The impact of suicide prevention on experienced Irish clinicians

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Abstract

The Irish Poet W.B. Yeats coined the famous refrain "All changed, changed utterly, a terrible beauty is born" in his poem "Easter 1916" (as cited in Martin, 1989, p. 176-177). This quote aptly encapsulates the reality of seven experienced Irish psychotherapists who work exclusively in the field of suicide prevention. Emerging research coming from the person-centred and psychodynamic traditions in the past 15 years have examined the traumatic dimension of suicidal behaviour on clinicians. However, there is limited empirical literature on the impact of suicidality on Irish psychotherapists. 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. This elicits the question, how does suicide prevention impact Irish mental health professionals who work with these vulnerable populations?

In this article, the process of interpretative phenomenological analysis (IPA) was applied to the data of clinicians who were "changed, changed utterly" with identity disruption evident in their self, bodies, intimate relationships and professional identity. "A terrible beauty was born" was demonstrated in the overarching theme of the restorative nature of client engagement in the life of the therapist. This was particularly evident in humanistic practitioners, who where acutely aware of their own sublimation of melancholia. Most striking across all seven transcripts was the mix of the corrosive nature of suicide prevention on the self of the therapist, combined with unparalleled opportunities for personal growth and spiritual reformulation.

Key words: Suicide, vicarious trauma, resilience, burnout, melancholia

Introduction

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 (Farber, 1983). Professional literature is sated with practical guidelines for risk assessment and in formulating life-orientated strategies. 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 emerging British research examining the traumatic impact of suicidal behaviour on clinicians, Dr Ella Arensman (personal communication, 2015) director of the National Suicide Research Foundation of Ireland, reports that there is scant attention on the effects of suicidality on Irish psychotherapists. Arguably, the risk of suicidal behaviour is common across many Irish clinical situations and could potentially be regarded as 'an occupational hazard'[2] (Foley & Kelly, 2007). This elicits the question, how does suicide prevention impact mental health professionals? This paper aims to examine in-depth how accredited psychotherapists in Ireland (IACP[3], IAHIP[4]) who predominantly treat suicidal clients are affected.

[2] The decriminalisation 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.
[3] Irish Association for Counselling and Psychotherapy
[4] Irish Association of Humanistic Integrative Psychotherapists

Literature Review

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

"There is no such thing as a baby, there is a baby and someone"

(Winnicott, 2006, p. xiv)

The therapeutic process is complex, with reciprocal responses shaping the dyadic dance between therapist and client (Rasmussen, 2005). As therapists must contain and bear witness to disturbing emotions and content, theoretically, mature defense mechanisms assist clinicians in regulating intense affect (Egan, 2006). 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'. 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 countertransferential responses set the stage for vicarious trauma, as immature defenses, like a contagious disease can infect the Other with shame, guilt, anxiety and fear.

Widely represented in child psychoanalytic literature is Bick's (1986) research into the containing property of the mother's skin, which facilitates an internalisation of soothing experiences for her infant. Informed by his work with psychotic patients, Bion (1962b) extended Klein's work in his concept of the mother-infant as 'Container/Contained' observing that the 'good enough' mother puts her psyche at her infant's disposal to contain these inexorable states. Additionally, Meltzer's (1994) formulation of 'adhesive identification' describes how the infant primitively manages separation anxiety with the caregiver by superficially attaching herself to the surface of the object, in a desperate attempt to abate crippling anxieties concerning the body-self rupturing and spilling out.

Vicarious Trauma

Although, there are discrepancies in conceptual terminology, the psychotherapeutic community in the past 20 years are in agreement that work involved with traumatised clients can have deleterious effects on the clinician (Figley, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). 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. 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). The term vicarious trauma (VT) (McCann & Pearlman, 1990) refers to the cumulative negative responses as described in Post Traumatic Stress Disorder (APA, 2000), which become manifested in the person of the therapist. These intense interpersonal transactions 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; Trippany, White Kress & Wilcoxon, 2004).

Burnout

'Burnout' conceptualised by the psychoanalyst Freudenberger (1980)[5] is defined as an occupational syndrome consisting of overwhelming exhaustion; detachment from the job; and reduced personal accomplishment (Maslach & Jackson, 1981). Burnout gradually develops as a result of heavy caseloads presenting with chronic symptomatology, as found in clients contemplating suicide (Farber, 1983). Correspondingly, Freudenberger (1980) declared unrealistic expectations as *the*

[5] Despite having analytic roots, burnout is rarely studied from this viewpoint. The Lacanian theorists, Vanheule and Verhaeghe (2005) elucidate that there is a strong link between burnout, professional identity and intersubjective experiences.

critical factor in contributing to burnout. When therapists do not understand that some clinical dilemmas are unsolvable, they may become disillusioned and doubt their meaningful contribution. This can lead to a sense of 'detached concern' within their interpersonal dealings resulting in a dehumanised approach that serves to protect against moving identifications and emotional attachments with clients (Menzies-Lyth, 1988).

