“All Changed, Changed Utterly”
- A TERRIBLE BEAUTY IS BORN -

An Exploration on the Effects of Suicidality on the Experienced Clinician

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Declaration

I declare that this thesis is my own work, and it has not been submitted as an exercise for a degree in any other University. I agree that the library at Dublin Business School may lend or copy this thesis on request.

Signed: ____________________ Date: ____________________

Heather Moore
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Abstract

Psychotherapy is a life-enhancing pursuit. The treatment and management of suicidality are considered the most vexing dilemmas a therapist will face in their entire clinical career. Those providing care to suicidal clients are vividly aware of the awesome responsibility, intense dedication and exquisite sensitivity required for this work. Not surprisingly, the overwhelming fear generated by suicidality, stems from the unpredictability that coincides with a ‘death threat’ hanging over the therapeutic relationship. Indeed, the subject of suicide cuts deep into the heart of this encounter. Suicidality is commonly conceived in benign terms, as part of depressive state, a cry for help, or as a means to manipulate others. It matters how we conceptualise suicide, and in this study, a psychoanalytic illumination of the process of suicide is deemed critical to understand the impact of suicidal acts.

Despite extensive research examining the effects of traumatic experiences on therapists who work with sexual abuse or domestic violence, there is limited empirical literature on the impact on those practitioners working exclusively with suicidal populations. In Ireland, it is estimated that 500 citizens die by suicide each year, while approximately 11,000 ‘Accidents & Emergency’ admissions are the consequence of suicide attempts. The establishment of the Irish National Task Force on Suicide in 1995 generated a proliferation of therapeutic preventative programs.

Therefore, this research seeks to explore and examine the effects of suicide prevention on seven accredited and experienced Irish psychotherapists. The process of interpretative phenomenological analysis (IPA) was applied to the narratives of these mental health professionals, and three salient superordinate themes emerged from the data: 1) Overworking; 2) “All Changed, Changed Utterly”/Identity Disruption; 3) “A Terrible Beauty is Born”/A Spiritual Practice. Most striking across all seven transcripts was the mix of the corrosive nature of suicidality on the self of the therapist, combined with unparalleled opportunities for personal growth and spiritual reformulation.
Chapter One: Introduction

“Therapists consider suicidal statements to be the most stressful form of patient behaviour encountered in their practice”
(Farber, 1983, p. 697)

1.1 Introduction

To face death is a terrifying feat for humanity. Hence, practitioners providing care to suicidal clients are exquisitely aware of the awesome responsibility, dedication and sensitivity required for this work (Fox & Cooper, 1998). Professional literature is replete with practical guidelines for suicide risk assessment, ideation, and in formulating life-orientated strategies (Arensman, McAuliffè, Corcoran & Perry, 2004; Bongar & Harmatz 1991). The very subject of suicide touches a raw psychotherapeutic nerve. It is articulated that there are two types of clinicians working in suicide prevention: those who have had a client suicide and those who have not had one ‘just yet’ (Kleespies, Penk & Forsyth, 1993; Menninger, 1991; Bongar & Harmatz, 1991; Valente, 1994). Arguably, the risk of suicidal behaviour is common across many Irish clinical situations and could potentially be regarded as ‘an occupational hazard’ (Chemtob, Bauer, Hamada, Pelowski & Muraoka, 1989; Foley & Kelly, 2007; Jobes, Luoma, Husted & Mann, 2000).

In recent years, there has been a plethora of qualitative investigations into the area of bereavement through suicide (Begley & Quayle, 2007). However, there is a dearth of research on the influence of attempted, threatened or even completed suicide on the practitioner (Alexander, 2007; Fox & Cooper, 1998; Rycroft, 2005; Tillman, 2006). This elicits the question, how does suicidality in the broadest sense impact mental health professionals who work with these vulnerable populations? Dr. Ella Arensman (personal communication, 2011), the director of the National Suicide Research Foundation of Ireland, reports that there is scant attention focused on the effects of suicidality on Irish psychotherapists. Suicidologists define death by suicide as self-inflicted, a consequence of the established actions and intentions of the deceased (Corcoran & Arensman, 2010). Mars, Berman and Silverman (2000) recognise “completed suicide is the tip of proverbial self-destructive iceberg” (p.4). For the purposes of this inquiry, suicidality will be employed in the broadest sense of the definition. Therefore, the term is inclusive of completed suicides, suicide attempts, ideation, parasuicide, deliberate self-harm and a plethora of self-destructive symptomatology (ibid.).
1.2 Irish Context

The recording of death by suicide in the Republic of Ireland is a monumental undertaking requiring the collaboration of many multi-disciplined agencies, such as coroners, medical examiners, pathologists, registrars and the Garda Síochána (Corcoran & Arensman, 2010). Ireland is largely associated with underreporting due to the correlation with stigma, religion, guilt and shame (Kelleher, Corcoran & Keeley, 1997; Walsh, Cullen, Cullivan & O’Donnell, 1990). Corcoran and Arensman’s (2010) study underscores the elevated risk of suicide affiliated with marital breakdown and unemployment in post-Celtic Tiger Ireland. The decriminalization of suicide in Ireland in 1993, followed by the establishment of the Irish National Task Force on Suicide in 1995, has resulted in the proliferation of preventative programs. Consequently, efforts have been made to address this national issue at multi-levels of society, but current research documents that more people die by suicide in Ireland annually, than road traffic accidents (Health Services Executive, 2011). Unlike most European countries where suicide rates increase with age, young Irish males are overrepresented with peak rates among those aged 15–34 years (McMahon, Reulbach, Corcoran, Keeley, Perry, Arensman, 2010; World Health Organisation, 2011). These figures demonstrate that suicide rates among young Irish people aged 15–19 years are the third highest in the European Union (McMahon, et al., 2010).¹

1.3 Dyadic Relatedness

“There is no such thing as a suicidal patient” (Seager, 2008, p. 216).

Informed by Winnicott’s (1965) statement, “there is no such thing as a baby” (p. xiv), we can truly comprehend a suicidal client in the context of their reciprocal care-giving systems (Seager, 2008). The subject of suicidality has always held centre stage in psychoanalytic inquiry² (Appendix A). Contemporary Object Relations theory affirms that a central tenet of suicidal ideation is the early dyadic relationship and the frustrated psychological needs of the child (Briggs, Couch & Lemma, 2008). The attachment

¹ European statistics highlight that suicide is the second reason for death amongst young people aged 15–29, followed by unintentional injuries (Blum & Nelson-Mmari, 2004). Globally, one million people die from completed suicides annually. However, these figures are not representative of suicide attempts, which are 20 times more frequent than completed suicides (WHO, 2011). It is estimated that 500 Irish citizens die by suicide each year while approximately 11,000 Accidents & Emergency admissions are the consequence of suicide attempts (Gordon, 2009).

² In 1910, the Vienna Psychoanalytic Society (VPS) held a symposium, which represented a landmark shift in the conceptualisation of suicide. Wilhelm Stekel who presented at the conference controversially asserted that suicidality is associated with revenge.
postulate understands a suicidal attempt as an inability to be nourished by a satisfying internal model, leading individuals to report that there is ‘nothing left’ (Bowlby, 1969; Magagna, 2008). Potentially this is lethal, when the life-sustaining images of loved ones cannot be internally held (Lobo Prabhu, Molinari, Bowers & Lomax, 2010). Indeed, Schneidman (1993) views suicide as a logical conclusion to this intense psychological pain he termed ‘psychache’. Therefore, suicidal dynamics are embedded in the domain of ‘dyadic relatedness’ and ‘dyadic conflict’ (Briggs, et al., 2008).

Internationally, psychodynamic researchers acknowledge Freud’s (1917) seminal paper “Mourning and Melancholia” as the bedrock for conceptualising suicidality (Briggs, et al., 2008; Maltsberger & Goldblatt, 1996; McGinley & Varchevker, 2010). Freud (1917) formulated that the aetiology of the suicidal act is rooted in the loss of an ambivalently loved and hated caregiver. The concept of the internal object exemplified by Freud’s (1917) famous maxim: “the shadow of the object falls on the ego” (p. 249) implies that emotional behaviour is situated in response to the ‘Other’. The (m)Other casts her shadow unconsciously at the preverbal stage, where the child is used as a poison container for the parent’s harsh projections (Bolas, 1987). Although, mourning and melancholia are clinically two distinct responses to object loss, they resemble each other in their decreased interest in life, combined with a persistent reactive depression (Jones, 2010). However, there are differences, “melancholia suffers from continual self-approach, low-self esteem, and in a delusional way anticipates some sort of punishment” (Polmear, 2010, p. 46). Central to the suicide discourse are these supremely judgemental tendencies, which originally targeted towards the object, become aimed at the body-self, which then has to be destroyed in order to find relief (Campbell, 2006; Freud, 1917; Menninger, 1933; Polmear, 2010).

1.4 Theoretical Orientation

This study will draw on a rich synthesis of clinical theory, research and practice from a psychodynamic framework. Crisis intervention work with suicidal clients and the ensuing impact can be situated within the professional trauma literature. The theory of

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3 Psychoanalytic thought proposes that the ‘passage à l’acte’ (Lacan, 2004) is a communication, which holds the “less acceptable face of suicide as an act aimed at destroying the self’s body and tormenting the mind of the other” (Campbell & Hale, 1991, p. 4).

4 Melancholia is a dangerous state holding much sadism and masochism; thus hatred becomes targeted towards the ego.

5 Freud believed that judgemental tendencies are a result of a “diseased” superego. This was further developed in ‘The Ego and the Id’ (Freud, 1923), concerning the conflict between ego and the “diseased” superego, in particular pathological states, notably melancholia (Freud, 1917, p. 247).
intersubjectivity contributes a metatheoretical ground from which to conceptualise the richness that lies between clinician and client (Rasmussen, 2005; Orange, Atwood & Stolorow, 1997). Clinically, ego psychology has expanded our constructs of psychological defences, which prove vital in understanding our response to trauma material (A. Freud, 1966; Vaillant, 1992). Object Relations theory affirms the indelible influence of early relationships on personality formation and how this implicit knowledge is re-enacted in the therapeutic dyad (Fairbairn, 1952; Guntrip, 1968; Winnicott, 1960, 1967; Schore, 2001; 2002). Consequently, these enactments are manifested in the countertransferential material, with the traumatised client coercing and seducing the therapist to hold the denied projections, roles or affects (Allen, 2001; Davies & Frawley, 1994).

1.5 Aims and Objectives

This research aims to explore and examine in-depth how accredited psychotherapists (IACP, IAHIP) who predominantly treat suicidal clients are affected by this work. The meanings that Irish psychotherapists attribute to their experience and how they would describe the phenomenon is still largely an unexplored territory. An overarching aim is that findings will broaden theoretical understanding and strengthen resources for the clinician in private or institutional practice. With this in mind, the study will elucidate the extent of therapist, client and organisational factors on practitioners working with this specific clinical population. The clinician’s influences such as personal trauma history, defensive styles, theoretical training, supervision and social supports are examined. The persistence of client traits as perceived by the therapist will be discussed in terms of transferences, comorbid presentations and high lethality. Moreover, organisational aspects need investigation as to whether they act as a ‘holding environment’ (Winnicott, 2006) for therapists or exacerbate issues. These properties could be viewed as protective or potential risk factors for vicarious trauma and burnout (Voss Horrell, Holohan, Didion & Vance, 2011).

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6 IACP: Irish Association for Counselling and Psychotherapy  
IAHIP: Irish Association of Humanistic Integrative Psychotherapists
Chapter Two: Literature Review

“Human kind cannot bear very much reality”
(T.S Eliot, as cited in Kenner, 1959, p. 253)

2.1 Introduction

Freud (1937) argued that psychotherapy was one of those “impossible professions” (p. 248), referring to the challenging demands that the therapeutic encounter engenders in the practitioner. Contemporary empirical, as well as in-depth clinical observations, confirm Freud’s insightful assertion that stress is inherent to the intersubjective space (Pearlman & Saakvitne, 1995; Rasmussen, 2005; Trippany, White Kress & Wilcoxon, 2004). Indeed, the clinician is in a “constantly draining position” being at the receiving end of projected hostility, jealousy, depression, anxiety and suicidal ideation (Freudenberger & Robbins, 1979, p. 186). Nguyen (2011) has christened the 21st century as the “century of trauma studies” (p. 28). To begin this literature review, the author will discuss secondary trauma constructs and how these core theoretical concepts relate to the practitioner treating traumatised populations. Psychoanalytical literature will elaborate the dynamic processes of interpersonal trauma in the clinical setting. Following this, the new phenomenon of stress-related growth or vicarious resilience will be examined. To conclude, phenomenological studies concerning the impact of client suicide on the psychotherapist will be critically reviewed.

2.2 Vicarious Trauma

Emergent studies in the last fifteen years indicate that therapeutic work with clients who have been traumatised can impair the psychological, physical and spiritual functioning of practitioners (Figley, 1995; Pearlman & Maclan, 1995; Pearlman & Saakvitne, 1995). The literature regarding secondary trauma phenomena is replete with terms concerning secondary traumatic stress, compassion fatigue, vicarious trauma and burnout. These definitions sometimes used interchangeably, have vastly influenced research inquiries around the therapist’s well-being (Devilly, Wright, & Varker, 2009; Sexton, 1999). Although, there are discrepancies in conceptual terminology, the psychotherapeutic community appear to agree that the work involved with traumatised clients can have deleterious effects on the clinician (Figley, 1995; Iliffe & Steed, 2000; McCann & Pearlman, 1990; Pearlman & Maclan, 1995; Pearlman & Saakvitne, 1995). Indeed, many high-risk clients present with histories of attachment traumata, sexual abuse, self-injurious behaviours and psychological sequelae as evidenced in borderline...
and narcissistic processes (Sperry, 2003). Rothschild and Rand (2006) write, “Empathy is the connective tissue of good therapy” (p. 208) and due to this empathic connection with the client, there is a transformation in the therapist’s inner realm (Pearlman & Saakvitne, 1995).

The term vicarious trauma (VT) (McCann & Pearlman, 1990) derived from the constructivist self development theory (CSDT), refers to the cumulative negative responses as described in Post Traumatic Stress Disorder (APA, 2000), which become manifested in the person of the therapist. Vicarious traumatisation directly relates to the treatment of psychologically distressed individuals and is distinct from countertransference as it accrues over time due to repeated exposure to narratives of cruelty, sadism, neglect, abuse and exploitation (Rasmussen, 2005). Thus, intense interpersonal transactions can violate our ‘assumptive worlds’ (Murray-Parkes, 1993) - the tendency to assume predictability concerning people and life. This can result in dire professional and personal consequences causing disruption to the therapists’ sense of self, sense of other, worldview and belief system (Egan, 2006; Fox & Cooper, 1998; Trippany, et al., 2004). Therefore, supervision for trauma therapists must heed the clinician’s personal trauma history, organisational issues framing the work, social context and self-care strategies (Hernández, Engstrom & Gangsei, 2010).

2.3 Burnout

‘Burnout’ was first conceptualised by the psychoanalyst Freudenberger (1980) and remains a well-researched construct particularly in organisational and social psychology (Vanheule & Verhaeghe, 2005). Maslach and Jackson (1981) defined and measured burnout as an occupational syndrome consisting of overwhelming exhaustion; detachment from the job; and reduced personal accomplishment. Burnout is defined as a condition that affects many health professionals despite their client populations. It gradually develops as a result of heavy caseloads presenting with chronic symptomatology, as found in clients contemplating suicide (Farber, 1983). Quantitative research highlights that work overload; limited collegiate support and role ambiguity persistently exacerbates this condition, which is more prevalent among neophyte therapists and master therapists (Devilly, et al., 2009; Jenkins & Baird, 2002; Maslach, Schaufeli, & Leiter, 2001). Also, the accumulation of these long-term stressors result in three variants: individuals may

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7 Known as The Maslach Burnout Inventory [MBI]
8 Practitioners with more than 10 years experience in clinical work.
strive more to achieve satisfaction; they cease employment, or function at minimum potentiality (Egan, 2006; Farber, 1990). Hence, a ‘spillover’ (Tennant, 2001) of anger or depersonalisation can occur in the therapist’s personal life with the increased risk of alcohol and nicotine abuse for disengagement purposes (Maslach, 1998).

Despite burnout having analytic roots, it is rarely studied from this viewpoint; thus limited insight has been gleaned as to the personal meanings associated with this phenomenon (Vanheule & Verhaeghe, 2005). The Lacanian theorists, Vanheule and Verhaeghe (2005) elucidate that there is a strong link between burnout, professional identity and intersubjective experiences. Underneath indistinct grievances concerning workload and exhaustion, lies the core identity issue that one is valued by what one achieves, bringing to mind the Rogerian (1980) notion of the external locus of evaluation. Lacanian thought, parallels Maslach’s (1998) assertion that burnout is embedded in the context of the clinician’s personal, social and organisational variables. Rycroft (2005) describes how the professional domain can invade the personal in the form of intrusive thoughts, feelings and dreams; she calls this “burn-in” as distinct from burnout (p. 87).

Correspondingly, Freudenberger (1980) declared unrealistic expectations as the critical factor in contributing to burnout. The clinician’s high expectations of treatment may be eroded by the client’s chronic self-harming tendencies or preoccupations with suicide plans (Fox & Cooper, 1998). When therapists do not understand that some clinical dilemmas are unsolvable, they may become disillusioned at their lack of achievement and doubt their meaningful contribution. This can lead to a sense of ‘detached concern’ within the practitioner’s interpersonal dealings resulting in a dehumanised approach to clients (Maslach, 1998). Informed by her studies of the nursing service, Menzies-Lyth (1988) proposed, that in any interpersonal profession, there is the temptation for the carer to develop professional detachment, to protect against personal involvement, moving identifications and emotional attachments with patients.

