

**Client suicide and clinician identity:
an investigation of identity development
in clinician survivors of client suicide**

Volume 1 of 2

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“I confirm that the word count of this thesis is less than 100,000 words”

Dedication

**This thesis is dedicated to the memory of my late brothers,
Gerard Henry Aidan O’Keeffe and Adrian Francis O’Keeffe.**

“But however much concerned I was at the problem of the misery in the world, I never let myself get lost in broodings over it; I always held firmly to the thought that each one of us can do a little to bring some portion of it to an end.”

Albert Schweitzer

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I have been changed by this research experience. I have renewed my compassion for myself and for suicide survivors everywhere, whether clinicians or otherwise.

Abstract

This study investigated identity development in clinician survivors of client suicide. The study's idiographic approach facilitated the examination of each clinician survivor's identity redefinition. The Identity Structure Analysis conceptual framework, augmented by semi-structured interviews, provided a reliable methodology for acquisition and analysis of primary data from 23 respondents in three cohorts – clinician survivors (target), clinician survivors by proxy (comparison) and non-clinicians (control). Client suicidal behaviour was shown to modulate clinicians' identity processes across a range of contexts. Results demonstrated that the response of each clinician survivor to their loss experience was unique to that individual therapist. Colleagues of clinician survivors, whose experience was indirect, or by proxy, were shown to experience different features of identity redefinition. It was found that clinician survivors' orientation towards their social world, whether 'defensive' or 'open', would influence the extent and nature of their response. Further, clinician survivors' own levels of suicidality were shown to be a function of their identifications with a client's propensity to suicide. Again, clinician survivors' identity development affected their systems of values and beliefs, modulating their coping resources as they contended with integration of their loss experience. Although client loss by suicide was long regarded as an occupational or professional hazard for clinicians, an individual client suicide event could not be predicted with any certainty. Further, clinicians were believed to experience client suicide both personally and as professionals. Consequently, a related key outcome – the critical importance for clinical outcomes of clinicians' competence in assessment of clients for suicidal behaviour – was emphasised. The study's overall findings should therefore inform clinicians' education, formation, professional practice and supervision, in the context of working with clients at risk of suicidal behaviour, noting each clinician survivor's tendency to respond idiosyncratically to their serious loss experience and configuring any related individual aftercare needs accordingly.

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Chapter One: Introduction

Chapter 1: Introduction

1.1 Background

1.1.1 Definition of suicide

At the outset it is sensible to consider carefully the meanings of some key words used in current research to ensure transparency and clarity.

Suicidology is the scientific study, knowledge or science of suicide (Reber and Reber, 2001: 483). A conventional view exists that suicide occurs when a person takes their own life. A standard psychology dictionary, adding the notion of intent, distinguishes 'suicide' meaning *a person* who intentionally kills herself or himself, from 'suicide' meaning *the act* of taking one's [own] life (Reber and Reber, 2001: 724). Shneidman (1985) writes at length about what he, an acknowledged suicidology authority, understands by 'suicide'. He reminds us that:

'sui-cide' 'is a fairly recent word... according to the Oxford English Dictionary the word was first used in 1651 by Walter Charleton when he said "To vindicate one's self from inevitably...Calamity by Sui-cide is not...a Crime" ' (Shneidman, 1985: 10).

Shneidman (1985) arrives at his formal definition by way of his:

'assertion [that] suicide has two branches...first...suicide is a multifaceted act [with] biological, cultural, sociological, interpersonal, intrapsychic, logical, conscious and unconscious, and philosophical elements...present, in varying degrees, in each suicidal act [and] second...[the] essential element...of each suicidal event is a psychological one...each suicidal drama occurs in the mind of a unique individual' (Shneidman, 1985: 202).

This leads to his 'proposed definition':

'Currently in the Western world suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution' (Shneidman, 1985: 203).

A number of writers subsequently developed Shneidman's (1985) work arguing that 'suicidology finds itself confused and stagnated for want of an nomenclature' (O'Carroll et al., 1996: 237). They demonstrated how legitimate interpretations by clinicians of 'suicide attempt-related injuries' that varied with professional orientation, e.g. liaison psychiatrist, medical sociologist or epidemiologist, could lead to the term 'attempted suicide' meaning so many different things that 'it runs the risk of meaning nothing at all' (O'Carroll et al., 1996: 238). More recently Silverman

(2006), Silverman et al. (2007a) and Silverman et al. (2007b) have attempted to take this work forward by proposing a revised nomenclature for the study of suicide and suicidal behaviour. A brief glossary is annexed (appendix 9) that offers the researcher's understanding of terms used in current research.

1.1.2 Derivation and motivation for the study

In its beginnings (2001) this study was conceived as a development of the researcher's earlier work on postvention strategies for suicide survivors (O'Keeffe, 2000). As a trainee clinician, however, the researcher's focus shifted towards clinician survivors of client suicide, their predicament and their particular postvention needs, both personal and professional (American Association of Suicidology, Clinician Survivor Taskforce, 2007).

Major contemporary studies of suicide in Northern Ireland (Foster, 1997; Foster et al., 1997; Foster et al., 1999; O'Connor et al., 1999b; O'Connor et al., 2000) did not specifically allude to or address the extent to which client or patient suicide impacted, influenced or intruded upon clinician survivors' personal or professional lives. Litman's (1965) seminal study had investigated the responses of 200 US psychotherapists to loss of their client(s) by suicide, concluding that clinicians react 'personally as human beings much as other people do and also according to their special role in society (Litman, 1965: 576).

Initially the researcher hypothesised that the clinician's professional duty of care might make a significant contribution to their response to their client's suicide. Litman (1965) had speculated that the intensity of the clinician's relationship with the deceased client correlated with therapists' human reactions. He referred to 'the pain affecting the therapist's professional role' (Litman, 1965: 576) and suggested that group discussion with colleagues was helpful.

The researcher investigated Litman's (1965) argument within the context of three questions:

- a) How are clinician survivors' interpersonal relationships affected?
- b) How are clinician survivors influenced by personal knowledge of the suicide phenomenon and by their experience of client suicide?
- c) How are clinician survivors' systems of values and beliefs influenced by exposure to client suicide?

1.1.3 Aim of the study

The study examined the predicament of clinicians, principally counsellors like the researcher, whose education as a psychotherapist did not include adequate consideration of strategies for working with the suicidal client. Much of the available literature described the clinician survivor's grief response in terms of shock, guilt, fear of blame, anger and betrayal (Litman, 1965; Kahne, 1968; Cryan et al., 1995; Grad et al., 1997 and Hendin et al., 2000). The current research study proposed to adopt a different strategy by investigating, systematically and scientifically, and in the context of the clinician's grief response, what happened to the identity of the clinician survivor, when impacted by and confronted with the loss by suicide of their client.

1.2 Structure of the dissertation

The thesis proceeds in chapter 2 with consideration of counsellor psychotherapeutic identity and the role of the psychotherapist in a range of contexts regarding the suicidal client. These included client autonomy, confidentiality and trust, psychoanalytic theory, ego states, client transference and counsellor countertransference. Other topics that are considered include self-awareness and awareness of process, client issues and expectations, physical, emotional, spiritual and intellectual aspects of counsellor identity and ethical issues, including the importance of clear and safe boundaries.

Chapter 3 on the client suicide phenomenon is a systematic description of relevant views expressed in empirical literature and upon which the study's theoretical postulates (chapter 5) are based. The principal research instrument employed in the study, viz. the Identity Structure Analysis conceptual framework, is considered in the context of this research study in chapter 4. Remaining chapters include research methodology (chapter 6), case study summaries and findings (chapter 7) and discussion and conclusions (chapter 8).

1.3 Prelude

This research study was registered in mid-2001 and has experienced a long and slow gestation. Soderland's (1999: 1) allegation that 'the scarcity of research on how therapists deal with the suicide of a client smacks of a collective avoidance of what can be a massive personal shock equivalent...to the loss of a parent' has been addressed to some extent in the intervening decade. There is currently much more

interest in the subject and it is hoped that the present work can contribute in some measured way to advancing awareness and understanding in the psychotherapeutic world of the issue of client suicide, its potentially deleterious effects and some approaches towards their easement.

Chapter Two: Psychotherapeutic Counsellor Identity

Chapter 2: Psychotherapeutic counsellor identity

2.1 Introduction

A range of descriptors has developed over time to describe human communication and interaction between a designated person, a ‘helper’ and another person, a ‘client’ that is aimed at enabling the client to ‘come to grips with problems in living’ (Egan, 1998: 4). ‘Counselling may be viewed as a special kind of helping relationship, as a repertoire of interventions, as a psychological process or in terms of its goals, its clientele and the people who counsel. No really valid distinctions can be drawn between counselling and psychotherapy’ (Nelson-Jones, 1998) which ‘may be said to be on a ‘continuum or even interchangeable’ (Mellor-Clarke, 2000). Both major UK / Irish professional associations – British Association for Counselling and Psychotherapy (BACP) and Irish Association for Counselling and Psychotherapy (IACP) – changed their names to include both ‘counselling and psychotherapy’ (Irish Association for Counselling and Psychotherapy, 2002 :1).

This chapter describes some dynamics within the psychotherapeutic caring profession that influence practitioners’ identity development in the context of suicide and the clinician’s relationships with clients, including those at risk of suicide.

2.2 Psychotherapy, counselling and counselling psychology

Psychotherapy, counselling and – more recently, counselling psychology – individually and collectively refer to ‘an interdisciplinary activity...psychological in part but...also social, cultural, spiritual, philosophical, aesthetic and much more’ (McLeod, 1998: 1). Among many that are canvassed, one comprehensive definition of counselling states that:

‘Counselling involves a deliberately undertaken contract with clearly agreed boundaries and commitment to privacy and confidentiality. It requires explicit and informed agreement. The counsellor’s role is to facilitate the client’s work in ways which respect the client’s values, personal resources and capacity for choice within his or her cultural context’ (British Association for Counselling and Psychotherapy, 1998).

Psychotherapists, psychotherapeutic counsellors or counselling psychologists are among current professional designations for practitioners in an occupational group of individuals within a developing healthcare profession whose members are practitioners of psychotherapy and counselling. The term ‘practitioner’ is used

generically to refer to anyone with responsibility for the provision of counselling or psychotherapy-related services:

‘ “Practitioner” includes anyone undertaking the role(s) of counsellor, psychotherapist, trainer, educator, supervisor, researcher, provider of counselling skills or manager of any of these services. The term ‘client’ refers to the recipient of any of these services’ (British Association for Counselling and Psychotherapy, 2002: 2).

2.3 Psychotherapeutic practitioner identity

This study seeks to explore and to assess the assimilation into the counsellor’s sense of identity of the experience of a client’s suicide. Suicidologists accept the existence of a spectrum of suicidal behaviour ranging from intentional ‘self-injurious thoughts and behaviours’, including verbal self-deprecation at one extreme, to ‘completed suicide’, at the other (Kosky et al., 1998). Hence each occurrence of suicidal behaviour can be both complex in nature and unique to the individual who experiences it either directly as perpetrator or indirectly in its aftermath by survivors including, perhaps, a clinician survivor.

Weinreich (2003: 2) argues that an individual’s sense of identity ‘will be unique’ because of ‘idiosyncratic personal experiences’ but that each person will ‘exhibit various degrees of commonality’. Thus the clinician’s unique sense of self will be influenced in the aftermath of their client’s suicidal behaviour.

But such identity uniqueness is subject to continuous change. A person’s identity is such that:

‘one does not form or ever achieve a totally fixed notion of one’s identity...(in) appraisals and reappraisals contingent on biographical experience and reflection over time, one elaborates, refines, expands and contracts one’s perspectives on life, people and self. As a consequence one’s identity is open-ended and continues in flux, ranging from gradual updatings...to major transitions’ (Weinreich, 2003b: 77).

In other words:

‘The person’s identity is a continuing process that involves a complex elaboration of experiences of interactions with others over time, with a past biography and a future orientation located within a contemporary socio-historical context’ (Weinreich, 2003b: 80).

It follows that development of a psychotherapeutic practitioner’s identity is conditioned by ‘biographical experience and reflection over time’ (Weinreich, 2003b: 77) and ‘experiences of interactions with others over time’ (Weinreich, 2003b: 80)

and also by influences specific to a practitioner in their professional, clinical relationships with patients or clients. Many of these influences are interdependent and interacting and include the following:

- i) the counsellor's duty of care towards the client or the patient
- ii) client autonomy
- iii) confidentiality and trust
- iv) psychoanalytic theory, ego states and client transference
- v) counsellor countertransference
- vi) self-awareness and awareness of process
- vii) client issues and expectations, and
- viii) the physical, psychological, spiritual and intellectual aspects of counsellor identity, and
- ix) ethical issues and boundaries

The suicide phenomenon crosses all human boundaries. 'Suicide has permeated Western culture like a dye that cannot be washed out' (Alvaraz, 1974: 235). Gender, ethnic group, sexual orientation, religious affiliation, social class, unemployment, rural isolation, imprisonment, medical illness, age and alcohol and substance abuse are among factors that affect suicide rates (Williams, 2001: 28-38). These factors are to a great extent analogous to related counsellor and client identity attributes including religious belief, political opinion, racial group, age, gender, marital status, sexual orientation, disability and dependency status (Northern Ireland Act 1998) in the context of statutory duties on public authorities in relation to equality of opportunity. The practitioner's engagement with clients takes careful account of these attributes.

The above-mentioned influences upon counsellor identity development listed above are now considered in the context of client suicide.

2.4 Counsellors' duty of care towards their clients

The duty of care of counsellors towards their clients is a primary duty emanating from the 'primum non nocere' – above all do no harm – dictum expressed in a 'Code of Ethics and Practice for Counsellors' as follows:

'Counsellors should take all reasonable steps to ensure that the client suffers neither physical nor psychological harm during counselling' (B2.2.1) (British Association for Counselling, 1992).

This expresses the second of four principles from moral philosophy 'which have proved useful to other professions:

- 1 Beneficence: What will achieve the greatest good?
- 2 Non-maleficence: What will cause the least harm?
- 3 Justice: What will be fairest?
- 4 Respect for autonomy: What maximises the opportunities for everyone involved to implement their own choices?' (Bond, 1998: 33-34)

It is further argued that:

'The duty owed by counsellors [to their clients] is the same as that owed by any other professional. They are required only to exercise reasonable care and skill in rendering their services to clients. The duty of care does not require that there should be no deterioration or even actual improvement. Reasonable care will be assessed by a court...courts have...adopted a[n] ...approach which judges that a professional is not negligent if she follows the practice accepted at the time as proper by a reasonable body of professional opinion skilled in the particular form of treatment (Rogers, 1989)' (Bond, 1998: 48).

Stiver (1991: 265) suggests that counsellors should show that they care about their clients through 'an emotional investment in the [client's] well-being.' However the clinician's duty of care extends beyond the immediate client and includes the 'duty to warn and protect in cases where the client threatens violence to another person' (McLeod, 1998: 277). McLeod (1998) illustrates this 'painful and difficult dilemma' with reference to the Tarasoff case (Skovholt, 2001: 72) concerning a client who disclosed to his clinician his intention to kill his girlfriend (Ms Tarasoff). Despite the clinician's best endeavours, he failed to prevent the client from acting upon his intentions. The outcome of this tragic case demonstrates that clinicians 'need to be willing to breach client-therapist confidentiality when the safety of others is at risk' (McLeod, 1998: 277). An equivalent duty to warn and protect exists in relation to a client's risk of harm to self including suicide.

Therapist-client contracts normally include an agreed clause that permits confidentiality to be breached if necessary, and where client consent is not forthcoming, where a client's intention to harm self or others emerges during therapy (British Association for Counselling, 1984; American Association for Counselling and Development, 1988).

The relationship between therapists' duty of care and client suicidal behaviour is linked with the issue of client autonomy which is considered next.

2.5 Client autonomy

Weinreich (2003a) asserts that one's 'sense of autonomy and being in control' varies according to situation and prevalent identity state:

'In some situations one has a fair degree of autonomy and may have a good deal of control over one's own activities... some individuals strive to maintain control over their own activities...to a far greater extent than do others... [autonomy varies] both situationally and in terms of individual propensity' (Weinreich, 2003a: 38).

Any discussion, therefore, of human autonomy, or self-determination, must take careful account of 'the variable nature of its expression' (Weinreich, 2003a: 38).

Client autonomy may be described as the client's right to choose their own behaviour in all circumstances. Clearly this is not an absolute right as 'all people will experience variable degrees of personal autonomy...[this] characteristic feature of human behaviour and experience is not constant but fluctuates enormously' (Weinreich, 2003a: 41). Bond (1998) identifies 'two fundamental ethical principles' in counselling that are regarded as integral to securing 'the aim of enabling the client to achieve his own improved well-being' (Bond, 1998: 18). These are respect for client autonomy and the importance of confidentiality.

The latter is now acknowledged as being limited rather than total in the counselling context. 'The counsellor's role is to facilitate the client's work in ways which respect the client's values, personal resources and capacity for self-determination' (British Association for Counselling, 1992). In the context of the suicidal client, a counsellor may be faced with an ethical dilemma. The client may disclose either 'casual' or 'serious' suicide-related thoughts, intentions and/or behaviours. Counsellors may then either choose to facilitate the client's self-destructive behaviour as a way of respecting client autonomy or they may choose to breach confidentiality in the interests of preserving the client's life.

It seems that where suicide ideation is present within the counselling relationship, strict adherence by the counsellor to *both* of the above-mentioned 'fundamental principles' may be logically impossible: in law counsellors may not simultaneously facilitate client suicide by inaction *and* maintain confidentiality: hence

the dilemma. Orbach (2001) suggests that client autonomy applies as much to the suicidal client as to the non-suicidal client. He argues that ‘therapeutic empathy with the suicidal wish’ involves the counsellor in ‘assuming the suicidal person’s perspective and “seeing” how this person has reached a dead end without trying to interfere, stop, or correct the suicidal wishes’ (Orbach, 2001: 166-184). Birtchnell’s (1983) view is that suicide can be rational even in the absence of terminal physical illness and that the therapist should empathise with such a perception. He also suggests that the more the therapist respects the client’s right to take their own life, the more open the client will be about suicide intent. Orbach (2001: 174) suggests that the therapist might ‘ask the suicidal person to actually “convince” me that suicide is the only solution left...[as] a way of connecting with the patient’s experience and offering myself as a listener and companion at a time of crisis’.

Jobes (2000: 13-15) describes a similar treatment model involving a ‘clinical alliance’ that ‘places the clinician and patient on the same team’. This collaborative assessment and management of suicidality (CAMS) approach enables the ‘team’ to ‘co-author’ the client’s treatment plan.

Orbach (2001) cites Szasz’s (1961) writings about the freedom to commit suicide and argues:

‘that the suicidal person’s right to commit suicide emanates from (their) unbearable pain and that...the ability to empathise and address this pain (is) the basis for intervention. The suicidal person, as I see it, “gains the freedom” to commit suicide, not from a moral or an ethical standpoint, but from the experience of unbearable pain. The best way to “intervene” in the decision to commit suicide is by understanding and “sharing” the intolerable pain’ (Orbach, 2001: 174).

It is informative to locate the above discussion on client autonomy, including Orbach’s (2001) contribution, in the context of Harré’s (1998) earlier ideas. Harré (1998) conceptualises ‘a formulation of personhood in which the unique person (‘Person’) comprises the self in three aspects...the agentic self...[the] reflexive self [and] the public self’ (Harré, 1998).

The ‘agentic self’ is that aspect of the ‘Person’, that ‘singular self’ (Harré, 1998), located in time and space, who intentionally acts, interacts with others and appraises the living circumstances of the ‘Person’, by way of linguistic discourses and conversations (Weinreich, 2003a: 36).

The ‘Person’s’ awareness when in ‘agentic’ mode, of their characteristics and of their values and beliefs, including those about oneself, represents the ‘reflexive self’, sometimes referred to as the self-concept.

The third aspect of the ‘Person’ is that ‘public self’ in interaction with others together with this public self as perceived by others (Weinreich, 2003a: 36, 37).

The confidential encounter between counsellor and client seeks engagement with ‘the private sense of self’ (Harré, 1998: 43) of the client that may emerge when expression of each of the three aspects of self is empathically facilitated. It is worth noting that the agentic self that ‘some commentators refer to as the *authentic self* (italics in original) is not amenable to assessment, only the ‘self-conceptions (reflexive) and ‘self-expressions’ (public) aspects of self are available. This is the case whether assessment is by agentic self directly or by way of observations of oneself by others’ (Weinreich, 2003a: 39).

2.6 Confidentiality and trust

Attitudes to and practice regarding confidentiality within helping relationships have evolved inter alia as a consequence of outcomes of legal proceedings instituted, for example, by patients against medical practitioners and by clients against counsellors, for example, the Tarasoff case (see par. 2.4 above). Bond (1998) cites a case involving a student counsellor who relied upon adherence to total confidentiality when working with a suicidal client and did not seek alternative help for the client. After the suicide of her client, it was suggested in the Coroner’s Court ‘that such a policy was only sustainable if the counsellor was trained and competent in the assessment and treatment of suicidal clients’ (Bond, 1998: 13).

The Samaritans suggest that most people harbour some kind of suicidal thoughts at some stage in their lives: ‘at least 1% of us is experiencing suicidal thoughts (Meltzer et al., 1996) we may reject it, we may set it aside for all sorts of reasons, it may pass quickly, but it will be there’ (Lawrie, 1999). Consequently any client within a counselling relationship may be experiencing suicidal thoughts and may therefore be described as a potentially ‘suicidal client’.

Maltsberger (1988) emphasises the ‘quandary’ the clinician may be in because ‘the enormous amount of information available...on the...risk factors...tests...and scales – are not adequate to allow one to adequately answer the question: “Is the patient, sitting here with me now, about to commit suicide?”’ (Maltsberger, 1988: 47).

Freud (1901/1976) observed that ‘the trend to self-destruction is present to a certain degree in very many more human beings than those in whom it is carried out’ (Freud, 1901/1976: 236). Litman (1996) reflected that he did not ‘realise the magnitude of the suicide risk problem especially that at any time there are millions of people considering suicide at various levels of intention (Litman, 1996: 6). An approach to addressing this issue is offered by Firestone (1997) who comments that:

‘direct questions should be asked regarding the patient’s thinking about suicide. In particular the clinician needs to ask the following questions: Do you currently consider suicide an option? How suicidal do you see yourself as being now? Do you have a plan for committing suicide? Do you have the means to carry out your suicide plan? What is the time frame for your plan?’ (Firestone, 1997: 237)

Firestone’s (1997) approach seems to be a more formal version of that advocated by Orbach (2001) and Jobes (2000), at par. 2.5 above. How clients respond to such ‘suicide questions’ may depend upon their level of trust in the counsellor and in the counselling relationship:

‘Counselling is possible only when sufficient trust is established to encourage the active participation of the client, who has to be willing to take risks in exploring and often disclosing personally identifiable material’ (Bond, 1998: 10).

But the client’s trust ‘is often related to the level of confidentiality on offer’ (Bond, 1998: 132). Bond suggests that to address the risk of ‘actionable breach of confidence’ counsellors may ‘be explicit about reserving the power to breach confidentiality for a suicidal adult client’ (Bond, 1999: 8). Alternatively (see par 2.5 above) the counsellor may wish to remain silent out of respect for the client’s autonomy. But

‘disclosure may be authorised by client consent or the law... practitioners (are) accountable to their clients and to their profession for their management of confidentiality in general and particularly for any disclosures made without their client’s consent’ (British Association for Counselling and Psychotherapy, 2002: 7).

2.7 Psychoanalytic theory, ego states and client transference

Client behaviour in counselling may be influenced by conscious and unconscious intentions and expectations, and the need to contend with psychological pain associated with ‘problems in living’ (Egan, 1998: 4). Client response and counsellor intervention are also affected by underlying dynamics within the counselling

relationship, as postulated in Berne's (1988) study of ego states and in Identity Structure Analysis (Weinreich, 2003a) (see chapter 4 below).

Suicidal clients may engage in suicide-related behaviours that have their origins in both conscious and unconscious intentions and expectations which under rational examination have little basis in fact. Orbach (2001) describes a client, whose daughter had suicided and who suffered 'tormenting guilt' and who 'started to talk about dates and means to kill herself in order to join her beloved daughter'. Orbach (2001) suggested that she might "talk" to her daughter about her guilt and need for punishment'. The client left the session telling the therapist (Orbach) that she was seriously considering suicide. However instead of killing herself she visited her daughter's grave and "talked" to her daughter, asked for forgiveness and went home feeling slightly relieved (Orbach, 2001: 174, 175).

Here the expressed 'new intentions' of the client – to take her own life – were not acted out possibly because the client was not 'in character' i.e. a person who is fully agentic and acting wholly in accordance with intentionality, that is with maximal personal autonomy' (Weinreich, 2003a: 40). Her life was not taken because 'compromised agency represent(s) states of diminished personal autonomy' (Weinreich, 2003a: 40): that is to say that her ability to control events, including the planning and execution of a completed suicide, being 'modulated in accordance with...appraised consequences' (Weinreich, 2003a: 40), was insufficient following her interaction with her internalised dead daughter at the latter's grave.

