

# **University of Chester**

**Working with suicide: An exploration of the tensions that may exist if  
counsellors' beliefs and agency suicide policy conflict**

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**University of Chester**

**Abstract**

**Master of Arts in Clinical Counselling**

**A qualitative study of**

**Working with suicide: An exploration of the tensions that may exist if  
counsellors' beliefs and agency suicide policy conflict**

**By Elaine Lesley Jones**

**October 2015**

This research explores the experiences of counsellors working with suicidal clients with a focus on how counsellors respond to, and are affected by, a suicide policy with which they have disagreements.

A comprehensive review of the literature was conducted. Four counsellors who have tensions with their agency's suicide policy were interviewed and their experiences explored. The data was analysed using Interpretative Phenomenological Analysis. The research concludes that counsellors who would otherwise feel confident in their work with suicidal clients feel anxious and concerned for the safety of their clients as a result of working within a policy that feels inadequate. The research also demonstrates that counsellors feel isolated when in this position and points to the need for counsellor organisations, such as the BACP, to provide a forum in which such issues can be addressed. The research has also resulted in the production of suggestions as to how policy could be improved and demonstrated that the implementation of these changes would alleviate the stress felt by counsellors and provide more support to clients experiencing a suicidal crisis. In addition the conclusions of the research suggest, controversially, that it is ethical for counsellors to breach policy if they believe that the policy does not have the best interest of the client at its heart, and if it does not protect the client in times of crisis.

## **Declaration**

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

**Signed:**

**Elaine Lesley Jones**

**October 2015**

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# Chapter One

## Introduction

### 1.0 Preface

When researching for this dissertation I came across Jamison's (1999) book *Night Falls fast: understanding suicide*. For several months I had put off reading the book having been unable to get past the opening quote,

*Whether the throat is strangled by a knot, or water stops the breathing or the hard ground crushes in the skull of one falling headlong to its surface, or flame inhaled cuts off the course of respiration – be what it may; the end is swift (p.11).*

As I finally read the book, I recognised that the 'matter of fact' approach I had to suicide hid feelings of immense sadness at the despair that must be felt when people decide to end their life. It became clear that in this research it would be necessary to confront how difficult it is for counsellors to be with a client in that despair, as well as give consideration to the ethical, philosophical and policy issues which are the focus of the study.

### 1.1 Background

I became interested in the ethical issues concerning suicide at the beginning of the Clinical Counselling MA. When I started the course, my belief was that the decision to end one's life is a human right. I believed that people should be in control of what happens to their bodies and ultimately have the right to decide whether to live or die. For myself, I saw suicide as an 'exit strategy', a way of escaping if life's challenges became unbearable; a view that I

thought of as being rational and practical. However, when I began to think about how I would feel if family members, friends and clients were considering suicide, my opinions changed. I would, in those instances, take what action I could to keep them alive. These conflicting views made me give further consideration to my values and beliefs regarding suicide, and were one of the factors that led to suicide being the focus of my research project. Another factor which influenced my desire to research this issue further was the impact that my placement suicide policies had on me. I was on placement with two agencies, both with very different suicide policies. At one, the policy was that the counsellor cannot inform others of a client's suicidal intent unless the client consents to confidentiality being broken. At the other, at the start of therapy, a suicide agreement was contracted. This contract states that, if the client expresses suicidal thoughts at any point during therapy, they will be given a phone number on which they can contact their counsellor at any time. The client will be asked to agree to phone their counsellor if they are planning to act on their thoughts. The counsellor's role in such circumstances is to try and convince the client not to harm themselves before the next session and, if that fails, for the counsellor to contact the emergency services. Reflecting on my own views and feelings regarding these two different policies made me realise that the policy which boundaries a counsellor's practice will have an impact on the counsellor and therefore on their clients. This led me to the decision to research the question:

***How do agency suicide policies impact on counsellors and the counselling relationship?***

Further reflection led me also to consider what I would do if I disagreed with a particular policy: How I would feel? What actions I would take? And, most importantly, what impact could those feelings and actions have on the client? This consideration led to the particular focus of the research being:

***An exploration of the tensions that may exist if counsellors' beliefs and agency suicide policy conflict.***

In writing this introduction I am aware that what is driving the research is my own interest and dilemmas, and that it is important throughout the project to stay aware of that.

However, as Rodriguez and Ryave (2002) comment,

*A researcher can explore his or her assumptions, expectations and biases and, at the same time, look at how these are constructed within the wider social reality which we share with our participants and fellow clinicians and researchers (p.19).*

Incorporating this dimension of how we, and our participants, understand and construct our social reality is an important part of a qualitative research project, and paying attention to it can potentially add to the quality of the results.

## **1.2. Aims of the research**

In this dissertation I will be investigating how an organisation's policy, regarding how a client expressing suicidal thoughts and intent should be responded to, impacts on the counsellor. I will investigate how it makes the counsellor feel, how it affects how they are with a client, and how it affects their actions. Before considering these questions, the issue of how counsellors and organisations respond to suicidal clients will be placed into its wider historic

and social context. The factors which could influence a person's, or organisation's, beliefs regarding suicide will be considered. The influence of political/government regulations concerning how suicidal clients should be responded to, will be addressed. The legal, professional and ethical issues which may impact on counsellors will be stated, and the issue of whether the counselling approach which the counsellor adheres to influences the counsellors' actions, will be raised.

In the interviews for the research, the participants will be asked about their values and beliefs and other issues that may inform their views of suicide. They will then be asked about their agencies' policies and the tensions that exist between their views and beliefs as to how suicidal thoughts and intent should be responded to, and the policy which boundaries their practice. The aim is to investigate the impact that such tensions may have on the counsellor, and to examine how that then affects the client. In previous research studies on counsellors working with suicide, the issues that are the focus of this research have been commented on but there is no research on this specific question. The hope is that the results of this research will add to the current knowledge of the counselling profession regarding working with suicidal clients; that it will deepen our understanding of how counsellors respond to suicide; that it will add to the debate in the British Association of Counsellors and Psychotherapists (BACP) on the importance of ethical practice; and that it will influence those who formulate policy. It is also hoped that it will encourage counsellors to give further consideration to how their beliefs and approach to suicide can influence and affect a suicidal client and that it will encourage counsellors to reflect on how agency policy on suicide may impact on them and on their work with suicidal clients.

### **1.3 Structure of the dissertation**

This introductory chapter has explained what lead the researcher to explore this subject. It also outlines the aims of the research. Chapter Two will examine the literature relevant to this subject. Chapter Three will look at the methodological approach chosen and explain how that approach was implemented in this study. Chapter Four presents the findings from the data analysis. Chapter Five will examine these findings and explore how they add to current theory and practice. Chapter Six will conclude the dissertation.

## Chapter Two

### Review of Relevant Literature

#### 2.1 The range of literature

There has been a great deal of research into the issue of suicide. The studies cover a range of disciplines including sociology, religion, philosophy, psychology, health care, genetics and politics, all of which can be useful when trying to put this subject into context. For the purpose of this research I have included particular aspects of the available literature. The literature in sections 2.2 to 2.7 puts the issue of how society responds to suicide into its historic context. In this literature, the development of religious and philosophical beliefs in regard to suicide is outlined, the ideas of sociologists and suicidologists noted, and the theories that influence how suicidal individuals are responded to highlighted. The literature included in sections 2.8 to 2.9 looks at the political strategies and policies that influence the counselling setting. This includes a review of risk prediction and prevention strategies and an assessment of Government guidelines and support service provision. The literature reviewed from 2.10 to 2.14 is concerned with the issues that may influence the counsellor as a member of the counselling profession. This includes a review of counsellor specific guidelines for working with suicidal clients, ethical and professional considerations, the influence of the counsellor's modality and a review of the research that specifically looks at counsellor's work with suicidal clients.

In conducting this literature review various combinations of the keywords: suicide, policy, counselling, psychotherapy and statistics, were searched on a number of databases

including Chester Rep, CINAHL, Cochraine, ProQuest, PsycARTICLES, PsycBOOKS, PsychINFO, SocIndex, Taylor and Francis online, University of Chester Library and Wiley online.

## **2.2 A definition of suicide**

As Reeves (2010) states, quoting O'Connor and Sheehy (2000), the term suicide has only a "relatively recent history with no recorded use before 1634" (2010, p.15). Previously, the act of suicide was referred to as "self-destruction" or "self-killing" (p.15). The currently used definition of suicide is "the action of killing oneself intentionally" (Oxford Dictionary of English, 2010). However, even if the definition of the word can be agreed, the interpretations and explanations given as to why a person completes suicide are complex and influenced by a variety of factors. In addition, while there may be agreement on the definition of the act of suicide, for counsellors, it is important to break down the term suicidal further. In counselling, the terms suicidal ideation and intent are used to describe a spectrum of thoughts and feelings that can possibly indicate that a client may decide to end their life. Ideation covers a range of thoughts and feelings that range from 'fleeting' to those that are more persistent, whereas intent implies "more of an intention to act" (Reeves, 2015, p.38).

## **2.3 The influence of religion**

The ideas, beliefs and practices of the numerous world religions influence many millions of people. In the UK census (2011), the answers people gave regarding their religious belief were: Christianity (59.5%, 37.5 million), No religion (25.7%), Not stated (7.2%), Islam (4.4%),

Hinduism (1.3%) and Other (1.9%). Even though a substantial number of those surveyed gave the answer 'no religion' they will be aware of, and potentially influenced by, those beliefs. It is therefore necessary, for the purpose of this research, to be aware of what those influences may be.