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9 This involves work relations with colleagues, peers, clients and superiors.
10 Due to an intrinsic lack of identity, Lacan (1958/1977) claims that humans turn to others to fill that lack; hence, we compare ourselves to our imaginary others - our peers and strive for recognition. Therefore, we construct a tantalising version of ourselves and attune the ego to this ideal image by a process of “imaginary identification” (Vanheule & Verhaeghe, 2005, p.289). This tension precipitates the well-known dynamics of personal depletion, depersonalisation and deterioration in interpersonal relations (Vanheule & Verhaeghe, 2005; Zizek, 1998).
11 Female practitioners tend to report higher levels of emotional exhaustion than their male counterparts, whereas male therapists report higher levels of depersonalisation than female therapists (Deutsch, 1984; Egan, 2006; Hickey & Egan, 2000a; Maslach, 1998).
2.4 The Process of Trauma

The therapeutic process is complex, with reciprocal responses shaping the dyadic dance between therapist and client (Rasmussen, 2005). Intersubjectivity is a metatheory, which conceptualises the organisation of experience as firmly situated in the context of relatedness (Orange, et al., 1997). Rasmussen (2005) writes, “Pathology can never be located solely within the person, but instead must be understood within the intersubjective configurations and emotional contexts from which it is embedded” (p.23). Orange (1995) highlights how the ‘unvalidated unconscious’ contains affects, memories and events that were not affirmed by caregivers, which, holds significance for understanding the effects of interpersonal trauma in the clinical setting. As therapists must contain and bear witness to disturbing emotions and content, theoretically, mature defense mechanisms assist clinicians in regulating intense affect (Egan, 2006) (Table 1). In these situations, Vaillant (2000) advocates how mature adaptive defenses can “turn lead into gold” (p. 89). These mental stratagems, independent of socio-economic backgrounds are vital in modulating perceived “internal and external realities that they are powerless to change” (ibid.). Conversely, therapists who utilise immature or neurotic defensive styles may experience more spillover, exhaustion and burnout (Spector, 1999). The Irish researcher Egan (2006) stipulates that clinicians who work with clients employing immature defenses may be more prone to clients ‘getting under their skin’, which may activate the therapist’s own primitive mechanisms. In this “dyadic contagion of affects” it becomes difficult to discern mine from thine (Vaillant, 1992, p. 59). Pearlman and Saakvitne (1995) posit that these particular countertransference responses set the stage for VT, as immature defenses, like a contagious disease can infect the Other with shame, guilt, anxiety and fear.
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Van der Kolk (1996) expounds that with trauma “the body keeps the score” and widely represented in child psychoanalytic literature is the concept of psychic skin containment. The researcher contends that this framework illuminates the “contagion of affects”. Bick’s (1986) research into the containing property of the mother’s skin in early Object-Relations facilitates an internalisation of soothing experiences for her infant. Accordingly, this provides the baby with a primitive notion of a body boundary and a container; a necessary psychic space where splits and projections reside contributing to Klein’s (1935) paranoid schizoid and depressive positions. Informed by his work with psychotic patients, Bion extended Klein’s work in his concept of the mother-infant as ‘Container/Contained’ (Sandler, 2009). He observed that the ‘good enough’ mother puts her psyche at her infant’s disposal and contains these inexorable states (Bion, 1962b). In a sense, she detoxifies the “nameless dread” and can respond with ‘reverie’ (ibid., p. 183).

Bion conceptualised projective identification as a communicative function related to developmental growth and vitality. Nonetheless, Meltzer’s (1994) formulation of ‘adhesive identification’ describes how the child primitively manages separation anxiety with the caregiver. Indeed, the infant superficially attaches herself to the surface of the object, in a desperate attempt to abate crippling anxieties about the body-self rupturing or spilling out.

Viewed from the relational perspective Stolorow and Atwood (1992) postulate “the essence of trauma lies in the experience of unbearable affect” (p. 52). What emerges in the therapeutic setting are early ways of being and relating, a term Bollas (1987) describes as the “unthought known” (p. 4). The concept of projective identification highlights how the client unconsciously uses the clinician as an object, inducing through the countertransference the enactment of early traumatic scenes (Bollas, 1987; Heimann, 1950; Little, 1981). The discourse of Object-Relating lends itself to the continuous interplay between the client’s transference and the therapist’s countertransference. In contemporary relational psychoanalysis (Greenberg & Mitchell, 1983), countertransference responses are vital in comprehending the client’s inner world (Heimann, 1950; Racker, 1968). Additionally, Figley (1995) stresses that primitive splitting in clients can result in secondary trauma in therapists, which can lead to splits in psychotherapeutic communities. Therefore, the introduction of open dialogue into health

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12 A core concept of Kleinian (1946) theory is ‘projective identification’, referring to intolerable aspects of the self being projected into the (m)Other. Quintessentially the ‘paranoid-schizoid position’ in early infancy (0-3 months) is a denial of reality, whereby the infant utilises the primitive defence of splitting (Klein & Riviere, 1964). Ultimately, the baby’s goal is survival and the ruthless possession of the goodness inside the mother (Klein, 1930).
centres, can serve to identify and heal splits in teams (ibid.). In any human endeavour, we find elusive, invisible processes\textsuperscript{13} at work, which can enhance or hinder the creative fabric and integrity of health settings (Gabriel & Carr, 2002). Briggs (2008) affirms that if mental health is provided under the auspices of a national health sector (HSC), not only are lawsuits feared, but also the institutional audits that focus on risk assessment. In this culture, the centre can degenerate defensively into an omnipotent organisation strategy (Menzies-Lyth, 1988; Nguyen, 2011).

2.5 Vicarious Resilience

A body of clinical explorations in its infancy has yielded a new phenomenon defined as vicarious resilience (VR). The concepts of resilience, posttraumatic growth, reciprocity or ‘altruism born of suffering’ have all emerged as a result of clinical investigations into the impact of trauma from different vantage positions (Hernández, et al., 2010). This has contributed to a multifaceted perspective on the processes by which the therapeutic relationship and the self of the therapist are influenced by distressing material (ibid.). Throughout these initial studies, researchers have begun to examine the factors influencing the therapist’s vicarious growth in their capacity to provide care to unique client populations (Sprang, Clark, & Whitt-Woosley, 2007). The formulation of VR has emerged as an inverse paradigm to research evaluations into vicarious traumatisation (Arnold, Calhoun, Tedeschi & Cann, 2005; Hernández, et al., 2007; 2010). Accordingly, resilience is conceptualised as “a dynamic process encompassing positive adaptation in the face of high-risk circumstances within the context of significant adversity” (Luthar, Cicchetti, & Becker, 2000, p. 543).

Arguably, there is a dimension to the suffering experience, which can trigger valuable gains for the survivor despite terrible losses (Knafo, 2004). Developmental studies of children with mothers diagnosed with schizophrenia, describe resilience as a pattern of positive adaptive behaviour that develops despite enormously challenging circumstances (Cicchetti & Garmezy, 1993; Masten & Coatsworth, 1998). Resilience research has been expanded to include multiple adverse conditions such as socioeconomic disadvantage, maltreatment and catastrophic life events (Luthar, et al., 2000; Masten & Coatsworth, 1998; Werner, et al., 1971). These writings consolidated a systematic search for protective forces that distinguished children with healthy coping constitutions from psychoanalysis postulates that pathological organisations defend against depressive anxiety: fear of damage to the Other and paranoid-schizoid anxieties: fear of disintegration (Bion, 1962; O’Shaughnessy, 1999; Rey & Magagna, 1997).
those who were comparatively less well adjusted (Luthar, et al., 2000). According to developmental psychopathologists, context and environmental supports play a crucial role in forming protective components in the individuals’ life (Garmezy, 1991, Hernández, et al., 2007; Luthar et al., 2000). Moreover, Bernard’s (2004) research into youth work identified these particular personality traits: a capacity to learn from experience, humour, spontaneity, creativity and compassion.

Correspondingly, clinical evidentiary validations, propose that the negative effects of secondary exposure to trauma have been considerably overestimated (Devilly et al., 2009; Jenkins & Baird, 2002; Van Minnen & Keijsers, 2000). Clinically VR is conceptualised as a process that naturally arises from the witnessing of how hurting individuals constructively overcome detrimental situations and this has significant implications for enhancing clinical work (Hernandez, et al., 2007; 2010; Voss Horrell et al., 2011). Consequently, this has a permanent positive effect on the therapist in terms of worldview and beliefs, including spirituality and faith (Arnold, et al., 2005). Arnold and colleagues (2005) interviewed 21 clinicians and a notable 18 of the psychotherapists felt that their work with traumatised clients had transformed their worldview positively, amplifying their compassion, sensitivity and spirituality. Spirituality and faith enrich meaning, which may be a protective factor in countering the effects of VT and restoring hope (Sexton, 1999; Trippany et al., 2004). Additionally, the positive psychology movement concentrates on ‘strength-building’ during trauma work in order to access the individual’s potentialities once again (Carr, 2004; Seligman & Peterson, 2003). Fundamentally, this postulate asserts that effective psychotherapy should uphold the centrality of the authentic encounter, encouraging autonomy, nurturing the clients’ assets, as well as promoting resilience.

Hernández and colleagues (2007) concede that vicarious trauma and vicarious resilience though initiated by trauma and stress are natural phenomena, with one counterbalancing the other. The developing literature on VR espouses that witnessing the vanquishing of tragedy in the client, radically alters the practitioner’s inner world due to the empathic link. However, the notion of transcending pain has been around for centuries, as ancient Hebrew, Greek and Christian texts testify (Munson, 2009). Knafo (2004) argues that the transformative nature of the near-death experience as embodied in trauma can be a catalyst for self-renovation and self-actualisation. Interestingly, Becker

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14 Van Minnen and Keijsers (2000) used a control group to compare the constructs of VT among trauma and non-trauma therapists and found that there was no significant difference between the two groups.
(1973) views the transference as quintessentially “a taming of terror”, which holds hope for excavating meaning from suffering in the therapeutic relationship. Fundamentally, working in this psychotherapeutic domain has the power to wound and to heal.

2.6 Suicide and the Psychotherapist

Undoubtedly the self-imposed death of a client is the most feared experience for mental health professionals. Empirical explorations into clinicians as suicide survivors have extensively been questionnaire based, due to the researcher’s reluctance to interview such a vulnerable sample (Hendin et al. 2004). However, contemporary psychodynamic research has sought to qualitatively evaluate the impact of completed suicide on practitioners (Alexander, 2007; Campbell, 2008; Fox & Cooper, 1998; James, 2005; Rycroft, 2005; Tillman, 2006). Tillman’s (2006) phenomenological research discovered that the experience of having a patient commit self-murder shared many common features to those found in the bereavement literature. These same in-depth studies highlight salient themes of personal devastation, shame at not recognising the warning signs, anger towards the client, the fracturing of a professional ego ideal, fear of judgement from colleagues, combined with the threat of legal ramifications. Briggs (2008) describes how clinicians can suffer from bouts of punitive self-dialogue and “abnormal superego functions” (p. 226), which can impair a much needed compassionate self-reflective process. In addition, damaging superego activity is evidenced in how the ‘psychological skeleton’ gets projected into the surrounding survivors, the client projects into the therapist and the clinician projects into colleagues and family members (Schneidman, 2001).

Indeed, “suicide is the ultimate narcissistic injury for an analyst” (Gabbard, 2003, p. 254). Fox and Cooper (1998) highlight that these vulnerable feelings can also compound the therapist’s isolation from much needed collegiate support, which is fundamental in ameliorating VT and burnout. The injury of suicide impacts the practitioner’s professional identity and can be evidenced in cautious patient assessments and in more realistic attitudes towards treatment success (Alexander et al., 2000; Pilkington & Etkin, 2003; Tillman, 2006). Chemtob et al. (1988, 1989) report that ‘developing’ practitioners are significantly more affected by patient suicide than more experienced colleagues. These researchers argue that accessing a specialised postdoctoral education serves to reduce the risk of suiciding clients compared to clinicians who do not,
as well as the fact that female therapists\textsuperscript{15} report fewer suicides compared to their male counterparts. One notable study by Hammond (1991) proposes that health professionals, who had experienced a suicide both personally and professionally, found that clinicians experienced more distress and felt more responsibility for their client’s suicide.\textsuperscript{16} Finally, these clinical evaluations affirm that contracting must be on a long-term basis with a wholehearted commitment from the client towards life and healing (James, 2005; Tillman, 2006).

2.7 Summary and Rationale

The psychotherapeutic community has long recognised that working with distressed clientele can be toxic and trigger parallel states in the clinician due to the empathic engagement (Dunkley & Whelan, 2006). Vicarious trauma relates specifically to the process of trauma work, and results in impairment to the self, others, imagery and belief systems. Burnout is a well-researched, measured syndrome, referring to the psychological fatigue in treating chronic populations. Paradoxically, the vicarious resilience framework underscores how witnessing the exceeding of the pre-trauma state in clients can elicit healing in the clinician. In reviewing the literature on the aftermath of completed suicide, it was found that practitioners endured a double loss: loss of the client and loss of professional confidence. Although, extensive research examines the effects of traumatic experiences on therapists who work with sexual abuse, torture or domestic violence, there is no empirical literature to date on the impact on practitioners who work solely in the area of suicide prevention and self-harm. Essentially, this study attempts to explore the effects and meaning of suicide prevention on seven accredited Irish practitioners who work in this domain.

\textsuperscript{15} A Slovenian study (Grad, Zavasnik & Groleger, 1997) indicates that female practitioners experience more guilt and shame as suicide survivors compared to male therapists.

\textsuperscript{16} Bissell’s (1981) qualitative investigations into clinical nurses’ reactions to suicidal casework led her to suggest that there are four common stages: naïveté, recognition, responsibility and individual choice. The naïve stage was characterised by shock and denial. In the recognition stage, denial gave way to fear, helplessness and confusion. The responsibility phase was characterised by self-recrimination, projected anger, guilt and omnipotence, and in the final position the nurses realistically acknowledged the individual choice of the patient. Hence, the clinician’s experience of completed suicides firmly dissolves naïveté.
Chapter Three: Methodology

“One must approach such a phenomenon as suicide with the greatest caution, for any act that opposes the instinct of life is bound to arouse in us a set of reactions, which interfere with a clear, and purely rational understanding of the phenomenon itself”
(Zilboorg, as cited in Yap, 2011, p.9).

3.1 Rationale for a Qualitative Approach

Qualitative research has proved most effective in studying areas of complexity and subtlety, as it invites a focused exploration on a topic, which fits well with the aims of this study (Brocki & Wearden, 2006). Phenomenological approaches analyse the subjective, idiosyncratic world of the person gaining the essence of a participant’s felt response (Kirshenbaum & Henderson, 1989). Correspondingly, a qualitative approach has the ability “to get closer to the ‘actor’s perspective’ through detailed interviewing and observation” (Silverman, 2005, p.10). Furthermore, this form of inquiry generates a rich knowledge base and provides an understanding of phenomena when there is little known in an area.

3.2 The Sample

The sampling is non-probable and purposeful, allowing for participants to elucidate the topic of interest by providing rich narrations of their experience (Smith & Osborn, 2003; Trochim, 2006). Coalescing with the aims of this study, seven accredited therapists from an agency devoted to suicide prevention were interviewed. Originally the author requested to interview three solution-focused practitioners and three humanistic-integrative therapists. However, three experienced therapists were person-centred, three participants were trained as humanistic practitioners, and one respondent originated from a rational-emotive orientation. All subjects integrated the solution-focused approach, due to the ethos of the organisation. Generally, participants started their initial training with the agency when it commenced 6 years previous, and they were accredited a mean average of 2.7 years with Irish regulating bodies. Hence, there were no master therapists in the sample. Psychotherapists who were working towards accreditation and student therapists were excluded from this project. The respondents were female ranging between 40-55 years old. A focus group approach was deemed inappropriate, due to the busyness of the centre and the sensitive nature of this study.
### DEMOGRAPHICS OF THE SAMPLE

<table>
<thead>
<tr>
<th>Code</th>
<th>Age range</th>
<th>Years in Centre</th>
<th>Years as therapist</th>
<th>Years Accred.</th>
<th>Accred. Body</th>
<th>Hrs. per Wk</th>
<th>Orientation</th>
<th>Qualification</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>40-55</td>
<td>6 yrs</td>
<td>8 yrs</td>
<td>3 yrs</td>
<td>IAHIP</td>
<td>16 clients &amp; 4 assess</td>
<td>Humanistic Integrative</td>
<td>Dip.</td>
</tr>
<tr>
<td>PB</td>
<td>40-55</td>
<td>4 yrs</td>
<td>7 yrs</td>
<td>3 yrs</td>
<td>IACP</td>
<td>16 clients &amp; 4 assess</td>
<td>REBT</td>
<td>Dip.</td>
</tr>
<tr>
<td>PC</td>
<td>40-55</td>
<td>5 yrs</td>
<td>5 yrs</td>
<td>1.5 yrs</td>
<td>IACP</td>
<td>16 clients &amp; 4 assess</td>
<td>Person Centred</td>
<td>Degree</td>
</tr>
<tr>
<td>PD</td>
<td>40-55</td>
<td>4 yrs</td>
<td>5.5 yrs</td>
<td>2.5 yrs</td>
<td>ACPC</td>
<td>12 clients</td>
<td>Person Centred</td>
<td>Degree</td>
</tr>
<tr>
<td>PE</td>
<td>40-55</td>
<td>5 yrs</td>
<td>8 yrs</td>
<td>3 yrs</td>
<td>IACP</td>
<td>8 clients</td>
<td>Person Centred</td>
<td>Degree</td>
</tr>
<tr>
<td>PF</td>
<td>40-55</td>
<td>5 yrs</td>
<td>8 yrs</td>
<td>3 yrs</td>
<td>IACP &amp; PSI</td>
<td>15 clients</td>
<td>Humanistic Integrative</td>
<td>Degree &amp; Msc</td>
</tr>
<tr>
<td>PG</td>
<td>40-55</td>
<td>6 yrs</td>
<td>7 yrs</td>
<td>4 yrs</td>
<td>IAHIP</td>
<td>12 clients 13 superv ision</td>
<td>Humanistic Integrative</td>
<td>Degree</td>
</tr>
</tbody>
</table>

*Table 2*

#### 3.3 Recruitment of Sample

Presently, the researcher is a sessional therapist in an agency that exclusively counsels suicidal and self-harming clients. Initially, the head of the centre (CEO) was notified in writing as to the intention of this research. The inclusion criteria stated that the sample must consist of six of the most experienced and accredited counsellors who work in the agency, with a possible balance of solution-focused and humanistic practitioners. When permission was granted, the researcher was given seven possible candidates to contact who met with these criteria. Although, the researcher knew all potential candidates, each was contacted by e-mail and possible participants were sent an information packet. This packet consisted of a cover letter (Appendix B) explaining the nature of the study and a consent form (Appendix C) that was to be signed if participants wished to take part in this project.
3.4 Data Collection Methods

The primary research method was the narrative approach and data was collected about therapist’s experiences of suicidality through in-depth, open-ended interviews in a private room, in the clinic (Quinn Patton, 2002). A consultation with my academic supervisor occurred to ensure that the interview questions were suitable for the current study. Initially, respondents were asked demographic questions (Appendix D) before the taped interview. The researcher conducted semi-structured interviews (Appendix E) informed by an extensive review of the literature, lasting approximately 40-45 minutes. This served to focus the discussion. Moreover, the qualitative process was validated through observing how the individual told their story. Tape-recorded interviews provided the conversation in their actual original form and had the advantage of yielding valuable transcripts later on for analysis. The researcher anticipated that respondents would disclose case studies; therefore the building in of information-rich vignettes into the design was highly desirable (Silverman 2005). Quinn Patton (2002) stresses the importance of taking extensive field notes (Appendix F) during this process to “strive for thick, deep and rich description” (p. 331).