Conscious and unconscious intentions or aspirations (motivations) in the suicidal client may be further understood in the context of Freud's psychoanalytic theory which hypothesised the existence of three regions of the human mind:

- i) the irrational 'id': an *unconscious* reservoir of primitive instincts and impulses which are ultimate motives for our behaviour and governed by the 'pleasure principle'
- ii) the 'superego' or conscience: an *unconscious* storehouse of rules and taboos that are mainly internalisations of parental values and attitudes, and
- iii) the 'ego': the *conscious* or rational part of the mind, the decision taker and interface with 'external reality' (McLeod, 1998: 35, 36).

Orbach's (2001) client's intentions and behaviours may be understood through the reported *conscious*, psychological pain of her 'tormenting guilt'. The client had 'talked a lot about how she failed the most important goal in her life – to be a better

mother to her children than her mother had been to her' (Orbach, 2001: 174). This sense of failure originated within her *unconscious* as a reaction to those internalised maternal attitudes that she had rejected.

The psychoanalytic concepts, upon which the psychodynamic approach to counselling and psychotherapy is built, emphasise 'the importance of working through defences and resistances as well as the use of transference and countertransference' (Jacobs, 1998: 1). Transference is defined as the passing on or displacing (i.e. transferring) of an emotion or affective attitude from one person to another person or object (Reber and Reber, 2001: 761). 'Past relationships can also be reflected in the relationship style(s) which the client adopts towards the counsellor or therapist, a phenomenon known as transference that can occur in all human relationships' (Jacobs, 1998: 12). Within the counselling relationship and 'in the transference', the client's interactions may be understood to be shaped within a range of 'ego states' (Berne, 1988: 11). As postulated, 'transactional analysis (TA) is the study of ego states, which are coherent systems of thought and feeling manifested by corresponding patterns of behaviour' (Berne, 1988: 11).

One ego state, the 'Parent', is based upon parental influence in the formation of conscience. A 'process of incorporation, internalisation, identification or introjection' of parental characteristics creates 'the critical or warning "voice" which many people are aware of in themselves [that] is often capable of being identified... with one or both parents at least as they were perceived by the client when a child' (Jacobs, 1998: 5).

A second ego state, the 'Adult', acts logically and 'appraises his environment objectively...calculates its possibilities and probabilities on the basis of past experience (and) functions like a computer' (Berne, 1988: 11-12). The third ego state is called the 'Child':

'each person carries within a little boy or little girl, who feels, thinks, acts, talks, and responds just the way he or she did when he or she was a child of a certain age...not...as "childish" or "immature"...but as childlike...anywhere between two and five years...it is important for the individual to understand his Child, not only because it is going to be with him all his life, but also because it is the most valuable part of his personality' (Berne, 1988: 12).

The notion of ego states allied to the inevitability of client transference within the counselling relationship strongly influences counsellor identity. McLeod (1998) describes the 'process...called transference' as the projection by the client of 'an

image of his or her mother, father [or other significant authority figure] on to the therapist' which allows the therapist to observe early childhood relationships as they are re-enacted in the counselling room (McLeod, 1998: 37). Counsellors strive to remain in their adult ego state – using logic, objectivity and their own psychotherapeutic experience – while acknowledging, with Freud, that on occasion 'clients perceive their analysts as reincarnations of important figures from their childhoods and project on to them moderate to intense feelings and emotions appropriate to these earlier models' (Nelson-Jones, 1998: 172). The feelings aroused in the client by and about their counsellor, and the counsellor's awareness of these feelings are crucial to the change process that is the purpose of counselling involving 'movement between and within the minds of both counsellors and clients' (Nelson-Jones, 1998: 4).

Counsellor identity, as defined earlier (see par. 2.3 above) encapsulates all those interpretations (construals) of self in the past, current and future. Consequently a developed sense of awareness of client feelings within the counselling process is a fundamental aspect of the counsellor's personality, which is itself an important constituent of counsellor identity (Klapp, 1969).

However transference does not explain all of the feelings that a client may have towards a counsellor. All positive responses cannot be called 'positive transference' nor can all negative responses be considered aspects of 'negative transference'. 'Many of these reactions may have a reality base, and clients' feelings may well be directed to the here-and-now style that the therapist exhibits' (Corey, 1996: 115-116). A counsellor's behaviour may trigger a client's emotional response that is more related to that behaviour than to any transference response. Egan (1998) held that 'there are any number of ways in which helpers can challenge clients to develop new perspectives, change their internal behaviour and change their external behaviour' (Egan, 1998: 170).

The ancient precept 'nosce te ipsum' ('know thyself') (Ehrlich, 1999: 161) seems emphatically to apply to the counsellor particularly since 'being a therapist affords us the opportunity for continual spiritual, intellectual and emotional growth' (Kottler, 1996: 41-42). Further 'a desirable attribute for...counsellors and psychotherapists' (Wosket, 1999: 121) may consist in being 'introverted enough to have a highly developed self-awareness, yet be able to easily relate to other people' (Hycner, 1991: 13).

The importance (in relation to client transference) of such counsellor attributes as self-awareness, counselling style and continual personal growth and development is emphasised because each is powerfully influenced by client work:

‘Clients are a continuous major source of influence and serve as primary teachers...clients have a powerful impact on [counsellors’] professional functioning...they are constantly providing information about causes [of] and solutions to human distress’ (Skovholt and Ronnestad, 1995: 118).

Interpersonal encounters are more influential than are interpersonal data:

‘In the work context...clients, peers, colleagues...supervisors, professors, one’s own therapist-counsellor, experts and mentors...were significant [but] clients were considered as most significant’ (Skovholt and Ronnestad, 1992: 512).

2.8 Counsellor countertransference (CT)

Rosenberger and Hayes (2002a) reviewed empirical countertransference (CT) literature. They referred to Racker (1957) who described countertransference as ‘both the greatest danger and the best tool’ in counselling. CT was variously conceptualised as avoidant behaviour (Bandura, Lipsher and Miller, 1960), as over- or under-emphasis of client material that is emotionally threatening (Cutler, 1958) or as a withdrawal of the counsellor’s personal involvement (Yulis and Kiesler, 1968).

Rosenberger and Hayes (2002a) surveyed CT research conducted over the previous 25 years and commented on implications for counselling practice. They noted the definitional difficulties that have arisen since Freud’s ‘classical’ definition focused on the analyst’s unconscious and neurotic reactions to the patient’s transference (Kernberg, 1965). A second ‘totalistic’ CT definition emerged that included all conscious and unconscious reactions the clinician has towards the client (Heimann, 1950). A third ‘moderate’ perspective on countertransference ‘maintained that it represented the counsellor’s reactions to the client that are based on the counsellor’s unresolved conflicts’ (Gelso and Carter, 1985; Gelso and Hayes, 1998; Langs, 1974). However Rosenberger and Hayes (2002a: 264, 265) now assert that ‘despite nearly a century of musings and debate about CT, a comprehensive and testable theory...absent until recently’ has now emerged. Work by Hayes et al. (1998) offered:

‘a structural theory of CT that may serve as a useful framework for reviewing and synthesising research on CT. Hayes argued that it is conceptually useful to categorise CT into five main components: origins, triggers, manifestations, effects and management. CT origins are areas of unresolved conflict within the

counsellor. Triggers are the actual counselling events that touch upon or elicit counsellors' unresolved issues. When these CT origins are triggered counsellors experience cognitive, affective, and behavioural reactions or manifestations. CT effects are the subsequent results of CT manifestations on the quality of the counselling process and outcome. Finally CT management refers to counsellors' strategies for handling and coping with their CT' (Rosenberger and Hayes, 2002a: 264, 265).

Hayes et al. (1998) reported that 'counsellor needs, family issues, cultural issues and counselling-specific issues (e.g. termination) represented the most common sources of CT'. They found that although some CT responses were linked with 'concrete events or stimuli...e.g. the client discussed death or termination was approaching', much more often CT was provoked by the counsellor's

'subjective perception...about how well the client was doing in counselling or perceptions of the client as similar to the counsellor...In other words the counsellor's phenomenological reality typically determined whether and when CT would be stimulated' (Rosenberger and Hayes, 2002a: 268).

Hayes et al. (1998) also concluded that:

'most CT reactions affected the distance between client and counsellor , in some cases drawing them closer together (e.g. through the counsellor's identification or over-identification with the client) and in other cases pushing them apart (e.g. through the counsellor's feeling blocked, confused or bored)' (Rosenberger and Hayes, 2002a: 268).

More recently Rosenberger and Hayes (2002b) used a case study approach to evaluate the integrative model of Hayes et al. (1998). They found that although:

'conflictual material (client verbalisations that touch on the therapist's unresolved issues) was inversely related to the therapist's avoidant behaviour...[this] might initially suggest that the therapist was not affected by conflictual material...but the more the client talked about issues related to the therapist's unresolved conflicts, the less attractive, expert and trustworthy the therapist felt...CT management was directly related to the therapist's perceptions of ...social influence attributes i.e. attractiveness, expertness and trustworthiness' (Rosenberger and Hayes, 2002b: 228)

Rosenberger and Hayes (2002a) said that their literature review documented the various ways that CT influenced counselling particularly along cognitive, affective and behavioural dimensions:

'In terms of cognitions CT has been shown to take the form of distorted perceptions of clients, inaccurate recall of client material, reactive, defensive mental activity, blocked understanding, uncertainty and changes in treatment planning. On an affective level, state anxiety has been the most commonly

studied CT reaction in laboratory studies and it has consistently served as a useful indicator of CT. Field studies, however, are beginning to demonstrate the wide range of possible emotions that could denote CT, including anger, sadness, boredom and nurturing feelings. Behaviourally CT has typically been operationalised as counsellor avoidance or withdrawal, both in laboratory and in field studies' (Rosenberger and Hayes, 2002a: 269).

These authors note that although by definition CT involves a counsellor's reaction to clients or client material, little attention has been paid to powerful cultural differences that can trigger CT reactions in terms of race, ethnicity, age, religion, sexual orientation, disability or other cultural dynamics. They suggest that future CT research might include individuals from diverse cultural backgrounds in order to generate hypotheses that addressed client and counsellor cultural characteristics (Rosenberger and Hayes, 2002a).

The CT response triggered by a traumatised client is now examined. Black's (2002) work explored the concept of vicarious traumatisation in the context of clinicians' experiences of working with traumatised clients (Black, 2002: 98). The potentially deleterious effects for psychotherapists of working with clients who bring trauma-related material into the counselling relationship was described as vicarious traumatisation (McCann and Pearlman, 1990). The potential effects of working with traumatised patients have been empirically differentiated from the effects of working with 'other difficult populations' perhaps 'because the clinician is exposed to emotionally shocking images of horror, cruelty and suffering that are characteristic of serious trauma' (Black, 2002: 98). Suicidal clients may belong to any of those difficult populations referred to by Black (2002: 98) or to the population of clients who have experienced serious trauma.

Black (2002) surveyed empirical research on two strands of traumatic exposure, viz. exposure to combat-related trauma and exposure to the trauma of sexual abuse (Black, 2002: 99). Green (1990) attempted to describe the relationship between traumatic events and traumatic responses. He listed eight generic dimensions of traumatic stressors that 'cut across different types of traumatic events' (Green, 1990: 1638):

1. Threat to one's life and bodily integrity
2. Severe physical harm or injury
3. Receipt of intentional injury
4. Receipt of intentional harm

5. Exposure to the grotesque
6. Witnessing or learning of violence to loved ones
7. Learning of exposure to a noxious agent
8. Causing death or severe harm to another

In the aftermath of working in a therapeutic relationship with a client who took their own life, only one of Green's (1990) dimensions appears to be associated with the therapist's experience of client suicide: witnessing or learning of violence to loved ones. In this context the client who dies by suicide occupies the position of a loved one in relation to the therapist who experiences this event. Patterson (1996) elucidated his view as a psychotherapist, following 40 years in counselling psychology, as follows:

‘My position is that the relationship is psychotherapy and that the therapist conditions can be summed up as agapé – or love. [One] student asked: ‘What is the most important thing for a counsellor to do?’ After a few moments reflection, I replied, “Love your client...that is all there is to psychotherapy” ’ (Patterson, 1996: 340)

The current research explores the psychotherapist's identity development, in relation to assimilation of a ‘client suicide’ event, whether or not this experience or the clinician's response may be categorised as traumatic.

Black (2002) examined CT in the context of trauma counselling and offered ‘a new conceptualisation of traumatic countertransference that explicates the process and outcome of countertransference experienced in the traumatic setting’ (Black, 2002). Using Identity Structure Analysis (Weinreich, 2003a) concepts, Black (2002) redefined countertransference in the traumatic setting, in terms of process and outcome, as ‘the identification processes of contra-identification with the traumatised client plus empathetic identification with the traumatised client as the process of countertransference and conflicted identification with a traumatised client being the outcome of countertransference process’ (Black, 2002: 534).

He contrasted clinicians who adopted an open or transparent style (taking a more affective orientation with clients) with clinicians who adopted a more defensive or closed style (adopting a cognitive approach with clients). Believing that therapists needed to recognise that they were imperfect persons with flaws, Carl Rogers suggested that only in recognising their vulnerability and imperfection could therapists become useful in helping others: he further argued that those who were

defensive in nature could not fully be healers (Baldwin, 1987: 51). Black (2002) asserts that:

‘the concept of openness and defensiveness remains an important consideration both professionally and personally. In terms of clinician identity clinicians may be naturally defensive...personally they may have a defensive predisposition both in terms of their identifications and their belief and value systems. They may be defensive in either having an idealistic view of their relationships or by evaluating themselves in such a way as to be defensive about negative relationships. In defensiveness, their beliefs and values systems are impenetrable essentially being closed to considering new ideas. In professional terms, clinicians may be defensive (and) avoid self-disclosure ...not allowing self to obtrude upon the therapeutic relationship as a mode of their professionalism. The clinician may remain at a professional distance from their client in order to maintain personal anonymity. They may be defensive against experiencing discomfort in the context of a traumatic experience. The clinician may become defensive as a consequence of being exposed to their client’s traumatic material as a countertransference response’ (Black, 2002: 114, 115).

Black (2002) further argues that clinicians with a more open orientation in the traumatic setting will invariably be more vulnerable to their client’s traumatic material: ‘...no matter how theoretically sophisticated or experienced a therapist is, he can forget the concept of transference in the intensity of his countertransference’ (Pearlman and Saakvitne, 1995: 369). Black holds that:

‘traumatic experience both challenges and alters the clinician’s sense of identity...by changes in their core beliefs in combination with their emotional responsiveness... Those changes...deplete the clinician of physical, emotional and intellectual energy. Such depletion may simply...inhibit the therapist’s awareness of countertransference in the psychotherapeutic setting...In experiencing a sense of loss in some aspect of their identity...the clinician may reflect feelings of anger, guilt, frustration, shame and despair... such... disruption in...identity as a competent professional may lead them to change their style of work without (conscious) reflection’ (Black, 2002: 118).

The crucial importance and critical relevance of Black’s (2002) work in relation to the CT response with regard to current research rests in its contribution to the exploration of the practitioner’s professional orientation and behaviour before, during and subsequent to assimilation of the experience of client suicide.

Student counselling texts such as Corey (1996) comment on the potential benefit for neophyte counsellors to:

‘receive some form of psychotherapy...to help them to learn to deal with countertransference (the process of seeing themselves in their clients, of over-identifying with their clients or of meeting their needs through their clients)

[although] [S]ome practitioners view themselves as beyond making personal use of the kind of therapy they offer to others...and that seeking professional help is a sign of personal and professional weakness' (Corey, 1996: 20, 21).

An earlier literature survey found that 'those [psychotherapists] who...have received personal therapy...have more positive views toward its value than those who have not' (Garfield and Kurtz, 1976: 190). Other writers allude to counsellors' developing self-awareness of 'their own countertransference feelings...which tempt them to take on the role of the dominant, knowledgeable, over-ordered, authoritative and judgemental parent' (Jacobs, 1998: 131) and, adopting Hayes' (1995) 'moderate' perspective, postulating that:

'...recognising the manifestations of their countertransference reactions is one of the most essential abilities of effective counsellors [but] it is unrealistic to think that counsellors can completely rid themselves of any traces of countertransference or that they can ever fully resolve certain issues from the past' (Corey, 1996: 20).

From his experience when working with potentially suicidal clients, Firestone (1997) identified 'potentially dangerous...errors arising from countertransference' (Firestone, 1997: 243). In particular,

'because suicidal patients often provoke feelings of dislike, aggression, discomfort, and even malice in therapists...experiencing these reactions should alert the therapist that the client may be at risk of suicide' (Firestone, 1997: 237) The hate that is aroused, especially when it remains outside the therapist's awareness, tends to distort clinical judgement and can lead to unfortunate outcomes or even tragedy' (Firestone, 1997: 243).

See pars. 3.9.5 and 8.3 below for discussion on clinicians' attitude to suicidal clients.

2.9 Self-awareness and awareness of process

Examination of these counsellor identity processes – transference and countertransference – leads to consideration of what causal relationship, if any, may exist between personal therapy for practitioners and enhanced self-understanding as an aspect of countertransference management, viz. 'counsellors' strategies for handling or coping with their countertransference [response]' (Rosenberger and Hayes, 2002a: 265) within the counselling relationship:

'If we are fearful of facing ourselves, how can we help others look at their lives? If we have limited vision, how can we help our clients expand their vision of what they might become?' (Corey, 1996: 21)

What effective approaches exist for practitioners when working with potentially suicidal clients? As mentioned in par 2.6 above, any client may be experiencing suicidal thoughts before, during or after the session (Meltzer et al, 1996; Lawrie, 1999). However, in the context of a client's acknowledgment of suicidal ideation and/or behaviour, Orbach (2001) refers to the therapist's 'sense of responsibility for another person's life' which may extend somewhat the professional 'duty of care' imperative. In this context, the therapist's 'own suicidality' (Orbach, 2001: 171) is a critical factor in relation to effective working with suicidal clients, in the context of the therapist's countertransference response to death and suicide (see also par 5.13 below). The therapist who is aware of and able to engage his own 'death anxieties, fear of hopelessness and mental pain' can become his client's partner in their existential struggle without being overwhelmed (Orbach, 2001: 171). A measure of this existential awareness was examined by Rogers et al. (2001).

In an investigation of counsellor attitudes to rational suicide, Rogers et al. (2001) surveyed 1,000 members of the American Mental Health Counsellors Association (AMHCA). These counsellors were thought to be more likely than others to encounter suicidal clients/patients and to be informed by relevant professional experience. A 24.1% response rate was obtained without any follow-up or reminders. Of these 241 usable responses:

72% (N=170) replied positively to the question: 'Have you ever had a client attempt suicide?'

28.7% (N=68) replied positively to the question: 'Have you ever had a client commit suicide?' and

20% (N=48) replied positively to the question: 'Have you ever seriously considered suicide?' (Rogers et al, 2001: 365-372).

This latter response was described as a 'surprising finding' with a range of implications that confirmed 'our confidence in the responses to our survey as reflecting the respondents' attitudes' (Rogers et al., 2001: 365-372).

Robert Litman (1996) was chief psychiatrist of the Los Angeles Suicide Prevention Centre for over 30 years. He differentiated the 'chronically suicidal' with 'persons who were in a crisis' on contacting the Centre. Those who eventually had committed suicide came 'almost entirely' from the former group, about 1% of whom had ended their lives within two years (Litman, 1996: 2). He suggests that therapists must avoid feeling isolated when suicide becomes an issue by adopting a 'team

approach' with a therapy team and a social network. He cautions clinicians to 'be prepared for failure':

'in the present state of our knowledge we are unable to predict suicide...the prediction of suicide is...like the prediction of earthquakes. We can pick out individuals and groups who are more vulnerable to suicide than other individuals and groups, but we cannot predict which individual will commit suicide or when...even the most painstaking assessment does not resolve the dilemma of prediction, because it really is impossible...The relatively few patients who are evaluated as highest risk seldom commit suicide, whereas some of the large number of patients evaluated correctly as low suicide risk actually do commit suicide...[and]...reviewing suicide deaths, most of those decedents would not have been evaluated as seriously nor as imminently suicidal or requiring hospitalisation, had they been interviewed 48 hours before they committed suicide' (Litman, 1996: 3).

Halgin and Caron (1991) suggested a referral filter for clinicians to identify those clients that match therapist competencies with client needs, including such questions as:

- i) Does the person need therapy?
- ii) Do I know the person?
- iii) Am I competent to treat this person?
- iv) What is my personal reaction to the client?
- v) Am I emotionally capable of treating the client?
- vi) Does the client feel comfortable with me? and
- vii) Can the client afford treatment under my care?

(McLeod, 1998: 224)

Perhaps what makes client suicide so difficult for clinicians is that the act of suicide appears to be in direct conflict with the aim of counselling to enable the client to 'come to grips with problems in living' (Egan, 1998: 4). This difficulty is exemplified in Baechler's (1979) definition of suicide: 'When people are using their own deaths instrumentally to try to solve their problems of living, we are talking about suicide' (Litman, 1996: 4).

The therapist's understanding and awareness of the process of counselling normally includes:

- i) a sense that change is being facilitated;
- ii) a sense that factors exist which may promote or inhibit therapeutic effects;
- iii) an essential human quality of being and becoming: 'Life is ...always in process of becoming' (Rogers, 1961: 27), and

- iv) the work that clients and therapists do to comprehend or assimilate difficult experiences in their lives.

(McLeod, 1998: 220-221)

It follows that the suicidal client's decision or choice, in isolation from other humans, to act out completed suicide is at odds with the counselling process, as categorised above. Neither Firestone's (1997: 237) suggested approach to Maltzberger's (1988: 47) therapist's 'quandary' (see par 2.6 above), nor the 'set of key questions' within the referral filter that Halgin and Caron (1991) offer, appear to be adequate to address the apparently contradictory stance of the suicidal client who takes their own life after having been a voluntary participant within a counselling relationship. Litman (1996) says that:

'the good news is most suicidal clients do not commit suicide. There are countless reasons not to commit suicide. Usually the mental health counsellor is one of those reasons. It is possible, however, for the therapist to make things worse, either through countertransference insensitivity or overzealous adherence to a technique that is not helpful under the circumstances...the bad news is that...hospitals are not guaranteed to be safe...Drug treatment is not guaranteed to be safe...Anti-depressant drugs make many people less suicidal and...might make some people more suicidal. A trusting, dependent transference to the therapist does not guarantee safety...We live with risk' (Litman, 1996: 2).

2.10 Client issues and expectations

Counselling is aimed at addressing a client's 'problems in living' (Egan, 1998: 4) that may arise from adverse life events involving serious losses or enforced lifestyle changes, both actual or perceived. In his case control study of suicide in Northern Ireland, Foster (1997: 25) hypothesised that adverse life events often preceded suicide. Foster (1997) referred to a list of threatening events (LTE) (Brugha and Cragg, 1990) or adverse life events in his 'psychological autopsy' survey of 129 completed suicides during the year 1992/93. A study by Barraclough and Hughes (1987) suggested that adverse life events might lead to suicide by:

- i) precipitating mental illness;
- ii) rendering the mentally ill vulnerable to suicide by psychological impact or by disrupting protective social relationships; and
- iii) causing suicidal thoughts' (Foster, 1997: 19).

The results of Foster's (1997) study 'support the original hypothesis that there are more "threatening experiences" [adverse life events] during the past 12 months among the suicides than among the controls' (Foster, 1997: 90):

'An increased risk of suicide was associated with two specific life-events occurring within 4 weeks of death: "a serious problem with close friend, neighbour or relative" and "broke off steady relationship"...it would appear that taking into account the presence or absence of DSM-III-R (American Psychiatric Association (APA), 1987) Axis 1 disorder, suicide risk assessment in Northern Ireland should be assisted by enquiry about at least one (especially more than one) "threatening experience...during the previous 52 weeks and specifically a "serious problem with close friend, neighbour or relative" during the previous 4, 12, 26 and 52 weeks' (Foster, 1997: 90).

Foster (1997) examined the correlation of religious commitment and suicide. His results 'would appear to support the original hypothesis of a stronger (religious) commitment in the control group than in the suicide group...[but] "religious participation" items failed to discriminate between suicides and controls' (Foster, 1987: 92). Foster (1997) reported findings of a survey of 231 psychiatrists (Neeleman and King, 1993) that regardless of their personal position on religion, 92% felt that a patient was better understood as 'biopsychosocial-spiritual whole' (Waldfoegel and Wolpe, 1993):

'Such a holistic approach is particularly important in assisting terminally ill patients who, 'in saying that they want to die' are in most (if not all) cases 'asking for assistance in living – for help in dealing with depression, anxiety about the future, grief, lack of control, dependence, physical suffering and spiritual despair (Block and Billings, 1995)' (Foster, 1997: 91,92).

Foster (1997) found that although studies (Curran et al., 1988; Darragh, 1991) reported a 'high rate of suicide among security force personnel in Northern Ireland' there was 'no difference between the suicide group and the control group in terms of exposure to civil disorder'. Consequently he felt that 'enquiry about exposure to civil disorder, especially after taking into account the presence or absence of at least one current DSM-III-R (American Psychiatric Association, 1987) Axis 1 disorder, has little to offer suicide risk assessment in Northern Ireland' (Foster, 1997: 94, 95).

