to sort of... to sort of...

P: That's absolutely right...

M: Yeah... yeah...

P: because obviously... the last thing I want to do is if I'm feeling... I'm feeling stressed inside... the last thing I want to do...
M: 

P: ... about this client, I think you know that I’ve been thinking about what to do, and among all these things, ... well, to put it simply, we ... 

M: 

P: ... and obviously I’m having to ... something about making a decision about suicide, you know. 

M: 

P: ... you know, I’m having to say to the client that I’m really concerned about what you’re taking me and ... 

M: 

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M: 

P: ... you know, I’m having to say to the client that I’m really concerned about what you’re taking me and ...
M: ... enable them to come through that and perhaps choose a different path...

P: ... if you know, accept how desperate things are for them and tried at you know ... yeah, rather than have them feel that, oh, you know, things aren't that bad, you know ... I think it's about accepting where they are now ... but with the hope of...

M: [laughter]

P: Things changing in the future

M: [laughter]

P: Yeah, and I suppose in a way, to ... aim to gain, get some measure of well and to, I'd love to see yourself and get everything that I could...

M: So you're using them almost to check out that anxiety about 'am I good enough'...

P: Yes...

M: ... am I up to this job? 'Have I done everything'...

P: 'Have done everything' ... yeah, 'have enough for the client' ... yeah, I'd definitely say it's a kind of and is a measure ... you know it and get that reassurance...

M: I feel the ... I sense here as though there's that is intense sense as though you're feeling perhaps burdened with something ... I'm working with those kind of clients ...

P: [laughter]

M: How would you describe that ... something that ... that burdens if you like...

P: Yeah... I think it's about... well, it's that kind of feeling of responsibility again, and that, yeah, the feeling of ... suppose this client's ... not just the client's wellbeing but the client's life...

M: [laughs]

P: If I'm honest do you know that ... it's a way, you know, that I'm ... that I'm responsible for. I know I do ... I think it's that noting of responsibilities towards and ... suppose if it's that difference isn't it between seeing responsibility towards a client and feeling responsibility for them...

M: Yeah, yeah... and it's interesting that you bring that word up because that's the final section, I mean if almost ... got this image in my head when you were describing that burden in this way, I almost get this sense of ... it's the client's kind of... what's actually going on metaphorically is almost like the client's kind of... saying 'here you go...' (gestures handing something to the participant)

P: Yeah, yeah

M: ... then you go it's your responsibility now and you're going what is what do I do with this, and then you're kind of... having yeah... how do I actually deal with this and then you're off to supervision saying 'I feel like this, have I done this right'...

P: Yeah...

M: ... and then almost trying to spell that whole the supervisor, it's almost like pass the parcel kind of...

P: It is, yeah, it's, it's almost like a staring isn't it?

P: Yeah... that's really interesting isn't it, cause just as you were talking about that question I was thinking ordinarily with clients I don't feel any... I don't respond to them...

M: Yeah

P: ... but actually don't feel responsible for them...

M: Yeah...

P: and I don't feel responsible for clients because attitudes they're expectations for themselves but it's interesting having just talked about suicidal clients that feel much more responsible for them

M: [laughs]

P: Supervision as reassurance.

M: Feeling some responsibility for the suicidal client. Being a responsible professional.

M: Feeling some responsibility for the suicidal client. Feeling some responsibility for the suicidal client.

M: Responsibility transferred. Sharing or passing on the burden of responsibility.

M: Feeling some responsibility for the suicidal client. Client autonomy.

M: Feeling some responsibility for the suicidal client. Client autonomy.
M: ... but you're feeling ready, right. That's your responsibility, you're a responsible professional...

P: Yeah

M: ... but they're responsible for their life. OUT, when they tell me they're thinking of ending their life. Suddenly...

P: Yeah, yeah...

M: A proportion of it passes to you. I mean could you quantify it in any sense or... cause it feels like... some or all passes onto you, something passes onto you...

P: Not all of it, but a lot of it. I understand, perfectly some. I would find it hard to quantify really...

M: Hard to quantify...

P: ... but definitely...

M: ... but you can feel some...

P: Absolutely.

M: “Feeling on...” I suppose what just occurred to me then was, what to feel like this is something you're taking or something that the client is giving you...? Or is it both?

P: Probably I would say I think the client's giving and I'm willing to take...