3.5 Interpretive Phenomenological Analysis (IPA)

Originating from the field of psychology, Interpretive Phenomenological Analysis (IPA) has gained recognition in the last 15 years, emphasising the dynamic role of the researcher in contributing to the process (Smith, Flowers & Larkin, 2009). IPA involves a two-fold or ‘double hermeneutic’ interpretation analysis in which the researcher tries to interpret the participant’s ‘sense-making’ practice (Pringle, Drummond, McLafferty & Hendry, 2010; Smith, 2004). Therefore, phenomenology discovers meaning and hermeneutics interprets meaning17 (ibid.). This implies that IPA is firmly embedded in the participant’s dialogue with direct quotes and metaphors used liberally to substantiate findings and inform master themes (Pringle et al., 2010). In investigating other forms of data analysis (Mason, 2002; Smith, 2003; Wertz, 2005), IPA was considered as its philosophy and methodology correlated well to the line of investigation in this inquiry. Moreover, the remit of IPA is to contribute to theoretical discourse in a broader more extensive capacity. IPA elucidates how respondents construct meaning from their personal and affective dimensions; thus, it facilitates the empathic exploration of issues.

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17 IPA tends to interpret the participant’s stories and meaning-making in a questioning way which is different from the ‘interpretation of suspicion’ (Smith et al., 2009).
which is fundamental to the ethical rigour needed concerning therapist’s treatment of suicidal clientele (Smith & Osborn, 2003). What is more, this approach assists the use of a psychodynamic-psychoanalytic lens to interpret data in gaining access to phenomena not encountered in the therapeutic setting (Cartwright, 2004). Kvale (1996) believes that a psychoanalytic approach led by the participant’s free associations and the researcher’s ‘free floating attention’ allows for the emergence of a deeper, more informed understanding that is truly an ‘inter-view’.

The researcher wished to conduct analysis in a manner that remained faithful to the personal experiences of the participants and to facilitate the articulation of their in-depth account of events (Smith & Osborn, 2003). Additionally, IPA stresses that the research exercise is a dynamic process recognising the central role of the researcher in the analysis (Smith, 2004). “The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world” (Smith & Osborn, 2003, p. 53). Ultimately, this active role in the analytic work involves a deep immersion in the data and McLeod (2003) stipulates that the researcher must “temporarily internalise and ‘own’ as much of the data as possible” (p. 85). This is essential to the integrity and creativity of the analytical process.

### 3.6 Reliability and Validity

With the burgeoning use of qualitative methods in psychotherapeutic research, the criteria for judging their value have become increasingly significant. Validation measures in qualitative research emphasise process rather than verification in establishing trustworthiness and credibility (McLeod, 2001). Morse, Barrett, Mayan, Olsen and Spiers (2002) argue that reliability and validity are central to the qualitative inquiry, stipulating that the characterological profile of the researcher is integral to the establishment of trustworthiness throughout this endeavour. The emphasis on sense-making requires a strong therapeutic alliance between researcher and participants (Rogers, 1957). Therefore, commitment to the participant’s experiencing world was tantamount from the interviewing process to the treatment of the data.

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18 Kvale (1996) believes that the psychoanalytic approach is critical to modern qualitative interviews as this allows for the emergence of a deeper, more informed understanding that is truly an ‘inter-view’ in which the co-constructed knowledge is an ‘inter-subjective knowledge’.
3.6.1 Credibility Checks

IPA acknowledges the dynamic partnering of the researcher in accessing and understanding the individual’s experience and the interaction between them\(^\text{19}\) (Brocki & Wearden, 2006). Therefore, the credibility of the present inquiry lies with integrity and personal reflexivity\(^\text{20}\) of the researcher to establish perspicuity throughout the analytic process. In qualitative studies, reliability refers to dependability (Merriam, 2002) and the creation of audit trails increased dependability throughout. This was attempted by organising external audits of the data, interpretations and analysis through regular peer and academic supervision (Smith & Osborn, 2003). In this context, the researcher made every effort to thoroughly ground the interpretations in the data and provide many quotations in order that narratives would resonate strongly with the reader (Pringle et al, 2010).

3.7 Data Analysis

In accordance with IPA procedures, each transcript was listened to and read three times in order to gain an overall sense of the narrations. Thereafter, each interview was analysed using the IPA steps delineated by Smith and Osborn (2003). A detailed case-by-case analysis of each transcript, with manual transcribing and coding was employed to develop an intimate acquaintance with the data (Pringle, et al., 2010). Interview A was printed out, and blank pages were attached to each printed page. No restrictions were placed as observations, paraphrases, annotations, associations and the participant’s descriptive words were written on this adjoined page (Smith & Osborn, 2003). Subsequently, refined observations from Interview A were copied onto a separate page. The same procedure was employed for Interview B and so on,\(^\text{21}\) and each transcript was approached on its own terms and merit (Smith et al., 2009). A review of the themes transpired which resulted in convergent and divergent themes being placed into relevant clusters. When conducting the process of identifying master themes, the researcher attempted to “imagine a magnet with some of the themes pulling others in and helping to make sense of them” (Smith & Eatough, 2006, p. 335). A listing was compiled from all

\(^{19}\) Additionally, these researchers assert that validity checks are not aimed at obtaining a single objective truth, but at reinforcing the credibility and coherency of the presented material.

\(^{20}\) Integral to an IPA study is personal reflexivity, thus attending to one’s conscious and unconscious processes is essential and involves reflecting upon how interpretative frameworks, which will shape the research (Salmon, 2003). Personal reflections (Appendix F) were kept throughout as the quality of the analysis coincides with the degree of reflexivity engaged with during the study (Smith, 2004).

\(^{21}\) Codes were attributed to each theme to facilitate ease in tracing them back to the original transcript, for example, PC5.3c = Participant C, page 5 of the transcript, section 3c.
interviews, which naturally displayed significant overlapping of themes between participants (Appendix G). However, superordinate themes were not only selected on the prevalence within the data, but factors such as the depth of passages, which, richly-illustrated the themes were also considered (Smith et al., 1999). After reviewing the final list of themes, both the primary investigator and the academic supervisor decided upon three master themes. Finally, a table consisting of three superordinate themes and subordinate themes emerged from this process.

3.8 Ethical Considerations

The subject of suicide is a highly sensitive matter and results in the conversing of painful memories from the psychotherapeutic encounter (Appendix H). At the start of the interview, respondents signed the consent form and were assured of confidentiality and anonymity of their responses. It was necessary to stress from the beginning, that as soon as the individual experienced discomfort, the interview may be ceased until the participant felt comfortable enough to resume. Participants were assured both verbally and in writing that they might refuse to answer any question, that they may stop the interview at any time, or withdraw personal material at their own discretion. Moreover, all participants were assured that withdrawal from the study was without prejudice. The limitations to confidentiality were explicitly expressed in the information sheet, consent form and commencement of interviews. Thus, limitations to confidentiality applied even if participants subsequently withdrew from the study. Anonymity was critical; thus, care was exercised in the storing of confidential information after the interviews. Importantly, the psychotherapists, possible clients, and indeed any identifiers were removed from the data presented in this dissertation. Supervision and debriefing were indispensable procedures throughout for the interviewer (Quinn Patton, 2002). Furthermore, there was an opportunity given by the researcher to clarify any aspects of the study at the end of the interviews.
Chapter Four: Findings

4.1 Introduction

Participants were requested to talk extensively about their experiences of working predominately with suicidal clients. The process of interpretative phenomenological analysis from the transcribed interviews elicited three superordinate themes:

<table>
<thead>
<tr>
<th>Superordinate Themes</th>
<th>1. Overworking</th>
<th>2. All Changed, Changed Utterly/Identity Disruption</th>
<th>3. A Terrible Beauty is Born/A Spiritual Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Working under a death threat 110%</td>
<td>i) Disruption to the Self</td>
<td>i) The Agapean Mission</td>
<td></td>
</tr>
<tr>
<td>ii) Under my skin</td>
<td>ii) Disruption to Other-Intimacy</td>
<td>ii) Community of Believers</td>
<td></td>
</tr>
<tr>
<td>iii) Holding the Therapist Hostage</td>
<td>iii) Disruption to Professional Identity</td>
<td>iii) Regeneration</td>
<td></td>
</tr>
</tbody>
</table>

Each of the superordinate themes and the emergent subordinate themes are presented systematically with raw data to illustrate each. Throughout this section, pseudonyms are used and the quotations are coded to identify the participant, page, and section of text from the relevant transcript (e.g., PA3.9c = Participant A, Page 3, Section 9c).

4.2 THEME 1: Overworking

Persistent in all participants’ extracts, was the theme of frantically ‘overworking’ with clients in “supporting them to stay in this universe” (Sandra). It is divided into three subordinate headings: 1) Working under a death threat 110%, 2) Under my skin, 3) Holding the therapist hostage. Each interview emitted an energetic urgency and therapists ‘overworked’ by providing extra sessions, between-session phone calls and in being
consumed by the client ‘after hours’ (Vanheule & Verhaeghe, 2005). As a result of deeply regressed transferences (Campbell, 2006; Olin, 1976), additional ‘therapeutic accommodations’ (Briggs et al., 2007; Goldblatt, 2008) are required of the therapist in the prevention of suicide. Transcripts were replete with adjectives such as “daunting”, “draining”, “heavy”, “terrifying” and “scary”. One clinician summed up suicide prevention as “the cold face of the work…probably the most challenging work that you can do” (Denise). Cathy encapsulates the feelings of many participants when she articulated “sometimes, sitting in that despair can be really, really difficult…I just say to them, drop the coffin”. Thus, encouraging the client to “drop the coffin”, the transitional object of self-death, engulfs the clinician with anxiety as considerable energy is expended in enticing the client to embrace life.

4.2.1 Working under a death threat 110%

Tara’s account of being a ‘guide’ to suicidal teenagers, gives us a glimpse of how arduous this job can be:

PA2.2a Tara: “Initially…when I started off…to be truthful with you…it terrified…it terrified me…to have the responsibility of someone’s life…that they are coming into you and that effort to keep them going can be heavy to hold onto. But I think with experience…which I got to recognise is that…you are just sharing part of their journey of processing…it needs to be like guidance in the right direction…and sometimes unfortunately, they let that guidance go. But you cannot take on the responsibility of someone else’s life because if you do…I think you would burn out very quickly.”

This extract conjured up a picture of the therapist giving her clients a heart to live as she travailed with them through ‘The Shadow of Death’.

Martina’s description of over-accommodation (Goldblatt, 2008) in extending personal boundaries is a familiar refrain told by all respondents:

PC2.2a Martina: “…when I started I was giving my phone number out…everyone had my phone numbers emm…not being able to switch off, just because these weren’t regular clients…these were clients who were suicidal. So yeah, changing hours to suit them, ringing them just to check they were ok…”

Sandra voiced the helpless terror that is so inherent to this form of psychotherapy adding to the frenetic aspect of the job:

PB2.2a Sandra: “Sometimes it can be scary and sometimes you think, ‘O my
God what am I going to do?’ How am I going to help this person? And then you realise, well you know what…you are only really there to facilitate them to help themselves…and…you put the work in with them and they might receive it or not receive it, and you do your best, 100%, a 110% sometimes…”

Further, she captures the national crisis of suicide and the urgency of growing caseloads:

PB5.4b Sandra: “when you have long waiting lists that impacts…that causes me anxiety [voice gets louder] when you have people that you know are high risk…yes high risk clients…there is…there is an anxiety. Sometimes, I have to pull myself back and remind myself that there is only so much I can do…”

The participant conveyed a sense of the unwelcome anxieties of Irish society being dumped into the centre, bringing to mind Meltzer’s (1994) concept of the ‘toilet breast’.22 Hence, the organisation carries all responsibility for the suicide risk.

Helen resolutely believes that no matter how experienced you are working in the field of suicidology, death terror never disappears:

PE2.2a Helen: “Well I think that some of the things I have learned after so many years of being in it…is that no matter how skilled you are when someone walks in the door and tells you that they are really suicidal and thinking of taking their own life, the first thing that I am aware of is…I immediately feel panic…I feel fear…I feel anxiety…”

4.2.2 Under my Skin

The researcher noted that all practitioners dressed impeccably in feminine, tailored clothes. Interestingly, five participants elucidated how they symbolically separated work from home by the “defrocking process” (Sandra). In addition, participants spoke of showering as metaphorically cleansing the contamination of the work (Vaillant, 1992). Sandra expresses this:

PB3.2c Sandra: “I have a ritual when I leave work every day when I go home…I change my clothes…I never stay in the same clothes…when I get home…throw my clothes into the washing machine and put on different clothes and I do that every day, I’d often have a shower so I’m not carrying all that negative stuff around. I’m leaving it behind.”

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22 Meltzer’s (1969) ‘toilet breast’ signifies the breast not just as a feeding object but also as a cleansing object for waste disposal, the place where excrement gets dumped, to be flushed but not necessarily processed. Hence, in this Irish context centres such as this are expected to clean up the mess of an entire nation.
Natalie echoed Sandra’s response:

**PD6.6a Natalie:** “I go up and change my clothes and put on my comfortable tracksuits, so that is almost like a ritual. If I come home in the evening time, I get into the shower.”

Cathy reiterated this sentiment:

**PG8.6a Cathy:** “And then when I go home, as soon as I go home, I change again. I find the changing of my clothes huge.”

However, despite Sandra’s careful attention to her physical rituals, she describes ‘an off-duty’ penetration of her emotional boundaries (Bick, 1986; Turp, 2007; Meltzer, 1994; Willoughby, 2001). Surprisingly, after a client assessed as ‘low risk,’ Sandra found that she had ‘carried’ the client home, waking up in the early hours of the morning with concern for his well-being:

**PB5.5a Sandra:** “O my God, I hope he’s ok…about 2 o’clock in the morning, and I thought ‘oh my gosh, what is this all about?’ You know that’s not something that would happen very often. I don’t know what it was…but it was there all the same…I brought him home with me…”

Like an infectious disease, individuals with immature defenses often transmit their contagion to the therapist who ends up bringing the client home (Heyno, 2008; Vaillant, 1992). Therefore, the constant preoccupation with the client serves to control the situation (Pearlman & Saakvitne, 1995). Tara mirrors how this overwork theme comes spilling into her personal world:

**PD6.6a Tara:** “How would I recognise tiredness? I would recognise it because I’m lying awake thinking about clients…ok and I think about the next day, which is quite normal, but the work balance has to be brought in…”

### 4.2.3 Holding the Therapist Hostage

All seven participants described their most difficult situation to date in an animated manner, as if the episode had occurred yesterday. This subordinate theme highlighted the complexity of cases they were involved with, the co-morbidity of symptomatology as well as the ambivalence inherent to the suicidal threat (Paris, 2007). An extract from Martina’s interview illustrates this:

**PC3.2b Martina:** “…one was a phone call from a man who lived in […] who was going to commit suicide, he was going to jump of this bridge, where the trucks go by and I know the area very well so I kept him on the phone, this was 10 o’clock at night […] and I talked him into going to hospital. I was
terrified, absolutely terrified. Relieved as soon as he was in hospital because then he wasn’t my responsibility.”

As she recounted more, it seemed that this particular perverse call, communicated the bondage in being held hostage to the situation (Campbell & Hale, 1991, Goldblatt, 2008; Glasser, 1979; Hendin, 1991; Sabbath, 1969). Moreover, it highlights the breaking of personal boundaries in the desperate attempt to keep someone alive:

**PC3.2c** Martina: “Then another call again this was the same man, 7 o’clock in the morning, he told me ‘I’m just ringing to say good bye’. I rang his wife immediately and said ‘Look I’m after getting this really disturbing call’ and she said, ‘well he’s in bed here, and by the way, you’re after waking me!’ And that was like FORGET THAT! No more phone numbers being given out…I was horrified.”

Natalie narrates with deep emotion, a powerful incident that rendered us both speechless:

**PD2.2b** Natalie: “…this girl in her early twenties she had been with me a long time…there was psychiatric stuff going on. And emm…she…you know…we connected, we were working well, and she rang me one evening and just said to me ‘I’m just wondering when I’m gone would you counsel my sister’ […] I copped onto to what she was doing and so I asked her where she was? She said she was in her car…emm…connected up to the gas, and she asked me how long would it take her to die and this kind of thing. She wouldn’t tell me where she was and I was 10 minutes on the phone…10 minutes, and I was bawling and crying and I was actually thinking this is really not professional of me! And I couldn’t help it…I was just completely traumatised I suppose.”