### **2.3.1 Christianity**

In the Bible references to self-killing are, according to Barraclough, as quoted by Reeves (2010), "purely descriptive" (p.16). It is therefore assumed that amongst early Christians there were "no positive or negative interpretations" (p.16) applied to suicide. From around AD400 the Christian church began to change its attitude. From AD566 mass could not be said for those who died by suicide and they could not be buried in hallowed ground. Today the Catholic Church's belief is that "we are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of" (Vatican, 2015, 2280). This belief results in suicide being considered a grave or serious sin. The views of the many Protestant denominations vary considerably. Conservative Protestants such as Evangelicals, Charismatics, and Pentecostals, argue that suicide is self-murder, and so anyone who commits it is sinning in the same way as it would be if murdering someone else. Amongst other denominations, while, officially, suicide is generally considered morally wrong, compassion and understanding is often shown to people who are suicidal. Despite the similarity in views between the Catholic and Protestant religions, interestingly, the rates of suicide are higher amongst Protestants when compared to Catholics. This difference was first noticed by Durkheim (1897), in his classic text, 'Suicide'. Durkheim believed that the

differences had to do with the fact that Protestants are more individualistic and place greater emphasis upon individual autonomy, whereas Catholics place greater emphasis upon church communities.

### **2.3.2 Islam**

In the Islamic religion suicide is believed to be a major sin. It is considered a greater sin than killing another person. Therefore, “The Prophet stated that the one who commits suicide will be punished with something like that with which he killed himself” (Al-Munajjid, 2015, p.1).

### **2.3.3 Hindu**

The Hindu religion’s views on suicide are “heavily influenced by gender. Suicide is not seen as acceptable for males, whereas for females ... it is honourable ... [particularly] following bereavement” (Reeves, 2010, p.17).

### **2.3.4 Secularism**

The views of secularists and atheists are often in opposition to what is seen as a dictatorial and uncompassionate religious attitude to suicide, with many concluding that deciding to end your own life is a human right and a valid exit to the struggles of life. However, according to Hecht (2013), instead of secularists developing their own views on suicide many tended to let their views be shaped by a purely oppositional stance to those of the dominant religions. She argues that,

*The secular rejection of Christianity's simplistic anti-suicide arguments took a wrong turn. Secularists based a moral decision on a fight with religion rather than on a consideration of suicide on its own terms. This has led secular moderns into a dark fatalism (Hecht, 2013, p.B11).*

### **2.3.5 Summary of religious influences**

This brief review of religious, and secular, attitudes to suicide demonstrate that an adherence to any of these philosophies may considerably influence policy makers, and counsellors, in their responses to suicidal clients. Some of those influences may be open and obvious, for example; if someone holds the view that someone who commits suicide has committed a sin equivalent to murder then it is likely that expression of it, in the counselling settings of Western European society, would result in disagreement and debate. However, such ideas can, potentially, find more subtle expression. It is therefore important for such views to be acknowledged and their potential influence debated.

### **2.4 Individual rights**

As capitalism developed, there was an increase in the influence of the philosophical ideas which stated that all people should have individual rights and freedoms. These rights were enshrined in Bills of Rights and declarations as seen in the English Bill of Rights (1689) and the French Declaration of Human Rights (1789). From this came the idea that individuals should be autonomous, i.e. self-directing, and that, ultimately, they should have the right to decide whether they live or die (Human Rights Europe, 2011, p.1). Autonomy is a principle that the British Association for Counselling and Psychotherapy (BACP) supports and it is

included in the BACP ethical framework for good practice (BACP, 2013). However, such principles also need to be put into their historic and social context. The principles of individualism, individual freedom and autonomy, while progressive against those of feudalism, are the ideas that are dominant in a particular form of society i.e. capitalism. They are not value free and therefore should be subject to debate. For example, as Marx (1845) states,

*Only in community [with others has each] individual the means of cultivating his gifts in all directions; only in the community, therefore, is personal freedom possible (p.1).*

Or Blunden (2015),

*Freedom is always limited by the opportunities that the community provides for the development of a personality. Freedom is not enhanced simply by the removal of limitations on the autonomy of individuals (p.1).*

The principle of individual autonomy, like any other concept, is specific to time and place. However, it is these ideas, particularly the principle that it is a human right to decide to end your own life, that inform policies which say that client confidentiality can't be broken even if they have made clear their intention to kill themselves.

## **2.5 Medicalisation of emotional distress**

Also with the expansion of capitalism, came an increase in the influence of science which led to emotional distress being explained in terms of mental illness. The emergent discipline of Psychiatry focused on the categorisation of this mental illness and increasingly developed 'treatment' for it. The treatment for suicide included hospitalisation, medication and

“restraint and control” (Reeves, 2010, p.19). Today, as a result of the continued dominance of the medical model of emotional distress, there is still often an assumption that medication is the most effective treatment for people who are suicidal. Most policies on suicide state that if clients are suicidal then their GPs should be informed, the expectation being that they will then be given medication. However, despite the widespread prescription of such medication, current research (Simon & Savrino, 2007; Olmer & Strous, 2012; Jobes, 2006) suggests that, with the exception of Lithium which is prescribed for Bipolar disorder (Goldblatt & Pompili, 2012), there is “virtually no empirical support that medication alone has a meaningful impact on suicidal behaviors” (Jobes, 2006, p.39).

## **2.6 Societal causes**

Sociologists, like Durkheim (1897), focused on the environmental issues that can be part of the reason why people decide to end their life. These studies (Chen et al, 2012; Payne, 2012; Pickering & Walford, 2000; Stack, 2000) show that there is a correlation between poverty, unemployment, government policies, cuts in services and suicide rates. They show how economic, political and social developments, lead to changes in suicide rates and therefore demonstrate that suicide can be the result of unbearable economic and social pressures.

## **2.7 Suicidologists**

A great deal of research has been conducted by people who specialise in the study of suicide. This research has been carried out by the founder of suicidology, the Psychologist Edwin S. Shneidman (1910 -2009) and by those influenced by him (e.g. Black, 1993;

Diamond, 1995; Leenaars, 1997; Orbach, 2003). There is in this research often a combination of a sociological and a psychological perspective, which, it can be argued, is best illustrated by the work of Jobes (2006). Jobes, although writing about the US, has developed an approach to working with suicide that can be seen to be increasingly influential in the UK. Jobes developed a method of responding to suicidal patients which he called Collaborative Assessment and Management of Suicidality (CAMS). Jobes argues that “time specific plans [should be used] to... ensure the patients out-patient stability and safety” (p.27). This is an alternative to the use of “safety contracts” or “no suicide contracts” (p.27). These plans, drawn up in advance of a crisis, emphasise what the client and practitioner will prospectively do should the client become acutely depressed, impulsive and suicidal. This approach can be seen in the policies of some UK organisations where counsellors are encouraged to develop a Suicide Action plan with suicidal clients.

## **2.8 Risk prediction and prevention strategies**

In recent years in the UK, we have seen the growing dominance of the discourse of ‘risk’ when talking about potentially suicidal people (Reeves, 2010). The focus is on collecting statistics to determine which sections of the population are most at risk of suicide, conducting risk assessment questionnaires and putting in place policies which determine how an individual who is deemed to be high risk should be responded to. It can be argued that knowledge of such statistics can be useful for a counsellor. For example, if a particular individual fits into an ‘at risk’ category then more care could be taken in listening for potential signs of suicidal ideation and the question asked as to whether they have any

suicidal thoughts. However, rather than the statistics being used to usefully inform counsellors' practice, they have instead been used to justify the development of policies that can be prescriptive. The resultant policies may vary but they tend to include clauses which say that if a client is assessed as being at risk of suicide that counselling stops and clients referred on to psychiatrists and GP's or clauses which are driven by the organisations attempts to protect themselves from prosecution. This approach is what Reeves (2010) calls the Prediction-Prevention culture and is the approach that is influenced, and fuelled, by Government policy.

In many counselling settings Government policy and guidelines determine responses to suicidal clients (Foster, 2007). Government documents show the sections of the population most at risk of suicide (Dept. of Health, 2012), give guidelines for best practice in managing risk (Dept. of Health, 2007) and outline prevention strategies (Dept. of Health, 2015). However, despite the production of statistics which highlights the factors that lead to increases in suicide and guidelines which suggest what organisations need to do in response, the actual impact of Government policy is to make the situation worse. The Government's own guidelines on suicide prevention start by stating,

*There is a wealth of evidence that periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide... A number of studies have demonstrated an association between the areas of England worst affected by unemployment during the financial crisis and increased suicide rates (Dept. of Health, 2015, p.6).*

The Government's response to these unavoidable truths is to continue cutting tax credits and housing benefit, to continue with a policy of benefit sanctions and to continue to allow the use of zero hour contracts. These policies result in increasing numbers of people living in

poverty and result in people feeling anxious and frightened for the well-being of themselves and their family. In addition the Government reduces funding to the organisations they call on to provide support to suicidal people. They cut local authority spending and funding to the NHS which result in mental health day care and respite services being closed, reductions in counselling provision and the closure of acute mental health support services. The BACP and other organisations concerned with provision of counselling and mental health support have come together in the, We Need To Talk Coalition (2014) to produce a report to highlight the affect that this lack of access to talking therapies has on peoples mental health. This survey found that one third of people had to ask for therapy, rather than being offered; that half had waited more than three months for an assessment; and that 1 in 10 had waited more than a year for assessment. While waiting for therapy, 67% became more mentally unwell, 40% harmed themselves, and 1 in 6 attempted to take their own life. These facts can potentially impact on the counsellor. It may raise concerns for them over where clients are 'referred on' to, if policies state the counsellor should refer them on. It also may be the case that the impact of working in an environment in which jobs and services are being cut may make them less likely to raise their concerns and disagreements over suicide policy through fear of losing their own job.