In relation to other presenting client issues and their potential in relation to client suicide, Foster (1997) examined the relationship between suicide and unemployment. He found that 20% (N=26) of his research cohort were unemployed at the time of death. He concluded that unemployment was a risk factor that was independent of the presence or absence of DSM-III-R (APA, 1987) Axis 1 disorder. A

wealth of research (Platt, 1984; Smith, 1985; Daly et al., 1996; Johansson and Sundqvist, 1996) supported Foster's (1997) findings. Foster (1997: 96) referred to findings by Murphy et al. (1992) who studied the lives of 50 alcoholics who committed suicide. They discovered that unemployment was one of seven factors closely linked to suicide. Continued drinking, major depressive episode, suicidal communication, poor social support, serious medical illness and living alone were the others (Murphy et al., 1992).

In relation to suicidal communication, Foster (1997) reported that suicide notes were found after death for 38% (N=49) of suicides while 56% (N=72) of suicides had signalled 'broad communications of intent' and 36% (N=46) of suicides had made 'explicit communications of intent', respectively, before death. In relation to 'living alone' it was found that 22% (N=28) of suicides lived alone – the same proportion as the general population (Foster, 1997: 97, 98). Family history of suicide was found by Foster (1997) to be almost twice as high among the suicides compared with the controls (Foster, 1997: 99).

A client's counselling needs and expectations viewed from the therapist's perspective can be understood as facilitating a change process from an unsatisfactory situation (current scenario) towards a more satisfactory situation (preferred scenario) by action strategies leading to valued outcomes (Egan, 1998). When a client believes that the present predicament cannot be eased other than by suicide, the clinician's principal goal, as exemplified in their therapeutic approaches by Orbach (2001), Jobes (2000) and Firestone (1997), is suicide prevention:

'As they consider ending their lives, most people are ambivalent; they have mixed feelings about it...they see suicide as a solution to their problems in living, but they would rather live if they could find a better answer. Suicide prevention and crisis telephone services are based on the twin concepts of communication of intention and ambivalence about dying. By offering sympathetic counselling to people in life crisis, we hope to help some of them decide to live' (Litman, 1996: 1, 2).

Litman (1995: 139) notes that about half of the patients treated at mental health outpatient clinics have a history of suicide ideation or suicide attempts (Asnis et al., 1993):

'all of these "suicidal" patients will have other problems that demand treatment, problems of anxiety, insomnia, low-self-confidence, excessive personal demands made upon themselves, depression, schizophrenia, alcoholism and drug abuse, etc. Every sort of problem can be associated with

suicidal ideation...one of the keys to successful...treatment is to accept the risk of suicide and not let it interfere with the ongoing treatment...for this most therapists need the confidence of the team concept, with ready consultation for sharing the responsibility when taking risks (Litman, 1989)' (Litman, 1995: 139).

Litman (1995) reports that interpersonal therapists Klerman et al. (1984) believe that 'exploration of the meaning of suicide to the patient is in order, beginning with the assumption that suicide represents an attempt at interpersonal communication or problem solving' (Klerman et al., 1984: 208). Cognitive therapists (Beck et al., 1990; Linehan et al., 1991) explore 'dysfunctional thinking especially hopelessness'. A suicidologist focuses on 'psychache' or psychological pain, linked with frustration of needs, and asks the client: "Where do you hurt?" (Shneidman, 1993).

Pharmacological approaches seek 'to find in theory and practice, models for fitting the medication to the patient and the patient to the medication' (Litman, 1995: 134-142). O'Connor and Sheehy (2000) believed that:

'suicidal individuals frequently do not present with the traditional risk factors; therefore they remain untreated and...a small proportion go on to end their lives. It is not surprising...that experiences such as these engender feelings of inadequacy among healthcare professionals' (O'Connor and Sheehy, 2000: 119).

O'Connor et al. (1999b) analysed 142 suicides (105 male / 37 female) by content analysis of the respective coroner's inquest papers. Each case was classified using coding classes including physical health, mental health, psychiatric history, history of self-harm and incidence of life stressors. Patterns in the resultant data were explored using a cluster analytical procedure (Alderdice et al., 1994). Three stable and internally consistent clusters emerged.

Those in cluster #1 45% (N=64) were often working, depressed and living alone. They were unlikely to have had any recent contact with a GP, any lifetime psychiatric history or to have been hospitalised in the year before death (O'Connor et al., 1999b: 635). Cluster #2 40% (N=57) individuals were similar to cluster #1: many were depressed but not usually living alone. They may have been hospitalised for physical or medical conditions and a majority had previously attempted suicide. 15% (N=21) individuals in cluster #3 resembled the traditional profile for suicide: they were depressed, had another mental illness, often lived alone and some were working. All had a psychiatric history, had previously attempted suicide and had visited their

GP in the six months before death. This important study challenges traditional beliefs about who is likely to die by suicide:

‘GPs encounter more psychiatric-type suicides and this may lead them to overestimate the prevalence of this particular type of suicide. Traditionally, it has been the view that only individuals with a history of psychiatric illness kill themselves. This is not the case...the traditional picture of suicide may only be true 15 per cent of the time, the remainder are atypical – they are “normal” people (O’Connor et al., 1999b)’ (O’Connor and Sheehy, 2000: 119).

These writers re-emphasise the importance of the ‘suicide question’ as ‘an accurate method of risk assessment that does not induce risk from suicide’ (O’Connor and Sheehy, 2000:119). Williams (2000) offers a rational approach – once a person has self-harmed – to ‘therapy for suicidal feelings and behaviour’ that includes assessment of risk and problem-solving and behavioural therapies (Williams, 2000: 195-216). But this may not necessarily engage preventatively with an unknown number of the 85 per cent of suicides by ‘normal’ people, ‘usually men, [who] have been socialized so as to value coping strategies based upon keeping problems self-contained, private and self-managed’ (O’Connor and Sheehy, 2000: 121).

2.11 Physical, emotional, spiritual and intellectual aspects of counsellor identity

Corey (1996) contends that ‘current theories [of counselling and psychotherapy] can be expanded to incorporate a multicultural component [for] dealing with the complexity of a culturally diverse population’ (Corey, 1996: 451). The counsellor’s awareness of gender issues, cultural differences, spiritual concerns, family and systemic concerns and religious beliefs and practices is crucial when dealing with client issues around multiculturalism, gender and spirituality (Pate and Bondi, 1992). Spirituality, for instance, can be regarded as:

‘a force that can help the individual to make sense of the universe and to find a purpose...for living...for some, spirituality entails embracing a religion, which can have many different meanings. Others value spirituality without any ties to a formal religion...therapists [are] aware that spirituality is a significant force for many...clients [and] pursue spiritual concerns if the client initiates them’ (Corey, 1996: 451).

Clinicians also seek an understanding of their clients’ physical presence, ‘of their general physical health and their attitudes and practices [in relation to] their physical health [and] inquire about their clients’ values, beliefs and the sources from which they have attempted to find meaning in life’ (Corey, 1996: 451, 452). How the counsellor experiences a client initially is not unconnected to that individual’s

persona: 'that which we present to the outside world' (Pettifor, 2003) or, as previously (see par 2.5. above) 'the totalities of personal impressions we make on other people' (Harré, 1998: 5). Among numerous attempts to define personality (e.g. Allport, 1961; Millon, 1982; Liebert and Spiegler, 1994) common themes emerge including uniqueness, organisation and style of adapting or coping:

'The perceptions, thoughts, feelings and behaviours of each individual are organised in different patterns. This difference in patterns makes each person in some ways different from every other person and determines the characteristic style of responding' (Rice, 1999: 97).

There is an emerging consensus that most personality differences can be captured by five dominant traits: neuroticism, extraversion, openness, agreeableness and conscientiousness....each of these is anchored at the other end by the opposite characteristic (Booth-Kewley and Vickers, 1994). Hence, five 'robust factors': neuroticism/stability, extraversion/introversion, openness to experience/closed to experience, agreeableness/antagonism and conscientiousness/undirectedness, might represent personality trait continua along which each individual may be located at a point in time.

Emotional aspects of identity involve relationships with other people: emotional balance includes intimate relationships with close family and friends and less intense personal contacts with other acquaintances. Intellectual aspects of identity relate to mental growth and stimulation and involve continually finding ways to challenge our mind and continue learning (Burcham et al., 2003).

Skovholt (2001) contrasts 'high touch' with 'high tech' career fields where the former involves relating to others by way of expert people skills in counselling, teaching and healing. He addresses the consequences for clinicians of the 'giving of the self' that helping work requires. Sustaining 'the personal self', he argues, is a serious obligation because the work, 'giving of the self', cannot proceed without it (Skovholt, 2001: 146). He elaborates the notion of 'nurturing one's self' across a range of 'parts of the self' including the emotional self, the financial self, the humorous self, the loving self, the nutritious self, the physical self, the playful self, the priority-setting self, the recreational self, the relaxation-stress reduction self, the solitary self and the spiritual or religious self (Skovholt, 2001: 148).

Skovholt (2001) does not include suicide of a client in the 'drama of human tragedy, disappointment and pain' where clinicians are actively present. He cautions

practitioners 'to be assertive about their own wellness...by a focus on the...interplay' between four dimensions of health: physical, emotional/social, spiritual and intellectual and the balance between them (Skovholt, 2001: 162).

2.12 Ethical issues and boundaries

The British Association for Counselling and Psychotherapy (BACP) publishes an ethical framework for good practice (BACP, 2002/2009). This incorporates a statement of ethics for counselling and psychotherapy, guidance on good practice in counselling and psychotherapy and a professional conduct procedure. All practitioner members are required to have formal supervision/consultative support for their work (BACP, 2009: 5).

The framework addresses situations 'in which clients pose a risk of causing serious harm to themselves and others'. It recommends

'consultation with a supervisor or experienced practitioner...whenever this would not cause undue delay...the aim should be to ensure...a good quality of care that is respectful of the client's capacity for self-determination and their trust as circumstances permit' (BACP, 2009: 6).

Owen's (1997) concept of 'boundary' means

'the expectations of counsellors for appropriate behaviour...set by their professional body, their training and their professional literature, which...defines required and disallowed forms of involvement' (Wosket, 1999: 163).

Boundary violations occur when the clinician acts on the basis of his or her own needs or desires rather than the client's needs and best interests (Wosket, 1999: 163).

The importance of the client-counsellor contract is evident (see par. 2.4 above) where a client discloses suicidal intent. Where a suicidal client refuses informed consent for the counsellor to contact their GP, the local mental health crisis or other supportive resource, an ethical dilemma may arise for the clinician where the client is deemed to be at serious risk of self-harm. Either confidentiality is breached and the client is offered support or the client's personal autonomy is respected at risk of the client acting out their suicidal intent. Bond (1998) alluded to a legal opinion, expressed at a coroner's inquest into a client's suicide, that the latter option may be available only to clinicians 'trained and competent in the assessment and treatment of suicidal clients' (Bond, 1998: 13).

It is clear that counselling ethics in relation to clients with suicidal ideation or intent demands appropriate contracting, and ongoing assessment for suicide by a competent clinician, supported by adequate backing from mental health colleagues and resources.

2.13 Client suicide phenomenon

In chapter 3, below, the client suicide phenomenon is considered in relation to clinician identity development in the aftermath of a client's death by suicide. This includes a systematic description of relevant views expressed in empirical literature upon which the study's theoretical postulates (chapter 5) are based.

Chapter Three: Client Suicide Phenomenon

Chapter 3: Client suicide phenomenon

3.1 Introduction

This chapter examines relevant literature researching the clinician's response to the loss of their client by suicide. Writers' views, mainly those of practitioner researchers, are summarised including those that contrast the predicaments of bereaved family members and the bereaved clinician. In addition, related topics from the literature – listed below – are discussed in some detail following introductory remarks.

When a current or former client¹ of a counselling practitioner takes her/his own life this is described as *client suicide*. In this context the practitioner is described as a '*clinician survivor*' of client suicide (American Association of Suicidology, 2000; Campbell, 2006: 459). The precise frequency of this phenomenon is unknown but it is estimated that from 22% (Kahne, 1968a) to 82% (Cryan et al., 1995) of psychotherapists have experienced the loss by suicide of a patient who was currently or recently in their care.

The current research notes the existence of a new category of suicide survivor not recognised to date in the literature (see also par 3.6.2 below). Clinicians, including those in independent or private practice, seldom work in isolation from colleague clinicians. Accordingly the researcher designates the term '*clinician survivor (by proxy)*' to acknowledge and identify the coincidental status of colleague clinician(s) who, although not clinician survivors per se, share a professional relationship with a clinician survivor.

Litman (1965: 572) observed that 'suicide of a patient while in treatment is not a rare event'. One general insight into the prevalence of the client suicide phenomenon was offered by a therapist called Marshall Swartzberg in a personal communication to a colleague in 1981 on the day after a client committed suicide: 'There are two kinds of therapists: those who have experienced the suicide of a patient and those who will' (Farberow, 2001:13; Jones, Jr., 1987: 127).

¹Note: The term 'client' is inclusive of the term 'patient' and refers to a person under the care of a psychotherapeutic counselling practitioner (Reber and Reber, 2001:124, 515). The terms 'counsellor', 'clinician', 'psychotherapist' and 'therapist' are used interchangeably to designate 'a psychotherapeutic counselling practitioner' including clinicians such as psychotherapists, psychotherapeutic counsellors, counselling psychologists and the like. The context for this research into the client suicide phenomenon is non-institutional care of the client by a clinician within a voluntary, supervised, counselling relationship. Institutional care, e.g. of the involuntarily hospitalised patient, provides an illuminating, and contrasting perspective.

What the literature contributes to the study of the clinician survivor's response to client suicide is now considered in some detail under the following headings:

- i) Research into the impact on clinicians of their client's suicide
- ii) Clinician survivors writing about their own experience of patient suicide
- iii) Learning from the client suicide experience
- iv) Experiences of clinician survivors and family survivors: similarities and differences
- v) Psychological consequences for clinician survivors – clinician survivor (by proxy) – psychological synthesis and active postvention
- vi) Foreseeing / predicting suicide – unexpected death – ethical considerations – contrasting aftermath of loss by murder / accident / suicide – assessment for suicide
- vii) Collective avoidance – mistakes by clinicians – litigation fears
- viii) Communication of suicidal intent – suicide threat – guarded suicidal client – contact with mental health professional (MHP) before death – clinicians' attitudes to suicidal clients
- ix) Consequences for clinicians of their psychotherapeutic practice
- x) Influence of alcohol misuse
- xi) Conclusions

3.1.1 Cross-referencing

Appropriate cross-referencing links relevant empirical findings to emergent themes (ET) at pars 5.8.1 to 5.8.11 (inclusive) below, and to theoretical postulates (TP) at pars 5.10 to 5.16 (inclusive) below.

3.2 Research into the impact on clinicians of their client's suicide

3.2.1 Litman (1965) presented a report 'on the reactions of the psychotherapist when a patient commits suicide' to the American Psychological Association (Litman, 1965: 570). He disclosed that 'no systematic investigation of ...the psychologic reactions of psychotherapists after their patient commits suicide...has been published (Litman, 1965: 571). As chief psychiatrist in a suicide prevention centre, Litman and his colleagues investigated more than 1,000 suicides so as to 'reconstruct the life situation and attitudes' of each deceased as part of a 'psychological autopsy' (Litman, 1965: 572). A preliminary examination of 50 randomly selected cases of suicide revealed that 20% (N=10) of the subjects were 'in treatment' with a clinician at the time of their death. A further 8% (N=4) died by suicide soon after their treatment ended. In

all, 28% of this sample of 50 cases died by suicide while in treatment or shortly afterwards (Litman, 1965: 572).

In what was described as ‘an initial clinical-anecdotal exploration of therapists’ psychological reactions’ (Cain, 1972: 19), Litman (1965) interviewed 200 psychotherapists soon after their patient committed suicide. He found that clinicians ‘experienced essentially the same reactions after such an event as family members, that is...the familiar feelings of shock, numbness, denial, anxiety, shame grief, guilt, depression, anger...in addition [clinicians] experienced feelings that were inherent to [their] role as a therapist...feelings of failure, self-doubts about therapy skills and clinical judgement, questions and doubts about professional competence, fear of being blamed, fear of criticisms, fear of censure of colleagues and supervisors and fear of litigation’ (Farberow, 2001: 12,13).

Litman (1965) found that clinicians’ reactions varied according to the ‘intensity of the relationship with the deceased’ (Litman, 1965: 575). Clinicians were found to employ ‘denial [as] the most common defensive mechanism’ (Litman, 1965: 576). They were helped in ‘working through the pain affecting the therapist’s role’ by colleagues’ support, by seeking to learn from the experience, by positive adaptation both as individuals and as therapists in enhancing their sensitivity and in improving their professional judgements and decisions’ (Litman, 1965: 576). See also ET at par 5.8.5 below.

3.2.2 Cain (1972) Referring to clinical staff in mental hospitals, Cain (1972) described briefly ‘the sensitive wrestling with themes of cause and culpability’ experienced by mental health professionals in the aftermath of patient suicide, ‘struggling amidst self-conscious soul-searching and readiness for self-blame’ (Cain, 1972: 18). Studies by Kahne (1968a), Havens (1965) and Stotland and Kobler (1965) reported therapists’ ‘tortured reactions’ including ‘expressions of guilt and self-recrimination, painful awareness of the ‘silent accusations’ of colleagues, veiled implications that others are equally if not more responsible for their patient’s suicide, self-doubt and marked loss of confidence’ (Cain, 1972: 18). Cain (1972) observed the ‘general stereotypy if not a caricatured quality in both individual and organisational responses’ to patient suicide (Cain, 1972: 18). Stotland and Kobler’s (1965) study of ‘an epidemic of suicides in a failing mental hospital’ depicted ‘the snowballing impact of patient suicides on staff – a full measure of inability to communicate, a profound

sense of guilt-laden responsibility, evasion, avoidance and growing anxiety' (Cain, 1972: 18).

Contrasting clinician survivors' experiences within (Kahne, 1968a; Havens, 1965; Stotland and Kobler, 1965) and outwith an institutional setting (Litman, 1965), Cain (1972) observed that the 'disruptive impact of a [patient] suicide is not so readily buffered by institutional supports as the relatively isolated practitioner would like to believe' (Cain, 1972: 19). See also ET at par 5.8.4 and TP at par 5.14 below.

3.2.3 Holden's (1978) study in a large private psychiatric centre found that 43% (N=12) of its 28 therapists (psychiatrists and psychologists) had experienced at least one patient suicide (Farberow, 2001, 13). Holden (1978) described how 'every therapist involved in long-term intensive individual psychotherapy...struggled with intense affects after that patient's suicide' (Farberow, 2001: 13). Their reactions were similar to those reported by Litman (1965) and Cain (1972), including the use of denial as a defence 'often persisted for long periods of time in the form of wish fulfilment fantasies' and the experience of 'temporary impairment of the sense of competence and self-esteem' (Farberow, 2001: 13).

3.2.4 Henn (1978) assessed the incidence of patient suicide for therapists in training. He reported that 'patient suicide is a common if not universal part of psychiatric residency' (Brown, 1989: 418). But Brown (1989) noted that 'most of the residents in his [Henn's] study were unaware of the suicide because he counted all patients [who died by suicide] who ever had professional contact with a resident' (Brown, 1989: 418). Cryan et al. (1995) reported Henn's (1978) finding that the known to unknown ratio of patient suicide among psychiatric residents was 1: 12, a much higher ration than, for example, in Ireland (Cryan et al., 1995: 6). See also ET at par 5.8.8 below.

3.2.5 Marshall (1980) reviewed extant literature noting that the 'management of therapists' emotional reactions to an actual [patient] suicide has still not been thoroughly discussed' (Marshall, 1980: 29). He noted that 'useful suggestions which may be applicable to the therapist who experiences the suicide of a patient' were provided in Resnik's (1969) approach to 'reconstructive and therapeutic work with family [survivors of suicide]' (Marshall, 1980: 30). Noting that very few cases of suicide are published in the literature, he observed that 'therapist responses have been found to be highly individual and personal...professionals react to loss as do others... [their] response to [patient] suicide is varied, painful and possibly damaging to the therapists involved...[and] the literature is minimally helpful...[to] professionals [in

processing] the feelings experienced after someone has committed suicide' (Marshall, 1980: 32). See also ET at pars 5.8.2, 5.8.4 and 5.8.10 and TP at par 5.11 below.

3.2.6 Goldstein and Buongiorno (1984) acknowledged their own clinician survivor status: 'having treated patients who have committed suicide, we were concerned with the effects of a patient's suicide on the therapist' (Goldstein and Buongiorno, 1984: 392). Finding a gap in the literature – 'few [writers] address the professional and personal needs of the psychotherapist whose patient commits suicide' – they interviewed therapist colleagues. They tried to 'enlarge the sample size' by advertising in professional literature over several months. This effort yielded one additional respondent (Goldstein and Buongiorno, 1984: 392). However they did not confirm Marshall's (1980) findings regarding 'highly individual and personal' responses (Marshall, 1980: 32). Instead they were struck that 'all psychotherapists recorded similar responses of guilt, anger, disbelief and shock' (Goldstein and Buongiorno, 1984: 396). They found it 'significant' that research subjects 'reflected a common process that a psychotherapist experiences in coping with suicide...an initial flooding of feelings, then attempts to re-establish equilibrium and defences' (Goldstein and Buongiorno, 1984: 397).

3.2.7 Brown (1987a) reported findings (Brown, 1987b) from a 10 year study (1974-83) of 55 psychiatrists of whom 33% experienced the suicide of one of their patients during their training (Brown, 1987a: 104). In a follow-up study, Brown (1987a) surveyed staff among all mental health disciplines asking 155 subjects: 'Did a patient of yours commit suicide during your training years?' Response levels were highest for psychiatrists and they reported the highest number experiencing patient suicide at 37% (Brown, 1987a: 105). He focused on the impact on trainees of patient suicide feeling that 'even casual observation of any therapist following the suicide of a patient confirms that the experience is powerfully shocking and disturbing' (Brown, 1987a: 106). He believed that for trainees the adverse reaction is intensified, offering four reasons:

- i) trainees have a deep investment in being helpful although their clinical experience and the complex needs of 'severely disturbed inpatients' may not prevent suicide;
- ii) some supervisors consider that – as with cardiac surgery – when trainees are working with suicidal patients 'a certain number of patients will not survive the treatment' (Brown, 1987a:106). Trainees may feel that they have failed as a person

since they may ‘put near total emphasis on helping the patient through their own personal [rather than professional] qualities’ (Brown, 1987a:106);

iii) trainees may lack adequate skill to understand and help seriously suicidal patients...indeed some patients may not benefit from what any therapist can offer; and
iv) the enormous difference between the threat and the actuality of patient suicide (Brown, 1987a: 107).

Brown (1987a) considered that patient suicide represents ‘a major crisis’ in a trainee’s life. Accordingly he believes every training programme should have a conscious perspective and approach so that ‘growth through crisis’ can be influenced by trainee preparation and ‘important sustaining relationships within the training programme’ (Brown, 1987a: 111). See also ET at par 5.8.8 below.

3.2.8 Jones, Jr. (1987) represents therapist reactions to patient suicide from the literature (Alexander, 1977; Carter, 1971; Goldstein and Buongiorno, 1984; Gorkin, 1985; Holden, 1978; Kahne, 1968a; Kolodny et al., 1979; Levinson, 1972; Litman, 1965; Marshall, 1980; Perr, 1968; Stern, 1985 and Woods, 1973) under headings: personal – affective, cognitive and behavioural; and professional – fears, doubts and reorganisation (Jones, Jr., 1987: 131).

He adds perspective by describing his own loss experience. Jones, Jr., (1987) was responsible for managing ‘anti-depressant medication she [the client] was taking while in therapy with a psychologist’ (Jones, Jr., 1987: 128). The deep, long-lasting effect of his patient’s suicide – he was informed by telephone of her death by the patient’s psychologist – are evident in his marking the anniversary of her death each year. Jones, Jr. (1987) discovered that patient suicide was a ‘taboo area of psychology’ (Litman, 1965: 570). He found ‘only a handful’ of articles among thousands written about suicide that addressed the issue of therapist survivors of client suicide, although he confirms that more were available currently. See also ET at par 5.8.4 below.

Jones’ Jr. (1987) reflects upon the needs of clinicians for support and describes his personal contribution to establishing and participating in a therapist survivor group (Jones, Jr., 1987: 135-139). He concludes by explaining how the ‘crisis’ of patient suicide can become an ‘opportunity’ for therapists to grow their skills at assessing and intervening in the suicidal crisis, to broaden and deepen the connection and support they give and receive, to grow in appreciation of the precious gift that life is, and to help each other to live it more fully (Jones, Jr., 1987: 141).

3.2.9 Chemtob et al. (1988a) found by survey research that 51% (N=131) of 259 randomly selected psychiatrists had experienced patient suicide. Clinician survivors reported 'feeling anger and guilt...loss of self-esteem and having intrusive thoughts about the [patient] suicide' (Chemtob et al., 1988a: 227). This confirmed earlier findings (Litman, 1965; Brown, 1987a; Goldstein and Buongiorno, 1984) but a new finding was that a large majority of clinician survivors reported post-trauma symptoms found in clinical groups' (Chemtob et al., 1988a: 227).