The metaphor of a devouring baby, sucking the life out of the mother is presented in Cathy’s descriptive example (Bion, 1959; Feldman, 2000):

**PG4.2c** Cathy: “There was one client a number of years ago and she had a borderline personality and self-harmed a lot. But she used to say that she used self-harm to comfort herself…that never sat easy with me. But she was also very impulsive, and she was drinking a lot. But she had a fierce attachment I could feel it…it was like a baby pulling, you know, pulling out of me.”

The borderline process generated overwhelming anxiety and the stirring of taboo feelings in all clinicians (Asch, 1980; Maltsberger & Buie, 1980; Menninger, 1933; Paris, 2006; Winnicott, 1949). Cathy communicates how this distressed individual was threatened by the ending that was in sight:

**PG4.2c** Cathy: “She stormed out of the room, nearly taking the door off the hinges, down the stairs…and banged the front door, as well. That rage…that pure rage you know…and I was sitting here my breath was going…and of course that piece afterwards that if she wanted to come back…God! Part of me was wishing at some level that she wouldn’t come
back [Laughs]. But she did come back and we did work through it...yeah, and we did finish...but I was very angry with her...I was very angry. You know...we had worked a long time together. I believe that both people in the room are deserving of respect.”

Martina candidly discloses about “a client she fell in love with” that caused her to struggle with therapeutic boundaries around self-disclosure. Correspondingly, she recounts how the ‘ending’ again can cause clients to regress:

PC3.3a Martina: “I didn’t think he was well enough to finish because he was really bad when he came in, and he seemed to be ok, but he then dipped right back down at the end.”

Clients “unwell” at the end of 15-20 sessions can elicit significant stress in the clinician (Pearlman & Saakvitne, 1995). The presence of long-standing intrapsychic difficulties raises the question of how long-term work is needed (Birtchnell, 1983). Moreover, it communicates the haunting reality that suicidal ideation can always be a solution in the client’s life (Hale, 2008).

Helen conveys her ‘boundary transgression’ (Gabbard, 2003) by driving to her client’s house, to stop the suicide act. This piece reinforces the countertransferential responses that the clinician struggled to contain:

PE3.2c Helen: “That was over-involved! You know and I think...she was quite manipulative, and I fed into being manipulated and sure for me I experienced different feelings from such compassion to just...yes rage and to ‘O for goodness sake’...a whole mixture of emotions came up in me...part of me liked her and part of me wanted to tell her to go away, in fact, the whole staff knew her, she kept constantly coming into supervision, she was everywhere. It was there day and night with me, waking up with me in the morning...”

These accounts reflect the excessive engagement in overworking as therapists attempted to reclaim lives from the brink of suicide. The client’s ability to get under their skin, be carried home, seduce, manipulate and even torment the therapist explains this phenomenon. The participants’ experiences laid the foundation for the next section of how this ‘draining work’ impacts the self of the therapist.
4.3 THEME 2: “All Changed, Changed Utterly”/Identity Disruption

Given the life and death nature of this work, a notable theme was the transformation of the inner world of the therapist: their sense of identity, worldview and spirituality (McCann & Pearlman, 1990; Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995). These aspects of a person’s internal frame of reference provide the lens through which we view life. Therefore, any crack in this lens will reverberate through the entire personality, tainting how we see the world and ourselves. Interestingly, worldviews of all interviewees were profoundly impacted bringing to mind the line from Yeats’ poem “Easter 1916”, “All changed, changed utterly: a terrible beauty is born” (as cited in Martin, 1989, p. 176-177). The trauma of suicide can be heard to impact the clinician on three levels: 1) Disruptions to the Self, 2) Disruptions to Other-Intimacy and 3) Disruptions to Professional Identity.

4.3.1 Disruptions to the Self

Denise reflects how it is impossible to engage in these therapies and not remain unchanged. She reports a deep paradigm shift and a loss of self-security:

PF2.2a Denise: “Profoundly. Yeah, in terms of how I view the world…my worldview has changed profoundly […] I certainly don’t view the world as positively as I would have before…because I realise that actually a lot of people have very, very difficult lives, and that might sound really bad…but…I’m not sure I think the world is such a great place…it’s not a safe place. I’m not saying there aren’t great people and great things happening in it, because there is, but…I think for a lot of people probably most people…life is very hard.”

Sandra’s excerpt stood out as she honestly described the ramifications of being a ‘helpless witness’ (Weingarten, 2003, Appendix J) to countless disturbing narratives:

PB2.2c Sandra: “But if they tell their story and it’s very graphic and in the beginning that really impacted on me…so now I’ll ask them to tell the story without giving me all the details, because even now…and I suppose…I was kind of ignorant that…I didn’t realise the impact of vicarious trauma back…when I started this work, so now I just say you don’t need all the details, whether it’s sexual abuse or rape or taking your own life and I don’t need to know all those details so that helps me to manage that bit better. At the beginning, I had people telling me graphic details about sexual abuse, and it would be in my head and I would have to try and blank that stuff out.”
This striking extract is reminiscent of how violent projections into the therapist, can result in emotional withdrawing and intersubjective difficulties (Perelberg, 1999). Dissociation in the therapist, results in diminished attunement, which can re-traumatise clients (Herman, 1992; McCann & Pearlman, 1990). Additionally, in the following passage, an omnipotent view of the organisation is detected:

PB7.9c **Sandra:** “And now people say, ‘where do you work?’ I’d say here, and they say ‘Oh’ and it’s like everybody knows about this organisation and how it’s grown and how people appreciate it and think about the wonderful work done here. And it’s lovely to be part of that [Voice Louder]. I feel really proud for all of us who work in it and proud of the great work we do.”

As evidenced here, the very mention of working with suicidality can stir the admiration of others and clinicians can be seductively labelled as “heroes” or as “extra-ordinary” (Nguyen, 2011, p. 30).

Burnout characterised by depersonalisation (Maslach, 1998; Vanheule & Verhaeghe, 2005) is explicit in Helen’s quote:

PE7.4a **Helen:** “you hear this negative story and that story and there is a part of me now that is cutting off actually that stuff… I get compassion fatigue and I don’t want to know about starving children in Africa, or this, that and the other… I can’t think about it all… I just cut it out of my life, and it’s my way of coping.”

Helen used the signifier ‘cut’ in order to cope, which is fascinating as a lot of her work is with self-harming clients.

Martina elucidates how death anxiety infiltrated her dreams and paralysed her:

PC2.2a **Martina:** “I remember having this recurring dream… emm… and it was about me being cling-filmed and not being able to get out and there was a lot of layers… different parts to it. He [her therapist] asked me was there anything in my life that I was terrified of? And I immediately said ‘Work!’”

Further, she speaks of the enormous toll on her personal spirituality and the activation of her own ‘melancholia’ (Freud, 1917):

PC4.2d **Martina:** “This work can actually trigger those suicidal feelings within you… especially if you are dealing with lots of difficult cases and there is a

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23 Understandably, defence mechanisms operating unconsciously in this respondent are triggered to defend her against painful and conflictual realities (Gabriel & Carr, 2002; Menzies-Lyth, 1988).
lot of hopelessness in those cases you can really end up feeling…what’s the point? This work can really trigger that shadow side.”

Natalie expands on the melancholic theme when she feels an abiding “soul sadness” (Chessick, 1978) at a bodily experience. Recent literature suggests that countertransference can be experienced at a somatic level (Egan, Trimble, Booth & Carr, 2010; Egan & Carr, 2008; Pearlman & Saakvitne, 1995):

**PD4.3a Natalie:** “Definitely, sadness I feel in my heart area…or if I’m feeling that somebody is really touching into sadness or helplessness in me…I would feel it in the heart area…the chest area, massively.”

Again Helen relates how a completed suicide combined with a personal loss impacted her significantly in the body-self:

**PE6.3b Helen:** “But I know after the suicide and after my Dad’s death, a couple of months later I was diagnosed with a very under-active thyroid gland. I was extremely tired and they didn’t know what was wrong with me…and I had to actually resign from my full-time job…I put a lot of energy into my work, and I think that 20 hours of suicide a week is too much.”

Notably, the diagnosis of an under-active thyroid gland is located in the neck area and her client suicided by hanging.

### 4.3.2 Disruptions in Other-intimacy

An overarching theme in the data was how vicarious trauma carried far beyond the therapeutic space into the personal arena (Henry, Sims & Spray, 1973; Guy & Liaboe, 1986; Maltz, 1992). Helen aptly captures this:

**PE6.3a Helen:** “And sometimes you can get a fright when you look in that mirror. I can see the weight of this work hanging off me…and so it is heavy and…there are times when I cannot bear another person to talk to me. Don’t talk at me…just…I have no capacity to listen. Please don’t tell me your problems. Please, counsellor hat is off! It feels like I can become very anti-people. I do experience that quiet a bit. I probably have 16 clients a week now, and that zaps a lot of my energy.”

This excerpt portrays Helen’s disenchantment in her identity vis-à-vis the mirror (Vanheule & Verhaeghe, 2005). This work is “hanging off” her, because her client’s death by hanging is still with her. In order for Helen to maintain some sense of self, she...

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24 “Soul Sadness” is a condition that therapists can develop as a result of engaging with clients who suffer from debilitating depression and despair.

25 Vanheule and Verhaeghe (2005) assert that when the ego ideal loses its function, the mirror will fall, and the individual is confronted with an unrecognisable even threatening Other (Zizek, 1998).
retreats from mentalisation (Fonagy & Target, 1998); there is an impoverishment in her intersubjective relationships (ibid.).

Natalie communicates a disruptive sense of safety that translated into hyper-vigilance around her children (Egan, 2006; Pearlman & Saakvitne, 1995):

**PD4.4a** Natalie: “But what can be negative was when I started doing the work was…I became more watchful of my own children. And I think that you know, had positive and negative effects. And its almost like everything is not about suicide and it became the unspoken thing where my kids were saying, ‘you know Mam we’re not suicidal just because you work with it’”

Tara accentuates how crisis work can distort Other-esteem. Hence, devaluing and dismissing others’ concerns as trivial can render therapists less empathic to loved ones:

**PA4.3a** Tara: “I began to notice that…my tolerance levels of normality became quite limited especially with friends…I became quite intolerant, thinking, ‘God if they only knew’ of what I perceived as the simple things in life. I had to become very, very mindful of that because that wasn’t right. I began…emm…and even in my own personal relationship I suppose with emm…my partner I began to recognise that my tolerance level was extremely low.”

Martina expands on how impairment to interpersonal functioning occurs in her family life:

**PC5.4a** Martina: “When I get home…I feel like I have given 110% to my clients, and I really have to struggle to have something left for home and I’m very conscious of that…I might have just enough left for my kids…but by the time it gets to my husband like…O God! Just prepare yourself…[laughs] Do your own thing now. Don’t ask me for anything […] and sometimes I bring home angry from you know…clients that don’t show up.”

Martina’s clients receive her undivided attention encapsulating the “malignant grandiosity” (Schneidman, 2005, p. 11) of suicidal ideation, but her intimate bonds suffer, because of emotional depletion. Her anger at clients’ irresponsibility deflects onto her children.

Denise dramatically emphasises her decision to not have children and the disillusionment with other practitioners’ lives:

**PF5.5a** Denise: “…since working with suicidality…I actually…I don’t really want to be a parent, because I work with so many kids and I just…people say to

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26 Schneidman (2005) explains how suicidal individuals can experience an almost delusional, preoccupation that their suffering is unique.
Essentially, the myopic perception of suicidality is communicated here (Schneidman, 2005), where the death instinct can destroy the extension of the self in deciding not to bring forth life (Bion, 1959).

### 4.3.3 Disruptions in Professional Identity

Four out of the seven respondents lost a client to suicide. Three therapists experienced this trauma significantly as the client was still in active therapy at the time. A resounding theme was the fracturing of the professional ego ideal and fear of letting down the organisation. Indeed, the dissolution of the omnipotent rescuing phantasy (Bissell, 1981) is reflected in these words “I could not save him. I could not save him” *(Helen)*.

Tara gravely discussed how her naiveté was usurped, subjecting the professional self to self-recrimination and doubt:

**PA3.2b** Tara: “I think you go in thinking that it’s never going to happen to you and when it does happen...you feel you have emm...let everyone down...you question...question the work, you question do you want to be in this type of work? Am I suitable for this work? And it opens up the vulnerable side that’s there in the work as well.”

Helen expressed how this impairment to her professional ability resulted in a lack of desire to counsel high-risk individuals. However, the image of a wounded warrior who goes back into battle came to mind:

**PE5.2e** Helen: “I didn’t want to have any high-risk clients for a while...and it made me wonder, ‘Am I able to continue in this kind of work? Can I do this?’ And you know what, it actually made me stronger...and made me think, ‘Hang this...it just makes me want to go in there and fight back...’”

Interestingly, her ‘Freudian slip’ belied hidden anger concerning the client’s ultimate decision of death by asphyxiation. However, later on she consciously related her

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27 Accounts elucidate how having a client self-murder shared many features to those found in the bereavement literature (Freud, 1917; Tillman, 2006; Worden, 2003). This in-depth data highlights salient themes of personal devastation, sadness, guilt, denial, shame at not recognising the warning signs, as well as anger towards the client (Schneidman, 2001).
bargaining plea, “I was so angry…I just wanted him to give me a chance”. Suffering from a personal loss at the time, Helen wistfully highlights the guilt of missing the cues and the lack of acuity at the assessment level:

**PE4.2d**  
Helen: “He did it the following day [participant cries]. He was in a terrible stressed state when he came in and, unfortunately, at that time, I had lost my own father…and…emm…I had a break of a few weeks and I came back, and then I had him…I was in no fit state…I should not have had such a high-risk client at the time…but we didn’t think he was high risk.”

Denise asserts the apparent denial so inherent to suicide prevention (Alexander, 2007). She reiterates the narcissistic injury to the professional ideal (Gabbard, 2003) as well as expressing the defensive platitude of the tortured soul at rest:

**PF2.2c**  
Denise: “Well it was a real shock which sounds absolutely ridiculous because we work in suicide prevention…someone is going to die sooner or later. It was almost like…I never thought it would happen…I was emm…worried in all honesty how it would reflect on me as a therapist…I felt very sad about it. She was a lovely girl and just unfortunately…again she came from very dysfunctional background and didn’t really have any support in her life, and ah…it was just sad though…in some ways I was relieved for her…she was in constant pain the whole time…and I kind of felt well actually, she is at peace.”

Helen movingly stated her fear of the next suicide (James, 2005):

**PE5.2e**  
Helen: “I think at the present moment actually those of us who have lost our clients to suicide are all sort of like in terror that we might have another one. Who is going to be the first? Then I will have two people who will have died. I mean it’s awful.”

**4.4 THEME 3: “A Terrible Beauty is Born”/A Spiritual Practice**

In the narrative data of all respondents, the most striking phenomenological characteristic was that working with those who ‘were half in love with easeful Death’ (Keats, 1978, p. 311) carried spiritual significance. The transcripts from three humanistic practitioners stood out as specifically spiritual. There was almost a sense of being on ‘hallowed ground’ during the interviewing process. Spirituality was a quality that had increased for all participants; indeed, the centre was defined as “a spiritual practice” where “love transfusions” (Denise) happened. All participants’ recounted transformations as a result of being part of the process where clients are resurrected “from death to life”
In line with emergent research, the empathic attunement between the therapeutic couple can vicariously traumatize the therapist, but it can also stimulate vicarious growth (Arnold, et al., 2005; Hernández, et al., 2007; Tedeschi & Calhoun, 1995, 2004). Despite suicidal prevention being harrowing, all interviewees describe their job as a ‘blessing’, a ‘gift’ and a ‘privilege’. This theme is presented in three sections: 1) The Agapean Mission, 2) Community of Believers, 3) Regeneration.

### 4.4.1 The ‘Agapean’ Mission

In listening to the participants, the expressed wish to save clients acquired an almost religious fervour, as if the practitioners were specifically selected for this calling. Tara asserted, “I think we can be drawn to this work for a specific reason, and the spirituality part is probably questioned long before we even start”. Unquestionably, in the Irish post-Christian context, therapy has replaced the void that religion once filled (Weatherill, 2004).

Helen’s rescuing phantasy is explicit in her “militant spirit to see people live” and in her mission statement to “rescue those who are being led away to the slaughter” (Proverbs 24:11). In this vignette, Helen powerfully relates how she turned a suicidal man’s life around. However, grandiose expectations are voiced:

PE2.1b **Helen:** “And five years on...I accept...I do...that I have the power to change somebody’s life direction. Not only his, but the five of his children and his wife So when you actually do rescue somebody, you actually impact a whole family...a community...emmm...sometimes when you are in this work you actually don’t realise the impact of what you are doing.”

Cathy communicates her ‘love mission’ and why she engages in this work:

PF2.1b **Cathy:** “I love the work and I love the clients. I love the feeling of being in the room with somebody and they can take one baby step and in that they can get a sense of you know...I actually do have a say in this...I can take charge of this...I have potential...I have growth...you know...I still get up in the morning and I have to pinch myself, God I get paid to do this! Because I honestly feel it is more like a vocation! And there are days when I have trouble, and there are days when I have stress, you know, but would I change it? Not in the slightest. I love my work. I love my job.”

This excerpt conveyed a transcendent feeling, reminiscent of Buber’s (1937) ‘I-Thou’ encounter, where the relationship is an authentic dialogue of communion and presence.

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28 “We never come fully to grips with life until we are willing to wrestle with death” (Hillman, 1997, p.15).
29 Coming from the Greek word ‘agape’ meaning the unconditional love and grace of God.
An image of a priestess surfaced as Cathy explained how the therapist holding hope counters the despairing client clutching their coffin:

**PG2.2a**  
*Cathy:* “And often I say to the client, you know can you let me hold the hope for you...until you see it and feel it? [Chuckles]. Emm...because I believe, and I trust the process...yeah...but I have been blessed with the clients I meet in here...they are wonderful.”