## **2.9 Policy**

The influences outlined above can produce a range of possible policies in regard to responding to suicidal clients. However, it seems to be the case that the majority advocate one of the following:

1. Policies which state that if the client discloses suicide ideation then the counselling stops and the client is referred on to more 'specialist services'.
2. Policies which include some sort of suicide contract in which the client and counsellor agree to certain actions being taken in the event of the client becoming suicidal.
3. Policies which state that no action can be taken without the client's consent.
4. Policies which state that confidentiality can't be broken unless there is a danger of harm to self or others.

According to Reeves (2010) there are a number of reasons why developing a risk policy can be beneficial. These reasons include: to ensure a consistent and equitable response to all clients, to protect clients from an 'acting out' of a counsellor's personal agenda regarding suicide and to ensure that all counsellors are aware of which services to call on in the event of high suicide risk. However, problems can arise with any policy if the policy is too prescriptive, if it is more concerned with fear of litigation than what's in the best interest of the client, and if it fails to recognise "the unpredictable nature of suicide potential" (p.84).

## **2.10 Guidance for counsellors working with suicidal clients**

The main body of literature regarding counselling and issues concerning suicide in the UK is summarised in Andrew Reeves' book *Counselling Suicidal Clients* (2010). In this book, and his more recent *Working with Risk in Counselling and Psychotherapy* (2015), Reeves highlights many issues that need to be considered when counselling suicidal clients including the philosophical ideas that shape current attitudes towards suicide, ethical issues, the language used by clients when talking about suicide and how agency policies have been

developed. One chapter of the book that is particularly relevant for this study looks at how a counsellor's personal views and experience of suicide may influence their responses and actions. Reeves argues that,

*A counsellor's views on suicide, influenced by their personal or family history, spiritual or religious views, experience of supporting family or friends, for example, will have great significance in how they subsequently respond to suicidal clients in sessions (2010, p.127).*

It is therefore imperative that counsellors are aware of what those personal views and influences are, acknowledge the judgements they make when working with a suicidal client and for counsellors to be prepared to "unearth uncomfortable truths" (p.128) about their views. He argues that if counsellors don't do this they can unwittingly "be drawn into making judgements about life and death" (p.128) which can potentially impact on how they respond to a client contemplating whether they should live or die.

## **2.11 Physical health versus mental health presenting issues**

A range of potential influences on the beliefs and values of the counsellor are highlighted throughout this literature review. However, one aspect that is frequently overlooked when addressing this subject is how counsellor's views concerning euthanasia or people choosing to die because of physical ill health issues may overlap with, or be contradictory to, those concerning their responses to those who have decided to end their life for other reasons. Jamison (1999) shows how suicide risk is low amongst people being diagnosed with cancer, multiple sclerosis or other medical illnesses compared to those diagnosed with a particular mental health problem or, the most significant risk factor, of having previously attempted

suicide (p.101). As she comments, it is strange that these medical illnesses that are often linked to pain “are not linked to a higher rate of suicide” (p.102). Paradoxically, however, as Jackson (2014) states, support for the right of people diagnosed with illnesses like those above, to be able take their own life is high. The article by Mitchels and Reeves (2009) demonstrates this. In their example, the counsellor working with a client who decided to end their life as a result of physical illness, respected the client’s wish for confidentiality and informed no one of the client’s plans. Such a response is legal and ethical. However it is being quoted here to demonstrate that, an adherence to the belief that it is rational for someone to want to end their life as a result of physical ill health, will influence how a counsellor responds to a client and, may result in counsellors failing to explore other issues which are affecting the client’s decision.

## **2.12 Ethical and legal considerations**

The BACP information sheet, *Working with the Suicidal Client* (Reeves and Seber, 2010), outlines the ethical and professional issues counsellors need to consider when working with suicidal clients. These guidelines, as Kinder (2006) states, don’t offer counsellors definitive rules which can be followed to ensure their work with such clients is ethically and legally acceptable. Counsellors, instead, are expected to give consideration to a number of principles and the possible legal consequences of acting on one of those principles rather than another. The principles raised by Reeves and Seber (2010) which need considering in this work are the client’s right to confidentiality, the duty of care a counsellor has for a client, respect for the autonomy of the client and the requirement for confidentiality to

broken if there is a danger of harm to the client or others. As well as giving consideration to these principles, it is also necessary for counsellors to have an understanding of the meaning of capacity. The Mental Capacity Act (2005) came into force in England and Wales in 2007. The legal definition says that someone who lacks capacity cannot, due to an illness or disability such as a mental health problem, dementia or a learning disability, understand information given to them to make a particular decision, retain that information long enough to be able to make the decision, use or weigh up the information to make the decision or communicate their decision to others. It is necessary to understand this concept because concerns over a client's capacity, along with a judgement of whether a person's suicide plans are imminent, are often the point at which policies require that client confidentiality be broken. Other legal issues may also be of concern to counsellors. Starting from the US, but increasingly in the UK, discourse over ethical practice frequently refers to the possibility of legal action either from a client whose confidentiality is breached or from families whose loved one has died. Berg, Hendricks and Bradley's (2009) article is representative of those concerns. In this article "liability and malpractice information is ... discussed, including how counsellors can follow professionally accepted standards of care and what must be done to improve client care and decrease the chances of a lawsuit" (p.1). Fear of such action can potentially influence a counsellor, particularly if they are working in environments where there is a culture of looking for people to blame if a client ends their life.

### 2.13 Theoretical orientation and influences

Counsellors' beliefs on how to respond to a suicidal client may also be influenced by the theory of their chosen modality or by that of other counselling approaches. Even though the participants in this study are Person Centred or Integrative counsellors, it is possible that they have been influenced by the philosophy and beliefs regarding suicide found in other modalities. The philosophical discourse of psychoanalysis in particular, as a result of its longevity and because its adherents have produced a great deal of theoretical literature on the issue of suicide, may affect a counsellors beliefs and actions. Firestone (1997) looks at the ideas of several psychoanalytic orientated theorists including Freud (1917), Guntrip (1956), Winnicott (1965) and Shneidman (1988). Firestone (1997) quotes Schneidman to explain that such theorists don't view suicide as an illness; rather it is

*A human malaise tied to what is 'on the mind,' including one's view of the value of life at that moment. It is essentially hopeless unhappiness ...and that is not a medical condition (p.60).*

He then quotes Maltzberger (1986) to demonstrate what some psychoanalytic theorists see as the underlying cause of suicide. Maltzberger says that most of his suicidal patients had

*parents who are unusually critical or hostile. Most had been deprived of consistent empathic contact and had suffered considerable neglect and abuse. Maltzberger stated that what was once experienced as criticism from outside became criticism from inside in the form of an aggressive, critical superego...Introjection of parental attitudes has resulted in a severe and markedly sadistic superego (Firestone, 1997, p.62).*

Bowlby's (1980) attachment theory follows a similar approach stating that "the lack of a stable and secure relationship with his parents...being told how unlovable he is... [and

possibly experiencing] the actual loss of a parent” (Firestone, 1997, p.64), are all potential factors which can lead to suicidality. Firestone states that all of these theories consider internalised parental prohibitions and directives as the most important factor contributing to suicidal thoughts and that, even though theorists then elaborate a number of theories from that basic idea, the most important fact is that these “feelings and cognitions are retained in the form of destructive voices within the adult personality” (p.67). For Firestone, it then follows that those ‘voices’ need to be heard and understood. Although psychodynamic therapy is different from Person Centred, particularly in its approach to the therapist being the expert on the client’s life and in the ‘distance’ that is kept between the therapist and the client. It is possible to argue that Person Centred theory has a similar underlying theoretical understanding of the causes of emotional distress. For the Person Centred Approach (PCA) the root of emotional distress is in the internalised conditions of worth as experienced by the person, predominantly in childhood but also throughout their life. Merry (2002) explains that throughout early childhood we develop our concept of self: He says that the development of that self-concept is vulnerable to the overwhelming need for love and acceptance from the significant others in our life and, if those significant people then tell us, “you are bad, the behaviour is bad and you are not loved or loveable when you act in that way” (Rogers, 1951, p.500) then we can lose touch with our organismic valuing process and in the accuracy and reliability of our own inner experiencing. For Mearns and Thorne (2013), it is in this conflict between “the desperate need for approval and the wisdom of the individuals own valuing process” (p.10) that lies the root of much psychological disturbance. It can be speculated that the influence of this theory on a counsellor would be a belief that what is most beneficial to a client experiencing suicidal thoughts would be for that client to

experience a therapeutic relationship in which those thoughts could be voiced and accepted. It could also be assumed that Person Centred counsellors would be hostile to policies which instructed them to stop counselling and refer the client to a GP or to a psychiatrist. Firstly, because the theory holds that the relationship that can be provided could alleviate the client's distress and facilitate psychological change, and secondly, because adherents of the approach are often hostile to views which label emotional distress as 'illness' and attempt to treat it accordingly.

Another potential influence on the beliefs of counsellors is the debate between those who see suicide as an inherent right and those who argue that there are other issues that override that right. Szasz (1986), for example, argues that it is the inherent right of an individual to commit suicide and concludes that there should not be any intervention made to prevent it. Others, for example Firestone (1997) and Mather (1987) argue that, "although Szasz's position is important and logical, it does neglect other facts" (Firestone, 1997 p.118). As Mather (1987) states,

*people may feel differently about committing suicide after the passage of a suicidal crisis, that suicide cannot be reversed, and...it has traumatic implications for the survivors ... The present author maintains there are higher-order values to be considered and protected (p.882).*

Firestone agrees and adds that, in the act of suicide, "the basic rights of other human beings are being violated" (1997, p.118). He argues "that the suicide of a loved one, especially a parent, seriously damages the psyche of the survivors" (p.117). For Firestone, this is another factor which excuses intrusion on the person planning to act on their suicidal thoughts.

It is clear from the literature above that, as Trimble et al (2000) state, a counsellor's modality and training will influence how they respond to suicidal clients. Such influences

may also affect how counsellors view particular policy formations and may shape their responses to them.