Vicarious Resilience

A body of clinical explorations in its infancy has yielded a new phenomenon defined as vicarious resilience (VR). The formulation of VR has emerged as an inverse paradigm to research evaluations into vicarious traumatisation (Arnold, Calhoun, Tedeschi & Cann, 2005; Hernández, Gangsei & Engstrom, 2007; 2010). Clinically VR is conceptualised as a process, which arises from witnessing how hurt individuals constructively overcome their detrimental situations (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). Hernández and colleagues (2007) concede that vicarious trauma and vicarious resilience though initiated by trauma 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. Fundamentally, working in this psychotherapeutic domain has the power to wound and to heal.

Methodology

The Sample

The sample consisted of seven accredited therapists working in an agency devoted to suicide prevention, three of whom were person-centred, three trained as humanistic practitioners, and one respondent originated from a rational-emotive orientation.[6] Psychotherapists working towards accreditation were excluded from this project. Understandably, suicide is a highly sensitive matter and respondents were assured of confidentiality and anonymity, with possible identifiers removed from the data presented.

Data Collection Methods

The primary research method was the narrative approach and data was collected through in-depth, open-ended interviews, lasting approximately 40-45 minutes. 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.

Interpretive Phenomenological Analysis

In investigating other forms of data analysis, Interpretive Phenomenological Analysis (IPA) was considered as its philosophy and methodology correlated well to the line of investigation in this inquiry. IPA emphasises the empathic active role of the researcher in contributing to the process. It involves a 'double hermeneutic' in which the researcher tries to interpret the participant's 'sense-making' practice (Pringle, Drummond, McLafferty & Hendry, 2010; Smith, 2004).[7] In addition, this approach assists the use of a psychodynamic-psychoanalytic lens to interpret data in

[6] There were no master therapists (10 years or more) in the sample.
[7] Phenomenology discovers meaning and hermeneutics interprets meaning.

gaining access to phenomena not encountered in the therapeutic setting (Cartwright, 2004). The limitations of this study meant that interviews generated a wide plethora of data, themes and findings, however, the restriction of the word count meant that many rich excerpts were culled.

Data Analysis

A detailed case-by-case analysis of each transcript occurred, with manual transcribing and coding being employed to develop an intimate acquaintance with the data (Smith & Osborn, 2003). Importantly, superordinate themes were not only selected on their prevalence, but on the depth of passages, which richly-illustrated the themes (Smith, Flowers & Larkin, 1999). Finally, a table consisting of three superordinate themes and subordinate themes emerged from this process:

	SUPERORDINATE THEMES		
	1. Overworking	**2. All Changed, Changed Utterly/ Identity Disruption**	**3. A Terrible Beauty is Born/ A Spiritual Practice**
Subordinate Themes	i) Working under a death threat 110%	i) Disruption to the Self	i) The Agapean Mission
	ii) Under my skin	ii) Disruption to Other-Intimacy	ii) Community of Believers
	iii) Holding the Therapist Hostage	iii) Disruption to Professional Identity	iii) Regeneration

Table 1

Findings

Overworking

In each interview therapists described being 'overworked' by providing extra therapeutic sessions, between-session phone calls and were consumed by the client 'after hours'. Therefore, additional 'therapeutic accommodations' (Goldblatt, 2008) are demanded of therapists working with this unique client population. Cathy encapsulates the feelings of many when she articulated "sometimes, sitting in that despair can be really, really difficult…I just say to them, drop the coffin". 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 "stay in this universe". Sandra captures the national crisis of suicide and the urgency of growing caseloads:

> 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'[8] were the organisation carries all responsibility for the suicide risk.

The researcher noted that all practitioners dressed impeccably in tailored clothes and participants elucidated how they symbolically separated work from home by the "defrocking process". Participants spoke of showering as metaphorically disinfecting themselves from the work (Vaillant, 1992). However, despite Sandra's careful

[8] 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, but not processed. In this Irish context, centres such as this are expected to clean up the mess of an entire nation.

attention to her physical rituals, she describes 'an off-duty' penetration of her emotional boundaries. After assessing a client as 'low risk,' Sandra discovered that she had 'carried' her client home:

> 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?' 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 brings the client home (Vaillant, 1992). Their "overworking" highlighted the complexity of the cases, the presence of deeply regressed transferences, as well as the ambivalence inherent to the suicidal threat (Paris, 2007). The accounts reflect the excessive engagement required as therapists attempted to reclaim lives from the brink of death. The client's ability to get under their skin, seduce, manipulate and even torment the therapist explains this phenomenon. These experiences laid the foundation for the next section of how this 'draining work' impacts the self of the therapist.