Denise extols how this “actually is my dream job”; moreover, she links this innate transcendent quality to the therapeutic relationship:

**PF5.4a**  
*Denise:* “…maybe it sounds a bit corny, but for me working in the organisation is like a spiritual practice. We get to do something very spiritual I think...emm...so I guess in that way it has. I know it’s my job and it’s work, and sometimes I dread it...and sometimes it’s a pain in the arse, but like...it is...it is! I would say any work with clients is a spiritual experience. When you have that kind of certain relationship with them or connection with them...definitely.”

Again Denise’s quotation encapsulates the *agapean* principle at work and a positive addictive metaphor is used to exemplify this idea of a love exchange:

**PF7.7a**  
*Denise:* “…this is going to sound mad, but I think in the organization it’s almost like you get a love transfusion...you get it straight...take it into your veins and you bring it over and you put it into theirs [clients] and you keep sending it to them. I think that’s the biggest change that can happen. They actually start to kind of...love themselves a bit…”

Tara declares her passion for counselling teenagers and the sustaining belief that this work is worthwhile:

**PB2.1b**  
*Tara:* “…it’s so emm...great and a pleasure and a privilege to work with people when they come in, in the depths of despair, to work with people in their crisis...emm...there’s meaning for me and it’s very significant...and I think you have to be passionate in that because if that is not there it’s definitely picked up by the client.”

The nonmaterial rewards are reaped in not shying away from ultimate crises; therefore, witnessing the adolescent’s resilience has imbued her life with meaning (Masten & Coatsworth, 1998).  

4.4.2 Community of Believers

Four therapists professed a belief in God that sustained them in meeting the suicide risk; thus, it seemed that ‘Divine Intervention’ is required for suicide prevention (Arnold, et al., 2005; Golsworthy & Coyle, 2001). As Sandra articulates, “I would always look to

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30 The more immanent the death threats the more possibility for transformation (Hillman, 1997).
Him for help so I’m not doing it all on my own”. For Helen “My faith in God gives me hope, it holds me”. Nonetheless, there was a strong ethos conveyed by all participants that they could only do this work because they operate as a team. When the researcher asked Denise what supported her during the difficult weeks after her client suicided, she replied:

**PF4.2c Denise:** “Well the people in the organisation actually, because...emm...colleagues funnily enough...and that was grand...but my own supervisor wasn’t very good. She didn’t get it, and she started pretty much straight away asking me what would I have done differently?”

Denise expressed how her colleagues brought her back to the realistic limitations of what it means to be human:

**PF6.6b Denise:** “I suppose, I feel quite fortunate in that I can go and speak to people about clients...yeah...emm...you can laugh about stuff, it’s a bit mad, and ah...you can only do that with your colleagues [...] You are just not made to feel, it’s your fault if something goes wrong or if the person didn’t get well or...it’s kind of like everyone else is working there within their human capabilities, their ‘good enough’ and that takes away the pressure.”

This staff constellation increases the therapist’s sense of connection; there is a shared organisational experience that acts as a buffer against burnout. This directly contradicts research that those practitioners who practice in agencies are more stressed compared to those in independent practice (Pearlman & Saakvitne, 1995).

### 4.4.3 Regeneration

All transcripts emanated an overwhelming theme of regeneration in the person of the therapist. A sense of fulfilment in the clinician’s developmental journey was expressed from their original sublimation of what brought them into the work: their own suicidal ideation, bereavement or woundedness to the position of ‘wounded healer’ (Nouwen, 1990). What came to mind was an inversion of Beckett’s (1979) famous maxim “Birth was the death of him”, for these therapists – “death was the birth of them”. Indeed, their strong assumption “that life is possible after a relapse” (Cathy) relates the inherent paradox in suicidal ideation; we can only contend with life if we have wrestled with our own finitude (Hillman, 1997). When the therapist has embraced this journey there is a meaningful sense that metamorphosis is possible; the phoenix can rise from the ashes (Dietrich & Shabad, 1989):

**PG2.1b Cathy:** “I know what it is like to feel suicidal, and I know what is it is like to have suicidal ideation, I made a suicidal attempt in my past. Emm and...you know...I often say this to clients...the gift that comes from a suicide attempt is that we can really get life; we can really begin living.”
Cathy articulates a balanced spirituality that she attributes to working in suicide prevention. Frankl’s (1959) ‘will to meaning’ comes to mind:

**PG7.4a Cathy:** “I believe in God…I believe in the goodness of life and I believe in the goodness of people…and I think there are dark deeds, and a lot of crap out there…and there is evil too […] I don’t go to Mass, but I like going to church on my own…I like being in that space. I don’t really do any meditation or mindfulness [Laughs]. I read, I reflect when I’m driving in the car, and the worldview in terms of…I still have hope and that keeps me going…yeah, I still have hope.”

Birchnell (1983) posed the question “does the therapist’s love of life increase with every suicidal client he deters?” Cathy’s post-traumatic growth and integration of her own suffering have the effect of self-expansion:

**PG9.6a Cathy:** “…there is growth and I love my work. I feel very…as someone once said…‘an attitude of gratitude’ [Laughs]. I start each day with that gratitude, and I have a good long list…and the other end of that is the place where I felt very lonely, isolated and very anxious. It was very painful…but yeah, I’m grateful.”

For Denise, her involvement with near-death has afforded her “such a profound sense of meaning”. She is more reflective and her positive esteem for others has increased:

**PF7.8d Denise:** “I think I’m a better person because of this work…emm…I think it makes you think more about life and think more about the world outside yourself. I think I’m also quite an outward looking person, but not to the degree that I am now…and makes me more…more emm…sympathetic and empathic to other people and better at understanding people.”

Natalie voices how she feels “really exhilarated” in being part of someone’s journey. She relates how death is the ultimate shaper in self-reformulation (Mayan, Morse & Eldershaw, 2006), an impetus for altering one’s life and increasing a sense of inner peace:

**PD8.8d Natalie:** “Yeah, I’ve become calmer, it’s because I’ve realised that the little things don’t matter, not anymore. And it really helps put things in perspective…and most things are all those little things, because when someone is coming in saying ‘I’m going to take my life’ you know, that is the ultimate […] So in that way, it has made me value my life…emm…the opportunities in my life…and its…like when I have quiet-time or downtime or fun-time essentially I enjoy that.”

Martina, Tara and Cathy all repeat the same phrase to describe the meaning they derive from facing death in their clients – “Don’t sweat the small stuff”. As Tara simply states:
“you recognise what’s important in life; your priorities definitely change”.\(^{31}\) From the ‘Dark Night of the Soul’ (St. John of the Cross, 2008) to the sharing of suffering - there is light, hope and perspective:

PB9.7c Tara: “I suppose no matter how bad it gets, there is always a way out; you know...that we are all human and skin is only skin, emm... that you can go into that dark place, and you can come out of it. You may not be able to do it on your own and emm...look it is possible; its always possible, and there are always options. There is hope.”

Tara recognises that bearing witness to her client’s growth has elicited healing in relationship to the self, magnifying self-compassion and altruism in general:

PB9.8d Tara: “I think it has made me emm...like me a little bit more...and to recognise that...I am not perfect...ok...nor will I be perfect, but that there is goodness in me, and I know that would be wasted if I didn’t share it. And it’s a privilege to do that. It didn’t come easy; it came out of painful things, out of difficult things...and that’s one thing I can share with my clients, I always say in every session, you know, therapists who work here it’s not because they have had a good life, but because we have been in difficult situations and that things can change...And that is the best gift that I have got out of it.”

4.5 Summary

In summary, rich data illustrated the lethal nature of suicidality on the self of the therapist. Concomitantly, suicide prevention and facing one’s own mortality, provides the practitioner with unparalleled opportunities for personal and spiritual awakening (Mayan, et al., 2006). The next section will expand upon these themes.

\(^{31}\) Ultimately, death forces us to reconsider how we want to live our lives; increasing our disregard for material things and maximises our respect of the non-material aspects of existence.
5.1 Introduction

The primary research question in this study was to explore and to understand how suicidality impacts experienced Irish psychotherapists. Interpretative Phenomenological Analysis (IPA) was applied to the narratives of seven participants and three superordinate themes emanated from the data analysis process, which provided in-depth views on how these clinicians constructed meaning from their high-risk work. The findings indicate a complex blend of how confronting mortality consciously and unconsciously can cause severe impairment in the person of the therapist on one level, combined with a reformulated approach to living on the other. Four participants articulated their conscious awareness for working in this field, expressing their suicidality, loss of loved ones or battle with melancholia as the reason. It is clinically accepted that the client who comes for therapy brings the therapist her own problems (Hillman, 1997; A. Rogers, 2006). Nonetheless, two participants were lured by the seduction of working for a high-profile centre, and one participant was motivated by the challenge this work posed. Interestingly, theorists have cautioned that the treatment of suffering has become ‘in vogue’ and may lend itself to fetishisation (Freud, 1927; Nguyen, 2011, Sontag, 2001). Working with suicidality, commonly elicits the admiration of others, which can esteem the practitioner to the omnipotent clinical domain (Nguyen, 2011). This chapter will begin with a discussion of the findings and will conclude with a summary of its limitations and potential contributions.

5.2 Overworking

Increased interest, high anxiety and over-absorption with clients were consistent phenomena throughout the transcripts, which corresponds with analytic investigations (Birtchnell, 1983; Briggs et al., 2008; Goldblatt, 2008). Henderson (1974) posits that the expression of suicidal intents are strongly linked to the intensification of care-giving behaviours in the clinician. Participants in this sample, like parents, became instinctively more caring due to the fear of losing their clients to death (Birtchnell, 1983). Individuals make suicide moves when they feel intense psychic pain as a result of rejection or

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32 As Hillman (1997) stipulates there could be an archetypal attitude that guides the psychotherapist’s motivation.
abandonment from attachment figures (Bowlby, 1969; Magagna, 2008; Seager, 2008). Psychotherapists in this project prevent suicide by offering a nurturing relationship, which serves as ‘an incubator’ for the client’s development; hence, the therapist offers herself as a source of succorance (Birtchnell, 1983; Guntrip, 1968; Woskett, 1999). The presence of regressive, dependent and helpless states (Birtchnell, 1983; Campbell, 2006; Olin, 1976), activates an excessive attachment, which is reminiscent of the dyadic bond between neonate and mother (Birtchnell, 1983) Thus, clients are kept alive by the transferring of cathexis onto the therapist, and it becomes difficult to refer clients on after the designated 15-20 sessions (ibid.). This is consistent with the appraisal in the literature, which suggests that short-term work with suicidal clients can increase stress in therapists as a robust continuity of care is required (Birtchnell, 1983, James, 2005; Tillman, 2006). The ‘overworking’ theme is reflected in psychodynamic studies as the therapist becomes more personally involved than usual in the form of ‘therapeutic accommodations’ (Goldblatt, 2008) or ‘extratherapeutic’ factors (Woskett, 1999). To deny these supports could lead to the client feeling abandoned or rejected. Moreover, Meltzer’s (1969) ‘toilet breast’ concept is relevant because these practitioners are not only used as nourishing objects but as cleansing objects, flushing the unprocessed excrement of a nation who banishes the suicide reality, as mirrored in Sandra’s anguish over waiting lists.

Accordingly, five participants elucidated the need for purification of their body surface. Hence, the fear of contamination from suicidal clients or the penetration of emotional membranes is supported by the child psychotherapy literature with regards the function of the skin (Bick, 1986; Turp, 2007; Willoughby, 2001). Primitive defences at work in the session appear to disrupt the psychic skin functioning of the therapists involved (Bick, 1986). Therefore, attending to the countertransference responses and what is being ‘held’ in the skin is vital in order to comprehend the impact of the suicidal condition. The dominance of the ‘paranoid-schizoid position’ (Klein, 1935) and immature impulses, deplete the therapeutic relationship of life (Bion, 1959), due to unbearable aspects of the ego that are “phantastically expelled” (Sandler, 2009 p. 259) or ‘thrust’ into

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33 In Lacanian (1959/1977) terms people attempt to overcome their lack by turning to Others, where “desire is the metonymy of the want to be” (p. 259). Fundamentally, the suicidal question forces us to consider ‘to be or not to be’. Hence, the suicidal state is a form of “emotional limbo” (Birtchnell, 1983, p. 28) where the individual severs affiliative bonds with significant Others and yet the ambivalence prevails in their desire for attachment (Schneidman, 2005).

34 Bick’s (1986) research into the containing property of the mother’s skin in early object relations facilitates an internalisation of soothing experiences for her infant.
the therapist (Meltzer, 1994). Bion (1962b) observed that if the mother could contain undesirable emotions and the infant’s “nameless dread” (p. 183), then projective identification serves a communicable purpose fostering growth, creativity and vitality. Additionally, Meltzer’s (1994) concept of ‘adhesive identification’ could explain how clients are superficially sticking to the therapist’s skin surface as a defense against separation. In this “contagion of affects” (Vaillant, 1992, p. 58), the infected therapist brings the client home in a perpetual whirl of preoccupation, which could be perceived as a means to exact control into this intolerable dilemma (Pearlman & Saakvitne, 1995). Therefore, the practitioner must walk a delicate line between offering additional support, while being aware of the enticing pull of enactment and negative countertransference feelings (Goldblatt, 2008; Ringel, 2005).

A striking point was the degree to which participants attributed ‘overworking’ to their engagement with severely suicidal clients with personality disorders. Clinical writings emphasise that defences like reaction formation can cause the therapist to overwork in the hope that they can ‘rescue’ the client from the suicidal attack (Goldblatt, 2008). Consequently, clinicians are held captive to the client’s cruel and even perverse manipulations as voiced by Martina and Natalie’s vignettes. A form of ‘therapeutic bondage’ ensues that if unattended can leave the therapy doomed to failure (Hendin, 1991). Many high-risk clients have suffered horrendous variations of ‘soul murder’ (Shengold, 1999) and the internalisation of these abusive objects perpetually haunts them. In reaction to this, clinicians may position themselves to ‘disidentify with the aggressor’ or ‘embody the good object’ in a desperate attempt to disavow any connection to former bad objects (Gabbard, 2003; O’Connor, personal communication, 2012).

High lethality can invoke strong countertransference reactions in the practitioner as extensively asserted in the suicide literature (Hendin, 1991; Malsberger & Buie, 1980; Menninger, 1933). This can result in serious boundary transgressions as demonstrated when Helen drove to her client’s house to stop the suicide (Gabbard, 2003). Early analytic literature on countertransference encouraged honest explorations of the therapist’s “untherapeutic” responses (Pearlman & Saakvitne, 1995, p. 199) as the mismanagement

35 To quote Klein (1946): “These excrements and bad parts of the self are meant not only to injure but also to control and take possession of the object” (p.183). The use of projective identification to expel bad parts actually serves to blur the distinction between self and object (Steiner, 1993).

36 Theorists view the presentation of suicidality as a defence against a psychotic breakdown (Etzersdorfer, 2008; O’Shaughnessy, 1999; Rey & Magagna, 1997; Steiner, 2001; Winnicott, 1974).

37 Generally, ‘Soul Murder’ refers to the long-term effects of child sexual abuse – the body is intact, but the soul or the spirit of the person is destroyed.

38 It was Winnicott (1949) who pioneered the frank disclosure of a clinician’s hatred towards patients.
of aggression can iatrogenically hinder treatment (Asch, 1980; Gabbard, 2003; Winnicott, 1949). Accordingly, the denial of hatred can lead to a form of “therapy that is adapted to the needs of the therapist rather than to the needs of the patient” (Winnicott, 1949, p. 74). However, all participants freely expressed the vicissitudes of their forbidden feelings; as Helen related “I experienced different feelings from such compassion to just…yes…to rage”. Individuals diagnosed with borderline personality disorder were experienced as particularly challenging by all respondents because their suicidality was so intractable, which is consistently demonstrated in empirical discourses (Paris, 2006; 2007; Sperry, 2003). Etzersdorfer (2008) explains how violent evacuations of suicidal feelings into the clinician, can render the therapist helpless and impotent. As Birtchnell (1983) postulates, heightened activity generated by impotence is rarely beneficial. “Staying with the despair” as Cathy expressed can have a contagious effect on the therapist; yet paradoxically it can elicit intense catharsis and provide the client an opportunity to own his suicidality. Furthermore, borderline individuals may not have progressed beyond Mahler’s (1968) symbiotic relationship to the parent, where separation was not permitted, and attempts to do so in the form of endings or holiday breaks can generate overwhelming anxiety in both client and therapist.

5.3 “All Changed, Changed Utterly”/Identity Disruption

It is well documented that the psychotherapeutic engagement with traumatised clients can shatter personal interpretations of reality and the same findings were reflected in this endeavour. Therapists were altered in relationship to the self, to others, as well as in their professional capacity (Murray-Parkes, 1993; Trippany, et al., 2004). The tragic realities we encounter in the therapeutic domain can erode one’s fragile belief in ‘the thin veneer of civilisation’ (Freud, 1930), which can be replaced by a thick gloss of disillusionment. Coalescing with numerous clinical investigations, persistent exposure to suicidal narratives (Sandra), wrought a sense of affective numbing, protecting the therapist from active client involvement (Menzies-Lyth, 1988). Defence mechanisms such as dissociation or detachment defend respondents against death anxiety, but ultimately aggravate the burnout syndrome (Egan, 2006, Maslach, 1998). Freud (1927) stressed how ‘working through’ can become perverted by the clinician’s unconscious ‘acting out’ which can re-traumatise the client (Herman, 1992). Moreover, ‘acting out’

39 In the *DSM-IV-TR*, borderline clients are characterized by “recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour” (p.710) the characteristic that creates the most anxiety among those who treat this disorder (Appendix J).
results in the denial of the unbearable and the incapacity to hold the space of “empathic unsettlement” (La Capra, 2001, p.xi).\textsuperscript{40} Essentially, how we listen, witness and make contact with our clients carries not only clinical implications but also serious ethical weight (Nguyen, 2011).\textsuperscript{41}

Suicide attacks the body, and four participants expressed how suicide prevention significantly impacted the body-self, in the form of terrifying dreams, intensive muscular tension, ailments and sensations. Annie Rogers (2000) explains that dreams and symptoms are a means to process trauma and can be a way of interpreting the Lacanian Real\textsuperscript{42} in the body. As Denise admitted, “I am prone to muscular tension and headaches and I think it’s all from the work”. In line with Chessick’s (1978) explorations with the chronically depressed, Natalie experienced ‘soul sadness’ in her chest area. Volkan (2007) posits that in a group setting there can appear a ‘perennial mourning’ phenomenon, where a community can become stuck in grief. Interestingly, unmetabolised loss can become lodged in parts of the body. Hence, monuments to the trauma are erected to deposit the lost objects known as “suitable reservoirs”; these can be centres dedicated to suicide prevention (Volkan, 2007, p. 25). Unresolved grief around the death of a client to hanging in Helen’s situation resulted in an under-active thyroid gland that left her lethargic and without vitality. Therefore, these findings add to contemporary clinical research that countertransference can be expressed in multi-modes; as an emotional or cognitive reaction; in the emergence of fantasies or dreams relating to the client; and through the arousal of spontaneous somatic sensations (Egan, et al., 2010; Egan & Carr, 2008; Orbach, 2000). Both Stone (2006) and Wosket (1999) agree that the clinician possesses an embodied “tuning fork” that resonates with the unconscious psychic material of the client and in this ‘therapeutic use of self’, a body-centred countertransference can transpire.