#### **2.14 Research papers concerned with counsellor's experiences of working with suicidal clients**

There are a number of research projects that have been particularly concerned with studying the experiences of counsellors who work with suicidal clients they include Moerman (2011, 2012), Paulson and Worth (2002), Reeves (2005), Reeves et al (2004), Reeves and Mintz (2001), and Whitfield (2011).

Reeves and Mintz (2001) study found that counsellors experienced a range of distressing feelings when working with suicidal clients and that their responses to clients were influenced by a number of factors including, their own views and beliefs about suicide, the threat of litigation, and fears of accusation of malpractice. For the participants in this study risk assessment was seen as an informal, rather than formal, process. None of these counsellors used formal written contracts at the beginning of the counselling relationship and made no explicit reference to suicide in that contract. However, in Whitfield's (2011) study the findings were different. Almost all of these counsellors used contracts that specifically named suicide and revisited the contract when appropriate. This study's counsellors seemed more aware of the need for risk assessment than Reeves and Mintz (2001) counsellors and engaged more positively with it. In regard to policy issues, the focus for the participants in both the Reeves and Mintz (2001) and Whitfield (2011) studies was the issue of client confidentiality. These participants expressed opposition to breaking

confidentiality and felt that they were coerced, by the organisation they worked for, into breaking it. Reeves and Mintz (2001) commented that this demonstrated that some of the interviewees had not understood that there are boundaries to confidentiality and that there is a requirement to assess risk should 'harm to self or others' be suspected.

The studies by Reeves (2004, 2005) raised additional concerns. These studies found that Person Centred counsellors tended not to name suicide, or ask directly about it. They also found that Person Centred counsellors in their work with suicidal clients tended to just reflect back the client's words. This raised concerns that suicide risk may not be assessed and that the process of reflecting back may reinforce the clients despair rather than give hope. However, the findings of Moerman's (2012) study of Person Centred counsellors, seems to dispute this. This study found that counsellors did ask about suicide and did engage in risk assessments. Even though this was felt by the participants to be directive, they engaged in it in order to reduce the likelihood of client suicide.

Paulson and Worth's (2002) study looked at suicidal people's experience of counselling. In this study acknowledging and overcoming feelings of helplessness and despair was rated, by the clients, as the most helpful part of counselling. These participants identified that interpersonal connection and supportive relationships played a crucial role in their recovery. However they also described how disconnecting experiences with professionals 'reinforced [their] perception of isolation and despair' (p.91). In this study it was assumed that this disconnection came as a result of counsellor anxiety about death or when the counsellor was unwilling to identify and discuss the client's suicidal thoughts or behaviour. Reeves and Mintz (2001) and Whitfield's (2011) studies could be referred to in order to demonstrate that counsellors do often experience anxiety and fear when working with suicidal clients and

that their responses could lead to disconnection with the client. Conversely Moerman's (2011) study could be used to demonstrate that counsellors who have personal experience of suicide, and who, as a result of that experience, have explored their responses to it, are, potentially, more informed and therefore better able to connect with the suicidal client.

For the participants in Moerman's (2011) study, and in Reeves and Mintz (2001) and Whitfield (2011), the issue of training was seen as important. In Reeves and Mintz (2001) and, worryingly, ten years later, in Whitfield's study, concern was raised over the lack of training on core counselling courses on the issue of suicide. The fact that this lack of training has, seemingly, not been addressed should be of concern to the counselling profession, as the counsellors who have attended such training, for example those in Moerman's (2011) study, felt that such training increased their confidence in working with suicidal clients and made them better aware of the responsibilities they had to those clients.

One of the aims of this project is to add to the findings of the research outlined in this section of the literature review.

## **2.15 Summary**

The literature reviewed in this chapter sets the context for the project. In the next chapter the methodology chosen to conduct the research will be explained.

## **Chapter Three**

### **Methodology and Method**

#### **3.1 Methodology**

This is a small scale qualitative research study. The purpose of a qualitative study is to “focus on understanding human experience”, “emphasise rich descriptions”, and attempt to view human behaviour in its “context and complexity” (Dallos & Vetere, 2005, p.50). Within qualitative research there are a number of possible research approaches that can be followed including the Descriptive Phenomenological Method (Giorgi, 2009), Grounded Theory (Glaser & Strauss, 1967), Heuristic Inquiry (Moustakes, 1990) and Action Research (Reason & Bradbury, 2008). The methodological approach chosen for this project is Interpretative Phenomenological Analysis [IPA] (Smith et al, 2009). I chose IPA because its underlying theoretical and philosophical ethos, and the method that flows from it, will enable me to best explore the experiences of the participants in this study. It is an approach which is influenced by the phenomenological aspects of the philosophies of Husserl (1927), Heidegger (1927) and Sartre (1948). Those influences can be seen in the way the approach aims to help identify “the essential qualities of an experience” (p.12) and in its interest in psychological processes such as “perception, awareness and consciousness” (p.13). It can therefore provide a method by which I can explore the unique personal experiences of the research participants. It is also influenced by idiography, which is concerned with detailed study and analysis of an individual’s experience. It therefore provides a method by which to carry out a “detailed, nuanced analysis” (p.37) of these participants experience of this

particular subject. It is also influenced by hermeneutics and how we give meaning to a text. It is acknowledged, in this approach, that the beliefs and perceptions of the researcher will combine with that of the participants to produce the research outcomes and provides a method which is transparent about how this occurs.

## **3.2 Method**

In the rest of this chapter I will demonstrate how I have implemented the IPA approach in this particular study.

### **3.2.1 Sampling and participant recruitment**

The participants for this research were recruited using non probability, purposive, sampling. As Smith et al (2009) state, participants are selected purposively because they offer “insight into a particular experience” (p.48). The participants were recruited following a letter explaining the research project being published in *Therapy Today* (Jones, 2015), and from the advert being circulated by colleagues to individuals and organisations who they thought would be interested in the subject. From the counsellors who expressed interest, four people were selected. They were selected on the basis of “their experience, their interest and their knowledge of the subject” (Denscombe, 2010, p.25). In this case the participants who were chosen fulfilled the following inclusion criteria: Person Centred or Integrative Counsellors who are aware of their agency suicide policy; counsellors who are aware of the ethical issues that the policies raise for them; and counsellors who are aware of the tensions that arise for them in relation to those policies. The participants were then sent an

information sheet (Appendix 1) which explained the aims of the research and which outlined ethical concerns and protocol.

### **3.2.2 Data collection**

Semi-structured interviews were carried out with the four participants. They were asked four open questions. The questions were:

1. Could you explain to me what your personal views on suicide are?
2. Can you explain to me what your agency policy is regarding how to respond to suicidal clients?
3. What are your thoughts and feelings regarding this policy?
4. How do you think that affects your therapeutic work?

The interviews were recorded and transcribed verbatim.

### **3.2.3 Data storage**

The interviews were recorded onto a digital recorder which was kept in a locked drawer at my home when not in use. Recordings were transferred onto my PC and the files were password protected. Files were saved using a pseudonym and throughout the research participants are referred to using participant numbers to protect their anonymity. A back up copy of the files was held on a pen drive which was kept in a locked drawer. The transcribed interviews were saved to my PC and pen drive and the files password protected. All copies of the audio recordings and the electronic copies of the transcripts were deleted after the

dissertation had been successfully completed. A hard copy of the data will be kept for 5 years, in line with the University regulations, after which they will be shredded.

### **3.2.4 Ethical issues**

The research was underpinned by the Ethical Guidelines for Research in Counselling and Psychotherapy (Bond, 2004) and by the guidelines contained in the University of Chester Research Governance Handbook (2012). Ethical approval for the project was gained for the project from the University of Chester's, Department of Social and Political Sciences Ethics committee. As the study was concerned with a subject that might result in the discussion of issues that were distressing for the participants, I ensured that they had access to counselling support if needed. The participants could also have been concerned about issues of confidentiality and about their anonymity. They might have been concerned that their employer or placement might find out about their concerns regarding suicide policy and be fearful of the possible repercussions of such information being known. Therefore, in the Participant Information sheet (Appendix 1), the nature and limitations of confidentiality were explained, interviews were conducted away from the agency setting and pseudonyms were used within the transcript and the study to protect people's identities. The participants were also informed that they could withdraw from the research at any time prior to the write up of the dissertation. Participants then signed a research consent form (Appendix 2), which confirmed that they had read the Participant Information sheet, that they understood the boundaries of confidentiality and that they agreed to participate in the research. Lone worker procedure (Appendix 3) was also followed to ensure the safety of the researcher.

Following the interviews the participants were sent copies of the interview transcripts and asked to read and agree them.

### **3.2.5 Data analysis**

In order to draw findings from the data I studied the data “line by line” (Smith, 2009, p.79). I made initial notes on, and identified themes within, each individual transcript. I colour coded each transcript, cut up each transcript according to the initial theme identification and then organised the data into emerging themes. Common themes and patterns were identified. However, when analysing the data, as well as identifying common participant responses, I also highlighted examples of divergence in participant responses. This was done in order to ensure that the research expressed not only the participants’ common experiences, but also the detail and personal meaning attached to each individual participant’s experience. I then organised the data into a series of superordinate and subordinate themes.

### **3.2.6 Validity and reliability**

In order to assess the validity and reliability of the research it is useful to refer to, and judge it against, the validity criteria as outlined by Yardley (2008). In the conduct of the research I expressed sensitivity to the effects a discussion of suicide and of suicide policy may have on the participants. I ensured the participants had access to counselling support, if required, and that their concerns over anonymity were addressed. The research was conducted thoroughly and systematically and the process of the research is clearly explained throughout the study. A series of documents are also available to demonstrate the

authenticity of the data: Copies of the transcripts are available for my supervisor, and for internal and external examiners, to check, if required and the background information provided by the participants' is included in the appendix of the dissertation (Appendix 4). As Yardley states the ultimate test of the research is whether the research produces findings that are interesting and important. That question will be addressed in Chapter 6.