Chemtob et al. (1988b) in a parallel study found that 22% (N=81) of 365 randomly selected psychologists had experienced client suicide. They reported similar emotional responses (viz. anger, guilt and intrusive thoughts) as their psychiatrist colleagues although fewer (49%) experienced post-trauma symptoms (Chemtob et al., 1988b: 418, 419).

Chemtob et al. (1988a & b) expressed the hope that their results would lead to further research into factors that influence clinicians' reactions to patient suicide and support efforts to better prepare them for 'this occupational hazard' (Chemtob et al., 1988a: 227; Chemtob et al., 1988b: 420).

3.2.10 Kleespies et al. (1990) examined the aftermath of patient suicide on psychologists during 'formative training years' (Kleespies et al., 1990: 257). Based upon Brown (1987b) and Chemtob et al. (1988a & b) they found that psychologists, during training years as well as during professional practice, were half as likely as psychiatrists to experience patient suicide (Kleespies et al., 1990: 261). Almost 17% (N=9) out of 54 subjects surveyed by Kleespies et al. (1990) experienced patient suicide. This result is consistent with previous studies suggesting that patient suicide 'is not infrequent for mental health clinicians' (Kleespies et al., 1990: 261).

The strong emotional response including shock that patient suicide was found to cause, lasted for less than the acute phase of 8 weeks suggested by Brown (1987a) in his study of psychiatrist survivors. Those psychologist survivors who were interviewed about coping and recovery described their use of support systems, including supervisors, contact with the deceased's family and their level of education and training. Support from supervisors was found most helpful while education / training in suicidology was least helpful in their coping with patient suicide at an emotional or practical level (Kleespies et al., 1990: 261). The authors suggested, firstly, an immediate supportive response to the trainee to minimise isolation and traumatisation and secondly, a safe forum where the trainee could express feelings,

seek learning from the experience and seek to integrate it constructively into future work with high-risk patients (Kleespies et al., 1990: 262-263).

In a follow-up study, Kleespies et al. (1993) concluded that factors unique to the death by suicide can make for a complicated bereavement process. It was advisable to consider the therapist's response to patient suicide as an intense stress reaction rather than as PTSD (Kleespies et al., 1993: 301). See also ET at par 5.8.8 below.

3.2.11 Horn (1994) presented a literature review of research that described therapists' psychological adaptation to patient suicide in their emotional, cognitive and behavioural responses.

He said the literature suggested phased emotional response patterns of suicide survivors and that therapists' emotional response to client suicide was similar (Horn, 1994: 191). He referenced two initial phases: therapists first experience a personal response similar to anyone in the aftermath of the suicide of a significant other (Litman, 1965) including shock, disbelief, confusion and denial (Hamel-Bissell, 1985; Cotton et al., 1983).

The second response phase was characterised by anger, shame and guilt (Kleespies et al., 1990; Sacks et al., 1987) and depression (Feldman, 1987; Cotton et al., 1983). The therapist survivor reacted also as a professional helper through fear of being blamed for the suicide and with feelings of incompetence and self-doubt (Cotton et al., 1983; Kleespies et al., 1990; Feldman, 1987).

Finally the therapist survivor may reach emotional acceptance and resolution as intense feelings and bitterness pass (Horn, 1994: 191). This may involve any repressed feelings of guilt becoming conscious as therapists 'realise and accept the rage they harbour towards their patients and the institution' (Horn, 1994: 191).

Cognitive responses related mainly to therapists' professional role with thoughts of self-doubt regarding their clinical judgement (Sacks et al., 1987), beliefs and fantasies of silent accusations and criticisms by colleagues and supervisors (Sacks et al., 1987; Feldman, 1987). Horn (1994) detailed thoughts and concerns about possible malpractice and legal issues, developing hypervigilance regarding cues linked to suicidal potential and awareness of competency limitations including possible 'failure in empathy' when working with suicidal clients (Horn, 1994: 192).

Therapist survivors' behaviour as professionals may be adversely affected as they process complex grief reactions. This may involve more 'defensive' therapy such

as overcautious assessments of clients, avoidance of clients perceived as high-risk and more restrictive regimes including hospitalisation, cancellation of passes and closer supervision of suicidal patients (Horn, 1994: 192).

Horn (1994) accepts that ‘variations do exist’ in therapists’ reactions to patient suicide although he describes ‘a common response pattern’. He suggests that ‘therapists’ life experiences may provide a partial explanation’ for this (Horn, 1994: 192). Horn (1994) does not develop this idea beyond therapists’ professional status, as trainees or as established practitioners, their workload levels (Chemtob et al., 1989) and their treatment settings. He describes a model of psychological adaptation to trauma (McCann et al., 1988) that may offer insight about ‘the influence of therapists’ schemas (core beliefs or expectations about self and others)...in understanding their response to client suicide’ (Horn, 1994: 193). Horn (1994) suggests it may be that ‘the more intense the attachment between client and therapist, the greater the impact on the existing schemas and the more severe the therapist’s reaction to the suicide’ (Horn, 1994: 193). See also ET at par 5.8.5 and TP at pars 5.13 and 5.16 below.

3.2.12 Horn’s (1995) statistical study of 129 psychologists confirmed that 33% (N=42) had worked with a client who died by suicide, reflecting ‘a higher incidence of psychologists’ experience of a completed suicide...relative to other studies’ (Horn, 1995: 54). He tested several hypotheses finding as follows:

- i) therapists’ stress levels, measured on the Impact of Events Scale (IES) (Horowitz et al., 1979) did not increase as the severity of client suicidal behaviour progressed from suicidal ideation, to suicide attempt to suicidal death;
- ii) therapist survivors experience significantly greater acute emotional impact after the suicidal incident than colleagues whose clients did not die by suicide (measured by Acute Emotional Impact Scale – Kleespies, 1993);
- iii) the intensity of the therapist/client relationship is positively correlated with a) the length of the relationship and b) the acute emotional impact of the suicidal event; and
- iv) negative long-term effects of client suicidal behaviour are directly related to respondents’ use of supports, positive coping activities and time elapsed since the incident (Horn, 1995: 38-52). See also ET at par 5.8.5 below.

3.2.13 Cryan et al. (1995) surveyed 109 Irish consultant psychiatrists regarding their experience(s) of patient suicide. 82% (N=89) reported their clinician survivor status including 47% (N=42) who lost a patient to suicide during their five years as a psychiatrist trainee (Cryan et al., 1995: 5). Personal stress experienced by respondents

was 'significant' and comparable to mean scores for a clinically bereaved group seeking treatment following the death of a parent (Cryan et al., 1995: 6). Compared with American psychiatrist survivors, where 33% of a sample had clinical IES levels (Chemtob et al., 1988a), their Irish counterparts may have less intense relationships with clients, resulting in a different sense of loss and failure after patient suicide (Cryan et al., 1995: 6). See also ET at par 5.8.5 below.

Cryan et al. (1995) support Brown's (1987a & b) training initiative comprising a 'comprehensive programmatic response' including an awareness-raising educational phase and 'joint care with a senior psychiatrist for extremely suicidal clients' together with a carefully-timed psychological autopsy in the aftermath of suicide and ongoing follow-up support (Cryan et al., 1995: 6). See also ET at par 5.8.8 below.

3.2.14 Grad and Zavasnik (1998) compared three groups: psychotherapist survivors of patient suicide (Group 1), general practitioners (GPs) who experienced patient suicide (Group 2) and GPs who experienced the natural death of a patient (Group 3). They were interested in how family doctors – 'a forgotten group of suicide survivors' (Grad and Zavasnik, 1998: 287) – coped with patient suicide. By survey questionnaire they learned that 72% (N=87) of psychotherapists and 68% (N=75) of GPs experienced patient suicide while 84% of GPs experienced the natural death of a patient. Survey data were similar but with significant differences between suicide survivors in three areas: psychotherapists were more likely to have felt guilty, spoken with a supervisor and to have had problems showing feelings to colleagues (Grad and Zavasnik, 1998: 287-290).

Both writers acknowledged that they had lost a client to suicide and that they observed the psychological effects of patient suicide in themselves, in younger colleagues and in GPs. They believed that this study confirmed that not only family survivors but caregiver survivors were 'emotionally affected by the loss of [their] patient (Grad, 1996)' (Grad and Zavasnik, 1998: 290).

Three significant differences were noted above between psychotherapists and GPs in the aftermath of patient suicide:

- i) psychotherapists felt guilty because as 'the last in a chain of professional caregivers...they felt more responsibility which provokes more guilt, when unsuccessful';
- ii) psychotherapists benefit from contact with supervisors while GPs tend to work in isolation;

iii) psychotherapists had problems in showing their feelings to colleagues, behaving as if their professional role demanded that 'they have to cope [relatively unmoved] with every emotional stress' (Grad and Zavasnik, 1998: 291).

These writers concluded that a caregiver's denial of their feelings or of emotional involvement when losing a patient does not help but that 'it helps to talk to somebody, to accept support if needed...to find their own way through the grief' (Grad and Zavasnik, 1998: 291). See also ET at par 5.8.3 and TP at par 5.15 below.

3.2.15 Alexander et al. (2000) investigated the impact of suicide by patients on consultant psychiatrists in Scotland. Results emerging from a survey questionnaire revealed that 68% (N=167) of 247 Scottish respondents 'reported having a patient under their care commit suicide...since becoming a consultant' (Alexander et al., 2000: 1572). Comparisons with Cryan et al. (1995) were possible if patient suicides experienced by Irish psychiatrist trainees were removed from the overall Irish clinician survivor figure (N=89). This showed that 43% (N=47) of 109 Irish consultant psychiatrists experienced patient suicide compared to 68% (N=167) of their Scottish counterparts (Cryan et al., 1995: 6).

Alexander et al. (2000) reported adverse personal consequences for 33% (N=54) of their respondents, e.g. low mood, poor sleep, preoccupation with the suicide and decreased self-confidence, but noted that these were not so serious that any affected consultants took time off work (Alexander et al., 2000: 1572). A minority of Scottish respondents, 42% (N=69) altered their management of potentially suicidal patients, while team members, colleague psychiatrists, their family and friends proved to be sources of help in the aftermath of patient suicides (Alexander et al., 2000: 1572). See also TP at par 5.15 below.

Morris (1995) identified the unexpectedness of suicide as the most traumatising feature. Alexander et al. (2000) noted that many Scottish patient suicides were relatively unexpected: half involved outpatients and half had a history of self-harm. Some respondents emphasised the need for the inevitability of patient suicide to be featured in psychiatrists' training so that clinicians can be better prepared for its occurrence (Alexander et al., 2000: 1573). See also ET at par 5.8.11 below.

3.2.16 Hendin et al. (2000) presented their findings concerning the impact of patient suicide for therapists who worked with 26 individuals who died by suicide. They found that therapists acknowledged varying degrees of shock or disbelief, grief, guilt fear of blame or reprisal, anger and betrayal, self-doubt and inadequacy and shame or

embarrassment (Hendin et al., 2000: 2022-2024). They noted certain patterns which pointed towards elements of idiosyncratic processing by respondents. For example, one respondent indicated ‘no emotional response’ while another reported neither minimal grief nor any guilt, but only anger. Three respondents reacted with anger mixed with a sense of relief, suggesting ‘the stress they felt in treating the patients’ before they died by suicide (Hendin et al., 2000: 2024-2025). See also ET at par 5.8.2 below.

On reflection, most clinician survivors said they would have changed their patients’ treatment, most commonly by altering medication or hospitalising outpatients. Almost 25% (N=6) said they would have consulted with the patients’ previous therapists. Most respondents found interaction with colleagues and supervisors helpful particularly if these individuals were also clinician survivors. See also TP at par 5.15 below.

Contact with the deceased’s relatives was found to be helpful to both parties – clinicians and family members – in the aftermath of suicide. Clinician survivors appeared to have learned from the experience: they were more alert and sensitive to the possibility of suicide. It appeared however that there was no uniform response by clinicians in relation to how they treated psychiatric patients following their patient suicide experience (Hendin et al., 2000: 2025-2026).

It remains unclear whether brave attempts herein to generalise the particular and individualistic responses of clinicians to patient suicide can be more than partially successful, not least because of the compounding effects of idiosyncrasy in both clinicians and clients/patients.

3.2.17 Dewar et al. (2000) noted that ‘we do not know if patient suicide has a similar impact on NHS [UK] psychiatrists to that described by Chemtob et al. (1988a) and others’ (Dewar et al. 2000: 20). Consequently they researched psychiatrist trainees (registrars) in Scotland to ascertain their patient suicide experiences.

They analysed 103 survey questionnaires completed by registrars of which 47% (N=48) reported at least one incidence of patient suicide. Respondents were asked to reflect upon the ‘most distressing’ suicide and its personal and professional consequences for the clinician survivor. Respondents reported as ‘distressing’ that the patient suicide was the only suicide they had experienced, that the suicide was unexpected, that they felt to blame in some way, that the deceased was young or had children and a range of other factors such as knowing the patient well, disliking the

patient, the method of suicide (51% of these patient suicides were violent, e.g. hanging, jumping or shooting) being blamed by relatives or having been the last to speak to the deceased (Dewar et al., 2000: 21).

Adverse personal and professional consequences were reported that confirm conclusions from earlier non-GB studies. Informal support was of most value in the aftermath including contact with team colleagues, consultants and family / friends. Dewar et al. (2000) suggested that because ‘the theme of self-blame arose commonly [it was] especially important that trainee psychiatrists are helped to disentangle issues of clinical management and less rational feelings arising from concerns about personal failure and responsibility’ (Dewar et al., 2000: 23). See also ET at par 5.8.8 below.

3.2.17A Courteney and Stephens (2001) were both clinician survivors. They surveyed psychiatric trainees – senior house officers and senior/specialist registrars – to learn about their response to patient suicide. A 51% [N=209] response showed that 54% [N=109] were clinician survivors who had experienced a total of 168 patient suicides. 61% (N=67) of clinicians reported one suicide only while 39% (N= 42) reported up to seven (7) patient suicides (Courtenay and Stephens, 2001: 51).

Narrative analysis of clinician survivors’ responses showed that 75% (N=126) of these deaths impacted emotionally upon clinicians at a moderate to severe level. 24% [N=40] of the deaths caused a severe emotional reaction including extreme guilt or anger of prolonged duration, a need to take time off work, a sense of having lost confidence in their clinical judgment and feeling ‘devastated...and paranoid’. 51% (N=86) of the patient suicides were followed by ‘lesser degrees of emotional impact...shock, guilt or self-blame of shorter duration’ (Courtenay and Stephen, 2001: 51).

Many respondents obtained help in coping through consultant supervision or the community mental health team. Friends and colleagues were found to be supportive. 52% (N=57) of the 109 clinician survivors described beneficial outcomes including motivation to develop more thorough and comprehensive risk assessment skills. 16% (N=17) of the doctors experienced negative consequences such as fear, isolation, disillusionment and vulnerability (Courtenay and Stephens, 2001: 52).

The authors’ conclusions from their research included four recommendations:
i) support for trainees in the aftermath of patient suicide should be more available and accessible for those who request it;

- ii) support in a group setting (Cotton et al., 1983) can build the team and discourage inadequate coping strategies;
- iii) the vulnerability of trainees linked to the transient nature of work attachments should be acknowledged and addressed; and
- iv) Royal College of Psychiatrists should facilitate formal systems for support and education for trainees with regard to the impact of patient suicide.

See also ET at par 5.8.8 below.

3.2.18 Farberow (2001) reviewed the need for the development of postvention procedures for clinician survivors in training institutions, hospitals and clinics and for their counterparts in individual practice (Farberow, 2001: 11). He referred to 'the sparse literature on clinicians survivors' that focused on the frequency, characteristics and impact of the event, noting that the experience is 'neither rare nor an isolated event' (Farberow, 2001: 13). Kahne (1968a) predicted that one in four psychiatrists will experience a suicide in their practice while research studies showed that its occurrence ranged from 22% to 51% (Farberow, 2001: 11).

Farberow (2001) cited research correlating greater age and longer years of experience in psychiatry practice to reduced levels of guilt, negative intensity and loss of self-esteem. This relationship did not hold for psychologists: the intensity of their response was apparently uniform across all ages and career durations (Chemtob et al., 1988 a & b). Grad et al. (1997) found when researching male and female clinician survivors in Slovenia, that women clinicians reported more feelings of shame and guilt than their male colleagues.

Farberow (2001) reviewed studies of the predicament of clinician survivors. Although negative trainee experiences were described by Kleespies et al. (1993) and Ellis and Dickey (1998), a more positive prognosis was offered by Brown (1987b) and Feldman (1987) in relation to enhanced awareness for clinician survivors' of the limitations of therapeutic ambition, that their distress might generate (Farberow, 2001: 14, 15).

3.2.19 Yousaf et al. (2002) surveyed 89 psychiatrist trainees to assess the impact of patient suicide at the time of the event and at the date of the study. Almost 60% (N=53) responded of whom 43% (N=23) had experienced one or more patient suicides. The time interval between the suicide event and the study by Yousaf et al. (2002) ranged from one month to three years.

The authors applied statistical tests to the differences between immediate impact and that at the time of the study (Yousaf et al., 2002: 53) using the Impact of Events Scale (IES) (Horowitz et al., 1979) in relation to avoidance and intrusion symptom of traumatic stress (Kleespies et al., 1993). They also measured the effect on trainee survivors' personal and professional life using scales devised by Chemtob et al. (1988a). Clinically significant intrusion and avoidance were found to have been experienced by 52% (N=11) of trainee survivors in the immediate aftermath. At the time of the study 29% (N=6) trainee survivors were found to be clinically stressed.

The authors recommended further research using a prospective methodology (Bitektine, 2008), a larger sample and a control group to investigate the benefits for clinician survivors of 'risk assessment, preparation and supervision' (Yousaf et al., 2002: 55). See also ET at par 5.8.8 below.

3.2.19A Gaffney et al. (2002) surveyed 'front line staff' in an Irish health board following concerns expressed by staff working in a suicide prevention project. Focus groups and survey questionnaires were used to investigate the effect of client suicide on health board staff in regional, community and acute hospital services. 21% (N=447) of staff responded of whom 18.6% (N=83) reported at least one patient suicide during their career (median = 10 years in post). Frequency of client suicide experience ranged from 1 (N=43) to between 2 and 25 (N=25). Respondents included 46% (N=204) in nursing and 23% (N=129) in psychology / psychiatry / therapy / medicine / social work. These occupational groups included 86% (N=71) of front line staff survivors of client suicide (Gaffney et al., 2002: 87-89).

Gaffney et al. (2002) noted that survivors' responses matched those reported in earlier research – feelings of anger, guilt, sadness and post-trauma symptoms (Cryan et al., 1995; Chemtob et al., 1988a; Grad et al., 1997). Halligan and Corcoran (2001: 295-296) surveyed rural GPs in the same health board area. 86% (N=103) experienced patient suicide: 35% (N=42) felt guilty while up to 80% (N=96) reported 'no effects' after patient suicide. Protective factors included sharing patient care and not attending the scene of the suicide. While some GPs said they were 'absolutely devastated' or had their 'sleep pattern affected for up to six months' after patient suicide only a small proportion (20%) sought support, contrasting with psychiatrist survivors, of whom up to 90% benefited from colleague interaction (Halligan and Corcoran, 2001: 296).

Gaffney et al. (2002) found it 'striking' that in their study, front line staff suicide survivors' responses paralleled those revealed in an earlier study (Gaffney and Greene, 1997) of 'people bereaved by the suicide of a close relative [including] particularly difficult emotional responses' (Gaffney et al., 2002: 94). The principal concerns of staff, as professionals, were dominated by fear 'of being blamed, whether the suicide could have been prevented, and how the bereaved family could be approached after the death' (Gaffney et al., 2002: 94).

The authors noted that respondents identified 'the type of relationship they had with the client as the key factor' determining their reaction to the suicide. They also believed that it was critical that individual differences were respected. Gaffney et al. (2002) formed 'an overall impression of the uniqueness of each client suicide' in its impact on a professional carer and consequently the variability there is likely to be in the type and level of the post-suicide intervention needed (Gaffney et al., 2002: 95). See also ET at par 5.8.2 and TP at par 5.11 below.

Regarding future directions for research they recommended much more prospective research and further investigation of the formative influences of client suicide on professional practice (Gaffney et al., 2002: 97). They concluded that until the 'sense of stigma' around suicide and bereavement by suicide was dealt with by professionals and by society, the impact of suicide on clinicians will always be unnecessarily onerous (Gaffney et al., 2002: 98).

3.2.20 Hendin et al. (2004) surveyed 34 clinician survivors to investigate why some respond more intensely than others to a patient suicide. Their approach included several participant questionnaires, a detailed patient case narrative and several workshops during which the cases of two patients at a time were presented by clinicians and discussed in detail with the authors (Hendin et al., 2004:1442)

Findings from this ongoing study showed that 38% (N=13) of the clinician survivors experienced severe distress after their patient's suicide. Four factors were identified as sources of severe distress:

- i) Failure to hospitalise three patients who 'had made suicide intent clear in the final session' (Hendin et al., 2004: 1443);
- ii) four therapists felt severely distressed that treatment decisions contributed to their patients' suicides;
- iii) negative reactions by therapists' institution contributed to severe distress for two trainee clinicians; and

iv) fear of legal action by the deceased patient's relatives was the cause of severe distress for four clinicians.

Therapist characteristics that authors cited as possibly contributing to their severe distress included gender, training status and years in practice. Female therapists were found to be almost twice as likely as male counterparts to experience severe distress, confirming findings by Grad et al. (1997). Factors found to be unrelated to the experience of distress were clinicians' professional discipline or work setting, inpatient or outpatient status or length of time in treatment.

Grief and guilt felt by severely distressed clinicians appeared to be related to the levels of emotional connection and closeness of involvement of clinicians with their patients (Hendin et al., 2004: 1445). See also ET at par 5.8.5 below.

Protective factors for clinician survivors who did not experience severe distress included 'character and temperament'. They appeared to have 'a greater capacity to view their misfortunes as learning opportunities rather than as occasions for self-reproach' (Hendin et al., 2004: 1445). The authors felt that the long-term effects of patient suicide on professional practice needed further study (Hendin et al., 2004: 1445).

3.2.21 Ruskin et al. (2004) evaluated the incidence of patient suicide and its effects on clinician trainees and recent graduates from a training programme for psychiatry in Canada over a 15 year period. They investigated what effect suicide in their personal lives might have upon clinicians' reactions to suicide by their patients.

Patient suicide was reported by 50% (N=120) of 239 respondents. About a third of respondents reported a personal experience of the suicide of a close friend or family member but no connection was found between this and the frequency of their exposure to patient suicide. However the authors felt that this life event (suicide of a significant other) may be an important, unexplored factor in psychiatry (Ruskin et al., 2004: 108).

62% (N=74) of respondents reported patient suicide while in training including 53% (N=39) during their first residency year (Ruskin et al., 2004: 106). The emotional impact that many respondents reported included shock, feeling helpless and the experience of 'recurrent feelings of horror [and] substantial feelings of anxiety' (Ruskin et al., 2004: 107). A significant minority of trainee survivors experienced clinical levels of emotional disturbance: 22% (N=16) met acute stress disorder criteria and 20% (N=15) met PTSD criteria (Ruskin et al., 2004: 107). The authors shared

other investigators' concerns about trainees' emotional vulnerability to patient suicide, feeling that close supervision and support was indicated (Brown, 1987a; Chemtob et al., 1988a; Ruskin et al., 2004: 108).

Most clinician survivors may have the resilience to cope adequately with the experience of patient suicide but an important minority are vulnerable, many of whom are affected adversely in a profound and enduring way throughout their physician careers (Ruskin et al., 2004: 109). The destigmatisation of the patient suicide event by 'a disinterested independent group with no institutional ties to the therapists' (Hendin et al., 2000: 2022) was recommended to facilitate free discussion with outside clinicians that maintained a non-judgmental and non-blaming atmosphere (Ruskin et al., 2004: 109). See also ET at par 5.8.1 and TP at par 5.12 below.

3.2.22 Tillman (2006) recruited to her research project 12 psychoanalytical psychotherapists who had a client commit suicide while in treatment or shortly after leaving treatment. She wanted to gain a deeper understanding of the effects upon the bereaved clinicians (Tillman, 2006: 159). She used a phenomenological research strategy whose 'conclusions inspire confidence...because the arguments leading to them have been persuasive and true to the empirical evidence' (Polkinghorne, 1989; Tillman, 2006: 161). Audiotaped interviews lasting from 25 to 120 minutes were transcribed and analysed using a psychoanalytic framework. This generated eight themes that were sorted into 'three general structures [or] domains of general experience' (Tillman, 2006: 166, 167): traumatic loss and grief; interpersonal relationships and professional identity.

Tillman (2006: 168) paraphrased Pollock (1961) and Freud (1917) describing how 'the dual loss of the patient through suicide and the professional ideal involves features of mourning and melancholia, marked by moral self-reproach and criticism'.