Identity Disruption

Given the life and death nature of this work, a notable theme was the transformation of the inner world of the therapist. The trauma of suicide can be heard to impact the clinician on three levels: Disruptions to the Self, Other-Intimacy and Professional Identity.

- *Self*

Denise reflects how it is impossible to engage in these therapies and remain unchanged:

> 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.

Sandra's excerpt stood out as she honestly describes the ramifications of being a 'helpless witness' (Weingarten, 2003) to countless disturbing narratives:

> So now I just say you don't need all the details, whether it's sexual abuse or rape or taking your own life […] 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). Burnout characterised by depersonalisation (Vanheule & Verhaeghe, 2005) is explicit in Helen's quote:

> 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 uses the signifier '*cut*' in order to cope, which is fascinating as a lot of her work is with self-harming clients. Again Helen relates how a completed suicide combined with a personal loss impacted her ominously at a somatic level:

> 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…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.

- *Other*

An overarching theme was how vicarious trauma carried far beyond the therapeutic space into the personal arena. Participants revealed a disruptive sense of safety that translated into hyper-vigilance around their children (Egan, 2006). Martina expands how impairment to interpersonal functioning occurs in her family:

> 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…I have nothing left to give you [*Laughs*]. Do your own thing now. Don't ask me for anything […] and sometimes I bring home angry from clients that don't show up.

Martina's clients receive her undivided attention encapsulating the "malignant grandiosity"[9] (Schneidman, 2005, p. 11) of suicidal ideation, but her intimate bonds suffer 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:

> Since working with suicidality… I don't really want to be a parent, because I work with so many kids…dealing with the ins and outs of parents and even the other therapists in the organization, who are parents…like you get to hear a lot of stuff…maybe private information […] I don't know if I want to bring a child up in this world…that might seem mad, but I guess it has profoundly impacted me.

Essentially, the myopic perception of suicidality is communicated here, where the death instinct can destroy the extension of the self in deciding not to bring forth life (Bion, 1959).

• *Professional*

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.[10] A

[9] An almost delusional, preoccupation that one's suffering is entirely unique.
[10] 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 (Freud, 1917; Schneidman, 2001; Worden, 2003).

resounding theme was the fracturing of the professional ego ideal and fear of letting down the organisation. Tara gravely discusses how her naiveté was usurped, subjecting the professional self to self-recrimination and doubt:

> 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 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 expresses 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:

> I didn't want to have any high-risk clients…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' (italicised above) belies hidden anger concerning the client's ultimate decision of death by asphyxiation. Denise asserts the apparent denial so inherent to suicide prevention (Alexander, 2007) as well as expressing the defensive platitude of the tortured soul at rest:

> 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.

Spiritual Practice

The most striking phenomenological characteristic was that despite suicidal prevention being a harrowing experience, interviewees describe their job as a 'blessing', a 'gift' and a 'privilege'. In listening to the participants, the expressed wish to save clients acquired an almost religious fervour. Tara asserts, "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). Denise's quotation encapsulates the *agapean* principle[11] and a positive addictive metaphor is used to exemplify this idea:

> This is going to sound mad, but 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 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…

Nonetheless, there was a strong ethos conveyed by all participants that they could only do this work because they operate as a strong, specialised community. This directly contradicts research that those clinicians who work in agencies are more stressed compared to those in independent practice (Pearlman & Saakvitne, 1995).

All transcripts emanated an overwhelming theme of regeneration in the person of the therapist. A sense of fulfilment in the practitioners' developmental journey was expressed from their own sublimation of melancholia:

> I made a suicidal attempt in my past, 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.

Furthermore, Tara recognises that bearing witness to her client's growth has elicited healing in relation to the self:

> 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.

Discussion

Increased interest and over-absorption with clients were consistent phenomena throughout the transcripts, which corresponds with analytic investigations (Birtchnell,

[11] From the Greek word *'agape'* meaning the unconditional love and grace of God.

1983; Briggs et al., 2008; Goldblatt, 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). The 'overworking' theme is reflected in psychodynamic studies as the therapist makes more sacrifices than usual in the provision of extra 'therapeutic accommodations' (Goldblatt, 2008). 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 an Irish nation who banishes the suicide reality.