### **3.3 Summary**

Following this method resulted in the production of a large amount of data. In the next chapter the analysis of that data will be presented.

## Chapter Four

### Research Findings

#### 4.0 Overview

In this chapter the data from the analysis will be presented as a series of superordinate and subordinate themes as outlined in the table below.

<b>Superordinate themes:</b>	<b>How counsellors' beliefs and experiences affects their work with suicidal clients</b>	<b>The impact of suicide policy on the counsellor and on their practice</b>	<b>Professional and ethical issues and debates</b>
<b>Subordinate themes:</b>	Impact of personal experiences	Impact of working with this policy on the counsellor	Suggestions for improving suicide policy and procedure
	Influence of counselling training	Counsellors' response to the experience	Conform to policy or breach it
	Influence of professional code and counselling approach	How disagreement affects counsellors' opinion of the organisation in which they worked	Impact of the contract
		Potential impact on client	Intervening to keep people alive
		Impact on counsellor of a supportive policy	Physical health versus mental health presenting issues
			The need for increased awareness of the impact of personal and societal influences.

**Table 1: Superordinate and subordinate themes**

#### **4.1 Superordinate theme 1: How counsellors' beliefs and experiences affects their work with suicidal clients**

The data shows that the participants' beliefs and personal experiences affected their work with suicidal clients in a number of ways.

##### **4.1.1 Subordinate theme 1.1: Impact of personal experiences**

The data shows that the participants' personal experiences led them to an appreciation of the seriousness of the subject of suicide and gave them an understanding of how their responses to it were complex. All of the participants recognised that their beliefs and experiences could impact their work with clients. The participants sought extra training and explored their beliefs in supervision.

*P1 So rather than...avoid it, on behalf of all my clients who come to me, I've made jolly sure that I attend... as much training as I can (L184-191).*

*P2 I have done quite a lot in supervision about my understanding of my relationship with suicide and what it means, so that, as much as it can, doesn't interfere (L672-676).*

*P3 In training there's definitely something needed to cover suicide... I mean it's great that X puts on these courses, but again ...it's down to me to do it (L100-1005).*

*P4 I've done additional training (L888).*

These findings demonstrate how personal experience can positively impact on the counsellor. It can make the counsellor more inclined to seek knowledge of a subject and can lead to increased self-awareness. However, the concerns raised by these findings are that there is no consistency in how this subject is addressed. In the experience of these

participants, there was no compulsory component on counsellor training dealing with suicide, the agencies and places of work did not discuss suicide in core training events and it is left to the personal motivation of counsellors as to whether they seek further knowledge on the subject.

#### **4.1.2 Subordinate theme 1.2: Influence of counselling training**

The data showed that, as a result of their training, all of the participants were comfortable asking clients, directly, if they were suicidal and, understood the importance of doing so. The participants also all demonstrated their commitment to facilitating discussion of what may be causing their clients distress. Being with clients in this despair was often experienced by the participants as being desperately sad and often frightening. However, it was felt by all of them that, providing a relationship in which clients can give voice to their suicidal thoughts, is, potentially, therapeutic for the clients.

#### **4.1.3. Subordinate theme 1.3: Influence of professional code and of counselling approach.**

The data shows that three of the participants' work with suicidal clients had been influenced by their understanding of autonomy.

*P1 I think ultimately I believe in autonomy. I would say I do believe in autonomy, but I think there's a few 'buts' going with that for me (L112-115).*

*P1 I fantasise about facing somebody and saying, "oh yes, but it was their autonomy!" ... the family would be rightfully very angry if they thought that I knew. How does explanation of autonomy stand up to that? (L670-681).*

*P2 That would be influenced by my training and the thought that for that client, it might be the right thing and respecting their autonomy, respecting their right to choose (L831-845).*

*P3 At the end of the day it's going to be their choice, it's their autonomy, their choice, so I think that's where the person-centred influence comes in (L259-260).*

*P3 Maybe that's his autonomy. He is making a choice but his choice is asking me for help. And that's down to me. I suppose I have to recognise what he's doing and that's difficult I think (L1191-1204).*

Two of the participants raised concerns over whether maintaining the principle of autonomy with a client expressing suicidal intent was helpful. When they voiced their concerns they did so reluctantly. The fourth participant did not make reference to the concept. They had knowledge and understanding of the circumstances in which they and others may choose to die by suicide but that was not expressed using the term autonomy.

## **4.2 Superordinate theme 2: The impact of suicide policy on the counsellor and their practice**

The data shows that working within a suicide policy they disagreed with affected the participants, and their practice, in a number of ways.

### **4.2.1 Subordinate theme 2.1: Impact of working with this policy on the counsellor**

The data shows that participants experienced a range of distressing feelings as a result of working within a policy they disagreed with. All of the participants expressed feelings of powerlessness.

P1 What am I going to do?... I need to operate by policy (L598-562).

P2 I feel myself taking a step back because then...It's a kind of "let's go down the risk assessment slide" (L187-190).

P3 I didn't know what to do? (L969).

P4 The policy didn't give me, as a counsellor, power to put any protective measures in place for that person (L269-270).

The feelings of responsibility they felt for their clients and the feeling that they were powerless to act produced, in all of the participants', feelings of anxiety.

P1 I have to tell you that even as I'm talking to you now, right across the base of my stomach here, you know, my gut – I feel anxiety, you know (L638-642).

P2 There is part of me that's "oh, no, that means I've got to do this (L652-653).

P3 Something that's quite vague, causes a lot of anxiety, a lot of stress (L903-907).

P4 First time that I worried in between sessions about the physical safety of a client (L332-333).

The participants all discussed how they felt alone in this work. They felt that there was no-one to discuss their decisions with and that they would be left alone to deal with the consequences of any decision.

P1 I could tell you that that's what I think I'll do, but I don't know because it's scary as well, you know. It's lonely at that moment (L873-876).

P2 If a client of mine in this organisation, committed suicide, I think I would feel quite alone (L387-389).

P3 I have followed it but I suppose it felt very 'on my own' with it, is what I am saying (L899-901).

P4 So that it wasn't purely left purely in my hands. But that is very much how it would have felt if he had died (L515-517).

This theme of feeling alone also re-occurs when the participants discuss the dilemma of whether they should speak out about the policy. The data shows that the participants' view their decision as to whether to speak out or stay quiet about the policy as being about their individual responsibility to clients. There is, for these counsellors, seemingly, no other way in which such concerns can be raised.

#### **4.2.2 Subordinate theme 2.2: Counsellors' response to the experience**

The data shows that all of the participants discussed their concerns and responses to their agencies suicide policy with their supervisor. They all checked that they had acted ethically and professionally. These findings demonstrate the importance of supervisors being aware of the professional and ethical debates regarding suicide. They also demonstrate a potential danger, in that, concerns over suicide policies and their, potentially, damaging effects, may be contained within the supervisory relationship rather than result in concerns being raised within the organisation concerned.

#### **4.2.3 Subordinate theme 2.3: How disagreement affects counsellors' opinion of the organisation in which they worked.**

This theme demonstrates how the counsellors felt towards the organisation in which they worked once they became aware of their disagreement with that organisations' suicide policy. Two of the participants worked in agency settings, two worked, or used to work, in

the NHS. The two participants who worked in agency settings stated that they respected their organisations and that it was just on this issue they had disagreement.

*P1 I am very happy with the organisation I work for... To me they are family (L473-475).*

*P3 they are a really, really great agency and they do fantastic work and they have been going for many, many, many years. Just with this particular area, (L926-930).*

Their response to the failure of the organisations to adequately respond to their concerns over suicide policy was of disappointment. They were disappointed that they hadn't been heard. They called for more openness and debate and for counsellors to be included in policy discussion. However, under the reluctance to be seen as being critical of organisations otherwise experienced as supportive, was real concern regarding the impact of the policy they worked with. This theme demonstrates that loyalty to an organisation and the fear of losing their place within it could result in counsellors not speaking out.

As a result of their experiences of NHS suicide policy, the participants who worked in that setting felt that, not only were the policies inadequate in supporting them or their suicidal clients, but that if a client successfully completed suicide then the organisation would look for someone to blame for it.

*P2 It feels ...like there's a blame culture (L453-454).*

*P2 That actually if you make a judgement, you are kind of out on your own. (L467-468).*

*P4 If they had needed to hang out somebody for the death of that client then they would have quite happily done that (L716-718).*

*P4 they could have been like "you didn't follow policy – you're sacked" (L525-526).*

This climate of fear resulted in secrecy. One of the participants felt unable to discuss the issue with colleagues and felt unable to speak out about what was experienced as unethical practice. The other felt unable to discuss suicidal clients outside of the counselling team.

*P2 We don't say anything because those clients might be referred on to somebody else. We might be under pressure to refer them on (L561-569).*

These counsellors' experiences resulted in them feeling angry, unvalued and disconnected from the organisation.

#### **4.2.4. Subordinate theme 2.4: Potential impact on client.**

The findings under this theme demonstrate the potential impacts that both the suicide policy and the counsellors' reactions to it can have on the client. All of the participants in the study were aware that their actions could affect whether the client lived or died. For two of the participants the point at which they felt a suicidal client may die was if they abided by a policy commitment to not breach confidentiality without the client's agreement. For one participant the danger to the client's life resulted from abiding by a policy which stated that if a suicidal client signed a contract saying that they, the client, would seek additional help when they left the session, then they were to allow the client to leave. This meant that the counsellor was powerless to take action to ensure the client's safety, even though they knew the client was going to straight from the session to the place where they planned to kill themselves. For one participant it was the risk associated with continuing to counsel a suicidal client rather than refer them on to other 'specialist services' as the policy expected.