Several interpersonal relationships featured in clinician survivors' adaptation including those with their i) now-deceased patient, ii) patient's family, iii) supervisors iv) personal analyst, and v) peers. Some clinician survivors 'felt that they could only talk to other clinicians who had lost a patient to suicide...feeling that this would minimise...projections about blame and competence in both directions [as] they were now members of a special fraternity' (Tillman 168-169). See also TP at par 5.15 below.

Clinicians' professional identity was influenced by risk management concerns, negative feelings compounded by 'grandiosity, shame, humiliation, guilt, judgment

and blame' (Tillman, 2006: 166) and a sense of professional crisis combining loss of faith about psychodynamic / intensive treatment and concerns about competence (Tillman, 2006: 167).

Tillman (2006) concluded that 'the suicide of a patient is one of the most traumatising, rage-provoking and humiliating experiences in a professional career, leading to feelings of loss of competence and prestige' (Tillman, 2006: 174). Her study sought to explore her respondents' experiences in the aftermath of patient suicide using a methodology designed for psychoanalysts that was quite different from research approaches reported in the psychotherapy literature (Holden, 1978; Gorkin, 1985; Jones, Jr., 1987; Gitlin, 1999; Dewar et al., 2000; Hendin et al. 2000). In the event the experiences of many clinician survivors in psychotherapy and in psychoanalysis are seen to have more similarities, e.g. intense emotional experiences, legal issues and organisational pressures, than differences, e.g. psychoanalytical philosophy and underpinning, including awareness of unconscious process, and interpretation of dreams.

3.2.23 Campbell (2006) describes an approach to engagement by a clinician with survivors of his client after the latter's death by suicide. He notes that 'research is lacking regarding the efficacy of services for survivors [and] it remains unclear what is appropriate and what is needed for...clinician [survivors]' (Campbell, 2006: 461). He proposes an Active Postvention Model that includes a volunteer service, linked to the local coroner's office, to engage with survivors' needs, other than those of clinician survivors.

Campbell (2006) notes that clinician survivors' self-care is not seriously addressed describing this aspect of the aftermath of patient suicide as 'the most deficient response' (Campbell, 2006: 472). He offers a recommendation that encourages clinician survivors to seek appropriate support and to monitor personal activities for negative content including increased hypervigilance, cognitive confusion and levels of dissociation (Campbell, 2006: 473).

Campbell (2006) places responsibility for clinician survivors' well-being with each affected individual. He does not overtly refer to any institutional or organisational responsibilities for providing training and ongoing support for clinicians to ensure adequate competency for the provision of self-care, when necessary. See also 3.6.3 and ET at par 5.8.3 below.

3.2.24 Gitlin (2006) describes patient suicide as ‘surely among the most traumatic events in the professional life of a psychiatrist’ (Gitlin, 2006: 477). He notes that guidance for clinician survivors is remarkably sparse in the psychiatric literature. See also ET at par 5.8.4 below. Gitlin (2006) speculates that because the average psychiatrist experiences a patient suicide less than once in three years of practice (Alexander et al., 2000), the topic has not demanded ‘an agreed-upon set of coping skills’ for the profession. He describes death as ‘a more common outcome in most...medical specialties...a natural outcome of disorders that physicians treat’. Hence medical schools do not focus on suicide as a distressing event for the treating physicians, viz. psychiatrists (Gitlin, 2006: 478).

Around one third of trainee clinicians experience the loss of a patient to suicide (Brown, 1987a & b). Gitlin (2006) argues that, in view of the ‘regularity’ of patient suicide especially with psychiatric residents, an onus exists for professional carers ‘to better understand our own reactions and potential coping mechanisms’ (Gitlin, 2006: 478). He reviews the literature describing ‘general reactions to patient suicide’ (Menninger, 1991; Chemtob et al., 1988a & b; Brown, 1987b; Hendin et al., 2004; Alexander et al., 2000) and ‘specific reactions to patient suicide’ (Brown, 1987b; Gitlin, 1999; Hendin et al., 2000; Litman, 1965) offering ‘a characteristic set of psychological responses’ (Gitlin, 2006: 479, 480). These include initial reactions (shock, disbelief, denial and depersonalisation) and second phase reactions (grief, shame, guilt, fear of blame, anger, relief, behavioural changes and conflicting feelings of specialness).

Gitlin (2006) elicits several predictors of clinician survivor distress including age and experience (Chemtob et al., 1988b; Hendin et al., 2004). These appear to be logical extensions of the greater vulnerability of trainee survivors (Gitlin, 2006: 485). Other potential predictors are the level of the clinician’s intensity of involvement with the patient (Horn, 1995), clinician’s gender (Grad et al., 1997), overall resilience (Hendin et al., 2004) and the clinician’s own history of depression and anxiety (Gitlin, 2006: 486). See also ET at pars 5.8.1, 5.8.5 and 5.8.8 below.

Optimal coping in the aftermath of patient suicide involves decreasing any feelings of isolation, using cognitive approaches based upon anticipation and preparation during training and before a suicide event, for coping with a client suicide occurrence, and self protection where possible by seeking timely support in relation to

‘challenging...interesting [and] difficult’ patients (Gitlin, 2006: 489). See also TP at par 5.15 below.

3.2.25 Hamaoka et al. (2007) believed that ‘few experiences can match the emotional and cognitive challenge of a patient suicide’ (Hamaoka et al., 2007: 350). They were aware that denial, disbelief, guilt, a sense of failure and loss of confidence were often experienced by clinicians dealing with patient suicide (Litman, 1965; Hendin et al., 2000). They examined medical students’ responses to such an event and to ascertain the educational and support needs of students after a patient dies by suicide (Hamaoka et al., 2007: 350).

Sixteen students including members of the psychiatric on-call team, the resuscitation team and inpatient students were invited to participate in research by survey questionnaire about their response to a male psychiatric patient’s suicide. They reported how they learned of the suicide, their specific role if any during the event and in the patient’s care and commented on their personal reactions, the perceived effect on colleagues, what support they received from clinical staff and how medical students’ concerns might better be addressed regarding patient suicide. Twelve students responded providing the basis for several themes that emerged, the most prominent of which were sensitivity towards colleagues, appreciation of help, suicide prevention, personal education, being personally affected and a sense of loss (Hamaoka et al., 2007: 351).

The authors noted that nearly all students closest to the event (on-call team, resuscitation team and students, rotated on the inpatient ward where the suicide took place) disclosed feelings of ‘being personally affected’ while those who presented with ‘anger’ and ‘lack of support’ were students active in the patient’s daily care (Hamaoka et al., 2007: 352). Professional carers were often challenged to use adaptive responses to loss, death and dying. Hamaoka et al. (2007) believed that unexpected, rare and unpredictable events such as suicide ‘challenge the learning process’ and that medical educators ‘can help students by being sensitive to likely reactions, providing appropriate support and utilising these events to complement education after they occur’ (Hamaoka et al., 2007: 352). See also TP at par 5.11 below.

3.2.26 Foley and Kelly (2007) note that patient suicide is ‘a relatively common experience among psychiatrists...an occupational hazard’ (Foley and Kelly, 2007: 134). But ‘the effects...on mental health workers are rarely discussed and research

literature...is relatively sparse...no formal training is available...to prepare...for the personal and professional effects of patient suicide' (Foley and Kelly, 2007: 134). See also ET at par 5.8.4 below.

Their review of research discussed lifetime incidence of patient suicide (Chemtob et al., 1988a; Alexander et al., 2000; Dewar et al., 2000; Courtenay and Stephens, 2001; Yousaf et al., 2002; Linke et al., 2002) finding estimates ranging from 50% to 70% for consultant psychiatrists, 40% to 50% for psychiatric trainees and up to 86% for members of community mental health teams, possibly due in the latter case to shared case loads in multidisciplinary settings.

Foley and Kelly (2007) summarised the reported effects of patient suicide on mental health workers. They found that Gitlin's (1999) description of his personal experience as a clinician survivor provided 'a particularly valuable account' of an individual's personal response – see par 3.3.7 below – that was characterised by acute stress, anger, shame and isolation, fears of litigation and self-doubt (Foley and Kelly, 2007: 136). They also comment on possible responses of the deceased patient's family to clinician survivors that may range from hostility and denial (Hawton, 1986) to being helpful or very helpful (Alexander et al., 2000).

Foley and Kelly (2007) concluded from their research studies (Chemtob et al., 1988a; Alexander et al., 2000; Dewar et al., 2000; Courtenay and Stephens, 2001) that mental health workers 'derive most support from informal contacts with team members, family and friends': formal support structures for clinician survivors may either not be available or difficult to access where they do exist, not least due to the highly sensitive and personal nature of patient suicide (Foley and Kelly, 2007: 136).

These authors describe 'a local initiative' involving four-monthly 'patient suicide meetings' for the support of multidisciplinary team members, devoted to 'general issues regarding patient suicide [without] detailed reference to specific patients' (Foley and Kelly, 2007: 136). This carefully thought through response 'will be difficult to evaluate [for] effectiveness' but it is proposed to 'modify and refine the process on the basis of experience' including feedback from participants (Foley and Kelly, 2007: 136, 137).

The importance to each clinician survivor of informal support from their own family and friends (Chemtob et al., 1988a; Alexander et al., 2000; Dewar et al., 2000) cannot be underestimated. Foley and Kelly (2007) consider that 'this may represent a difficult, complex burden of support...that merits acknowledgement and appreciation'

by the clinician survivor when their acute reaction to the death is resolved (Foley and Kelly, 2007: 138). See also ET at par 5.8.3 below.

3.3 Clinician survivors, including ‘by proxy’, writing about their experience of patient suicide

3.3.1 Introduction The uniqueness of each client suicide and the individual characteristics of each clinician survivor point towards the variability of the type and level of intervention that might be used in the aftermath (Gaffney et al., 2002: 95). To examine this further several published responses of clinician survivors, including ‘by proxy’, to their individual experiences of the loss of a client by suicide are reviewed next.

3.3.2 Kolodny et al. (1979) were four mental health trainee colleagues each of whom lost a patient to suicide in early 1976. They began to meet together after the fourth suicide event to discuss what had happened. For each clinician this was their first experience of patient suicide. They each found it to be ‘a powerful, personal experience for which we had little preparation’ (Kolodny et al., 1979: 33).

Other than being clinician survivors in training at the same institution, they were ‘far from being a homogeneous group’. Two were residents in psychiatry, one was a postdoctoral psychology fellow and one was a trainee in the doctor of mental health programme. Their therapeutic relationships with clients reflected their diversity as trainee clinicians. But listening to each other ‘in silence and with marked empathy’ they seemed ‘to experience or...to re-experience those feelings which we had at the time of the suicides’ and to achieve ‘a more complete working through’ of these feelings (Kolodny et al., 1979: 42, 43).

Group members concluded that the aftermath of patient suicide was ‘a process of mourning...the usual elements of mourning were present’ although some were intensified and others were attenuated. Fear-based emotions, like shame and guilt were deepened as were ‘our feelings of anger about the deaths...directed at our patients, their families, our supervisors and ourselves.’ Kolodny et al. (1979) felt their sense of loss of their patient was ‘possibly attenuated...as these people were part of our lives in circumscribed ways’ (Kolodny et al., 1979: 43). These trainee survivors felt isolated but also experienced ‘an intense need for support, understanding and absolution’ (Kolodny et al., 1979: 43). They also felt that as individual clinician survivors ‘no exercise of imagination or intellect’ can prepare a clinician for such an

experience nor could support from supervisors or colleagues ‘entirely alleviate the pain and self-examination one must go through in the wake of a patient’s suicide’ (Kolodny et al., 1979: 44). They felt they had been through ‘a rite of passage’ containing profound learning about self and its limitations (Kolodny et al., 1979: 45).

Kolodny et al. (1979) concluded that training institutions should provide a forum where ideas might be exchanged about ‘complex therapeutic issues, including suicide’ and where experienced clinicians could ‘share with trainees their own questions and fallibility (Kolodny et al., 1979: 45) in an environment that recognised that patient suicide ‘is both painful and lonely and an opportunity for mastery and growth’ (Kolodny et al., 1979: 46). See also TP at par 5.15 below.

3.3.3. Gorkin (1985) discussed his own patient suicide experience five years earlier. He said that few therapists ‘discussed their particular reactions’ to this experience: neither Freud (1901/1976) nor Winnicott (1974) elaborated upon their respective experiences of patient suicide (Gorkin, 1985: 2). Gorkin (1985) asked, with Litman (1967), if an ‘important scientific problem’ existed when ‘the taboo on suicide [is] so intense that even psychoanalysts are reluctant to expose their case materials and personal experiences in this area (Litman, 1967: 327)’ (Gorkin, 1985: 2). See also ET at par 5.8.4 below.

Gorkin (1985) focused on what he referred to as ‘the typical reactions... including pathological expressions of mourning’ of therapist survivors (Gorkin, 1985: 3). He described his own experience of being ‘stunned’ on learning that his patient had died by suicide (i.e. by hanging) two days after a therapy session in which he had clearly indicated suicidal intent. Gorkin (1985) admitted that his failure to act on this ‘may have been a mistake’ (Gorkin, 1985: 4).

Gorkin’s (1985) own recovery included acknowledging the deficiencies in his relationship with his client: that his countertransference aggression may have influenced his failure to urge medication or hospitalisation for his suicidal client. He experienced some symptoms of pathological mourning including exaggerated feelings of guilt, expectations of severe judgment and recrimination from colleagues and feelings of diminished self-worth as a therapist or of the value of therapy at all (Gorkin, 1985: 7). See also ET at par 5.8.5 below.

Gorkin’s (1985) own experience led him to suggest that it is almost essential for survivors to bring their case into supervision with colleagues. He felt that a ‘standard procedure’ including access to a non-judgmental forum, should be available

to survivors within institutions. Such fora should, ideally, include another therapist survivor (Gorkin, 1985: 7, 8). All in all Gorkin (1985) felt that the clinician survivor can learn through the process of coming to terms with the event. When such learning takes place, a patient suicide ‘ultimately if tragically’ has some redeeming value (Gorkin, 1985: 9). See also TP at par 5.15 below.

3.3.4 Maltsberger (1995), a clinician survivor (by proxy), wrote sensitively about the aftermath of a Boston (US) psychiatrist’s former patient’s suicide, some time after the patient’s treatment became the responsibility of other clinicians. As an expert witness on the bereaved clinician’s behalf, Maltsberger (1995) did not accept that her treatment of her former client ‘caused’ this patient’s suicide. The destructive effect upon this clinician survivor was her retirement from practice following legal action taken against her by the deceased patient’s family.

Maltsberger (1995) described how his colleague’s former patient’s suicide ‘set off a fire that burned down the psychiatrist’s reputation and her career’ (Maltsberger, 1995: 226). She was unable to afford fees and costs, payable in advance and estimated at \$0.75 million. She elected to resign her licence to practice rather than ‘admitting to wrongdoing she had never committed’ (Maltsberger, 1995: 232).

Although this clinician survivor did not write (as yet) about her experience, she did not resile from Maltsberger’s (1995) version of ‘what happened to a doctor who did her best, made some regrettable judgments under great pressure, but who certainly never exploited her patient for a personal end’ (Maltsberger, 1995: 234). Rather her ‘all out effort for this man’ during four years of treatment prolonged his life: ‘the patient would have committed suicide long before he did without her extraordinary dedication and tenacity’ (Maltsberger, 1995: 227). See also TP at par 5.11 below.

3.3.5 Phillips (1995) described his experience of the death by suicide of his patient. An obese man in his mid-60s, the patient was in a cardiac care unit following his third myocardial infarction. He was hospitalised and discharged several times following treatment for congestive heart failure. Before leaving hospital for what was the last time, the patient, who had become friendly with Phillips (1995) visited the latter’s office to tell him ‘I’m giving everything away, Doc and I’d like to give you \$2,000 so that you and your wife can take a trip somewhere.’ Phillips (1995) who feared his patient would die soon, either by heart failure or by suicide, was concerned that this behaviour was ‘the final serious preparation for suicide’ (Phillips, 1995: 1542). As his

health had deteriorated, the patient had become more depressed. He had told Phillips (1995) earlier that he had prepared for ‘the day it all gets too much for me’ and that he had ‘100 sleeping tablets and a quart of whisky in a safe place’. Phillips (1995) referred him to a psychiatrist but this did not help him much (Phillips, 1995: 1542).

Phillips (1995) invited his patient, if he wished, to donate a gift to the university since to accept a gift of cash ‘could easily be misinterpreted’ (Phillips, 1995: 1542-43). Shortly afterwards Phillips (1995) was notified by the police that his patient was found dead at home. A suicide note was found.

Phillips (1995) did not allude to any emotional or other response to this death except to note how much he had learned from this patient and that, in an era of assisted suicide ‘most patients do not need the connivance...of their doctors if they are really determined to end their own lives’ (Phillips, 1995: 1543). See also ET at par 5.8.6 below.

3.3.6 Grad (1996) prefaced her remarks about how clinicians can help relatives, friends and colleagues bereaved by suicide and how clinician survivors might be helped, by referring to her own suicide survivor experience as a trainee therapist, and to the suicide six years later of her clinical supervisor (Grad, 1996: 136). The latter event triggered ‘disbelief and shock then diffused anxiety and fear’ about her chosen profession. Not only had she lost a supervisor and colleague but belief in the efficacy of ‘therapists’ knowledge and power as well’ (Grad, 1996: 137).

Grad (1996) described in detail some support strategies for suicide survivors (Farberow, 1992; McIntosh, 1993; Grad and Zavasnik, 1996) whether they were related to the deceased or not, referring to relevant clinical experience. She noted Bultema’s (1994) finding that studies of clinician survivors’ reactions represented a small fraction (4%) of published research into all suicide survivors’ experience. See also ET at par 5.8.4 below. Suicide was a catastrophic but inevitable event and apparently precautions cannot totally prevent it (Cotton et al., 1983). Grad (1996) contrasted the ‘inevitable or natural’ death due to physical illness, with death due to suicide ‘an unnatural event...which should be preventable’ (Grad, 1996). It was believed by medical and nursing staff in the aftermath of inpatient suicide that ‘they should have done better, should have assessed more carefully, been more aware of the hints of suicide and have provided closer supervision’ (Grad, 1996: 139). Grad (1996) inferred that medical staff rarely face such a negative response to a natural death of a patient in their care (Grad, 1996: 139).

Reviewing research since Litman (1965), Grad (1996) found that clinician survivors' reactions could emulate those of next of kin (a flood of different emotions, self-blame, denial and avoidance, guilt and shame, maybe even depression). At the same time responses more closely related to therapists' professional standpoint could emerge: they might feel like a professional failure, and as a person, might feel a loss of pride and professional standing, a painful experience of their own limitations and inadequacy or a fear of litigation (Grad, 1996: 139).

Grad's (1996) concern regarding the clinician survivor's predicament, like that of herself, focused on 'those inner, denied, unrecognised and intimate feelings we are struck by after such an event' (Grad, 1996: 139). However she recognised that each therapist experienced patient suicide differently (Worden, 1991) and that their bereavement process 'should be as individualised as possible' (Grad, 1996: 140). See also ET at par 5.8.2 and TP at par 5.11 below.

3.3.7 Gitlin (1999) commented on the 'relative silence...in the literature on suicide' concerning the reactions of mental health professionals to patient suicide. See also ET at par 5.8.4 below. He described his responses, as a clinician, to the death by suicide of his patient following six months of therapy (Gitlin, 1999: 1630). He was writing over 10 years after this event having lost other patients under his care to suicide since then. He described 'writing this clinical case conference with myself as the thinly disguised Dr G. as my alter ego' (Gitlin, 1999: 1633) as one example of a number of ways of coping with a patient's suicide.

He contrasted his individual responses with the 'typical reactions to patient suicide' reported in the 'small literature' (Gitlin, 1999: 1631). He seemed not to have had a great deal of denial or disbelief but 'instead his predominant initial response was depersonalisation, characterised by a feeling of numbness and unreality, while he maintained his usual behaviour patterns' (Gitlin, 1999: 1631). But his shame, guilt and fear of retribution were not unique nor his fear of a recurrence. His grief at his patient's death was compounded by awareness of 'permanently changed hopes and expectations' from a career in psychiatry. He was aware of altering his treatment practices 'even with patients who did not exhibit significant suicidal ideation' seeking to protect against any risk of patient suicide (Gitlin, 1999: 1631).

He reported that he continued over the following months to feel shame and to look for 'omens regarding potential suicide' in his patients (Gitlin, 1999: 1631). Although he continued to function normally, he was anxious and hypervigilant,

fearing that any phone call might inform him of another patient suicide by overdose of prescribed medications. His anger, anxiety, disturbed sleep, intrusive thoughts about the day of the suicide, startle response to phone calls and depersonalisation represented symptoms of posttraumatic stress (Gitlin, 1999: 1632). Gitlin's (1999) responses resembled those described in Chemtob et al. (1988a) a majority of whose respondents reported intrusive thoughts and avoidant behaviours at levels comparable to those of clinical populations (Gitlin, 1999: 1632).

Gitlin's (1999) attempt to share his experience with colleagues was not helpful. None had experienced patient suicide. See also TP at par 5.15 below. His meetings with former teachers were remembered as being very helpful including advice to exercise discretion in working with new patients 'known to have significant suicidal potential' until he had 'more substantially recovered' from his patient's death (Gitlin, 1999: 1632).

He questioned the utility of 'psychological autopsy' or suicide review fearing that 'public shaming' might be an unintentional outcome. He described two main factors – the therapist / client relationship and clinician's psychological makeup including personality and career stage that may shape the impact of patient suicide on the clinician (Gitlin, 1999: 1633). He described how they applied to his case including his inexperience, his identification with his client and his personality. See also ET at pars 5.8.5 and 5.8.6 below.

Gitlin (1999) concluded by describing three coping strategies for clinician survivors: decreasing their sense of isolation, making efforts at reparative, constructive behaviour and employing specific cognitive defences (Gitlin, 1999: 1633). He suggested that 'trainee programmes should prepare trainees for these tragic events' to help to reduce self-blame and to adopt a realistic perspective of the imperfection of therapeutic modalities (Gitlin, 1999: 1634). See also ET at par 5.8.8 below.

3.3.8 Meade (1999) described her personal reaction to the loss of a client and its consequences. Recalling events seven years previously and describing the mainly positive outcomes for her, Meade (1999) appeared to confirm most research findings (Litman, 1965; Jones, Jr., 1987; Pope and Tabachnick, 1993) about the personal and professional aspects of the patient suicide crisis, its complex and prolonged bereavement process and its status as the clinician's worst fear (Meade, 1999: 30).

Her emotional response – numbness, shock, denial, guilt, fear, and anxiety – did not prevent her taking practical decisions regarding her professional liability insurance company, a police interview and arranging an appointment with a consultant suicidologist. She shared her emotions with other colleagues but lost weight, experienced free-floating anxiety, questioned her competence and whether to continue working as a therapist (Meade, 1999: 30).

Her ambiguity about her career choice lasted for several years, a time of ‘spiritual searching for me with feelings of isolation’. Her decision to continue her clinical work was taken when she made contact with the American Association of Suicidology (AAS) to establish and administer the AAS Clinician Survivor Task Force whose remit is to support postvention services for clinician survivors and to research their predicament and its possible resolution (Meade, 1999: 31).

Meade (1999) believed that ‘each caregiver will...resolve their role in a client’s suicide in their own way...based upon...lifelong experiences’ (Meade, 1999: 31). See also ET at par 5.8.3 and TP at par 5.16 below.

3.3.9 Valente (2003) writes about her experience, as a nurse psychotherapist, of the loss of her former client to suicide. Her client was referred to the author for interim therapy in relation to severe depression and being suicidal while waiting for treatment for alcohol abuse. The client’s work with the author was at her own expense. Valente (2003) found pharmacotherapy with this client ‘challenging because of the adverse effects from antidepressants and because she...hid her alcohol abuse’ (Valente, 2003: 19).

After a year the client ‘requested’ electroconvulsive therapy, on effectiveness grounds and to reduce fees outgoings. Later the author referred the client for Jungian therapy. Some years later following contact with the client and with the Jungian therapist, the author learned that the client was no longer in therapy following ‘an impasse’ related to the client’s inability ‘to dispose of her stash of pills’ (Valente, 2003: 19). One year later, the author learned of the client’s suicide.

She described her ‘overwhelming sense of loss, embarrassment and loss...she felt numb and disconnected’ although she continued to work as before. She felt guilty and was worried and concerned that her former client’s family might blame her for not preventing the suicide of their family member. Other feelings experienced were deep sadness and loss, anger and frustration that the suicide was not prevented and

being ‘tempted to query the Jungian therapist’s decisions’ (Valente, 1999: 22). See also ET at par 5.8.5 below.

Valente (2003) found that seeking support from colleagues, supervisors and support groups ‘can help therapists to cope with client suicide’ (Valente, 2003: 22). See also TP at par 5.15 below.