Explicit in the findings was the notion of interpersonal impairment, which consolidates findings from previous analysis (Henry, Sims & Spray, 1973; Guy & Liaboe, 1986). Psychotherapy is a dialectical process, requiring in a Winnicottian (1971) sense the mirroring of the client. In Helen’s citation, the metaphor of the mirror was introduced to convey her unrecognisable identity. The Lacanian postulate on burnout delineates a close relationship between identity disruption and intersubjective difficulties, which evidenced

\textsuperscript{40} Schmid (2003) describes it as staying with the unknown and the not-yet understood.

\textsuperscript{41} Nguyen (2011) stresses how traumatic narratives need transmission, reception and symbolisation, first by the ‘listening-witnessing Other’ and eventually by the traumatised subject.

\textsuperscript{42} The Real is the unsayable, that which has not been put into words and is commonly connected with trauma. According to Lacan the real in analysis has to be spoken and put into signifiers.
in interpretations from the present data (Vanheule & Verhaeghe, 2005). When therapists form countertransference identifications with their clients, they can no longer reflect because they resemble the Other and as Hillman (1997) explains, “the mirror darkens and the dialectic is gone” (p. 53). In the current study, Helen who had not accessed postvention (Schneidman, 2001) assistance after her client suicided was left “with this work hanging of me”. Freud (1917) proposed that the “work of mourning” as that of severing “attachment to the nonexistent object” (p. 166). With extreme devotion or “imaginary absorption” with clients (Vanheule & Verhaeghe, 2005, p. 296), cracks appear in the mirror, which means that the ego ideal loses its power and the individual is confronted with the Other’s frightening jouissance (Zizek, 1998). In this case, the Other could be conceptualised as Death. Participants in this study maintained a sense of self by withdrawing from family and friends; hence interpersonal bankruptcy ensued (Vanheule & Verhaeghe, 2005). As Skovholt (2005) hypothesises, ‘The Cycle of Caring’ involves a continual cyclical process where the therapist offers empathic attunement, active involvement and meaningful separation for each client, and in short-term crisis work this is more exaggerated. Additionally, VT in the present study was detected in a form of over-protectiveness around one’s children (Egan, 2006; Pearlman & Saakvitne, 1995). Although, examples were not discovered in the professional literature, it could be interpreted that the participant who decided not to have children, was in some way succumbing to the death instinct, in that suicidality destroyed the extension of herself that could give life (Bion, 1959). Furthermore, burnout as exemplified in ‘mood spillover’ was realised in the seepage of anger onto family members, when the therapist was angry at ‘no shows’ and last minute cancellations (Egan, 2006; Spector, 1999).

Four respondents survived a client suicide and shared similar responses to the phases outlined in the bereavement literature, in terms of shock, denial, grief, sadness, guilt and bargaining (Freud, 1917; Worden, 2003). In reviewing the participants’ reactions to client suicides, a salient finding was the splintering of the professional ego ideal, which is consistent with existent psychodynamic case studies (Alexander, 2007; Fox & Cooper, 1998; James, 2005; Rycroft, 2005). Tillman (2006) argues that there is an inevitable double loss: the client to suicide and one’s professional ideal, which culminates in a

43 Complicated or “disenfranchised” (Doka, 1988) grief arises out of the ambivalence the participant feels towards her dead client that has impeded her detachment process (Freud, 1917).

44 Jouissance is a Lacanian (1992) term that refers to pain in pleasure or satisfaction in dissatisfaction. Jouissance is based on the law; it can only be obtained through transgressing. Hence the subject enjoys as little as possible.

45 Guy and Liaboe (1986) stipulate that this cycle “can leave the therapist experiencing repeated feelings of loss, loneliness and possibly abandonment” (p.112).
dynamic of mourning and melancholia, laced with self-reproach and self-criticism. Concurring with Bissell’s (1981) research, experience taught the present participants, that in the dissolution of naïveté after the first suicide, their omnipotence ceded to the reality of client responsibility. This stage was cemented by factors such as self-awareness, peer support, organisational assistance, understanding of psychopathology and the length of work experience. These bereaved participants related the inherent contradiction of working in suicide prevention, but feeling shock when a suicide transpired. Initially, this narcissistic injury (Gabbard, 2003) to their professional identity was experienced as a diminished sense of self-efficacy inherent in Denise’s statement “I worried in all honesty how it would reflect on me as a therapist”. Furthermore, Helen expressed how this professional crisis could lead to a fear of ‘surpassing the quota’, as indicated in James’ (2005) research.

5.4 “A Terrible Beauty is Born”/A Spiritual Practice

A compelling finding was the manner in which all participants confided that their involvement with adverse suffering, did not necessarily imply psychological damage but instead can lead to vicarious change in their own lives. Participants conceptualised their clinical practice as a spiritual endeavour, and this was clearly demonstrated in therapists trained in the humanistic tradition. Contemporaneously, this resonates with empirical elucidations from the vicarious resilience and post-traumatic growth literature (Arnold et al., 2005; Calhoun & Tedeschi, 2004; Hernández, et al., 2007). Respondents who openly expressed their own woundedness as being a conscious motivation for entering this work conveyed a deep appreciation for what Wosket (1999) called their ‘internal client’. From a psychodynamic perspective, Wosket (1999) describes the ‘internal client’ as part of the therapist that continues to grow, develop and receive healing as a result of deep engagement with clients. Hence, the catalyst for change is embedded in the therapeutic connection. According to Tedeschi and Calhoun (2004), the experience of working in

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46 Three therapists emphasised the narcissistic injury to the professional ideal, fearing how their colleagues and the organisation would view them after their client suicided (Gabbard, 2003). Vanheule and Verhaeghe (2005) stress that individuals who are more vulnerable to burnout are preoccupied not only with pleasing their superiors but also with the idea that others lack confidence in their professional work.

47 Interestingly, Helen’s concern of losing her capacity to work with long-term clients, demonstrate the dynamic of being swept up in a crisis management mode, where the practitioner is on longer able to appreciate the process (Pearlman & Saakvitne, 1995).

48 In the process of attending to their client’s needs the needs of the clinician are met, bringing to mind the Proverbs 11:25 “He who refreshes others, will himself be refreshed” (NIV, 1985).
traumatic situations can conversely produce three salutary outcomes: transformation in self-perception, in interpersonal relationships and worldview.

An enduring perception of mental health practitioners is their scepticism to religious or spiritual dimensions (Golsworthy & Coyle, 2001; Voss Horrell, et al., 2011). Surprisingly, the current sample produced evidence on the contrary, and a tentative hypothesis could be that working ‘under a death threat’ can cause serious damage to the therapist’s frame of reference and the belief system maybe activated to create a new meaning structure (Golsworthy & Coyle, 2001; Janoff-Bullmann, 1992). A conspicuous element to this finding was the participants’ zeal for their work and how religious terminology was used to describe their “vocation” in high-risk psychotherapy. Weatherill (2004) indicates how the therapeutic community has come to fill the emptiness which traditional religions once occupied; hence therapists have become the seductive royal priesthood, the ones who minister “devotional regime(s) for the self” (p. 4). Bell (2008) has noticed in organisations “the determination to save a patient acquires a religiosity, the staff believing themselves to be specially selected for this mission” (p.550). However, the idea of communion, presence and the sacred are strongly associated with the I-Thou encounter as espoused by Buber (1937). It is noteworthy that humanistic writers have long addressed this spiritual quality as intrinsic to the therapeutic relationship (Clarkson, 2003; Rogers, 1980, Rowan 1993; Thorne, 2000).

A resounding finding was the extent to which organisational factors played in the well-being of the present sample. The seven participants exuded a strong sense of belonging to a specialised community, and this concurs with contemporary studies that the ethos of the clinic itself has a dramatic effect in holding practitioners (McCann & Pearlman, 1990; Voss Horrell et al., 2011). Contrasting with the current literature on the support of supervision as a protective dynamic in combating VT (Bernard & Goodyear, 1998; Bordin, 1983; Egan, 2006; Pearson, 2000), this sample categorically emphasised the holding and containing from each other. However, the need to hold vigil and support the witnessing therapist is apparent across transcripts. This finding exemplifies James’

49 Spirituality inherently refers to the human propensity to embrace meanings that transcend the self and the material world (Golsworthy & Coyle, 2001; Janoff-Bullmann, 1992).

50 As discussed in the findings, participants articulated how much they “loved” their jobs, viewing clinical work as a “privilege”, a “gift” and a “blessing”, where “love transfusions occurred.

51 Yvonne Hunter (1994) recounts in addressing the soul in family therapy: “The dropping into and therefore, acknowledging the actual pain and suffering that is brought to therapy can lead to experiences that have such depth they could more properly be described as spiritual, or at least transformational” (p. 82).

52 Maltsberger (1992) stresses that suicide completions could produce pathologic grief reactions such as “narcissistic avoidance” where the clinician may withdraw from appropriate self-caring strategies and supervisory consultations (as cited in McAdams & Foster, p.107).
(2005) premise that when a suicide occurs within an organisational setting there is often a need for healing amongst many members of the community. Again, the ‘community of believers’ theme directly contradicts research suggesting that those practitioners who practice in agencies are more distressed compared to those in independent practice (Pearlman & Saakvitne, 1995). In our risk-evasive medical culture, Seager (2008) delineates how there needs to be an investment in a network of attachments that ensures that psychotherapists and clients are ‘held in the mind’ of the system as a whole.

The phenomenological characteristic concerning the ‘regeneration’ of the self was attested by all participants and is widely reflected in thanatology studies (Bonnano, 2004; Hall, 2001; Janoff-Bullman, 1992; Mayan et al., 2006). As Augustine wrote, “it is only in the face of death that man’s self is born” (as cited in Yalom, 1980, p. 30). The symbols of transformation, rebirth and growth in the present data indicate the developmental stage in the participants’ professional trajectory. This reiterates Hillman’s (1997) belief, “suicide is the urge for hasty transformation” (p. 73). The reality of death is heightened in suicide prevention, which can foster the quest for a fuller life. As supported by the bereavement theorists Bonnano and Keltner (1997), all participants displayed a joyous disposition in the face of adversity through the deployment of genuine humour and laughter that punctuated their transcripts. Historically, the display of positive emotions was dismissed as a form of denial (Bowlby, 1980), although defences can be pathological, mature defences like humour can be positively adaptive (Vaillant, 2000). Therefore, the contemplation of suicide begets the contemplation of the ultimates of existence: Eros and Thanotos (Hillman, 1997).

Humanistically trained participants transcended personal tragedies and their work with suicidal clients, into a state of spiritual awakening. Consequently, they reordered their priorities, shared life experiences, cherished wisdom from suffering and treasured their loved ones. This correlates with Mayan and colleagues (2006) clinical exploration into individuals facing death, whose suffering inspired an internal restructuring of their value hierarchy and expanded their self-concept to live life to the fullest. Dietrich and Shabad (1989) suggest that literally out of the ashes of loss and death, a phoenix-like process can transpire, that radically renovates the self. Accordingly, Knafo (2004) asserts that long before the recent empirical explosions from the vicarious resilience movement,

53 Freud (1916) poignantly argued in his essay “On Transience” on the intimate relationship between Eros and Thanatos, that the “proneness to decay of all that is beautiful and perfect” (p. 306) serves to deepen our sense of wonder and joy in all we hold dear.
the humanistic approach to trauma has always involved an intimate confrontation with one’s own mortality, enhancing more creative and transcendent shifts in consciousness. To conclude, the final words are given to Cathy: “the gift that comes from a suicide attempt is that we can really get life; we can really begin living”.

5.5 Conclusion

Psychotherapy involves a privileged intimacy with another; therefore, the threat or attempt of suicide of someone we have worked closely with is agonising (Hillman, 1997). It cuts straight to the heart of the therapeutic encounter. In the Irish context, suicide was condemned by the law as criminal and by religion as a sin, and society still shuns it, despite the tragedy of hundreds of completed suicides each year. Implicit in the research findings is the need to develop objectivity in the consideration of suicide. It is not enough to fall back on academic investigations into the suicide literature with its explanatory concepts of “diseased superego” and “destructive narcissism” because we essentially lose sight of the person. As psychotherapists, we cannot operate without a philosophy of death and additionally we need to develop our position on suicide through intimate explorations of our own and the other’s psyche (ibid.).

The suicidal client impels the therapist to face the reality of death anxiety; thus, we need to be mindful as to how this impacts our clinical practice. Considering the paucity of research on the impact of suicidality on clinicians, it is imperative that Irish psychodynamic researchers in the field investigate and create a sophisticated evidence base to inform psychotherapeutic practice. Respondents, who were acutely aware of their own sublimation of melancholia and the emergence from suffering, could deeply empathise and journey with their clients. Moreover, they articulated an ability to thrive, reassess life priorities and restructure the self. Freud (1910d) noted, “no psychoanalyst goes further than his own complexes” (cited in Laplanche & Pontalis, 1973, p. 413). In order for therapy to heal, attending to one’s personal process is crucial and familiarity with one’s early development provides the essential framework, which ‘holds’ us during the course of treatment (Casement, 1985).

Nevertheless, a conclusion that can be drawn is that psychotherapists who experience similar victimisation or suicidality as their clients do not necessarily suffer vicarious trauma. In fact, the ‘container/contained’ dynamic can promote transformation not only in the client but also in the therapist (Bion, 1962b). The treatment of suicide, I hypothesise is an unconscious endeavour to construct a more meaningful and spiritual existence in the
face of our ultimate death terror. Within the psychotherapeutic literature, theoretical frameworks have paid little attention to the roles of religion or spirituality, despite research, which has highlighted the importance of meaning-making processes after traumatic events (Golsworthy & Coyle, 2001; Janoff-Bullmann, 1992). Therefore, in reviewing the participants’ responses, a Christian framework was a holding and containing factor in their professional endeavour.

There are implications for the psychotherapeutic profession in how a practitioner can be best informed to work in the field of suicidality. The present study highlights how the ‘talking cure’ as the ‘love transfusion’ or ‘love cure’ educates us to the life-promoting attributes of attachment, containment and psychic holding. Conversely, it teaches us that the absence or perversion of these properties can manifest as lethal deadliness, terror, or a “nameless dread” that can destroy the human spirit (Seager, 2008). Therefore, an Object-Relations framework provides a rich conceptualisation for what constitutes as good and bad mental health. Implicated in this research, was the notion that short-term prevention work with severely suicidal clients, could result in increased anxiety in the practitioner, particularly when the therapist felt that the client was not well enough to leave the service. This necessitates how the referring system needs to be conceptualised psychoanalytically as a parental couple that works in tandem with the client’s interests (ibid.).

In our ‘medicalisation of distress’ (Sanders, 2005) era, there is an increasing need for a psychodynamic framework to inform the general ethos of Irish clinical institutions as to ‘good enough’ practice. ‘Psychological safety’ embodied in attachment; containment and object-relations include not just the experience of the client, but how practitioners are ‘held in the mind’ of the system of the organisation (Seager, 2008; Winnicott, 1958). Just as, the client needs containment from ‘good enough’ attachments, ‘containing the containers’ means that therapists require containment from the organisational settings they work in and also from the health sector itself. Undoubtedly, the current research expands the self-caring attitude beyond mere stratagems and coping rituals to a more mindful, self-compassionate process. In light of this endeavour, it is an ethical mandate how the professional psychotherapist maintains vitality, connectedness and wellness in the face of such intolerable suffering. Adding to the suicidology literature, this research strongly advocates the importance of debriefing, engaging in grief rituals and accessing collegiate and supervisory support after a completed suicide to facilitate the mourning process in the therapist. Alongside this, the egregious affects of meeting the suicide risk
surfaced, and participants were “profoundly changed” as a result of their encounters with this vulnerable clinical population. Dissociation, depersonalisation, omnipotence, narcissistic injury, fetishisation, psychosomatic illness, burnout and vicarious trauma are evident throughout the data. Consequently, the implication for working in these clinical settings highlights the emotional impact of suicide prevention and structuring ways in which staff can process it.

An overarching conclusion that can be tentatively drawn from the findings is the restorative nature of client engagement in the life of the therapist. Thus, implications for practice refer to promoting an environment where inner resources are facilitated to emerge, be it through improving the clinic’s system, fostering thoughtful therapeutic relationships or in continued professional development in the therapist (Seager, 2008). Furthermore, Freud’s (1917) “Mourning and Melancholia” understands that the problem of suicide is a problem of relatedness. Therefore, the treatment of suicide involves a new form of dyadic relatedness as engendered in the therapeutic couple. In conclusion, the words of Val Wosket (1999) succinctly describe this process:

> A therapist uses themselves and in as far as they are able to become a resonating chamber for the client’s emotions. Congruence and compassion open the way to the therapist’s primary instrument of healing: the personal vulnerability of his own trembling self (p. 214).