Two of the participants raised additional concerns over the potential effect their actions could have on the client. One of the participants stated that the tensions she had with the policy resulted in her feeling distracted from her work.

*P2 All those layers of my thoughts about suicide... they all come into play and it's kind of finding my way back to be with the client, so it is distracting. Definitely I feel distracted (L665-669).*

Both of them felt that their reactions could result in the client feeling that suicide was a subject that wasn't to be discussed in counselling.

*P2 It might just give them a message that this is not an area for them to talk about and take them away from that place (L701-709).*

*P4 I got to the point where I was contracting with clients so that they knew that would happen and you know when you're thinking at the back of your head – are they just not telling me this, that they're suicidal, because they know that I'm going to be worried about them and I can't do anything (L372-378).*

These findings demonstrate that counsellors' tensions with policy can cause a rupture in the client-counsellor relationship resulting in clients being unable to give voice to their distress.

In addition, one participant stated that her realisation that the policy didn't keep clients safe had another effect on her, which was, that she stopped asking clients if they were suicidal,

*P4 I felt less able to directly ask the question....I felt less able to ask the question because I thought well I'm powerless if they say yes (L455-463).*

This then resulted in the issue of suicide not being raised by her clients,

*P4 I can definitely say that, looking back when I stopped asking, I saw it less ...and I do think that continued to put people at risk (L611-616).*

These findings have implications, not only for a counsellor working under a policy they disagree with, but for all counsellors. It demonstrates the importance of counsellors asking people as to whether they are suicidal and the potential danger that can arise if they don't. The danger being that client's suicidal thoughts remain hidden and unacknowledged and the opportunity for them to be voiced and for the client's distress, potentially, to be eased, lost.

#### **4.2.5 Subordinate theme 2.5: Impact on counsellor of a supportive policy**

The data shows that when the participants talked about working within a policy that supported them and their clients, then all of the tensions outlined in section 4.2.1 disappeared. The tone of voice of the participants changed and they spoke of feeling supported, confident and happy, secure in the knowledge that they were doing their best for the client. Working within such a policy didn't mean that the participants wouldn't have concerns and worries about a suicidal client but they all said that the additional concerns about working with a policy that they felt was inadequate would disappear.

### **4.3 Superordinate theme 3: Professional and ethical issues and debates**

Under this theme the data which has implications for professional practice and for the ethical conduct of that practice is presented.

#### **4.3.1. Subordinate theme 3.1: Suggestions for improving suicide policy and procedure**

The participants outlined the following ideas for improving policy:

1. A recognition and acceptance that counsellors work with suicidal clients and that this work is beneficial to the client (P2).
2. For organisations to encourage debate and discussion of their policy (P1).
3. For organisations to encourage counsellors involvement in discussions on what action is best suited to that client (P1 P2 P3 P4).
4. For policies to include a range of options that could be taken depending on the needs of the individual (P1 P2 P3 P4).
5. When clear suicidal intent is expressed by the client for options to include breaking client confidentiality even if the client doesn't agree (P1), keep safe plans and taking the client to A&E (P3, P4).
6. Recognition that some clients may choose to end their life regardless of the support they receive (P1, P2, P3, P4), for policies to recognise the impact this could have on the counsellor and for any investigation to be sympathetic to that impact.

7. For organisations to provide compulsory training on working with suicide (P3).

All of the participants wanted policy to recognise the need to be flexible in responding to an individual in crisis and to provide them with support in their work with suicidal clients.

#### **4.3.2. Subordinate theme 3.2: Conform to policy or breach it**

The data shows that deciding whether they would conform to policy or breach it was a difficult dilemma for the participants. One participant hoped she would be strong enough to put aside policy if it was about saving a life but was uncertain about what she would actually do.

*P1 ...that I am strong enough to put aside policy if I deem it to be about saving a life (L860-871).*

*P1 So truly the honest answer would be I don't know, but ...if it's a life or death call, then it has to be life. I could live with that one better (L885-893).*

One participant stated she would break confidentiality to keep the client safe.

*P3 I would just hope at the end of the day that I've acted in a way that I feel has got my client's interests at the heart of it, even if that means that I had to go on and break confidentiality, to keep them safe (L1082-1087).*

Another felt that when she was working in the NHS she had no choice other than to conform to policy. However now, if she was in a similar position, she wouldn't.

*P4 But now I wouldn't care. I rather they told me off, sacked me, whatever, as long as the person was safe. But when you are a trainee and when you rely on the income, there's another whole pile of stuff comes into the*

*equation, that I don't believe should come into the equation, but it does because we are human (L794-801).*

This theme demonstrates that these counsellors felt that the policy stops them from intervening to stop someone from killing themselves. This felt wrong to them and they hoped they would breach that policy. However the weight of the authority of the organisation, the need/ wish to stay part of the organisation and, for two of the participants, the need to abide by the concept of client 'autonomy' means they are unsure as to whether they would breach it.

For one participant the dilemma is different. For her breaching the policy is potentially a continual process. The breach of policy is choosing to continue to work with a suicidal client when policy suggests that she refers the person on.

*P2 Should I have referred this client on?... but I also felt that she was finding the sessions useful ... She answered that she didn't want to be referred on, that she was happy to stay with what we were working on, so ... I guess, me having made that decision, did in a way isolate me (L242-434).*

#### **4.3.3 Subordinate theme 3.3: Impact of the contract**

This theme highlighted the impact that contracting can have on the suicidal client. One participant raised the problems that can occur if the client is expected to sign a contract, and agree to a particular course of action, when they become suicidal rather than at the start of the counselling relationship when they are, potentially, more able to make a considered decision as to how they would like to be responded to if they become suicidal. One participant raised concerns that, as a result of the wording 'confidentiality will be broken in

there is a danger of harm to self or others', the client could feel, from the start that there are some things that shouldn't be discussed.

*P2 We set the scene from the beginning that there are things it would be better not to tell me (L309-311).*

One participant raised concerns over the vagueness of the same wording,

*P3 Having to experience something for the first time with something that's quite vague, causes a lot of anxiety, a lot of stress, where I feel if we had some guidelines then maybe we would approach it in a more constant manner; a more self-assured manner, (L906-911).*

One participant stated that, as a result of her previous experience, the contract that she now uses in private practice is very clear about how she will respond should they, the client, become suicidal. She is clear that if they express an immediate intention to act on their suicidal thoughts that she, and her colleagues, will do what they can to keep them safe, which may include taking them to A&E.

#### **4.3.4 Subordinate theme 3.4: Intervening to keep people alive**

The data shows that a consideration of whether they should intervene to keep a client alive was an issue for the participants. One participant expressed this in terms of holding hope for the client.

*P1 So for me, there's always the hope that they might change their mind...even if there isn't 'at this moment'...I'd rather face court across the courtroom from my client and know that I've given them the choice (L753-763).*

*P1 And so for me, even in the depths of despair, where the client might not have hope, I hope in the relationship and I hold that hope, until that client is ready to hold hope themselves (L739-751).*

One participant emphasised that the client comes to counselling because they want help and that counsellors need to recognise and respond to this.

*P3 With that last client...it felt like he was hanging off the edge of a cliff and that he was reaching up and that I was to take his hand...He was going to do this, he was going to do this act unless someone helped him (L1191-1200).*

She also raised concerns over the potential impact a person's suicide may have on those left behind.

*P3 And we do talk about what life might be like for their loved ones without them (L438).*

These participants were unsure about whether their inclination to intervene was professionally acceptable. This was shown in the tone of voice and in the tentative way they spoke about the subject. The fourth participant was more confident in her opinion. She stated that, in her experience, clients who are kept alive are glad to be alive after the suicidal crisis has past.

*P4 But I don't think clients generally seem happy when you send them to a place of safety, in the immediate, but I've never have had a client yet say to me six weeks, six months, six years down the line "you should have just let me do it". They've all been glad to be here by the time they have got to a place of wellness, so I guess that what in forms my practice now (L937-949).*

#### 4.3.5 Subordinate theme 3.5: Physical health versus mental health presenting issues

The data produced findings which add to the debate regarding counsellors' responses to clients considering suicide as a result of their physical ill health. Two of the participants raised this issue. It was recognised that in society there is, by the majority, an acceptance that people with terminal/ serious physical health problems should be supported if they decide to end their life. However, the data suggests that if counsellors accept this without questioning then they could be overlooking some important issues. One of the participants, who has experience of working with terminally ill people, explained that

*P2 Often people are really scared of pain and the actual death itself and the people at the hospice can be very reassuring about what that particular person's end of life might look like... how they can be managed with drugs...I'd try to show them options but yes... I guess, at some level it feels different because of how poorly they are (L870-896).*

The other participant raised another aspect of the subject which is that, if counsellors accept this without questioning then, they could, inadvertently, be overlooking other aspects of the clients' experiences that are influencing their decision.

*P4 Yes, just because you have a terminal cancer diagnosis that doesn't mean that you can't also have depression. You could be suicidal because you are depressed not just because you have cancer...You could be putting yourself in a situation, if you make the judgement just on physical health, that you risk making an incorrect judgement decision (L1092-1108).*

#### **4.3.6. Subordinate theme 3.6: The need for increased awareness of the impact of personal and societal influences**

The data showed that for one participant the method by which the client was planning to die influenced her response to the client.

*P2 His prognosis was good and because of the side effects of the medication he was taking, he decided that he didn't want to take any more and ... I completely respected his right and his choice that that was something that he wanted to do (L914-924).*

*P2 Interesting, isn't it? If somebody – if that same person said to me "I'm going to hang myself next week", I think I would respond differently (L960-962).*

These influences only became apparent to the participant during the interview. These findings demonstrate the importance of counsellors thoroughly exploring and questioning their views, as many influences may otherwise remain hidden and unacknowledged.