3.3.10 Grad and Michel (2005) reported a discussion they had about what helped them to continue their work as clinicians after they each experienced client suicide. Grad is a female clinical psychologist while Michel is a male psychotherapist and psychiatrist. They reviewed the five factors that influence a clinician’s response to the loss of a client by suicide including:

- i) personality linked ways of dealing with stress, loss and crisis
- ii) gender (Grad et al., 1997)
- iii) the clinician’s vocation and style of therapeutic interaction with clients and colleagues
- iv) the client’s clinical experience, the connection of the client suicide event to other life experiences and their wisdom and acceptance of their limitations, and
- v) fear of litigation

The authors stressed that any help that is needed and sought by a clinician survivor ‘should be personalised and individualised’ to match the particular therapist’s needs while a basic protocol should have been prepared and agreed in advance (Grad and Michel, 2005: 72, 73). See also ET at par 5.8.2 and TP at par 5.11 below. Each clinician presented two vignettes of patient suicides, one that occurred while in training and one following up to 14 years practice.

Grad’s perspectives on each of her clients’ suicides were quite different. Aged 26 and an inexperienced trainee, her response was highly emotional and dominated by fear of being blamed for professional mistakes and held accountable. However aged 40, with 14 years practice experience, Grad regretted the death of her client and restored ‘some professional distance’ that facilitated a more measured response. She spoke to as many colleagues as possible, worked through her own grief and met with the deceased client’s family. She reviewed the case with a family therapy team and eventually understood more about her client’s decision to die by suicide and accepted what she had chosen to do (Grad and Michel, 2005: 76, 77).

Michel, aged 30, a 2nd year psychiatrist trainee, experienced his first loss ‘as a blow that hit me totally unprepared’ (Michel, 1997; Grad and Michel, 2005: 77). He

was so shocked that he could not think clearly nor could he speak with his deceased client's family. He developed acute stress symptoms – paranoid fear of being assaulted by his client's family, fear of the dark and agoraphobia. He felt isolated, receiving little help from his supervisors.

Michel's response, when he was aged 42 and after 12 years in practice, to his patient's suicide was more measured. He felt that he had done all that he could, with and for his client, whose depression eventually overwhelmed him. Michel conceded that he still had doubts about this patient that he had not been able to share until now. After discussing their experiences and any insights gained, Grad expressed the view that there are no rules on how to ease a clinician survivor's pain and disappointment. Each is affected differently and must find her/his own way to resolution. See also ET at par 5.8.3 below. Earlier Michel (1997: 130) had identified the need 'to create an institutional culture in which postvention after the suicide of a patient is a natural and common practice'.

3.3.11 Kapoor (2008) is a counselling psychologist who experienced client suicide while in training. She remembers being in shock and shaking for a few hours afterwards. She was unable to work with her current clients. She found it helpful to talk to others but self-recrimination and self-doubt remained. She says she was left with a 'number of dilemmas' concerning her role when her client 'wanted to escape from her madness' (Kapoor, 2008: 124, 125).

Kapoor (2008) felt conflicted about her understanding of her client's action. She felt angry with her but wondered why. It seemed that she felt unprepared by her training institution for the eventuality of client suicide. But she was able to obtain support and understanding from her supervisor particularly in relation to an internal enquiry into the client's death. She says that she was unable to be open about her feelings 'as I felt I had to get through this by myself' (Kapoor, 2008: 125).

She says she was 'haunted' by the fear that she could have prevented her client's suicide. Currently, as an experienced clinician, Kapoor (2008) continues to be 'more anxious, cautious and lacking in confidence especially...with suicidal clients' (Kapoor, 2008: 125). She continues to experience discomfort, including 'feelings of panic' when some clients do not attend their sessions and feels this is a legacy of her client suicide experience several years ago. Her memory of that tragic event is 'as clear in my mind as though it happened yesterday' (Kapoor, 2008: 125).

Kapoor (2008) believes that time has healed her. She has changed as a person and 'learned a lot about myself as a therapist' (Kapoor, 2008: 126). It seems that reading literature on the subject helped her to realise that 'my reactions were part of my mourning process...when I wrote about my experience, I was able to deal with most of my feelings' (Kapoor, 2008: 126).

3.3.12 Summary What emerges from individual narratives about the aftermath of client suicide are broad similarities and more specific differences. Each clinician experiences their loss personally and professionally. Trainee clinicians are seen to be more vulnerable than their more experienced colleagues. Female therapists differ from their male counterparts in some of their emotional responses. The quality of each therapeutic relationship, comprising a complex communication between client and clinician and within each partner in the dyad, may determine the outcome for the clinician when their connection is dissolved by suicide. See also ET at pars 5.8.2, 5.8.5, 5.8.6 and 5.8.8 and TP at par 5.11 below.

3.4 Learning from the client suicide experience

3.4.1 Beatriz Foster (1987) described her lengthy withdrawal from social and educational activities following a second patient suicide in less than three years. She immersed herself in client work taking on 'more cases especially high-risk ones...I had to prove to myself that I was strong and capable and needed by others' (Foster, 1987: 202). Both deceased clients die violently and 'both had an intense attachment to me...they wouldn't make a move without first...discussing it with me' (Foster, 1987: 198). See also ET at par 5.8.5 below.

She went through a period of hating these clients, for what they had done to themselves and to her. She lost interest in what she had enjoyed most. When not working, she escaped from the pain of grief through television. She describes how 'in an odd way I went to sleep, a sleep that lasted for several months...it was as if I was sleepwalking...in that state I made it possible for myself to heal' (Foster, 1987: 202).

Healing meant that 'things became clearer again...I was able to make sense of what had happened and...what might happen again' (Foster, 1987: 202). Foster (1987) learned much from her client suicide experiences:

- i) the patient's needs are paramount not the clinician's peace of mind
- ii) it is the client's prerogative to kill himself

iii) the clinician must be ‘acutely aware’ to avoid colluding with the suicidal client in covering up and repressing their pain or desperation as an alternative to dealing with their pain

iv) hospitalisation may be an immediate short-term solution for the immediate problem where it meets the client’s needs but hospitals can become ‘jails for the [patient’s] soul [where] the therapist’s soul is incarcerated too’ (Foster, 1987: 203).

v) clinicians must distinguish ‘walking a tightrope helping someone desperate find a good reason to live, and interfering with their right to die’ (Foster, 1987: 203).

Foster (1987) concludes that clinician survivors

‘feel things we were not aware of before...we...ask questions that shall remain forever unanswered...our omnipotence is diminished and our insecurity increased...so we enter another phase of growth...we either grow or pay a higher price to stay the same’ (Foster, 1987: 204).

Over 20 years before Foster’s (1987) contribution, a systematic investigation of 200 clinician survivors never found a therapist for whom client suicide was ‘philosophically acceptable...and congruent with [the] goals of therapy’ (Litman, 1965: 574). See also par 3.2.1 above.

3.4.2 Misch (2003) highlighted a specific occurrence of patient suicide and its aftermath. Although such an event is terrible for the patient, their family and others ‘it is also a potential learning opportunity’ not least for ‘the mental health professionals involved in the patient’s treatment [who] can use such tragic events to learn more about themselves as individuals’ (Misch, 2003: 460).

Misch (2003) was writing at length from a psychodynamic perspective about the hostility of a psychiatrist trainee towards him shortly after the trainee’s patient died by suicide and his personal response, as training director, to this. The trainee was required to undergo a quality assurance (QA) review of the death. Following this review that Misch (2003) attended, the trainee’s overt sadness, guilt and shame appeared to be replaced by an unrelenting anger towards him (Misch, 2003: 462). See also TP at par 5.15 below.

Transference reactions and enactments are especially likely when stressful events precipitate regressive mental processes. In other words, Misch (2003) experienced the projection of the trainee’s hatred for her alcoholic father, which was ‘transferred’ on to him because the trainee felt abandoned by him at the QA review (Misch, 2003: 462-472).

Misch (2003) believed the trainee's response would have been different if she had been in personal psychotherapy and able to benefit from 'safe exploration of the events [around the patient's death] and her feelings about them' (Misch, 2003: 473). He concluded that the tragedy of patient suicide can 'serve as a stimulus to productive introspection and significant learning, not only about...patients and [their] care but also about oneself as a therapist, supervisor, training director and person' (Misch, 2003: 474). Perhaps it would then be possible to transform a potentially destructive event – a patient suicide – into the beneficial lessons of hard-won experience (Misch, 2003: 474).

3.5 Experiences of clinician survivors and family survivors – similarities and differences

3.5.1 Litman (1965) found that clinicians react to the loss of their patient 'in much the same way as do other people [feeling] a special sort of guilt which was the exact replica of the type of guilt experienced by relatives of persons who have committed suicide (Litman, 1965: 572, 573). Relatives and clinicians both experienced denial and repression while some clinicians were 'extremely angry at someone...whom they held responsible for the death' (Litman, 1965: 573). Therapists in their professional role reacted with fear regarding responsibility and inadequacy. They feared blame, being sued, vilified in the press, being investigated or of losing professional standing (Litman, 1965: 574).

3.5.2 Ellis et al. (1998) surveyed psychiatry residents' training programmes. Chemtob et al. (1988a) reported that some clinician survivors had 'stress levels comparable to levels reported in...people seeking treatment after the death of a parent' (Ellis et al., 1998: 182).

Ellis and Dickey (1998) in a related study advised caution in structuring a postvention procedure that 'allows privileged communication' in relation to possible malpractice proceedings' (Ellis and Dickey, 1998: 496). Clearly the 'positive and beneficial resources such as discussion with a supervisor or therapist' that helps a trainee survivor to cope, should be part of a 'balanced plan' by the training institution that pays careful attention to justice for all concerned, including a clinician survivor, their deceased patient and the deceased relatives (Ellis and Dickey, 1998: 496). See also ET at par 5.8.11 below.

3.5.3 Peterson et al. (2002) surveyed family survivors about their attitudes to and perceptions of clinicians who were treating their loved ones at the time of death. Calhoun et al. (1982) found that suicide survivors had increased needs to comprehend the death (Peterson et al., 2002: 158).

It would appear that this ‘need to know’ on the part of family survivors may not be well understood or accepted by clinicians. Peterson et al. (2002) found that 74% (N=50) of family survivors knew who their relative’s clinician was. However only 11% (N=7) of respondents reported that the clinician had contacted them or their family before the death while 39% (N= 28) reported that the clinician tried to contact the family after the death (Peterson et al., 2002: 164).

For legal and professional reasons a clinician’s decisions regarding contact with their client’s family before or after the client’s death are complicated: before death the client’s informed consent may be necessary and after death, the clinician must balance the management of their own grief, the grief of family survivors, their relationship with their deceased client and...legal and ethical issues (Peterson et al. 2002: 165). See also ET at par 5.8.11 below.

3.5.4 Myers and Fine (2007) attempt to bridge the perspectives of survivors and clinicians: Myers is a psychiatrist while Fine lost her husband – a physician – when he died by suicide. They note that ‘an ever increasing scientific literature’ on the clinician survivor’s predicament is not readily available to a wider public. They believe that the ‘humanness and vulnerability’ of clinicians should become more widely known to family survivors and others. They hope by publishing their views on this (Myers and Fine, 2006) to explain ‘why some clinicians behave in confusing and defensive ways with families of their patients’ (Myers and Fine, 2007: 124). See also ET at par 5.8.4 below.

3.5.5 Sudak (2007) discussed his losses of four patients to suicide including during training and also his estranged wife’s suicide. His guilt, grief and shame made her death his ‘life’s worst experience’ (Sudak, 2007: 334).

He noted that various ‘Survivors of Suicide’ groups offered support based on self-help principles to family and friends bereaved by suicidal loss.

Sudak (2007) was quite clear that the clinician survivor’s response (varying degrees of shock, guilt, anger, shame, anxiety, preoccupation with the death) would be quantitatively less than what [the] immediate family would undergo but would be qualitatively quite similar with the added element of ‘professional’ concerns (Sudak,

2007: 333). He felt that the shocked trainee ‘survivor generally receives a frightening critical incident review...coupled with [either] little help from senior staff or a tacit departmental silence...which adds to the atmosphere of something shameful having taken place’ (Sudak, 2007: 333). See also ET at par 5.8.8 below.

Based upon the above-mentioned similarities, Sudak (2007) believed that clinicians should do more than hold ‘what went wrong enquiries’ (Sudak, 2007: 333). He recommended survivors-of -suicide (SOS) groups for mental health providers with early access to a designated, supportive, non-threatening colleague, available to meet with clinician survivors including trainees. Sudak (2007) believed this is ‘the least we can do’ and commended medical schools with such support resources (Jones, Jr., 1987). See also TP at par 5.15 below.

3.5.6 Cerel et al. (2008) reviewed the impact of suicide on the family in relation to social or family networks. They contrasted parents bereaved by the sudden violent death (viz. murder, accident and suicide) of their child, finding that ‘few changes in family [cohesion or adaptation] were unique to suicide’ (Cerel et al., 2008: 38). They suggested that the family’s response to a parent’s suicide can be related to ‘family type’ as understood by the existence or otherwise of family conflict or psychopathology (Cerel et al., 2008: 39). The authors noted that since Cain’s (1972) seminal work on suicide survivors ‘the impact of suicide...on family communications’ and interactions had not been systematically researched (Cerel et al., 2008: 41).

Cerel et al. (2008) did not discuss the potential effect of the suicide of a family member upon mental health professionals working in family therapy. This area also awaits scientific research. A recent clinical practice text for family therapists offered guidance for clinician survivors based on the authors ‘personal experience of survivorship’ and their personal journeys. However the authors are neither specialist family therapists nor are altered family dynamics referred to in the text: the dynamics around the interface between the clinician survivor and surviving family members, bereaved by a client suicide, may not yet have been adequately or fully investigated (Vorkoper and Meade, 2005: 224).

3.5.7 Berman (1995) offered as a metaphor for the impact of suicide, a billiard table that has several balls on its surface. The balls represent family members, friends and helpers (including clinicians). Each is impacted upon by a ball representing the suicide event. This causes each ball to rebound off to impact upon others, creating a series of rebounding impacts upon each other. In the real world, patient suicide

‘invariably means that family, society and the helper [clinician] may and often do collide, impacting on each other in successive transfers of energy having the potential to persist for years’ (Berman, 1995: 86). Berman (1995) proposed that ‘the impact of suicide on helpers is both universal and idiosyncratic’ (Berman, 1995: 86). He identified the

‘idiosyncratic [nature] of effects tempered by the character and resistances of the helper, by rebounding impacts between helpers and surviving family members, and by successive interactions among the survivor family, society and the helper...having the potential to leave indelible marks of collision’ (Berman, 1995: 87).

Berman (1995) described two contrasting case studies involving client suicide that illustrated his ideas of the universality and idiosyncrasy of the clinician survivors’ response. In each case the post-suicide relationship that developed between the clinician survivor and the deceased client’s family members revealed how each individual whether clinician or family member acted out ‘compromised mourning rituals, inadequate coping responses, feelings of isolation and crises of identity and control’ (Berman, 1995: 87). See also ET at par 5.8.2 and TP at par 5.11 below.

Berman’s (1995) conclusions from these cases were that suicide happens, that disturbed clients are likely to have disturbed families, that client confidentiality continued after the death of a client, that the key to helping the suicidal client was the quality of the therapeutic relationship and that contact with the client’s family, where possible, was best before rather than after an unforeseen suicide. He contrasted the limited levels of control that clinicians (or family members) have over the lives and choices of clients with the clinician’s perceived responsibility for his client’s well-being. See also ET at pars 5.8.5 and 5.8.6 below.

For their own protection, therefore, Berman (1995) emphasised the importance for clinicians of documenting ongoing assessment for suicide risk of their client, in the context of diagnostic workups and related treatment plans, so as to manage malpractice risk (Berman, 1995: 99). See also ET at par 5.8.11 below.

3.6 Psychological consequences for clinician survivors – clinician survivors (by proxy) – psychological synthesis and active postvention

3.6.1 Psychological consequences for clinician survivors Farberow (2001: 12) commented that the psychological consequences for clinician survivors in the

aftermath of the suicide death of a patient/client are similar for the therapist as those experienced by families and close friends when a loved one takes their own life. He listed these 'common feelings': loss, grief, guilt, anger, depression, shock, denial, etc. In addition clinician survivors' reactions that were inherent to their professional role included 'self-doubts about clinical competence, concern over clinical skills, fear of blame by family and colleagues, fear of litigation [and in relation to counselling trainees and students] anxiety and fear of loss of approval of supervisors and faculty' (Farberow, 2001: 11).

He reported that support services for people bereaved by suicide were likely eventually to 'be as big and formalised as the field of suicide prevention has become' (Farberow, 2001: 12). By contrast he believed that 'bereavement counselling (for) the clinician [survivor] has been comparatively less explored almost to the point of being ignored' (Farberow, 2001: 12).

Getz et al. (1983: 158) noted that client suicide triggered 'many clinical and sometimes legal issues'. They believed that 'no one affiliated with the deceased – relatives, friends, business associates and counsellors – escapes some impact'. They cautioned that 'such feelings as guilt, shame, anger, embarrassment and fear have to be faced and resolved in a healthy way so that the excesses of these feelings do not spill over and cripple' the clinician survivor (Getz et al., 1983: 158). Cohen (1979) added that legal issues arising from client suicide were best addressed in advance if the clinician maintained 'a complete and accurate recordkeeping system' when counselling suicide-prone clients (Getz et al., 1983: 157). See also TP at par 5.15 below.

3.6.2 Clinician survivor (by proxy) Meichenbaum (2005) experienced several client suicides, including one of his first clinical patients with whom he worked for some months. During the succeeding 35 years of practice he was 'involved with' three other psychiatric patients' suicides while a fourth patient, whose trainee clinician was being supervised by Meichenbaum (2005), took his own life. More recently he was in consultation with staff at a psychiatric facility where a young male patient was found hanged (Meichenbaum, 2005: 64, 65).

Calhoun et al. (1984) examined the responses of persons who were acquaintances of specific individuals who experienced bereavement following the death by suicide of a friend or family member. They found some evidence of discomfort in interactions with suicide survivors by those whose experience of the

suicide event is indirect, being at one remove, or by proxy (Calhoun et al., 1984: 259). This pointed to the existence of a psychological response of unknown dimensions by suicide survivors (by proxy) of a suicide event. The psychological response of the clinician survivor (by proxy) to the loss of a patient by a colleague clinician awaits further study.

Meichenbaum (2005) is both a clinician survivor following his direct experience of patient suicide and a clinician survivor (by proxy) in relation to two patient suicides where his relationship was indirect, either as a supervisor or a consultant to staff directly concerned with the now deceased patients. It remains unclear whether his 'involvement' with three other patients (see above) was direct or indirect (Meichenbaum, 2005: 64).

Meichenbaum (2005) recommends clinicians to use a comprehensive set of risk assessment guidelines for evaluating suicidal patients, on an ongoing basis. The assessment framework prepared by Meichenbaum (2005: 69-72) represents a type of resource that is necessary for clinicians regardless of their professional orientation or practice experience. An evaluation framework for assessing the needs of clinician survivors and clinician survivors (by proxy) could usefully complement Meichenbaum's (2005) resource and acknowledge their potential psychological liability in the aftermath of client suicide. See also ET at par 5.8.9 and TP at par 5.11 below.

3.6.3 Psychological synthesis and active postvention The work reported above (see par. 3.5) found similarities in emotional responses by family members and clinicians in the aftermath of client suicide (Litman, 1965; Ellis et al., 1998; Ellis and Dickey, 1998; Peterson et al., 2002; Myers and Fine, 2006 & 2007; Sudak, 2007; Cerel et al., 2008; Berman, 1995). Resnik's (1972) work on clinical responses to suicide survivors addressed the psychological disruption for parents of adolescent suicides, using a psychotherapeutic approach referred to as 'psychological resynthesis'. Its three phases – psychological resuscitation, psychological rehabilitation and psychological renewal – might also be relevant for clinician survivors within clinicians' professional context (Cain, 1972: 167-177).

Alternatively the philosophy that underpins the Active Postvention Program (APP) (Campbell et al., 2004) could prove useful for clinician survivors. Survivors of suicide become aware of postvention resources in some indirect way and often by chance (Campbell, 1997). The APP philosophy seeks to deliver immediate support to

survivors at the time of the suicide. Personnel staffing a postvention resource for clinician survivors would require a skills set that matched the expectations and needs of professionals in an appropriate ethical and legal context (Cerel and Campbell, 2008). See also par. 3.2.23 above.

3.7 Foreseeing / predicting suicide – ethical considerations – unexpected death – contrasting aftermath of loss by murder / accident / suicide – assessment of suicide risk

3.7.1 Foreseeing / predicting suicide Williams (2001) listed ‘common predictors’ of suicide:

mental disorder, especially depression; alcohol or drug abuse; suicide ideation, talking, planning; prior suicide attempt; lethal methods; isolation, living alone, few social supports; hopelessness; being white male; suicide in the family (modelling, genetic loading); work problems, unemployment, high-risk occupation; family and marital problems; stress and negative life events; problems of affective control (anger, impulsivity) and physical illness (Williams, 2001: 182).

In relation to suicide, Simon (1998) clearly distinguishes foreseeability – the reasonable anticipation that harm or injury is a likely result from certain acts or omissions (Black, 1999) and predictability – the ability to state what will be observed before it actually occurs (Reber and Reber, 2001: 556). The former is a legal term that has no equivalent clinical counterpart while no professional standards exist for predicting who will commit suicide.

Simon (1998) adds that foreseeability should also be distinguished from preventability. A suicide that may not be foreseeable may in hindsight have been preventable (Simon, 1998: 479, 480). Simon (1998) adds that there is no such thing as ‘a suicidal patient’. There are only patients who are at risk of suicide (Simon, 1998: 480):

...if the clinician assesses the patient to be at moderate to high risk for suicide the clinician is on notice to [intervene] accordingly...A risk of suicide, rather than a suicide itself, is foreseeable. Assessment provides visibility about risk, but the prediction of suicide remains opaque to the clinician (Simon, 2002).

O’Connor (2000: 127) reported research by Pokorny (1983, 1993) that demonstrated the difficulty of attempting to rely upon prediction as an aid to preventing client suicide. This research followed 4,800 psychiatric patients over a five

year period. During this time 67 patients died by suicide. Pokorny (1983) used notions of 'sensitivity' and 'specificity'. Re the former, if he predicted that a patient would die by suicide and that person did die by suicide then a 'true positive' existed. Re the latter, if he predicted that a patient would not die by suicide and there was no suicide then a 'true negative' existed. The results showed Pokorny's relative effectiveness in predicting 'a no suicide outcome' (74% true negatives) and his considerable ineffectiveness in predicting 'a suicide outcome' (55% true positives) but at a cost of 1,206 false positives. Of 1,241 subjects identified as 'suicides' only 35 (2.8%) were identified correctly (Pokorny, 1992: 119). Pokorny (1983) concluded: 'We do not possess any item of information or any combination of items that permits us to identify to a useful degree the particular persons that will commit suicide' (Goldney, 2002: 586). Pokorny (1993) subjected his data to 'further sophisticated re-analysis' but conceded that his results 'fell far short of any clinical utility' (Goldney, 2002: 586).

Clinicians might avoid 'actionable negligence' in their practice by using reasonable care in evaluating and treating a patient at suicidal risk (Simon, 1998: 483). Counsellors needed strategies in place that addressed the possibility of client suicide and its consequences. These included referral arrangements for

'inpatient treatment, optimum patient care and optimum risk management [with] an identical goal: the use of knowledge, skill and organisation to save lives by reducing, to the extent possible, "foreseeable" suicide' (Jacobson, 1999: 385).

Orbach (2001) believed that the therapist's 'sense of responsibility for another person's life' differentiated therapeutic work with suicidal and non-suicidal clients. In the former case, this 'duty of care' aspect was characterised by the therapist's 'ability to contain and bear another person's death wish without being overwhelmed and incapacitated by anxiety' (Orbach, 2001: 166-185). 'An important aspect of therapy is that the...therapist can fulfil various aspects of the "containing" function for their clients and patients' (Segal, 1998: 121). Bion (1967) described the 'containing function':

'As a realistic activity [projective identification] shows itself as behaviour reasonably calculated to arouse in the mother feelings of which the infant wants to be rid. If the infant fears that it is dying, it can arouse fears that it is dying in the mother. A well-balanced mother can accept these and respond therapeutically: that is to say in a manner that makes the infant feel it is receiving its frightened personality back again but in a form that it can tolerate

– the fears are manageable by the infant personality (Bion, 1967: 114). A... psychotherapist who can tolerate (their) client's emotional pain performs a similar function' (Segal, 1998: 122)

Orbach (2001) cautioned that what can be 'incapacitating in this work...is the therapist's "own suicidality", death anxiety, fear of hopelessness and mental pain, with suicidal clients'. See also TP at par 5.13 below. Furthermore, 'countertransference' – considered in detail at par. 2.8 above – 'has a most intense impact on the therapeutic relationship and on the ability to work with suicidal patients' (Orbach, 2001: 166-185). See also ET at par 5.8.6 below.