Accordingly, five participants elucidated the need for purification of their body surface. Hence, the fear of contamination is supported by the child psychotherapy literature with regards the function of the skin (Bick, 1986; Turp, 2007; Willoughby, 2001). 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). Additionally, Meltzer's (1994) concept of 'adhesive identification' explains how clients are superficially sticking to the therapist's skin surface as a defense against separation.

A striking point was the degree to which participants attributed 'overworking' to their engagement with severely suicidal clients with personality disorders.[12] In reaction, clinicians may position themselves to 'embody the good object' in a desperate attempt to disavow any connection to former bad objects (O'Connor, personal communication, 2012).

[12] Many high-risk clients have suffered horrendous variations of 'soul murder' (Shengold, 1999).

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). Persistent exposure to suicidal narratives wrought a sense of affective numbing, protecting the therapist from active client involvement (Menzies-Lyth, 1988). Freud (1927) stressed how 'working through' can become perverted by the clinician's unconscious 'acting out' which can re-traumatise the client (Herman, 1992).

Suicide attacks the body, and four participants expressed how suicide prevention impacted the body-self considerably, in the form of terrifying dreams, intensive muscular tension, ailments and sensations. Unmetabolised loss around the death of a client to hanging resulted in an under-active thyroid gland that left Helen without vitality. 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).

Explicit in the findings was the notion of interpersonal impairment, which consolidates with previous analysis (Guy & Liaboe, 1986). Psychotherapy is a dialectical process, requiring in a Winnicottian (1971) sense, the mirroring of the client. When therapists form identifications with their clients, they can no longer reflect because they resemble the Other. Participants in this study maintained a sense of self by withdrawing from family and friends; hence interpersonal bankruptcy ensued (Vanheule & Verhaeghe, 2005). Moreover, VT 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).

In reviewing the participants' reactions to client self-murder, 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 dynamic of mourning and melancholia, laced with self-reproach.[13]

A compelling discovery was the manner in which participants conceptualised their clinical practice as a spiritual endeavour, and this was clearly demonstrated in therapists from the humanistic tradition. Contemporaneously, this resonates with empirical elucidations from the 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'. 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.

A conspicuous element was the participants' zeal for their work and how religious terminology was used to describe their "vocation" in high-risk

[13] Initially, this narcissistic injury (Gabbard, 2003) to their professional identity was experienced as a diminished sense of self-efficacy. These bereaved participants related the inherent contradiction of working in suicide prevention, but feeling shock when a suicide transpired.

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.[14] It is noteworthy that humanistic writers have long addressed these spiritual qualities of communion, presence and 'the sacred' as intrinsic to the therapeutic relationship (Clarkson, 2003; Buber, 1937, Rogers, 1980, Rowan 1993).

A resounding finding was the extent to which organisational factors played in the well-being of the present sample (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 (Egan, 2006; Pearson, 2000), this sample categorically emphasised the containing from each other (James, 2005). The 'community of believers' theme directly contradicts research suggesting that clinicians practicing in agencies are more distressed in comparison to those in private practice (Pearlman & Saakvitne, 1995).

The phenomenological characteristic concerning the 'regeneration' of the self was attested by all participants and is widely reflected in thanatology studies (Bonnano, 2004; Janoff-Bullman, 1992; Mayan, Morse & Eldershaw, 2006). The symbols of transformation, rebirth and growth in the present data indicate the developmental stage in the participants' professional trajectory. Humanistically trained participants transcended personal tragedies and their work with suicidal clients, into a state of spiritual awakening. This correlates with Mayan and colleagues (2006) clinical exploration into patients facing death, whose suffering inspired an internal restructuring of their value hierarchy, expanding their self-concept to live life to the utmost. Knafo (2004) asserts that long before the recent empirical explosions

[14] Interestingly, 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).

from the vicarious resilience movement, the humanistic approach to trauma has always involved an intimate confrontation with one's own mortality, enhancing creative and transcendent shifts in consciousness.

Conclusion

In Ireland, suicide was condemned by the law as criminal and by religion as a sin, and society still shuns it, despite the annual tragedy of hundreds of completed suicides. Considering the paucity of research on the impact of suicidality on clinicians, it is imperative that psychodynamic researchers in the field create a sophisticated evidence base to inform psychotherapeutic practice. 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" which can destroy the human spirit (Seager, 2008).

'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). 'Containing the containers' means that therapists require containment from the settings they work in and also from the health sector itself. 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, working in these clinical settings highlights the emotional impact of suicide prevention and the need for 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). 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).

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