#### **4.4 Summary**

The findings from this research have implications for the theoretical understanding of working with suicidal clients and for the practice of working with such clients. In the next chapter these implications will be discussed.

## **Chapter Five**

### **Discussion**

#### **5.1 Positive effects of the experience on participants**

This research confirms Moerman's (2011) findings that difficult personal experiences can sometimes have a positive impact on counsellors' work with clients. The worries and concerns that came from working within a suicide policy with which they had disagreements, resulted in these participants questioning their beliefs, seeking extra training and giving greater consideration to their work with suicidal clients (see section 4.1.1).

#### **5.2 Confident working with suicidal clients**

This research, in contradiction to that of Reeves and Mintz (2001) and Whitfield (2011), demonstrated that some counsellors do feel confident in their work with suicidal clients. All of these participants demonstrated their knowledge of the theory as expressed by Firestone (1997), which states that clients benefit from having a space in which they can explore their distress (see section 4.2.1). They also all recognised the importance of understanding the language of suicide and the importance of naming it (Reeves, 2010). The findings also demonstrate the danger that can arise if counsellors do not have that knowledge or confidence (see section 4.2.4). The implication here is that if counsellors do not have the confidence to name suicide or recognise the language of suicide, and discuss it, then it may remain hidden and result in the client being left alone with those thoughts.

### **5.3 Training**

This research also found that, as in the studies conducted by Reeves and Mintz (2001) and Whitfield (2011), there is still concern over lack of training (see section 4.1.1). The research found that, although training was available on the issue, it was left to the motivation of the individual counsellor as to whether they accessed it.

### **5.4 Autonomy**

This research found that, amongst some counsellors, there may be confusion over what it means to respect a client's autonomy. Autonomy is one of the principles outlined in the BACP's ethical framework for good practice (BACP, 2013). In that framework the stated definition of the principle of autonomy is that it is important to "develop a client's ability to be self-directing within therapy and in all areas of life" (p.3). It specifically states that respect for a client's autonomy is demonstrated by counsellors giving clients the information they need to enable them to give informed consent to the counselling process. However, the responses from these participants suggest that they have given autonomy a meaning different to that stated in the framework (see section 4.1.3). As well as possible confusion over the meaning of autonomy that may come from counsellors' awareness of the BACP's ethical framework, the research also suggests that there may be particular confusion regarding the relevance of the concept of autonomy to the PCA. Two of the counsellors in this study demonstrated that they believe that respecting a client's autonomy is an important part of the PCA. Such an interpretation is open to debate. The PCA, in its explanation of the theory and practice of counselling, rarely talk about autonomy. Instead

the PCA gives attention to the conditions which Rogers argues are necessary to facilitate constructive personality change. Those conditions include the requirement for the counsellor to experience unconditional positive regard for the client, for the counsellor to experience an empathic understanding of the client's frame of reference and for both of those to be communicated, to a minimal degree, to the client (Mearns & Thorne, 2013; Merry, 2002; Rogers, 1951). This research demonstrates that misunderstandings of theoretical concepts can affect the actions of the counsellor and therefore affect the client. It also implies that consideration should be given as to why such misunderstandings may arise and attention given to how these concepts are explained on counselling courses, at training events and in theoretical and professional publications.

### **5.5 Environmental pressures and isolation**

This research found that the need to stay in a job, or complete a placement, can have an impact on whether counsellors feel able to speak out about their agencies suicide policy (see section 4.2.3). The participants describe work environments in which people are fearful of raising their concerns and disagreements and the resulting feelings of isolation that this produces (see section 4.2.1). This research demonstrates that the counselling profession faces a challenge in overcoming the feelings of isolation that counsellors experience in regard to such issues and demonstrates the need for more aspects of counselling to find collective, rather than individual, forms of expression.

## 5.6 Policy

This research agrees with the findings of Reeves and Mintz (2001) and Whitfield (2011) when they state that suicide policies need to be flexible in their responses to suicidal clients if counsellors are to feel supported in their work. In addition this research produced a list of suggestions as to how those policies could be improved (see section 4.3.1). They include the suggestion that policies should recognise and accept that counsellors work with suicidal clients, that counsellors should be included in policy discussions and in discussions on what action is best suited to individual clients, and that there should be a range of options available as to what action to take with such clients. These suggestions could easily be incorporated into any policy. Their inclusion would alleviate the anxiety of counsellors and improve support for the clients.

The research has also produced findings that have implications for how the issue of suicide is contracted (see section 4.3.3). These findings suggest that policies/ contracts which state that the client can decide how they wish to be responded to when they are in the middle of a suicidal crisis, as opposed to considering it before the crisis, are problematic. Similarly the findings suggest that the wording 'confidentiality will be broken if there is a danger of harm to self or others', is unhelpful. Such a formulation is vague and can lead to both the counsellor and the client speculating as to what may or may not happen if certain subjects are raised. It would be more beneficial for policies to clearly state what the counsellor will do if the client expresses their intent to act on their suicidal thoughts. Such policies would dispel any uncertainty caused by vague and unclear wording and would mean the client would know what support to expect if they were to become actively suicidal.

### **5.7 Conform to policy or breach it**

This research demonstrates that a dilemma facing counsellors when working within a policy they disagree with is whether to conform to the organisations policy or breach it (see section 4.3.2). It is usually expected that when counsellors work within an organisation they abide by the policy of that organisation. Such policies are meant to provide a framework in which responses to a potential suicidal client are transparent, to ensure that there is an equitable response to all clients and to ensure that counsellors don't 'act out' their personal views on suicide (Reeves, 2010). However, if conforming to that policy means the client doesn't get the support they need to help them survive a suicidal crisis, and if that policy results in the practitioner feeling professionally compromised, then it is, arguably, ethical to breach those policies. This research demonstrates that a reluctance to breach policies that are experienced as unethical is often a result of pressures that are external to the counselling relationship, for example, fear of losing a job or place on a placement, rather than what's in the best interest of the client. If the external pressures, and the misunderstanding of theory, were removed then the participants in this study would have breached policy. It is arguable that such responses would have been or would be ethical.

### **5.8 Impact on client**

This research shows that the main fear the participants had regarding the impact the policies had on clients was that they increased the likelihood of clients successfully completing suicide. This outcome could be a result of policies failing to provide the support necessary to a client in crisis or a result of the, less obvious, effects the policy could have on the client as a

result of a rupture in the client-counsellor relationship. These findings add to those of Paulson and Worth's study (2002). This study showed that, if a client feels that the counsellor is anxious when discussing suicide, then this can result in the connection between the counsellor and the client being broken. This may then have a further impact on the client in that their feelings of isolation and hopelessness are reinforced. In the Paulson and Worth study it was suggested that the anxiety of the counsellor came from being fearful of discussing suicide, whereas in this study, the counsellors' unease wasn't a result of being fearful and anxious about discussing suicide per se but was a consequence of working within a particular policy.

### **5.9 Intervening to keep someone alive**

Another question raised by the research was, on what basis do counsellors make the decision to intervene to keep someone alive? For three of the participants in this study, their reasons as to why they would wish to intervene to keep a client alive went beyond consideration of the legal issues of capacity or the policy that they worked within (see section 4.3.4). For one participant, their opinion had come from consideration of the question, What if the client may live to see a better day? For another it was based on her view that clients come to counselling for a reason, and sometimes that reason is to get help through a crisis. For another of the participants, the decision to intervene was based on her experience of working with many suicidal clients. Her experience was that, although often at the time of the suicidal crisis clients were unhappy about being taken to A&E, all of them, whether three weeks or six months later, were glad to be alive after the crisis passed. If it is

the case, as this research and that of others (Hecht, 2013; Mather, 1987) suggest, that many people are glad to survive their suicide attempts, then the literature which is meant to inform counsellors work with suicidal clients should draw counsellor's attention to that fact. Having this knowledge could result in counsellors, like two of those in this study, feeling that their desire to intervene isn't just based on a personal wish to keep someone alive, but is theoretically justified.

### **5.10 Physical health versus mental health**

The research produced data which adds to the debate regarding counsellors' responses to people deciding to end their life due to their physical health. With two of the participants the issue was raised of how often people respond differently towards those considering ending their life as a result of physical ill health as opposed to mental health issues (see section 4.3.5). It was recognised that, in general, people tend to respond with acceptance to those considering ending their life due to physical illness (Jamison, 1999) and question the validity of those planning to end their life as a result of emotional distress. However these participants also agreed with Jamison in her assertion that such acceptance can mean that other factors may be overlooked. For example, one participant explained that once the issue of pain is addressed for people diagnosed with a terminal illness the wish to end their life early tended to disappear. The other participant highlighted another point which is, if counsellors accept that the client's reason for contemplating suicide is physical then they could fail to explore other reasons that may be causing them distress. Again these findings concur with those of Jamison (1999), whose research shows that people who complete

suicide for reasons of physical ill health, usually, also have an underlying mental health condition. These findings demonstrate that counsellors' pre-conceptions concerning the presenting issues of the client could, inadvertently, result in them expressing approval of the clients decision to end their life and result in them failing to explore all of the issues that could be causing the client distress.

### **5.11 The impact of personal views**

This research also confirms the findings of Reeves (2010), in that it demonstrates that counsellors' responses to suicidal clients are complex and that it is possible for some influences to remain hidden and unacknowledged unless they are thoroughly explored (see section 4.3.6).

### **5.11 Summary**

The findings from this research have raised many issues which are of relevance to the counselling profession and to counsellors' work with suicidal clients. In the following final chapter the key findings will be summarised and the research process itself reflected on.