Jacobson (1999: 385) stated that although suicide is not predictable in the individual case (Roy and Draper, 1995; Pokorny, 1983, 1992, 1993) the expectations of the suicidal client's family and their legal representatives are that 'the clinician [would] not take risks that *foreseeably* might result in suicide (Jacobson, 1999: 385 – italics in original source).' Furthermore

'the courts have held the clinician liable for "foreseeable" suicide when that suicide was deemed to be part of the negligent failure to exercise appropriate "duty of care", that is, when the clinician failed to assess risk properly or once risk had been assessed, had failed to take proper protective action (Simon, 1992b; Applebaum and Gutheil, 1991; Bongar, Maris and Berman, 1993)' (Jacobson, 1999: 385).

The context for Jacobson (1999: 385) was 'inpatient management of suicidality'. The appropriate duty of care for a clinician working in a counselling relationship with a client perceived to be at assessable risk of suicide paralleled the duty of care of the inpatient clinician: the duty of care of 'the carer' towards 'the cared' was not context-dependent:

'If the clinician appropriately assesses risk; re-evaluates that risk at selected points along the treatment; communicates with nursing staff, the patient's family and others who have relevant knowledge of the patient, documents the risks and benefits of relevant treatment plans; assesses the patient's suicide risk prior to discharge; and makes reasonable disposition arrangements for the patient and following this the patient commits suicide, then the great likelihood is that the death, unfortunate and difficult as it is for the patient's family and the clinician, will not be deemed to have been "foreseeable". If however the clinician omits one of these steps and the omission of that step can be shown to be causally related to the patient's death, the clinician may very well be held professionally liable' (Jacobson, 1999: 385).

See also ET at par 5.8.11 below.

3.7.2 Ethical considerations Bond (1998) considered the ethical responsibilities of the counsellor for their suicidal client. He introduced the ‘counsellor’s traditional ethic of respect for the client’s autonomy’ (Bond, 1998: 78) but did not avert either to foreseeability or predictability of suicide by the client. He described the ‘duty of care’ of counsellor for client as being ‘the same as that owed by any professional’ (Bond, 1998: 48). He discussed beneficence, non-maleficence, justice and respect for autonomy – four principles of moral philosophy that proved useful to other professions and that might ‘assist the counselling practitioner’ (Bond, 1998: 33). The practice of non-maleficence was defined in these terms: ‘the practitioner has an ethical responsibility to strive to mitigate any harm caused to the client even when the harm is unavoidable or unintended’ (BACP, 2002/2009: 3). Beneficence ensured that ‘the client’s best interests are achieved...an obligation to act in the best interests of a client may become paramount when working with clients whose capacity for autonomy is diminished because of immaturity, lack of understanding, extreme distress, serious disturbance or other significant personal constraints’ (BACP, 2002/2009: 3).

Expressed as a question, non-maleficence highlighted the counsellor’s ‘*primum non nocere*’ duty (viz. above all do no harm) by asking: ‘What will cause least harm [to the client]?’ Similarly beneficence asked the counsellor to consider ‘What will achieve the greatest good?’ Bond (1998: 46) also cited a Code for Counsellors (BAC 1992a):

‘Counsellors should take all reasonable steps to ensure that the client suffers neither physical nor psychological harm during counselling’ (B.2.2.1).

Bond (1998: 151) addressed the issue of client suicide from several perspectives. He noted, with reference to the Suicide Act, 1961 (UK) (Bond, 1998: 81) that ‘because suicide is no longer a crime, there is no general right to use reasonable force to prevent suicide attempts or suicide’ (Bond, 1998: 151). However Section 2 of the same legislation created a new offence that stated: ‘A person who aids, abets, counsels or procures the suicide of another or an attempt by another to commit suicide shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years’ (Bond, 1998: 81). He defined ‘to counsel’ in this legal context as ‘to conspire, advise or knowingly give assistance which are not activities usually encompassed within counselling’ (Bond, 1998: 81).

Euthanasia involved the killing of a patient, following that person's request(s), by their physician administering a lethal substance to their patient, while they were unable to effect their own deaths (Hendin, 1998: 12). Assisted suicide occurred when a patient took their life by self-administration of a lethal substance prescribed by their physician at the patient's request. But, as stated above, actively to assist another person to take their life was a criminal offence in UK law and in all but a handful of jurisdictions worldwide, for example, the Netherlands (Hendin, 1998: 12).

Bond (1998: 79-84) discussed a range of ethical scenarios surrounding the predicament of a counsellor when their terminally-ill client stated their intention to take their life where this involved 'making a decision which is authentic, deliberated and clear-headed' (Bond, 1998: 80). Where such evidence existed of the client's informed consent then the counsellor's ethical dilemma was whether there were grounds to intervene to prevent suicide (Bond, 1998: 80). Counsellors were under an ethical obligation to respect their client's autonomy (BACP, 2002/2009: 3) in relation to all of their client's decisions including when that decision was to take their life.

Regarding disclosure in such situations of client information to third parties, there was a degree of uncertainty about how the law of client confidentiality applied to counsellors (Bond, 1998: 124, 125). It was considered essential that counsellors should seek guidance 'through regular supervision' (Bond, 1998: 44) and 'proper advice through their lawyer, professional [counselling] association or any legal helpline [through] their professional indemnity insurance scheme' (Bond, 1998: 125).

Bond's (1998: 142) view was that in counselling relationships total confidentiality was 'unrealistic'. But counsellors should have secured clients' trust by 'careful attention to client consent and confidentiality [since] respecting client confidentiality is a fundamental requirement for keeping trust' (BACP, 2002/2009: 6,7). Contracting with the client before commencement of counselling, including specific agreements in advance about when, in the absence of informed client consent, confidentiality could be breached, was now standard operating procedure for counsellors at all levels, from trainees to consultants. Clearly where such disclosures to third parties were made with informed client consent they did not amount to a breach of confidentiality.

3.7.3 Unexpected deaths Schwartz et al. (2007) and Holmes (1997) raised the issue of 'unexpected deaths' in psychiatry and in medicine and in surgery. Schwartz et al. (2007) believed that the prevailing medical culture continues to view death as a

medical failure. They held that the educational needs of a psychiatry resident who experienced a patient suicide were similar to the needs of a medical or surgical resident who experienced an unexpected death (Schwartz et al., 2007: 338).

Holmes's (1997) view was that deaths on medical and surgical wards were a common occurrence since many patients die from chronic illness. He felt that major mental illnesses have an 'expected' mortality involving suicide. He thought clinicians were responsible, through their 'therapeutic need to remain optimistic' for the notion of 'unexpected' deaths in psychiatry that he felt was a misnomer (Holmes, 1997: 187, 188).

3.7.4 Contrasting aftermath of death by murder / accident / suicide Several writers researched bereavement processes experienced by survivors of murder, accident or suicide. Seguin et al. (1995) measured the responses of parents who lost a son by accident or suicide. They found that for suicide survivors 'shame seems to be unique to the experience of suicide bereavement' (Seguin et al., 1995: 495). A more complex change evidenced itself in suicide survivors' sense of inadequacy as 'competent providers for the rest of the family', and being distressed and hurt when this feeling created 'dissonance in their concept of self [through] actions or attitudes...inconsistent with their own idea of who they are or who they ought to be' (Seguin et al., 1995: 495).

Bailley et al. (1999) confirmed earlier findings but stressed the variability that existed within the 'uniqueness' of grief due to suicide. Their research, using several measures of grief, showed that suicide survivors (in contrast with people bereaved by accidental death or anticipated / unanticipated natural death) experienced rejection and abandonment, related to the method of death and feelings of responsibility for the death (Bailley et al., 1999: 268).

Ellenbogen and Gratton (2001) suggested alternative research pathways to try to isolate a specific grief reaction that occurs uniquely in the aftermath of suicide but that is absent from the reactions of other survivors.

Jordan's (2001) literature review of suicide bereavement challenged the view that its mourning processes may not differ other than marginally from processes after other types of death. He suggested that suicide bereavement is distinct in three significant ways: the thematic content of the grief, the social processes surrounding the suicide and the impact that suicide has on family systems (Jordan, 2001: 91).

Levin (2005) reported that ‘if a psychiatric patient [dies by suicide], a murder is committed and the murderer is our patient with whom we have had an empathic relationship’ (Levin, 2005: 11). Plakun and Tillman (2005) confirmed that clinicians may specifically make themselves emotionally available in a substantial empathic attachment to patients. They held that the connection between clinician and patient may therefore be qualitatively different to that between a surgeon or other physician and a patient. The complex context for the clinician’s response to his patient’s suicide may then be characterised by guilt and intense ambivalence (Plakun and Tillman, 2005). Suicide as suicide or as self-murder contributed to a complicated grief response for clinician survivors (Darden, 2008). See also ET at par 5.8.5 below.

McIntosh (2007) stated that the emotional effects of losing someone to suicide were similar to those generated when someone was murdered. He said that ‘the effects on surviving friends and family members are similar to those coping with the murder of a loved one, like the shock of sudden loss, searching for answers and feelings of anger and guilt. With suicide...people struggle with social isolation due to negative stigma’ (Andrews, 2007). See also TP at par 5.15 below.

3.7.5 Assessment of suicide risk Bond (1998) argued that counsellors working ethically with suicidal clients accepted with ‘respect the client’s choice and autonomy’ and would act only where evidence is absent of the client’s ‘capacity to make [their] own decisions’, or where there is a ‘substantial risk of suicide, and...the counsellor can do something, that has a reasonable chance of averting the suicide or involve someone, who has the power to prevent the suicide’ (Bond, 1998: 84). The counsellor’s supervisor and expert experienced professionals needed to be consulted ‘to provide support for the counsellor and to clarify issues [around availability of] non-counselling [support] services’ to facilitate the suicidal client to make informed choices (Bond, 1998: 85). A robust assessment procedure was suggested in order to resolve ethical dilemmas that arose. Bond (1998: 84, 85) integrated assessment procedures that were suggested by Eldrid (1988) and Hawton and Catalan (1987). These were summarised as an assessment of:

- a) Suicidal intentions: strength of feelings about going on or ending it all; degree of planning and preparations already accomplished; exploration of client’s intentions in any [serious] attempt at suicide
- b) Current difficulties: exploration of nature of problems and duration, e.g. loss of close relationship, job, finance, sexual or addiction difficulties, etc.

- c) Psychological state: comparison between usual psychological state and present with particular regard to hopelessness, anxiety, guilt, obsessions, anger, dependency, inner isolation.
 - d) Psychiatric history: previous history of mental illness and attempted suicide; and any evidence of current mental illness including depression.
 - e) Resources for coping: the availability of support from social network of partner, friends, family, etc. and religious faith; previous coping strategies for problems.
- (Bond, 1998: 84, 85)

Bond (1998: 87, 88) argued persuasively that such an assessment procedure had three possible conclusions:

- i) the client was competent to take decisions for self about counselling and about control issues
- ii) the client's mental state precluded client's responsibility for self and there was a substantial risk of suicide; the client was agreeable to seek a second professional opinion
- iii) the client was unable to accept responsibility for their own actions or the consequences thereof; the assistance of a doctor or approved social worker or other professional was sought while protecting the client's identity.

Bond (1998: 88) offered a structured procedure which relied heavily upon the accuracy of the counsellor's judgements about client competence in making 'an authentic and considered choice' in relation to suicide:

For the counsellor, a systematic assessment procedure provides a means of resolving an ethical dilemma [e.g. to disclose or otherwise to a third party in the absence of informed client consent]. Although it is not always possible to be infallible in one's assessments, at least the counsellor knows that s/he has done all that can reasonably be expected of him/her and has also maximized the likelihood of the client making an informed and authentic choice...Many counsellors working with suicidal clients [value] consultation with at least one other person. If a client does commit suicide, the counsellor may experience regret and concern that, perhaps, something more could have been done to prevent it. It is at times like this that it is useful to know that the decision was not taken on one's own. Consultations with a counsellor-supervisor, doctor or social worker are a simple way of helping to minimise some of the inevitable distress following some suicides (Bond, 1998: 88).

See also ET at 5.8.10 and TP at 5.15 below.

The post-client suicide predicament for the counsellor was considered likely to cause 'regret, concern and [possible] distress' (Bond, 1998: 88) where a conscientious and robust assessment procedure was carried out accurately and competently by the counsellor. Bond's (1998) rational argument appeared in sympathy with the view that where the counsellor behaved reasonably and competently when working with

suicidal clients, then completed suicide was ‘a professional hazard’ (Clark and Goldney, 2002: 480). See also pars 8.3 and 8.4 below regarding clinicians’ perceptions of clients’ levels of suicide risk.

3.8 Collective avoidance – mistakes by clinicians – litigation fears

3.8.1 Collective avoidance Soderlund (1999) considered that ‘the scarcity of research on how therapists deal with the suicide of a patient smacks of a collective avoidance of what can be a massive personal shock equivalent...to the loss of a parent’ (Soderlund, 1999: 1). He summarised relevant research (Litman, 1965; Resnik, 1972; Chemtob et al., 1988b; Kleespies et al., 1993; Horn, 1994, Fox and Cooper, 1998) but conceded that ‘there is no right way to deal with such a loss’ and suggested that clinician survivors ‘use your own discretion’ (Soderlund, 1999: 1,2). See also ET at par 5.8.2 below.

3.8.2 Mistakes by clinicians Henn (1978: 745) noted that ‘it is presumed...that [patient suicide] would not occur unless the [clinician] involved “made a mistake”’. Perhaps uniquely among writers on client suicide, Gorkin (1985) – see par.3.3.3 above – stated that a key decision he made about the hospitalisation of his suicidal patient ‘may have been a mistake’ (Gorkin, 1985: 4). Stone (1971) writing almost four decades ago, considered the question, then ‘virtually taboo...can psychotherapy precipitate or contribute to a suicide?’ (Stone, 1971: 19). He raised the issue in the context of ‘the difficulty in attributing any result to psychotherapy, good or bad’ (Stone, 1971: 19).

His psychodynamic perspective envisaged scenarios involving the unwitting abandonment by the clinician of their client while the latter was psychologically dependent upon the clinician, producing ‘enormous depression, suicidal ideation, and...serious suicide attempts’ (Stone, 1971: 26). He alerted colleague psychotherapists to ‘the possibility of malignant intervention’ (Stone, 1971: 26) leading to potentially negative outcomes. See also ET at par 5.8.7 below.

Light (1972) investigated ‘a major event of potential error in psychiatry – suicide of a patient – as a means of understanding basic beliefs and organisational features of the psychiatric profession’ (Light, 1972: 821). From a sociological perspective, he analysed the social organisation of professional work through the filter of ‘mistakes and acts which might be regarded as mistakes’ (Light, 1972: 821). Light

(1972) defined a clinical profession as one 'where routine is made of other people's emergencies and uncertainties' (Light, 1972: 822). The issue for him was whether a patient suicide, viewed as a professional crisis and clearly a failure, represented 'a mistake' (Light, 1972: 826). He discussed the reported responses of clinicians to patient suicide in relation to their beliefs about suicide. See also TP at par 5.16 below. He concluded that the issue of 'mistake' is problematic because, as Stone (1971) suggested, success and failure in psychotherapy are usually unclear (Light, 1972: 825).

Christensen et al. (1992) and Schwappach and Boluarte (2008) examined the impact of perceived mistakes and medical error on medical staff. Patient suicide was not specifically addressed although the death of a patient, resulting directly or indirectly, from medical error was found to have psychological consequences for some physicians. The severity of physicians' distress might be linked to their belief systems and levels of perfectionism (Christensen et al., 1992: 430). Many physicians responded to medical error in serious emotional distress with long lasting effects that may 'imprint a permanent scar' (Schwappach and Boluarte, 2008: 5). Evidence suggested that colleagues and supervisors represented the most helpful resource for physicians.

3.8.3 Litigation fears Rudd et al. (1999) referred to 'the existing litigation-determined standard of care' for the psychotherapeutic treatment of suicidality and made recommendations based upon empirical literature (Rudd et al., 1999: 437) as an initial step in improving the care for individuals in greatest need of help for suicidality (Rudd et al., 1999: 444).

Simon (2002) addressed the current situation for clinicians working with suicidal patients and who feared the tragic event of their patient's suicide. He advocated use by clinicians of systematic, formal suicide risk assessments that inform treatment as the key to protection in the event of malpractice suit. Since suicide cannot be predicted (Pokorny, 1983 & 1993) assessment of suicide risk was an informed judgement call, not a prediction (Simon, 2002). Simon (2002) reviewed litigated suicide cases discovering 'a recurring fundamental problem: the absence of documented, systematic suicide risk assessments when they are clinically indicated' (Simon, 2002: 17). See also pars 8.3 and 8.4 below.

In an overview of the law and suicide, Feldman et al. (2005: 96) described the most common form of legal action filed against clinicians as a suit alleging

malpractice, which Black's Law Dictionary defines as '...failure to exercise the degree of care and skill that a (clinician) of the same (clinical) specialty would use under similar circumstances (Garner, 1999)'. They confirmed Simon's (2002) view that

'the best protection against liability for negligence resulting from a client's suicidality is to adhere to accepted standards of care of one's clinical profession in assessment, diagnosis, care planning and treatment; to [become familiar] with [legal] guidelines addressing confidentiality and breach of confidentiality; to ensure [treatment is carefully documented] in the client's permanent record; and to seek professional or peer consultation, particularly when inexperienced, uncomfortable or uncertain' (Feldman et al., 2005:102).

See also pars 8.3 and 8.4 below.

3.9 Communication of suicidal intent – suicide threat – the guarded suicidal patient – contact with mental health professionals (MHPs) before death – clinicians' attitudes to suicidal clients

3.9.1 Communication of suicidal intent Litman (1964) discussed the responses given by potential rescuers when individuals asked them for help in an intolerable situation. These appeals might be matters of life or death to a suicidal person. It was found that such communications were made by two thirds of those who subsequently died by suicide (Robins et al., 1959). People who were in a position to help often failed to act because anxiety, tension and concern rendered them helpless. Litman's (1964) study examined such communications of suicidal intent within a close interpersonal relationship where 'conscious recognition of its significance is avoided, denied and repressed' (Litman, 1964: 282). He called this an immobilization response to suicidal behaviour.

Isometsa et al. (1995) looked at communication of suicidal intent by clients in therapy. They found that only a minority of clients communicated their suicidal intent to a mental health professional (MHP) during the final appointment before their death by suicide (Isometsa et al., 1995: 921). The authors encouraged health professionals to examine the mental status of their clients, particularly regarding depression and suicidal thoughts: 'One cannot expect the person in danger of suicide to express such intent spontaneously' (Isometsa et al., 1995: 922).

3.9.2 Suicide threat Suicide threat is regarded as a form of manipulation that stresses the possibility of a suicidal act with intent to control or influence the behaviour of others (Maris et al., 2000: 267). Gutheil and Schetky (1998) presented examples of

patients who voiced their intent to die by suicide if certain conditions were not met. They called this time-based and contingent suicidal intent (Gutheil and Schetky, 1998: 1502) and offered considered therapeutic strategies to address such 'blackmail' (Gutheil and Schetky, 1998: 1505). Farber (1962) described as 'the most difficult of all potential suicides to treat – or help in any way' the patient who reveals to no one that suicide is a secret...solution to any difficulty life may throw in his path' (Farber, 1962: 126). Up to 60% of suicides have never told a professional of their plans (Clark and Fawcett, 1992: 59).

3.9.3 The guarded suicidal patient Simon (2008) recommended clinicians to consider using pattern recognition of behavioural suicide risk factors when treating a 'guarded suicidal patient'. This patient might be evasive in their interactions with MHPs without necessarily having the conscious intent to deceive the clinician (Simon, 2008: 517). Assessment of behavioural risk factors could facilitate appropriate treatment in this challenging setting (Simon, 2008: 521).

3.9.4 Contact with mental health professionals (MHPs) before death Up to 41% of those in the general population who die by suicide might have contact with psychiatric inpatient care in the previous 12 months. Up to 9% died within one day of discharge. Contact with health services was common before death by suicide. Detection and management of such patients in advance of their suicidal behaviour remained a challenging work-in-progress (Pirkis and Burgess, 1998).

Hodelet and Hughson (2001) observed that many suicide victims will have no contact in their lives with mental health services. O'Connor et al. (1999) demonstrated that up to 45% (N=64) of their 'death by suicide' cases were 'out of the blue', not foreseen by family or GP and without any known contact with mental health services (See par. 2.10 above).

Luoma et al. (2002) reviewed 40 studies into contact by patients, before their suicide, with primary or mental health care providers. They found that a majority of individuals who died by suicide did make contact, particularly older adults. They concluded that alternative suicide prevention approaches were needed for those individuals, specifically young men who did not readily engage with care providers (Luoma et al., 2002: 914).

Draper et al. (2008) completed a pilot study of a suicide victim's last contact with a health care provider (HCP). They interviewed 37 MHPs who had contact with 28 individuals who subsequently died by suicide. 19% (N=7) of these MHPs were

unaware of their patient's suicide. 60% (N=22) of the deceased who presented with major depression were assessed for suicide risk: none was felt to be suicidal. Family informants with more detailed knowledge of their relative's potential suicidal tendencies frequently did not communicate this to HCPs (Draper et al., 2008: 100). Education for families and the general public about the practice of suicide prevention remained an important strategy for reducing suicide.

3.9.5 Clinicians' attitudes to suicidal clients The emotional response by clinician survivors to their patient suicide experience is frequently reported to contain varying degrees of anger (Litman, 1965; Holden, 1978; Goldstein and Buongiorno, 1984; Chemtob et al., 1988 a & b; Horn, 1994; Hendin et al., 2000; Gaffney et al., 2002; Tillman, 2006; Gitlin, 1999 & 2006; Hamaoka et al., 2007). Merely working with clients who are known to have suicidal intent has potential to predispose clinicians to experience a range of negative emotions. As mentioned at par.2.8 above, potentially suicidal clients can provoke negative emotions in clinicians resembling passive anger (Firestone, 1997).

The negative influence of unaddressed countertransference hate, which consists of a mixture of aversion and malice, had the potential to poison the therapeutic relationship (Maltsberger and Buie, 1974; Watts and Morgan, 1994; Jobes and Maltsberger, 1995) through the effect of a sense of empathic dread, causing the clinician to experience malignant alienation from the client. Strategies were documented for preventing and managing the alienation process for difficult patients on psychiatric wards with the aim of reducing inpatient suicide. Watts (1994) noted that clinicians might benefit from training in the adoption of these approaches.

Almost all clinicians (97.2%) were found to fear that their client will kill themselves (Pope and Tabachnik, 1993) while clinicians' attitudes towards their client deteriorated from warmth towards anger in proportion with clients' increasing levels of suicide risk (Dressler et al., 1975). Scheurich (2001: 1036) illustrated a related phenomenon, the low evaluation that some clinicians may have of suicidal clients. His client shot himself in the left shoulder causing little damage. While he was being bandaged in casualty, another clinician was overheard to remark: 'Next time he should aim a little lower'. See also ET at par 5.8.7 below.

3.10 Consequences for clinicians of their psychotherapeutic practice

3.10.1 Guy and Liaboe (1986) contrast the positive and negative consequences of psychotherapeutic practice for clinicians. They are concerned that negative effects predominate, citing an alarming rate of suicide and alcoholism among practitioners. Although many clinicians reported increases in assertiveness, self-assurance, self-reliance, introspection and expanded sensitivity, some experienced significant problems with anxiety and depression. Interpersonal functioning was adversely affected particularly family relationships (Guy and Liaboe, 1986: 111). Alcohol misuse may be a theme that links clinicians, clients and suicide.

3.11 The influence of alcohol misuse

3.11.1 Pirkola et al. (2000) analysed 997 suicides in Finland in 1987/88 of whom 35% (N=349) were considered to have misused alcohol. Murphy et al. (1992) identified several factors that were predictive of suicide in alcohol abusers including continued drinking and suicidal communication. Walsh (2008) believed the fundamental difficulty in preventing suicide was the juxtaposition of the rarity of its occurrence and the commonality of perceived risk factors for suicide. He questioned the effectiveness of initiatives, education schemes and health-related programmes that were not evidence-based. One significant factor that Walsh (2008) felt had been shown to be linked to suicide over time was alcohol misuse. Anderson and Baumberg (2006) showed that up to 17% of suicides were alcohol-related.

Walsh (2008) argued that controlling alcohol-related problems might be one of the only evidence-based measures for suicide prevention. He regretted that practical policies – prices increases, restricting access and controlling advertising – were not yet implemented to deal with a known and preventable factor in suicide (Walsh, 2008: 66).

3.12 Conclusions

Client suicide is a phenomenon about which more is now being written than previously. What emerges from the above survey is a potential challenge to a long-standing conventional view that clinician survivors of a client suicide experience broadly similar personal and professional responses that may be anticipated and worked through. It might therefore be possible to investigate whether each clinician experiences the loss of his client in a way that is peculiar to the therapist, his relationship with his now-deceased client and other relevant factors.

The next chapter considers concepts of human identity and identity development using the Identity Structure Analysis conceptual framework in the context of the clinician's experience of the loss of their client by suicide.

Chapter Four: Identity Structure Analysis

Chapter 4: Identity Structure Analysis

4.1 Introduction

For clarification, the meanings of three key terms or phrases used herein are explained. First, Erikson's (1950, 1959a, 1968) definition of *identity* 'spans one's past sense of self, what one is currently in the eyes of oneself and for others and one's expectations for the future' (Weinreich, 2003a: 7). Second, a *suicide survivor* is an individual who remains alive following the suicide death of someone with whom they had a significant relationship or emotional bond (American Association of Suicidology, 2000; Campbell, 2006: 459). Third, *identity development* describes a process wherein an individual's sense of themselves is influenced by life events.