M: Mean...

P: unless I think other clients are willing to try and give the responsibility to me...

M: Mean...

P: ... but I'm not willing to take it...

M: ... and I'm saying... and I'm feeling... you're feeling some kind of... (Garbled)

P: Ultimately... I guess a suicidal client is just like any other client, the... the issue... is different... but... I... yeah... I suppose I was treating them like any other client in the sense that I don't take any responsibility for them.

M: Because it depends what you mean by effective...

P: Yeah, and in the I thought that as I asked that, cause I almost depend on what you think the outcome should be...

M: Exactly, in the past of me that says it's every person's human right to... you know, we've got choice... I might think one way and... you know... the professional in me that wants to take some responsibility there...

M: Mean...

P: (Garbled)

M: So there could almost be two, it could depend on what the goal you thought it was, is the purely, let's say, suicide-centred goal could almost be achieved as well. If suicide is the right thing for them...

P: Yeah

M: and actually it means you've avoided everything else they choose not... that's it, I'm... that's it, it's a different thing really...

P: Mean...
P: I guess it’s being responsible for a client that goes against the idea that you want to empower your clients.

M: “cause it certainly feels like that’s obviously what’s going on for you, and I guess that’s where you know, this is what I think is interesting about this case is it’s sort of... if that’s what’s going on and that’s what you’re feeling... you should do... you know, is that actually, you know, what is the actual effect of actually taking on that degree of responsibility?...”

P: “Yeah...”

M: “Yeah... can you see any circumstances where it would be...” I don’t know, where there would be a positive side to it, or...?”

P: “Yeah...”

M: “...you might stop somebody from committing suicide...”

P: “...you...”

M: “...feelings of responsibility have led me down a path of getting...”

P: “Yes, yes.”

P: “Yeah...”

M: “...you know, when you’re... when you’ve got a very vulnerable client sitting in front of you...”

M: “Yeah

P: “...That’s the right thing to do... it would be the right thing to do... it would be the right thing to do...”

P: “...right thing...”

M: “...in general terms...”

M: “...it is the right thing to do...”

P: “No

M: “...we can’t prescribe...”

P: “No

M: “...in certain situations...”

M: “...in certain situations, you know...”

P: “Yeah

M: “...there may be times when...”

P: “Yeah

M: “...Yes

P: “...there...”

M: “...the thing that’s the biggest thing that’s come out of...”

M: “...No

M: “...the sort of difference between...”

M: “...Yes... the different...”

M: “...Yeah, and that would be a cognitive and...”

P: “Yes, yes...”
## Appendix IX: Outcome Propositions/ Categories and Themes

<table>
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<th>No.</th>
<th>Category Name and Rules of Inclusion</th>
<th>Themes/ Provisional Categories</th>
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</table>
| 1   | A respect for autonomy, and an awareness of risk but it still may not be enough...: The impact and limitations of training and experience  
Counsellors found it difficult to recall their core training with respect to suicide other than giving them a respect for clients' autonomy. Post qualification experience and training was felt to have had more influence but could still be felt to be inadequate when faced with a suicidal client. | Post qualification training in suicide  
Vague memories of training  
Value of training in recognising we can't know how others feel  
Client autonomy.  
Training facilitated exploration of issues without being directive  
Nothing can adequately prepare you for a suicidal client |
| 2   | Protective framework or restrictive constraint? The impact of organisational context, policy and procedure.  
Counsellors have to work within the context of organisations with their own needs and priorities. These impact directly on decisions counsellors have to make around breaching confidentiality when working with suicidal clients. | specific written contract  
Working context, the effects of.  
Other support involved can make the situation complex.  
organisational safeguarding policy  
Conflicting policy demands  
Formal contracting  
Not avoiding the term, being specific.  
Required to risk assess with forms every session (IAPT)  
Referring back to the contract as issues arise.  
Danger of complacency in outlining boundaries  
Verbal contracting in crisis situation, paperwork inappropriate  
The reassurance of policies and contracts |
| 3   | The Swan moment: Counsellors' thoughts and feelings when a client says they're suicidal  
Counsellors experienced a distinct cognitive/ emotional split between feelings of panic, anxiety and helplessness and thoughts of what the situation demanded of them as a professional. This potentially threatened to disrupt their natural empathic connection to the client. | 'The Swan'.  
Anxiety-driven exploration of extent.  
Initial panic/ anxiety  
Feeling helpless, 'what do I do now?’  
Opening a can of worms.  
Life and death, finality.  
This is going to be hard work…  
Empathic response.  
Glad they've shared suicidal feelings.  
Cognitive/ emotional split  
'The emotional contract' - betraying this |
| 4   | I respect your autonomy, I just don’t want you to act on it: Counsellors’ perceptions of suicidal ideation in clients. | Hard to empathise with suicidal feelings if you've never had them  
Trusting the client, difficulty of |
Despite believing strongly in their clients’ autonomy, counsellors found it difficult to trust in, as they sometimes struggled to fully empathise with suicidal feelings even though accepting them as the client's reality. Their own personal and professional experiences can impact in this area.