## **Chapter Six**

### **Conclusion**

#### **6.1 Reflection on the study**

The study has produced findings which demonstrate the complexity of the subject of working with suicide (Denscombe, 2010) and which will be of interest to, and have an impact on, the wider counselling community (Yardley, 2008). The research produced vast amounts of data. However, what proved to be difficult, was presenting it, within the word limit constraints, in a way that honestly reflected the concerns of the participants and demonstrated the breadth of issues an exploration of this subject raised, at the same time as enabling a more in depth, interpretative analysis of the findings. This was a limitation of the study. This highlights the concern raised by Smith et al (2009) that often description and breadth can detract from depth of analysis. A further limitation, resulting from the word limit, is that some of the theoretical implications of the findings are not thoroughly developed. This will hopefully be redressed by promoting the findings from the research, and raising the theoretical implications of it, in practitioner journals and amongst forums of counsellors.

#### **6.2 Personal reflection**

This research has affected me in many ways. I was touched by the personal struggles of the participants and their efforts to do the best they could for their clients. I have changed my

views as a result of studying the philosophical debates on the subject. The research also made me reflect on what sort of counsellor I would want for myself, or family members, if one of us were the suicidal client. I would want a counsellor who held hope for me and who believed I may see a better day; a counsellor who could accompany me in the exploration of that distress; and a counsellor who would keep me safe if I was to find myself in a place where I thought I couldn't carry on. I would also, as a result of this project, ensure that I was informed of the counsellor's beliefs and approach to suicide before counselling began.

### **6.3 Implications for practice**

The research has answered the question,

How do agency suicide policies impact on counsellors and the counselling relationship?

It has demonstrated that counsellors, who would otherwise feel confident in their work with suicidal clients, feel anxious and concerned for the safety of their clients as a result of working within a policy that feels inadequate. The research also demonstrates how counsellors feel isolated when in this position and points to the need for counsellor organisations, such as the BACP, to provide a forum in which such issues can be addressed. The research has also resulted in the production of suggestions as to how policy could be improved and demonstrated that the implementation of such changes would alleviate the stress felt by counsellors and provide more support to clients experiencing a suicidal crisis. In addition the conclusions of the research suggest, controversially, that it is ethical for

counsellors to breach policy if they believe that policy does not have the best interest of the client at its heart, and does not protect them in times of crisis.

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## Appendix 1.



### Research Information Sheet

#### **Title of Dissertation**

Working with suicide: An exploration of the tensions that may exist if counsellors' beliefs and agency suicide policy conflict.

#### **Researcher**

I am a 3<sup>rd</sup> Year post graduate student at the University of Chester studying for an MA in Clinical Counselling.

#### **Research rational**

The purpose of this study is to explore counsellors' experiences of working with suicide with particular focus on the tensions which may occur if there is a conflict between the counsellor's values and beliefs as to how suicidal thoughts and intent should be responded to, and the policy which boundaries their practice.

Counsellors work in settings in which suicide policy may vary greatly: Some policies state that if the client reports of suicide ideation then the counselling stops and the client is referred on. In others the suicide contract is put in place and the counsellor's role is to help keep that person alive, and in others no action can be taken without the client's consent.

Given all of the possible policy variations, it is likely that some counsellors will be aware of tensions that exist for them between their beliefs (and that of their modality) and the policies of the agency they work for.

The aim of the research is to explore the impact that agency suicide policy may have on the counsellor and on their client.

#### **Why you and what do you have to do?**

I am looking for participants who are:

- Person-Centred or Integrative counsellors: qualified or trainee.
- Counsellors who are age 21 years or older.
- Counsellors who counsel in an agency setting and are aware of their agency suicide policy.
- Counsellors who are aware of the ethical issues that the policies raise for them.
- Counsellors who are aware of the tensions that arise for them in relation to those policies.
- Counsellors who are fluent in English.

If you choose to put yourself forward to participate and meet the inclusion criteria your involvement will be an hour long audio-recorded interview based on the questions below. The interview will be held at a mutually convenient location. After the interview I will transcribe the audio recording. I will send you a copy of the transcript to check for accuracy.

You can choose to withdraw from the study up until the time the dissertation is beginning to be written up. (I will let you know when that is).

### **Interview Questions**

The intention is that these questions provide a loose structure for the interview which will enable you to talk about all of your experiences regarding this subject.

The questions that you will be asked are:

1. Could you explain to me what your personal views on suicide are?
2. Can you explain to me what your agency policy is regarding how to respond to suicidal clients?
3. What are your thoughts and feelings regarding this policy?
4. How do you think that affects your therapeutic work?

### **Benefits of the Research**

- There is currently no research on the impact suicide policy can have on the counsellor and therefore on the relationship the counsellor has with a suicidal client. It is important to investigate what those impacts might be if one of our ethical considerations is to ensure the well-being of the client. This study will fit within the current discourse within the BACP on the importance of ethical practice.
- The study could potentially encourage counsellors to reflect on how agency policy on suicide may impact on them, and encourage counsellors to give further consideration to how their beliefs and approach to suicide can influence and affect a suicidal client.
- This study will potentially help inform those concerned with suicide policy formation and will add to the currently existing knowledge on working with suicidal clients.

### **What are the risks?**

There is the possibility that, during the interviews, issues will be raised that will lead to the exploration of sensitive and painful experiences concerning your own experiences of suicide and that of friends, family or clients. If this was the case I would hope that you would be able to access support maybe from a counsellor or supervisor. I can also provide details of therapists in your locality if you require them.

### **Confidentiality**

Throughout the research I will ensure that your anonymity is maintained. You will be allocated a pseudonym and any information which could identify you or your clients will not be included. You may be particularly concerned about your agency becoming aware of your views on their suicide policy so, as well as allocating you a pseudonym, the agency you work for will not be identified, and the interview will be conducted away from the agencies premises. In the research you will be anonymous. However the data you provide will be available to dissertation supervisors and extracts from your interview may be included in the final report which will be public.

### **What will happen to the results?**

The results will form part of my MA dissertation which will be submitted to the University of Chester. I also hope to circulate the findings amongst the counselling community and to those who formulate suicide policy.

### **Data Protection**

The interviews will be recorded onto a digital recorder which will be kept in a locked drawer at my home when not in use. Recordings will be transferred onto my PC and their file will be password protected. Files will be saved under a pseudonym. These pseudonyms will be used throughout the research. A back up copy of the files will be held on a pen drive which will be kept in a locked drawer. The transcribed interviews will be saved to my PC and a pen drive and electronic files will be password protected. All copies of the audio recordings will be deleted after the dissertation has been successfully completed. My electronic copies of the transcriptions will also be deleted at that time;

however a hard copy of the data will be kept for 5 years in line with the University regulations. The hard copies will then be shredded. Data protection procedures will be followed.

### **Ethics**

The study will be conducted according to the guidelines and standards within the BACP Ethical Guidelines for Research In Counselling and Psychotherapy (Bond 2004) and the University of Chester Research Governance Handbook (2012). The research proposal has also been submitted to and approved by the University's ethics committee.

### **How to Complain**

If at any point during the study you are unhappy about the conduct of the research and feel unable to raise it with me please contact Dr Peter Gubi at [p.gubi@chester.ac.uk](mailto:p.gubi@chester.ac.uk) or the Dean of Faculty: Dr. David Balsamo at [d.basamo@chester.ac.uk](mailto:d.basamo@chester.ac.uk)

**If you would like more information or wish to contact me email Elaine at [1124531@chester.ac.uk](mailto:1124531@chester.ac.uk).**



### Appendix 3.



## MA, DProf & PhD in Counselling

### Lone Worker Procedures for Research Students

#### **Conducting interviews with participants in their own homes, in public places, or on the streets.**

Once the researcher is ready to conduct the interviews, the following sensible procedures must be adopted:

The researcher's own health needs should be checked and appropriate proactive strategies adopted to ensure the well-being of researcher and participant(s) e.g. medical conditions that would place a researcher at risk should be noted, emergency arrangements appropriate to the needs of the researcher must be put in place if needed.

The participant's health needs should be checked in a similar fashion to that outlined above, with clear information given to participants as to the reason why such information is being collected and how it will be kept confidential under Data Protection legislation

The security of the lone researcher must be ensured. This would involve the following measures:

- The researcher informs their research supervisor (or a nominated person) of the name and address of the person to be visited and the times of the interview. They must leave with the supervisor (or a nominated person) a mobile phone number on which they can be contacted.
- The researcher will phone the research supervisor (or nominated person) within half an hour of the end of the proposed interview.
- If the researcher does not phone, the research supervisor (or nominated person) will ring the researcher to check everything is OK.
- If no contact can be made, then support is called for by the research supervisor (or nominated person) as appropriate (e.g. police).
- If the interviews are to be conducted abroad, then parallel procedures to those described above must be put in place. The key issue is the appointment of a contact person with clearly delineated responsibilities should a researcher fail to make contact according to an agreed schedule.

#### Appendix 4.

##### Participant Background information: Participant 1 (P1)

Approach	Integrative
Counselling setting	Agency
Qualification	Diploma in Counselling
No. of years qualified	8
Experience of suicidal clients	33% of clients

##### Participant Background information: Participant 2 (P2)

Approach	Person Centred
Counselling setting	NHS
Qualification	MA in Clinical Counselling
No. of years qualified	2
Experience of suicidal clients	20% of clients

##### Participant Background information: Participant 3 (P3)

Approach	Person Centred
Counselling setting	Agency
Qualification	Diploma Level 5
No. of years qualified	Qualified 2015
Experience of suicidal clients	30% of clients

Participant Background information: Participant 4 (P4)

Approach	Integrative
Counselling setting	Was NHS now in private practice
Qualification	Post Grad Diploma in Counselling
No. of years qualified	4
Experience of suicidal clients	30% of clients.