### 5.6 Limitations

The interviews generated a wide plethora of data, themes and findings, however, the restriction of the word count meant that many rich excerpts were culled, and other significant themes that were expressed were not used. This appears to be an intrinsic challenge in qualitative research and leaves the researcher with the task of deciphering which themes are more salient than others. To excavate the wealth of data that was evidenced, I believe a doctoral thesis would do this greater justice. It was noticeable during the beginning of the interviews that some participants considered the interview more of an evaluation than an honest exploration of their work with suicidal clients. Some gave predictable responses to the open questions with a bias toward presenting socially desirable information. However, as interviews progressed, both researcher and participant relaxed, and the participants appeared to enjoy discussing their psychotherapeutic experiences. There were methodological limitations to the present study. As well as the influence of the participants’ characteristics, the researcher’s interpretative framework shaped this research. Importantly, the findings highlight the close interaction between the
participants’ accounts and the researcher’s reflective process. This inquiry offers one interpretation of the data and does not claim exclusivity from other possible interpretations that may have transposed.

5.7 Recommendations for Future Research

Given that all participants in this sample worked in a centre that specifically offers therapy to suicidal and self-harming individuals, a notable buffer to the deleterious effects of trauma was the community aspect of the clinic. A possible line of inquiry for future research could be to investigate the organisational properties that contribute to this effect. Client factors were evidently more stressful than organisational stressors based on the findings in the present study. Equally, there is the need for additional research into the impact of suicidal behaviour on private practitioners in Ireland. Surprisingly, despite our pluralist society, religion and spiritual beliefs arose in the findings as a holding property for practitioners; hence, further qualitative investigations are needed to elucidate this meaning-making process.

While it is tempting to conclude that humanistically trained practitioners are more resilient than other orientations it is felt that due to the small sample size, the results are not strong enough to make this contention. Currently, as advocated by the IAHIP (2011), Irish humanistic therapists engage in more personal therapy for training requirements compared to the baseline of fifty sessions for other modalities. Time-limited therapy with suicidal individuals elicited stress in the therapist when the client was not well enough to engage in other referral systems. Therefore, a possible study could be a qualitative project on crisis intervention therapy on the suicidal client. At the time of the current study, the centre was only six years established and therapists had an experience of working with clients long-term. Since the interviews took place, the introduction of the HSC into the management strata occurred, and this would certainly yield intriguing data for future researchers.54

54 Additionally, the current participants would be identified as master therapists and organisational factors, time-limited therapy would be more pronounced.
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Appendix A

THE SUICIDAL PHANTASY

Suicidality is generally conceived in benign terms, as part of depressive state, a cry for help, or as a means to manipulate others. Psychoanalytic thought proposes that the ‘passage à l’acte’ (Lacan, 2004) is a communication, which holds the “less acceptable face of suicide as an act aimed at destroying the self’s body and tormenting the mind of the other” (Campbell & Hale, 1991, p. 4). The subject of suicidality has always held centre stage in psychoanalytic inquiry. Therefore, attention turned from external factors to the interior world, consisting of the patient’s repressed feelings to their primary caregivers (Campbell, 2006; Stekel, 1910). Aggressive or vengeful impulses deemed unacceptable by the individual are retroflected towards the self in self-harming or destructive ways (Clarkson, 1989; Rosenfeld, 1987; Steiner, 1993). Fundamentally, the suicide phantasy is a solution to a terrible split conflict: the wish to merge with the good (m)Other, and the wish to escape the annihilating, bad (m)Other (Klein, 1935; O’Connor, personal communication, 2012). The infant’s body is the medium where the mother’s hostilities are played out, and the individual’s body becomes identified with this bad mother (Campbell & Hale, 1991; McDougall, 1986). Therefore, in killing the body the person is free at last to fuse in ‘oceanic’ bliss with the desexualised, idealised ‘good breast’ mother (Freud, 1930; Malsburger & Buie, 1980).

Glasser’s (1979) ‘core complex’ relationship is pivotal for understanding suicide. The individual involved in the core complex relationship is gripped by two opposing forces, the fear of intimacy which means being engulfed, and secondly the fear of abandonment by the Other (Hale, 2008). What distinguishes the core complex relationship from more ‘normal’ relationships is the intensity of these feelings and the manner in which the individual will control the Other through projective identification, thus, distance is maintained by acts of sadism, cruelty and coercion (Steiner, 1993). Analytic evaluations into this transient psychotic state highlight the mother’s omnipotent dominance in the suicide fantasy, which can obscure the father’s abstinence or passivity (Gerish, 2008; Hamilton, 1982). Campbell (2006) describes the father’s ‘staking a claim’ as providing the child with something different, which upholds the child’s separateness, creativity and integrity.

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55 Theorists describe the concept of “destructive narcissism” when the client’s internal world becomes psychotic, verging on perverse, taking on the form of a delusional Mafia gang that seizes control of the vulnerable sane parts of the personality (Rosenfeld, 1987; Steiner, 1993).
PARTICIPANT INFORMATION SHEET

Title of the Study: The impact of suicidality on the experienced clinician

Researcher: Heather Moore

Research Supervisor: Dr. Grainne Donohue

Clinical Supervisor: Claire O’Dowda

My name is Heather Moore and I am conducting a research study as part of a Masters Degree Programme in Psychotherapy and Counselling, at Dublin Business School.

Purpose of the study

The aim of the study is to better understand the impact of client’s suicidality on the experienced or mature therapist. The study is also to help inform psychotherapy practice and research, and to help in the development of interventions. If you decide to participate, I will ask you questions about your experience to date.

Criteria for participation in the study

To contribute in this study, participation includes being accredited with a professional body (IAHIP, IACP) and having experience of working with suicidal clients for more than three years. Ideally, participants will be those who are working as full-time therapists in the organisation.

Details of what involvement in the study will require

Participation in this study will involve conducting a face-to-face interview, which will be audiotaped and later transcribed by the researcher. The interview will take approximately 40 minutes. You will be given breaks as needed. You may experience some distress from talking about personal issues during this interview, however, you do not have to answer any question that particularly upsets you, and you may stop the interview at any time, this is without prejudice. Time will be allowed for reflection and you can decide if you want to proceed.

There will be an opportunity given by the researcher to ask questions or to clarify any aspects of the study. You will also be given opportunity to talk about your experience of being involved in this research. The venue of the interview will take place at your workplace. The time of the interview will be organised according to your preference.

Confidentiality

Your decision to participate is completely voluntary and all the information you provide will remain confidential to the researcher. A code number will identify all forms. Any names or other identifying information that you provide during the course of the interview will be removed during transcription.
Limitations to confidentiality

It is important for you to know that there are limits to confidentiality and this applies even if you withdraw from the study after disclosing such information. The only cases where confidentiality cannot be kept is if you tell me that children are in danger of harm, or if information indicates that a minor may be at risk. Any information given that indicates that a minor (under 18 years) may be at risk, or that you are at risk of harm to yourself or others will have to be reported in accordance with the organisations policy and procedure.

Freedom of Information and the right to withdraw from the study

If you initially decide to take part you can subsequently change your mind and withdraw from the study without prejudice, and request to have your data removed from the study. Additionally, under the Freedom of Information Act (1997) you have the right of access to information concerning you, which you may request from the researcher in writing.
Appendix C

CONSENT FORM

My name is Heather Moore and I am a post-graduate student at Dublin Business School. I am conducting a research study as part of a Masters Degree Programme in Psychotherapy & Counselling. The aim of the study is to better understand the impact of suicidality on the experienced therapist.

If you decide to participate, I will ask you questions about your experience as a therapist working with clients who present as suicidal. You are free to refuse to answer any question throughout the interview without prejudice. The interview will take approximately 40 minutes. You will be given breaks as needed.

Your decision to participate is completely voluntary and all the information you provide will remain confidential to the researcher. This limit to confidentiality applies to these interviews, even if you withdraw from the study after disclosing such information. Additionally, excerpts from the interview may be made part of the final research report, but under no circumstances will your name or any identifying characteristics be included in the report. If you initially decide to take part you can subsequently change your mind and withdraw from the study without prejudice, and request to have your data removed from the study.

I agree for the researcher to contact me at either of the numbers below.

Work No: _________________ Personal Mobile: ______________________

Please sign this form to show that I have read the contents to you.

______________________________________________ (printed)

______________________________________________ (signed)

_______________________ (date)

Thank you very much for your time,

Heather Moore
Appendix D

DEMOGRAPHIC QUESTIONNAIRE

I.D. NO.: _____________
DATE: _____________

To be answered before the interview

1 (a) How long have you been practising as a therapist?
1 (b) How long have you been counselling clients with suicidal ideation?
1 (c) How many hours do you work a week in this organisation?
1 (d) What’s your job description?
1 (e) Do you work as a therapist outside the organisation?
1 (f) How would you describe your theoretical orientation?
1 (g) What qualification do you hold?
1 (h) How long have you been accredited? With whom?
1 (i) Has there been a loss of anyone in their own life to suicide?
1 (j) Gender: _____________ Date of birth: _____________
Appendix E

SEMI-STRUCTURED QUESTIONS

1 (a) How would you describe yourself as a therapist?
1 (b) What has brought you into this work?
1 (c) What motivates you to continue in this work?

2 (a) Can you describe as fully as you can in your own words your experience of working with suicidal clients?
2 (b) What are the most difficult situations that you have encountered?
2 (c) **Probe:** What happens to you?
2 (d) How did you come to terms with the death of the client? *(only if suitable)*

3 (a) Can you describe any physical/somatic symptoms from the work, either during or after session?

4 (a) How has this type of work affected your personal worldview/perspective on life/spirituality?

5 (a) What type of things happen that you find spillover to your home life?
5 (b) How would this spillover manifest?

6 (a) What habits/rituals or supports have you found helpful as a therapist in keeping a good boundary between work and home?
6 (b) How does the organisation help you?

7 (a) What have you witnessed your clients overcoming in the therapeutic process?
7 (b) Can you describe how that experience was meaningful for you?
7 (c) What did your client stimulate in you that you want to nurture and expand on?
7 (d) From your first few months to working here till now, what has changed for you?
Appendix F

REFLEXIVE JOURNEY

Participant A:

The centre is so busy with phones ringing and people walking purposely around the building. We are based in the reception area that has been cordoned off for this lunchtime interview. My participant dressed elegantly, arrives on time. This practitioner holds a senior clinical position. She is passionate in how she speaks about her work with children. Moreover, she uses that word “passion” a lot during our time. There is intensity and a focus to this interview; her narration pulsates with urgency. I wonder had she lost a child, and that is the catalyst for her being in the work, but I feel that is being too intrusive to ask that question. She mentioned that she had suffered personal losses before starting this work and then worked with child bereavement. Even though, the participant relates that she works in a solution-focused way, she mentions the importance of attunement and having a connection with the client.

I notice a retrospective manner to her disclosure; this is a clinician who has known what it is like to feel burnt out, and she mentions that she experienced vicarious trauma in the past. She went back to personal therapy and sought help from her supervisor. I get a sense that she was sustained by the support of her friends and colleagues from the organisation. There is a sense of sharing from her experience, “you cannot do this work alone”. She seems to have an understanding to the limits of her capacity for the work. The impact of the client suicide was bruising emotionally and professionally. Her narrative is replete with words such as “experience teaches you” or “you learn from experience”. This participant is someone who has come out the other side of client suicide, and there is a sense accomplishment in her work with teenagers.

Participant B:

This respondent strikes me as pragmatic and practical, a no-nonsense woman who works in a direct manner with her clients. It seems difficult for her to answer some questions and I have to repeat the question and probe a bit more. Even asking her about her theoretical orientation throws her. There is a sense that the participant thinks that this is an evaluation, and one has to give predictable answers in this face-to-face encounter. It takes us a while to relax into the interview. Her answers circulate back to herself, and she is eager to talk about her self-care strategies. I’m tremendously interested in the “defrocking process”, of stripping off and cleansing off the debris of the day. Clients
infect rather than affect. Around the subject of the waiting lists in the centre, this participant expresses her heart and her anxiety about placing clients quickly with therapists. I can feel it. Clients can be difficult to contact, and there is a lot more involved than meets the eye.

Witnessing and hearing distressing stories has seriously affected her. She “blanks that stuff out”, there are some forms of shutdown or detachment in her work, and maybe she has heard too much. Yet, there is a detached, anaesthetic feeling to the interview, and it is hard to get to the deeper. This participant seems to get a lot of satisfaction from the feedback comments from her clients. She seems pleased to be part of this organisation, and I wonder about the omnipotence in this reflection.

Participant C:
This respondent is quiet-spoken, reflective and conscientious. The centre still seems so busy when I interview her, but she emanates calm amidst the chaos. Her answers are thoughtful and candid. She felt drawn to suicide prevention and became increasingly aware of her own melancholia, and her own suicidal ideation when she was a teenager. A client’s trauma and narrative resonated with her own personal history that brought this to her conscious awareness. I can sense that she gives a lot to her job and her clients get a lot of her, as she says herself “110%”. Unfortunately, this leaves her with so little personal energy for her family and she knows this. Her learning curve has involved the establishment of firmer boundaries to avoid the work spillover. She recounted stories where clients who took advantage of her lack of boundaries in the beginning and these accounts horrified me. What stands out is the phrase “this work can really activate your shadow side” especially when dealing with so much hopelessness in each case. She is honest about falling in love with a client and the ensuing anxiety when a client is not well enough to leave the centre after the designated session allotment. Fundamentally she believes that there is always hope.

Participant D:
A pleasant, caring and down to earth woman who related that she was motivated to become a psychotherapist due to her own battle with depression. Her voice is clear throughout this interview, which takes place in her house. She is remarkably honest about the complexities in working with more borderline processes. The participant tells a story of saving a client’s life from a suicide attempt that left us both speechless. The sheer
effort involved in dragging someone back from the brink of suicide. However, the participant candidly states the reality that suicide is always there as an option even after the 20 sessions of therapy. She is realistic regarding her limits in this work and has decided to work 12 hours a week. Moreover, she expresses her struggle with adolescent work. Therapists only have one or two hours a week with a child who will ultimately go back into chaos again. The enormous difficulty is in getting parents on board with their suicidal children. Despite this, she reiterates the same sentiments, as the other participants regarding “don’t sweat the small stuff”. What gets her through is the abundance of like-minded colleagues on staff who assist her in not bringing clients home. Her sense of joy and meaning has amplified because death is just around the corner. This work can be exhilarating, and there are immense rewards in seeing someone come back to life.

Participant E:

The participant presents as a very feminine, verbose woman with almost a sense of the theatrical. I feel like I am intrigued and captivated by the stories she relates in our interview. I get a strong sense of the “omnipotent rescuer”, the “saviour” throughout our time together. There is a strong sense of mission. Despite this, the reality of suicide cuts to the heart of this interview. She poignantly relates how she lost a client to suicide after a close family member died. “He didn’t give me a chance”. The dissolution of her professional identity was hard to bear, and the thought that you had let everyone down in the organisation and the individual’s family. The familiar ‘psychological skeleton’ that gets passed around after someone suicides, is noted in this interview. She suffered somatically with an illness that made her resign. Ultimately, she resigned from working 20 hours a week with suicidal clients. This participant honestly expressed her fear of the “next” client suicide and being the therapist who will have two clients suicide. Furthermore, she believes that working in a continual crisis position can interfere with more process and long-term psychotherapeutic work.

Participant F:

This was a profound and meaningful interview. I noted that she liked being involved in a therapy perceived as “the cold face of the work”. She likes the challenge inherent to suicidality and I wondered whether therapists could be addicted to trauma. She openly related how the work over the past five years had dramatically altered her worldview. Life was perceived as unsafe and distinctly negative. Hence, her capacious decision not to
have children. This certainly struck me as a form of deadness, and I wondered could her work with suicidal clients have killed off life and vitality in her. Flatness and lifelessness permeated this interview. The participant spoke eloquently and credibly of the profundity of meaning to be gained in this form of psychotherapy. She had suffered a client suicide and what helped her through that period was collegiate and organisational support. Fundamentally she believed that her first year in the organisation was more terrifying than the impact of the completed suicide. She stipulated that this was due to the fact, that she was two years working in the centre when this transpired.

Participant G:

I felt that I was on “hallowed ground” in this interview. It was a deeply moving, and enriching experience. The participant breathed life, vitality and joy into her narrations. She was consciously aware of the reason she worked in this domain. Her own suicidality, the “knowing” what it was like to be suicidal, to make an attempt, to not want to live. Her words remained with me when she left; that those who really get suicide “can really get life”. The life-death psychological contraries or polarities were evident throughout the interview. I learned a lot from this participant. She expressed “untherapeutic” feelings with regards some of her dealings with borderline clients. What is more, the difficulties in holding yourself steady in the work. It was evident that the therapist was a seasoned practitioner, that she was aware that this work holds a trajectory of losses, confusion, insecurity and pain. She was firm in her understanding that the choice of suicide needs to be handed back to the client, and that has to be respected. The more the clinician can reflect the client and is familiar with the other person’s process as its mirror; the better able to understand. Interestingly, she affirmed that there are two people in that clinical setting who are deserving of respect no matter what the clinical diagnosis. For her, the work has wrought an “attitude of gratitude” born out of familiarity with one’s woundedness and knowing that we are “wounded healers”. There was a transcendent quality to the forty minutes, and I remembered a talk by Rob Weatherill, when he asserted that psychotherapists have become the new priesthood in Ireland. The one’s who dole out grace and mercy.
Appendix G

LIST OF THEMES

**Describing themselves as therapists:**
The centrality of relationship with the client, attuned and empathic x3 Humanistic Integrative Practitioners
Vocation calling (Priesthood feeling)
One person couldn’t describe themselves (REBT background)

**Motivation to work in suicide prevention:**
- Wounded Healers, reparative, sublimation of their own losses or their own suicidal ideation – passion for work
- Vocation/Mission idea, determination to save the client acquires a religiosity the staff believing themselves to be selected for this mission
- The greatest challenge of all to work with suicide
- Concept of Transformation from death to life huge motivation, despair to hope/Therapy works
- Gift/Blessing/Privilege
- The idealised Omnipotent helper - I want to help the suffering, I’m a professional fetish idea
- Saviour and Rescuer, grandiose expectations
- Being an attractive high profile place to work

**Impact of Work:**
- Social context the crisis in Ireland the waiting lists
- Responsibility of this work, heavy burden, dark places, daunting especially when one begins in this area
- Walking, being ‘guide’ to client as they walk through despair in The Valley of the Shadow of Death, “drop the coffin” the transitional object”
- Death terror, death anxiety, panic never leaves when suicide present in the room
- Constant preoccupation with client as a means to control the situation
- Overworking, 110% of energy, exhaustion, over-involved – regressed transferences more holiday time needed only allowed 2 weeks at a time
- Carrying people, clients get under your skin (showering, taking off clothes after work), falling in love with clients, primitive anxieties, blurred boundaries,
porous/too rigid, contagion of affects, infected more than affected, bringing clients home, “off duty” penetration of therapist’s emotional boundaries

- Therapeutic over-accommodations, especially with high-risk & borderline clients
- Holding the therapist hostage, therapeutic bondage
- Complexity of cases, co-morbidity of symptomatology
- Clients still unwell at 15/20 sessions, anxiety of letting them go, importance of early trauma, psychiatric conditions etc., when they are not well enough to go.