**Assessment:** Informed, dialogic and continuous. Counsellors view assessment as a continuous, dialogic process, using their own skills and experience, sometimes informed by more formal tools.

5

**Assessment: Informed, dialogic and continuous.**

Counsellors view assessment as a continuous, dialogic process, using their own skills and experience, sometimes informed by more formal tools.

**Referral - no prior information**

**Assessment, dialogic and continuous, client's 0 - 10 rating**

**Uses awareness of possible risk factors in assessing.**

Feeling some responsibility for the suicidal client

Is taking responsibility effective?

Responsibility transfer.

Taking responsibility is justified by the client's vulnerability

Perceived vulnerability of young people

6

**I'm responsible to my clients, not for them- but when they're suicidal, I find myself feeling some responsibility: Responsibility for the suicidal client: where does it and should it lie?**

Counsellors believe that clients are responsible for their own lives and they, as professionals, are responsible to them. However, when the client was suicidal, counsellors found themselves feeling and sometimes taking a proportion of responsibility, which they found difficult to quantify, or evaluate in terms of therapeutic effectiveness.

7

**It feels worse when they're young... The vulnerability of young clients**

Counsellors feel young people are more vulnerable and less autonomous than adults, find them more challenging to work with because of this and feel a greater degree of responsibility both toward and for them.

8

**Being a responsible professional**

Suicidal clients can make counsellors feel inadequate as a professional, that they need to do more in order to do enough and fear the emotional and professional
| 9 | What I can offer to suicidal clients: space, hope and alternative options. Counsellors feel that they can offer a safe space for clients to talk about suicidal thoughts, helping them explore options other than taking their lives and giving hope and empowerment. |
| Client suicide as a professional failure  
Don't you dare do this to me- I'll feel bad!  
Consequences of client suicide- professional and emotional  
A kind of vicarious trauma.  
I've given honest responses, would others? |

| 10 | Holding the situation within the boundaries  
Counsellors can choose to continue to work with the suicidal client, sometimes contrary to organisational policy, on the grounds of their therapeutic approach and the ethical framework of their professional organisation but this feels risky to them. |
| Value of offering space to speak about suicidal thoughts  
Value of counselling in offering hope and empowerment  
Value of counselling in exploring options other than suicide  
Holding the client, exploring options.  
Holding the situation- not breaching according to contract  
Difficulty of breaching against client's wishes  
Justifying working to BACP guidelines instead of organisational policy  
Working within own professional boundaries and ethical code  
Concern that client will not continue because of confidentiality boundaries  
Use of hypothetical scenarios to illustrate confidentiality boundaries  
Being specific about self harm  
Being non-specific in contracting.  
The grey area |

| 11 | Putting on the brakes and putting up the safety nets: Counsellors' actions when working with suicidal clients. Counsellors channel concern for the client and their own professional anxiety into a variety of means of managing the risks to the client and also to themselves. |
| 'Congruent concern'.  
'Putting up the safety nets'.  
'Putting the brakes on'  
Challenging with the ripple effect  
Suicide prevention.  
Practical risk management  
Uncomfortable as a counsellor dealing with practical risk management.  
Covering the counsellor/ organisation, getting support for the client, even if not effective |

| 12 | Sharing or dissipating the burden. Counsellors sought to dissipate the burden of responsibility they can feel in working with suicidal clients by seeking reassurance and guidance from supervisors and, where appropriate, sharing concerns with supportive superiors. |
| Sharing or passing on the burden of responsibility  
Importance of good relationships with superiors.  
Supervision as a safe space  
Supervision as reassurance. |