The reality of long-standing intrapsychic and interpersonal difficulties, long haul needed. Frustration that clients need more time this is crisis intervention work

- You lose the ability to do long term work privately so used to crisis work
- Sadness or soul sadness of work
- Helplessness and powerlessness in face of such despair
- Helpless witness to painful stories: shutting down, emotional numbing, denial of the unbearable
- Dissociation in therapist “acting out”
- Stuck in the head, thinking rather than sensing
- Turned off CPD practices & Supervision just another thing to go to “pain in the arse”
- Trigger your own suicidal ideation and hopelessness, shadow side, melancholia, vulnerability
- Losses in your own life this work becomes exhausting
- Myopic tendency of suicide- tunnelling effect life is so narrow, diminished attunement
- Contextual factor: confidentiality of work, the isolation, the need to share with colleagues
- Reality that suicidal ideation can always be a solution may never disappear from client’s life
- Dis-identifying with the aggressor/Reaction formation

**Worst scenario:**

- Borderline stories, extreme anxiety and manipulation – Hungry babies who attach and suck the life out of you. Rage that saps the therapeutic space. Taboo feelings in therapist, anger, hatred & rejection. Tormenting the mind of the other
• **Adolescents**: sending them back into chaos and dysfunction, not being able to get parents on board

• **Death of a client**: sadness, grieving, traumatic, narcissistic injury. Shock denial, professional identity rocked, fear of letting down client, organisation, the family, professional suitability. Meanwhile still have other clients. Self-criticism, dysphoric feelings, judgemental to self, harsh super ego, anger at client

The reality that clients are out of torture or pain now, *at peace*

Contamination, infection of this into therapist’s families

Makes you a better therapist, you know your limitations

Made me stronger and more determined

You are not as in control as you think

Who is going to have the 2nd client die by suicide?

I cannot SAVE people

Naiveté over: You will meet suicide

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**Somatic Symptoms:**

Nightmares

Heavy in the body

Sickness – under active thyroid gland time off work, chronic fatigue after a suicide

Tension in shoulders and necks x4 participants

Soul pain, soul sadness in chest

Stomach dread ‘knowing’ the client is not ok

Affects sleep: waking up thinking about clients

Use of body countertransference as a tool in relationship

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**Worldview:**

• Impairment in therapist’s intimate relationship and personal life, disruptions in Other-intimacy, lack of interest towards others in our lives, interpersonal functioning disrupted; No energy for friendships, relationships

• Unable to respond to loved one’s needs, intolerance of “small things” in other people’s lives

• The world is no longer a safe place

• Suicidal clients just ordinary people like you or me

• Detaching/Switching off from the reality that life is unpredictable
• Choosing not to have children as result of this work
• Hyper-vigilance around therapist’s children
• Spirituality increased for all, this work viewed as a spiritual practice, “love
  transfusion”, sacred space
• Very meaningful work
• Birtchnell (1983) put forward the question “does the therapist’s love of life increase
  with every suicidal client he deters?”
• Spiritual reason why we do this work in the first place
• Don’t sweat the small things, Death is the ultimate shaper, Priorities change
• Gifts/Blessing/Privilege
• Attitude of Gratitude, greater appreciation for your family/time off/friends

“Spillover”:
• Numbness/lack of interest to intimate relationships more distance emotionally to
  family
• Clients get the best of you 110% nothing left for anyone else
• Displaced anger from clients to family, especially cancellations, No shows

Habits/Rituals to keep the boundary between work and home:
Take clothes off, showering
Don’t put work clothes on until just about to go to work
Running, walking, gym work
Mindfulness strategies
Filling out notes closing the filing cabinet behind you
Humour/fun in agency (mature defenses)
Taking responsibility for organising and scheduling caseloads
No high-risks back to back
Establishment of boundaries
More holidays needed

Organisation:
• You cannot do this work alone: Community of colleagues needed
  When in doubt share it out.
  The need to hold vigil with the witnessing therapist
• Collegiate support vital more important than supervision or peer supervision
• Peer supervision can be heavy
• Soft boundaries and easy access to support
• Centre’s clients not individual’s responsibility
• Back then…organisation had more time for one to one
  Now so much busier, less time for support
• Back then…you could see clients for as long as it took
  Now its only 15 sessions
• Postvention work
  Debriefing around death of a client procedures and protocols
• Buffering against burnout, wellness and vitality
• Experienced therapists share, mentor, impart and supervise new staff
• Holding in the agency, low staff turnover
• Therapist self-esteem and ego resources are strengthened by a high profile agency
  publicly recognised as “a centre of excellence”

Witnessing Overcoming…
Death to life
Fear, anxiety, panic, disabilities, self-loathing
Life experiences, childhood experiences and abuses, difficult relationships, breakthrough
Healing in relation to the Self…baby steps
Worthwhile, meaningful to bear witness to client’s growth and resilience activates
possibility and hope in therapist
Celebration of that healing
Dark night of the soul to transformation and embracing life
Development of self-protective boundaries
Positive sense of self-esteem- “heads bowed, heads held high again”
Myopia – larger perspective in client, bigger picture

The meaning? Post-traumatic growth
Profoundly, meaningful work; Rewarding and powerful to witness, promoting growth
makes life meaningful
Change is possible transformation, hope, if the client can overcome so can I
Transformation of client’s despair is life-altering, spiritual practice
Client’s courage helps us face our fears
Motivates them to be the best they can be in terms of training, further education
Always a way out, no matter how dark or confined
Sense of completion in therapists developmental journey from their sublimation, woundedness to wounded healer
Better person more understanding towards others
More loving towards themselves, self-compassion
Limitations of the therapist, holding our own polarities, being ‘good enough’
Limitations of the always-there vulnerability of a possible client suicide
Trust the process, enough for now
Active integration of these experiences into developing therapist identity
Boundaries necessary and vital
Therapist efficacy and accomplishment expanded
Therapist satisfaction
More competent, confident than before
Increase self-assertiveness and self-assurance
Less self-doubt
Calmer – “don’t sweat the small stuff”
Gifts/Blessing/Privilege
Attitude of Gratitude Greater appreciation and value for your family time off friends
Value and guarding of therapist personal and private space
Preserving our own humanity
Vicarious resilience can counter the numbing of vicarious trauma
Appendix H

POTENTIAL RISKS

The identified potential risks are as follows:

- Discussing the traumatic experiences of their work may emotionally distress participants.
- Participants may not be able to complete the interview if they get distressed,
- Participants may have a delayed reaction to the interview and become distressed after they have left.
- Participants may disclose information that indicates risk to self, others or a minor (under 18 years).
- Participants may withdraw from the study after disclosing information that indicates such risk.
- The limitations to confidentiality have been written explicitly in the information sheet and consent form. In addition it is explicitly stated that this limitation to confidentiality applies even if the participant subsequently withdraws from the study. Participants will also be verbally reminded of these limitations prior to commencement of the interview.

The researcher is also a final year student on the M.A. in Counselling and Psychotherapy and will monitor participants’ well-being throughout the interview process. The researcher will terminate the research interview should she deem it necessary.
Appendix I

WITNESSING POSITIONS

The groundbreaking book “Common Shock” by renowned trauma expert Weingarten (2003) posits a model to understand the degree to which the witness (health care provider, therapist, counsellor) is impacted by violent and disturbing interpersonal interactions. Weingarten describes four witnessing positions that vary depending on the level of self-awareness and self-empowerment.

In Position One, the witness is deeply aware, cognisant and mindful of the implications of the traumatic material and yet, can take constructive, effective action in spite of this. Position Two represents the witness who holds a position of power but is unaware of the meaning and significance of the traumatic experiences for the victims. Thus, a witness in this position can do more harm by their omissions as well as commissions.

In Position Three, the witness is neither aware of the implications of the violent situation nor is powerful enough to take action. Position Four, depicts a witness who is deeply connected with the meaning and significance of the scenario, but is disempowered and overwhelmed by the distressing interaction. Notably, clinicians can find themselves in any of these positions, but Weingarten (2003) proposes that many therapists who are susceptible to VT are entrenched in Position Four. The aim of Weingarten’s Witnessing Project is to assist individuals, in moving from a position of unintentional witnessing to active empowered witnessing, which has the capacity to transform toxic experiences into positions that heal and restore communities.
Appendix J

BORDERLINE PERSONALITY DISORDER

Diagnostic Criteria for Borderline Personality Disorder as outlined by the DSM IV (APA, 2000)

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment.

Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

3. Identity disturbance: markedly and persistently unstable self-image or sense of self

4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).

Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.

5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour

6. Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

7. Chronic feelings of emptiness

8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

9. Transient, stress related paranoid ideation or severe dissociative symptoms
Appendix K

ADDITIONAL EXTRACTS FROM PARTICIPANTS

THEME 1: Overworking

Working under a death threat 110%:

Sandra’s dialogue echoes this same arduous metaphor and the theme of over-responsibility.

PB7.6c Sandra: “when you come into the centre and someone dies you go into hyper alert, Oooo [sharp intake of breath]. You are reminded that this job carries a huge responsibility, even though ultimately it’s the client’s choice to live or die, but if you are walking along with them, you want to pull them back by the scruff of the neck and show them how good life can be, that you know…that the pain will pass”.

Further, she captures the national crisis of suicide and the urgency of growing caseloads:

PB5.4b Sandra: “when you have waiting lists that impacts…that causes me some anxiety [voice gets louder] when you have people that you know are high risk…yes high risk clients, there is…there is an anxiety sometimes, I have to come back and pull myself back and remind myself that there is only so much I can do…”

PA3.2a Tara: “Yeah, because this is the type of work that can drain you so much that you’ve got to look at how you are going to maintain yourself to keep that passion going and that does involve recognising, emm… your own limitations in the work.”

Additionally, Sandra voices the ‘overwork’ theme in the practicality of trying to make contact with clients and get them to come in for their assessments:

PB4.4a Sandra: “sometimes it is frustrating because it’s difficult to get clients to answer their phones and then to connect we have to write to them, so now I make sure that I have an address as well.”

Natalie stresses the limits of working with self-harming adolescents and how their systemic reality stays with her:

PD4.2b Natalie: “Well I think when you are working with teenagers and they are going back home into the chaos and you try and maybe talk to the family and… but you only have an hour a week or 2 hours a week with the client and they might leave you feeling a little bit better, but then they are going back into all that again…that I find frustrating!”

Natalie echoes this point of how clients can regress when an ending is nearing:
PD5.5a Natalie: “…maybe they’ve taken a step forward and then back to square one and that happens a lot in the work that we do. So I mean it might be back to that helplessness, it could be someone is coming towards the end of their sessions.”

THEME 2: “All Changed Utterly Changed”/Identity Disruption

Due to the high-risk nature of this work, participants are allowed two weeks of annual leave in the summer; Martina expresses her feelings around this:

PC8.6b Martina: “…well I think that from a holiday point of view we should have 3 weeks off because you need a decent break once a year, I think it should be mandatory to have 3 weeks off.”

Tara honestly conveys the reality of vicarious trauma:

PA4.2d Tara: “I definitely emm… recognise that I’ve suffered from vicarious trauma…emmm and it also it was only through the support of my supervisor that I began to recognise that…”

Moreover, Sandra’s theme of detachment is evident in her motivation to be in this work:

PB1.1b Sandra: “I thought if I go and train how to do this and I can learn how to detach from this when I go home at night, then you know, I could…because I’m passionate about it, passionate about helping people…so I just thought right, I’ll go and train and I can do this on a professional level…”

Nguyen (2010) and Schneidman (1993) warn that the common trajectory of the professional therapist is replete with failures, stresses, rejections, losses and confusions by mere virtue of the fact of being a therapist and a human.

The vivid language in Denise’s citation conveys the isolation and the constriction to the self after her client died:

PF4.2d Denise: “Nobody out side of the work really understands it either and you can’t burden people with it either, you can’t kind of…it’s not their job, they didn’t take it on. They don’t really want to know the ins and outs of an 18-year-old going off and hanging herself. I mean why should they have to know that?”

Denise’s disillusionment and tedium is depicted in her attitude to continued professional development.

PF6.6a Denise: “I must say I find it really hard to pick up a book in psychology. See those journals and stuff…I can’t read them [Laughs]. When people say to you at lunchtime did you see such and such an article, I’m not interested, you know. Of course there’s these one-day courses and all that,
and I’d often look at them and think do I really want to go to a course on a Saturday on my day off? Not really.”

In light of a completed suicide Tara’s describes impairment in her self-capacity when she suffered from relentless self-questioning and bouts of self-criticism:

PA4.2d  **Tara:** “…so you need *[deep breath]* I suppose that validation that you are ‘good enough’ at what you do, because you will question it over and over again, but emm…you forget to look at the clients you do save.”

**Disruptions in Other-Intimacy:**

Martina conveys this irritation with family members and somewhat lack of empathy for her children:

PC7.5A  **Martina:** “Emm… yea often trying to see it from other people’s point of view as well. I really have to do that especially with my kids who might be giving out about something, I would say ‘yea that’s dreadful but the other person’…and they wouldn’t hear it. I kind of learned from my daughter, ‘I just want to give out about it, I don’t want you telling me what it is like for the other person’. They are absolutely right though. I can be like that you know…’Would you just get a life!’ But when you realize what people are going through out there, you realize how lucky you are and that is how I start off *[lot of laughter]*

Furthermore, this attitude of emotional distancing is evident in Tara’s relationship with her children:

PA5.5a  **Tara:** “my response would be very different to a normal parent in around emm…because I have teenagers myself, so I think I’m more calm…but then I could be seen as maybe a bit more distant and that could be picked up maybe as too cool.”

**Disruptions to the Professional Identity:**

Helen concurred sadly with this sentiment:

PE4.2d  **Helen:** “…I think you would go through that no matter what you would do, there is always that self-examination.”

PE5.2e  **Helen:** “The worst thing would be to lose the urgency, because it would knock your confidence as well.”

Helen disclosed the shock she grappled with after her client suicided and the postvention assistance (Schneidman, 2001) that she declined due to family commitments:

PE4. 2d  **Helen:** “I can’t come in, I’ve got this…and I felt overwhelmed and shock. I then had to get in the car, drive to the North and spend the day with my mother, as if nothing had happened. I couldn’t, I couldn’t talk about it.”

She retrospectively evaluated how this was not self-supporting:
PE4. 2d Helen: “And the unfortunate thing was and I have learnt as well, if it ever happened again… I would debrief immediately.”

Further, Tara describes the difficult dilemma of treating other suicidal clients and containing that paralysing anxiety when you have lost one of your clients to suicide.

PA3.2d Tara: “you also have the responsibility of other clients that you do have, just because you don’t specifically have that client and to be there without bringing in that anxiety…”

Like Denise, in Tara’s citation we hear this comforting defense platitude:

PA3.2d Tara: “She was what I would call a tortured soul….”

Furthermore, Helen resolutely believes that working solely in this clinical reality can impair the practitioner professionally with long-term clients:

PE6.3b Helen: And when you work in crisis work all the time…you can actually begin to lose your ability to…you become solution-focused. I have to watch this very carefully in private practice.

THEME 3: “A Terrible Beauty is Born”/The Spiritual Practice

Agapean Mission:

PG11.7c Cathy: “Carl Rogers wrote somewhere that he was looking at some students assignment and she wrote it’s all about love. Yeah, it is, it is all about love.”

Community of Believers:

Martina concurs with Denise’s extract regarding the lack in personal supervision:

PC8.6c Martina: “but sometimes I’m not sure she [her supervisor] gets the crisis end of the work.”

PD6&7.6d Natalie: “Well I think you know the friendships in work are brilliant. There are a lot of like-minded people there. So I think…emmm…I seek them out those people and I know the one’s I can talk to and the one’s that support me. And we are able to work in close contact with like-minded people. That helps.

Once again Cathy’s reply mirrors the same sentiment of friendships and collegiate support:

PG9.6b Cathy: “Well our CEO supports me hugely and she is very approachable, very human…she is fabulous and we have a very good friendship as well as being colleagues you know. And like my relationship with the team
manager, I have a great relationship with her as well. And people on the team, you know who are friends as well and that is gorgeous. Emm…so that really supports me, but because we are growing so big and the demands of that can be very challenging at times.”

Cathy’s extract highlights how the organisation currently is rapidly expanding and there is a fear that the closeness so vital for this type of work will be lost in the future.

**Regeneration:**

PF7.8d  **Denise:** “Because you might have a friend who is horrible and they are shitty and then you kind of think, well my old reaction would be ‘What a bitch!’ [Laugh] but now actually, I think why are they like that?”

Natalie expressed the joy and expansiveness in being part of someone’s journey:

PD7.7a  **Natalie:** “Really exhilarated [Smile]. Its emm…it just confirms my belief that therapy does work you know, anything can happen…”