An earlier study investigated identity development of survivors in the aftermath of suicide using content analysis and identity structure analysis (ISA) as complementary research instruments (O'Keeffe, 2000). The current study builds upon the earlier study by investigating the influence upon clinician survivors' identity of experience(s) of client suicide.

4.2 Effects of psychotherapy practice

Guy and Liaboe (1986) described positive and negative consequences for therapists of their interaction with clients. Tanney (1995) elaborated the particular challenge for caregivers of intervening with 'a person at risk (PAR)...for suicidal behaviours [that may be] conceptualised as a crisis for the helper because the competencies to cope effectively with these behaviours are simply not within their repertoire' (Tanney, 1995: 103). Other writers examined the adequacy of self-care practice in psychotherapy and counselling, including supervision and personal lifestyles of therapists in relation to vicarious traumatisation (Coffey, 1998: 158; Black et al., 2000: 559-561). Vicarious traumatisation (McCann and Pearlman, 1990; Pearlman and MacIan, 1995; Saakvitne, 1999) or secondary trauma (Cerney, 1985) or 'sadness of the soul' (Chessick, 1978) was described by Skovholt (2001: 101) – he called it practitioner emotional trauma – as 'a side effect' of therapist empathy: 'the...dilemma of needing to connect with the other by using one's soft side of the turtle rather than the hard shell'.

This potential hazard for clinicians exists in several suicide-related practice scenarios:

- i) the client is a suicide survivor, not least because ‘survivors of suicide clearly constitute a vulnerable population, a high risk group’ (Cain, 1972: 10)
- ii) the client presents with suicidal ideation (Garfunkel, 1995: 148)
- iii) the client has made one or more serious suicide attempts (Tanney, 1995: 103), and
- iv) the client takes their own life (Jobes et al., 2000: 549).

The significance of the last of these scenarios, viz. client suicide in a clinician’s professional life, is especially poignant where they have experienced several client suicides. The identification processes inherent in a clinician’s appraisal, interpretation and incorporation within their identity of such biographical episode(s) is a more complex phenomenon than what is rendered by the misleading and somewhat simplistic shorthand phrase ‘impact upon the therapist’s identity of client suicide’. Such a ‘complex phenomenon’ merits careful, compassionate but intensive investigation.

This chapter describes the ISA research instrument, including underpinning theory, which is used for this investigation of identity development in clinician survivors .

4.3 Identity structure analysis (ISA)

Each person is unique, an individual unlike any other. But there are ways in which people are similar (Harré, 2003: xvii). A problem exists in how to describe the similarities exhibited when people are being compared and contrasted regarding their relationships with self and others. The identity structure analysis (ISA) project is an approach to devising a way to communicate using ‘a common generic vocabulary... that would...resolve the ambiguities of the vernacular, but stand above the huge array of cultural variations in ways of talking about people’ (Harré, 2003: xix). ISA was developed ‘above all’ to create a method that might be universally applicable for investigating ‘selfhood as identity, in both its individual and general meanings’. Hence ‘common method[s] of analysis [and] a common system of categories and attributes’ were necessary prerequisites to facilitate ‘valid comparisons, generalisations’ and the like when describing people (Harré, 2003: xix).

The ISA approach to elucidating the uniqueness of an individual is located ‘in the ways that people appraise [or interpret] their situations, the events in which they play a part and their own characters and roles in these events (Harré, 2003: xix). Furthermore it is argued that changes in how people understand themselves and

others, in and through their relationships with self and others, are ‘tied in with biography and autobiography’ (Harré, 2003: xix). The cognitive and affective processes implicit in these appraisals and interpretations underpin a key ISA principle:

‘A person’s appraisal of the social world and its significance is an expression of his or her identity’ (Harré, 2003: xix).

A further key ISA property that is necessary to facilitate the above-mentioned approach to the analysis of individuals is:

‘the cluster of concepts roughly comprehended under the idea of “identification with”. Identity formation owes a good deal to ways in which a person tries to be like or not to be like another’ (Harré, 2003: xix).

Consequently ISA is meant to monitor a person’s ‘identification with (or not with)’ a range of entities – people, communities, social institutions, events and occurrences, and so on – ‘that seem to have been important in the person’s life manifested in[their] self-construals [or interpretations or comprehensions or understandings of themselves]’ (Harré, 2003: xx).

Computer software to support ISA has been devised ‘as an identity exploration tool’ in conjunction with bipolar constructs ‘which...are independent of one another’ (Harré, 2003: xx).

4.4 ISA – an integrative approach

Client suicidal behaviour extends across a broad spectrum from a survivor’s personal experience of an intimate’s suicide, through suicidal ideation, from a ‘cri de coeur’ attempt to a ‘cry of pain’ (Williams, 2001: xi) attempt, from a serious suicide attempt after which a client recovers, by design or good fortune, to a serious suicide attempt resulting in intentional death, completed suicide. Clinicians, experienced and knowledgeable about others’ suicidal behaviour and knowledgeable about their own suicidality or tendency towards suicide, form new identifications through and in each encounter. In this identification process, clinicians

‘may acquire new modes of thinking about their social and material world...partly expressed in discourses derived from...[those] others’ (Weinreich, 2003a: 5).

This enables the ISA approach, where appropriate, to facilitate longitudinal studies about identity development through follow-up studies over time. Identity structure analysis (ISA) is regarded:

‘as an open-ended metatheoretical framework for deriving explanations in terms of theoretical propositions that constitute intercommunicating theories about the phenomena under consideration – intercommunicating because they share the same framework of concepts’ (Weinreich, 2003a: 5).

Weinreich (2003a: 7-20) appraised the scientific literature on identity noting that many approaches subsumed by the term ‘identity’ emphasised differing identity processes. He set about integrating valid identity processes into a unified schema that underpinned and informed the identity structure analysis (ISA) conceptualisation.

4.5 The meaning of identity

Identity had been said to encompass ‘all things a person may legitimately and reliably say about himself – his status, his name, his personality, his past life’ (Klapp, 1969).

But:

‘the ME can mean many things; the ME of yesterday, today, or tomorrow, or the ME of everyday, the ME in this particular action or situation, or the ME in all actions and situations’ (Reizler, 1950) [so] ‘one’s concept of oneself is situated within the social context of one’s family and the broader community within which one experiences the trials and tribulations of everyday life’ (Weinreich, 1992: 2).

Undoubtedly the loss of a loved one by suicide affects the suicide survivor’s sense of self: ‘It may be that your self-image and your image of the person you loved have been damaged’ (Shannon, 2000: 6). Something similar might be said of the clinician survivor: ‘Therapists are likely to feel personally wounded when patients kill themselves, this wounding appearing as guilt, shame or denial’ (James, 2005: 9). Identity exploration techniques offered insights into how a person’s identity may be changed by the potentially traumatising impact of suicidal loss. Assimilation of the client suicide experience involved acknowledgement of such identity changes perhaps through the use of appropriate counselling therapies, designed to help suicide survivors to cope with their predicament. Building upon others’ ideas of what a person’s ‘identity’ means (Harré, 2003; Klapp, 1969; Reizler, 1950) Weinreich (1992) offered the following definition of identity:

‘A person’s identity is defined as the totality of one’s self construal, in which how one construes oneself in the present expresses the continuity between how one construes oneself as one was in the past and how one construes oneself as one aspires to be in the future’ (Weinreich, 1992: 29).

Identity Structure Analysis (ISA) as developed by Weinreich (1980, 1983, 1986, 1989) may be used to analyse how a person’s identity is formed and reformed by engagement with life experiences. The outcome of the application of ISA processes to an individual in an idiographic or case study mode facilitates an assessment of:

‘[an] individual’s appraisal of self and others in a way that takes account of the wider social context and self’s idiosyncratic ways of relating to that context...It is custom designed to reflect the uniqueness of the individual’ (Weinreich, 1992: 2).

ISA is the principal research instrument in the current study to explore identity changes in clinician survivors linked to the aftermath of the suicide of their client. Postvention strategies, designed to take account of such changes that match clinician survivors’ actual psychological and other needs might then be considered.

4.5.1 Identity exploration and counselling approaches

The ISA’s metatheoretical framework employed:

‘concepts in the psychodynamic approach, social comparison theory, reference group theory, symbolic interactionism, personal construct theory and cognitive-affective consistency theory’ (Black and Weinreich, 2000: 28).

Some of these concepts were constituent elements across a range of counselling approaches. When used to underpin the ISA approach to identity development, some of these concepts might be helpful in explicating a deeper understanding of counsellor-client interactions. These are now discussed further in order to locate and highlight their contribution to the ISA approach.

4.5.2 The psychodynamic approach

The psychodynamic approach was ultimately derived from Freud’s (1901, 1909, 1910, 1917, 1933) psychoanalytic theory. His key assumptions were that

- a) emotional problems had their origins in childhood experiences,
- b) people were usually not conscious of the true nature of these experiences, and
- c) unconscious material emerged indirectly in counselling through the transference reaction to the counsellor and in dreams and fantasy (McLeod, 1998: 58,59).

But Erikson (1950), a neo-Freudian, and other recent writers in the psychodynamic tradition, broke away from Freudian theory to encompass the social as well as the unconscious. He emphasized 'the psycho-social development of the child rather than the sexual or biological aspects' (McLeod, 1998: 35). This offered psychodynamic insights to identity development including the notion of 'inner self' or ego. Erikson (1994) used the term 'ego identity' to denote

'certain comprehensive gains which the individual, at the end of adolescence, must have derived from all of his pre-adult experience in order to be ready for the tasks of adulthood' (Erikson, 1994: 108).

He restated this as follows: 'In the social jungle of human existence, there is no feeling of being alive without a sense of ego identity' (Erikson, 1963: 240).

There were four aspects that described the complicated inner state that was preserved by a sense of ego identity: (i) a sense of individual identity; (ii) a criterion for the silent doings of ego synthesis; (iii) a continuity of personal character, and (iv) maintenance of inner solidarity with a group's ideals and identity (Erikson, 1994: 109). Erikson (1994) conceptualised an eight-stage model of psychosocial development involving at 'each successive step...a potential crisis because of a radical change in perspective' (Erikson, 1994: 37), and incorporating three main categories – childhood (four stages), adolescence (one stage) and adulthood (three stages).

(Childhood)

Stage 1: Basic trust vs. mistrust. 0-18 mths – *Hope* – Trust in mother or central caregiver and in one's own ability to make things happen. A key element in an early secure attachment.

Stage 2: Autonomy vs. shame. 18mths-3yrs – *Will* – New physical skills lead to free choice; toilet training occurs; child learns control but may develop shame if not handled properly.

Stage 3: Initiative vs. guilt. 3-6yrs – *Purpose* – Organise activities around some goal; become more assertive and aggressive; Oedipus conflict of parent with same sex may lead to guilt; development of conscience.

Stage 4: Industry vs. inferiority. 6-11yrs – *Competence* – Absorb all the basic cultural skills and norms, including school skills and tool use. Learn technical skills that prepare children for adult roles.

(*Adolescence*)

Stage 5: Identity vs. role confusion. Puberty-20's – *Fidelity* – Adapt sense of self to pubertal changes, make occupational choice, achieve adult like sexual identity, and search for new values. A questioning of old values.

(*Adulthood*)

Stage 6: Intimacy vs. isolation. 20's-40's – *Love* – Form one or more intimate relationships that go beyond adolescent love; form family groups. Fear of competition in relationships could lead to isolation.

Stage 7: Generativity vs. self-absorption and stagnation. 40-60yrs – *Care* – Bear and rear children, focus on occupational achievement or creativity, and train the next generation; turn outwards from the self to others.

Stage 8: Ego integrity vs. despair. 60yrs onwards – *Wisdom* – Integrate earlier stages and come to terms with basic identity. Accept self.

The fifth stage, *adolescence*, was crucial to the process of identity formation, in resolving the psychosocial conflict between identity and role confusion as the adolescent integrated their past experiences into a new whole.

'The emerging ego identity...bridges the early childhood stages, when the body and parent images were given their specific meanings, and the later stages, when a variety of social roles become available and increasingly coercive' (Erikson, 1994: 96).

Marcia (1966, 1980) identified four identity statuses within adolescence of which there were two key parts, a crisis and a commitment. These were:

Identity achievement: The person has been through a crisis and reached a commitment to ideological goals;

Moratorium: A crisis is in progress, but no commitment has yet been made.

Identity Foreclosure: The individual has not experienced a crisis but nevertheless is committed in their goals and beliefs largely as a result of choices made by others: the young person accepts a parentally or culturally defined commitment.

Identity diffusion: The person is not in the midst of a crisis but may have experienced one in the past; they have not made any commitment to a vocation or set of beliefs. Hence diffusion may represent either an early stage of the process (before a crisis) or a failure to reach a commitment after a crisis (Marcia, 1966). The latter status offered the greatest challenge to therapists whose task was to help the individual to integrate

‘disparate identity elements into a coherent, meaningful identity structure’ (Marcia, 1987: 168).

4.5.3 Social comparison theory

Festinger’s (1954) social comparison theory offered insights into human beings’ awareness of others’ views including how humans compared themselves with those they perceived as being similar to themselves (Weinreich, 1992: 2). He suggested that people had an inner drive to validate those opinions and abilities that they used to function effectively in the world. He argued that opinions, beliefs and attitudes were ‘correct’ to the extent that they were anchored in a group of people with similar beliefs, opinions and attitudes (Festinger et al., 1950). Absence of physical or social comparisons rendered the individual’s self-evaluation unstable until a suitable comparison was found.

4.5.4 Reference group theory

Reference group theory suggested that individuals make comparisons using positive and negative reference groups for estimating their social standing or deciding whether to be satisfied or dissatisfied with their predicament (Merton, 1957). Significantly, Merton and Kitt (1950) suggested that when levels of aspiration or degrees of determination were being compared, ‘the individual must necessarily take the role of the other in order to make a comparison’ (Merton and Kitt, 1950: 65).

4.5.5 Symbolic interactionism

Cooley (1902) postulated that people learn about themselves from others, using the notion of the ‘looking-glass self’ to describe the development of self-concept. Mead (1934) believed that ‘perspective taking’ was the basis for self. The theory of social interactionism was concerned with understanding the socialisation process whereby individuals learned about themselves from the characteristics and values attributed to them by others.

‘Mead argued that individuals become socialised when they adopt the perspective of others and imagine how they appear from other people’s point of view. For Mead, this perspective taking ability is synonymous with the acquisition of self’ (Brown, 1998: 83).

Development of this ability depended upon an individual’s skills in communicating with symbols and in play. Initially individuals adopted the perspective of particular others towards self. Later they adopted the perspective of an abstract generalised other. At this stage, self was fully developed and socialisation was said to be

complete. Mead (1934) emphasised cognition rather than affective processes as central to self:

‘Self consciousness, rather than affective experience provides the core and primary structure of the self, which is thus essentially a cognitive rather than an emotional phenomenon’ (Mead, 1934: 173).

In contrast to Mead, Goffman (1959) presented short-term selves based upon roles acted out in social settings. The self interacted with society in short episodes:

‘in which the script is followed to the end, but when the “play” is over the individual sheds one costume and dresses himself up in another’ (Burns, 1979: 17).

Finally Stryker (1984) developed an ‘emerged structural symbolic interactionist framework’ where identities were derived from roles, such that an individual could have several identities arranged hierarchically in terms of salience:

‘Commitment to the role dictates the salience [or conspicuousness] attached to the identity it confers and salience subsequently shapes role performance’ (Breakwell, 1986: 30).

4.5.6 Personal Construct Theory

Personal construct theory was based upon the philosophical assumption of ‘constructive alternativism’, which stated that ‘all of our present interpretations of the universe are subject to revision or replacement’ (Kelly, 1955: 15). Mahoney (1988) considered that constructivism:

‘refers to a family of theories that share the assertion that human knowledge and experience entail the (pro)active participation of the individual’ (Winter, 1997: 219).

Guidano (1987) held that people actively construct their own worlds and ‘the maintenance of one’s perceived identity becomes as important as life itself’ (Winter, 1997: 219). Kelly’s (1955) personal construct theory examined the individual’s idiosyncratic construal – or interpretation – of their world: ‘not only do we construct our worlds but, as the client may discover in counselling, we can reconstruct them’ (Winter, 1997: 220). Kelly’s ‘scientist’ metaphor saw the self formulating hypotheses about themselves and the world, and testing and revising those hypotheses in the light of experience. A person tested this understanding:

‘by predicting future events. If these events are consistent with prediction, the construct is said to be validated. If the events are inconsistent with prediction,

the construct is invalidated and the person experiences pressure to change the system' (Leitner, 1985: 83).

The essentially anticipatory nature of human functioning was expressed in the fundamental postulate of personal construct theory:

'A person's processes are psychologically channelised by the ways in which he anticipates events' (Kelly, 1955: 4).

Kelly elaborated his fundamental postulate in eleven corollaries that explain the process of construing or interpretation. Each individual, according to Kelly, developed a system of bipolar constructs. Bipolarity meant that each construct offered 'a pathway of movement' for each individual (Kelly, 1955: 128). For example, one individual employed a construct contrasting being assertive with being reasonable. He was resistant to moving down the path of becoming more assertive because of its implication of also becoming more unreasonable:

'In choosing which pole of a construct to apply to an event, the person will select that option which is most likely to increase his or her capacity to anticipate the world. This notion may make even the most self-destructive behaviour comprehensible ... stutterers would not trade stuttering for fluency until the latter carried as many ... possibilities for anticipating their world, as did stuttering (Winter, 1997: 220).

The ability to interpret another person's construction processes was the essence of intimate relationships, or to use Kelly's term, role relationships. Personal construct theory was also a theory of experiencing. In 'experiencing', our bodies and 'we' were one. Kelly believed that body and mind did not work as different systems: learning equated with experiencing:

'We learn – we successively re-construe – we experience. Experience is more than the moment-to-moment awareness of our existence. We enter ever new pastures when a sequence of our psychological processes completes a cycle of experience [which] starts with anticipation and ends with reconstruction' (Francella and Dalton, 1990: 10).

Thus Kelly's was a theory of change: placing constructions on human experience was not entirely about 'thinking' and 'feeling' – it was the act of discriminating.

Kelly's critics have referred to his emphasis upon cognition and intellect at the expense of affect or emotion: Kelly's

'dryly scientific theory omits most of the characteristics that seem vitally and distinctively human: love and hate, passion and despair, achievement and

failure, inferiority and arrogance, sexuality and aggression...if emotion is unimportant, it is unclear why the prospect of revising major constructs should be anxiety-provoking or threatening' (Ewen, 1998: 373).

4.5.7 Cognitive-Affective Consistency Theory

Kelly's (1955) emphasis on cognition was balanced by recent writers who devoted more attention to the emotional aspects of personality. 'Kelly's cognitive approach needed to be complemented with the emotional and affect-laden qualities of people's experiences' (Weinreich, 1989a: 48). Bipolar constructs could 'be associated with both those desirable states to which one aspires and others that represent those features of life one wishes to avoid' (Weinreich, 1989a: 49).

'The cognitions that a person holds about himself and others may be consonant, that is consistent and harmonious. On the other hand, they may be dissonant, that is to say inconsistent or contradictory' (Irvine, 1994: 79).

Those cognitive-affective consistencies might be uncomfortable psychological states that motivated the individual to resolve inconsistencies and achieve consonance (Festinger, 1957; Rosenberg and Abelson, 1960; Osgood and Tannenbaum, 1955; Weinreich, 1969). Weinreich (1989a: 49) stressed that 'in conceptualising identity', affective dimensions were incorporated in relation to the cognitive categories used by people to interpret both others' behaviour and their own experiences.

4.6 Application of Identity Structure Analysis (ISA) to participants

The application of the ISA approach to current research participants is detailed in Chapter 6 Research Methodology. The next section describes how ISA facilitates the exploration of identity development.

4.7 ISA concepts and identification processes

Underlying concepts and terminology used in interpreting respondents' ISA results are set out below, including:

- (a) beliefs and values systems;
- (b) identification processes including role model identification, empathetic identification and conflicted identification;
- (c) theoretical postulates regarding resolution of conflicted identifications and formation of new identifications;
- (d) structural pressure;

- (e) theoretical postulates concerning constructs regarding core evaluative dimensions of identity, conflicted dimensions of identity and unevaluative dimensions of identity;
- (f) identity diffusion;
- (g) self-evaluation; and
- (h) identity states including negative identity state, diffused identity state and foreclosed identity state (Weinreich, 1992: 1-36).

4.7.1 Beliefs and values systems

Analysis of an individual's identity structure using bipolar personal constructs and entities involves ascertaining some dimensions of the individual's values and beliefs system while examining some of the individual's partial identifications with significant others (Weinreich, 1988: 2). While such systems may be 'ill thought-through, confused and inconsistent in practice...people within various cultures and sub-cultures often hold to shared everyday ideologies...which are generally not well articulated' (Weinreich, 1992: 9). ISA offers a methodology for exploring the power of one's actual values and beliefs system to condition one's identity.

4.7.2 Identification processes

There are two important identification concepts within ISA, namely role model identification and empathetic identification. Role model identification refers to the degree to which 'one might wish to emulate another when the other is a positive role model (idealistic identification), or dissociate from the other when a negative role model (contra-identification)' (Weinreich, 1989a: 52). People aspire to possess 'the attributes of their positive role models, and wish to avoid the characteristics of their negative role models' (Weinreich, 1992: 7).

Empathetic identification with another refers to 'the degree of perceived similarity between the characteristics, whether good or bad, of that other and oneself.' (Weinreich, 1989a: 52). Individuals therefore have aspirational identifications that co-exist with de facto identifications:

'One aspires to some ideal, represented in one's aspirational identifications with one's positive role models, whilst being of a more mundane existence in the here and now, when one's de facto identifications are more often close to one in shared experiences and characteristics' (Weinreich, 1992: 7).

Conflicted identifications occur when one simultaneously sees oneself as similar to another and recognises that other as having characteristics from which one wished to

dissociate oneself. Two ISA postulates emerge in relation to identification process dealing with attempted resolution of identification conflicts and emergence of new identifications:

Postulate 1: When one's identifications with others are conflicted, one attempts to resolve the conflicts, thereby reducing re-evaluations of self in relation to the others within the limits of one's currently existing value system.

Postulate 2: When one forms further identifications with newly encountered individuals, one broadens one's value system and establishes a new context for one's self-definition, thereby initiating a re-appraisal of self and others which is dependent on fundamental changes in one's value system.
(Weinreich, 1989a: 53)

4.7.3 Personal constructs and structural pressure

Construal of self is regarded as central to the ISA definition of identity stated above. Personal constructs, cognitive in nature, are used to evaluate the characteristics of self and others. Affective associations are considered in the evaluative connotations of the cognitive constructs in terms both of positive values (the individual's aspirations) and negative values (those from which the individual wished to dissociate). Structural pressure is an ISA index that estimates the extent to which individuals consistently attribute favourable or unfavourable characteristics to particular entities. Three ISA postulates emerge in relation to cognitive affective consistency and structural pressure on constructs:

Postulate 1: When the net structural pressure on one of a person's constructs is high and positive, the evaluative connotations associated with it are stably bound.

Postulate 2: When the net structural pressures on a construct are low, or negative as a result of strong negative pressures counteracting positive ones, the evaluative connotations associated with the constructs are conflicted: the construct in question is an area of stress.

Postulate 3: When the net structural pressure on a construct is low as a result of weak positive and negative pressures, the construct in question is without strong evaluative connotations.
(Weinreich, 1989a: 55, 56)

Application of these postulates allows an individual's beliefs and values system to be evaluated. Constructs represented by Postulate 1 are **core evaluative dimensions of identity**:

‘These reference the values and beliefs estimated as being central to the respondent’s identity, in the sense that the person uses them foremost to judge the merits of self and others. At the extreme (they) could indicate a rigid and perhaps bigoted orientation (and) may be regarded as resistant to change’ (Weinreich, 1992: 21).

Constructs represented by Postulate 2 are **conflicted (inconsistently, or non-evaluative) dimensions of identity**. These

‘indicate areas of a respondent’s identity...under stress...around which the person’s behaviour may be problematic...unpredictable. They may be unstable’ and subject to change over time (Weinreich, 1992:21).

Constructs represented by Postulate 3 are **consistently unevaluative dimensions of identity or dual morality dimensions of identity**. They denote ‘a tendency to... associate with valued others the opposite pole of a construct...to the one desired by the respondent’ implying a dual morality in relation to behaviour associated with the construct (Weinreich, 1992: 21).

4.7.4 Identity diffusion, self-evaluation and ego-involvement

Identity diffusion is defined as ‘the overall dispersion of, and magnitude of one’s identification conflicts with significant others’ and is capable of assessment in relation to both current and past self-images (Weinreich, 1992: 31). An individual with high identity diffusion may have strongly conflicted identifications dispersed across a number of significant others. Low identity diffusion indicates a person with little identification conflict, ‘indicating defensiveness against identification conflicts’, implying a failure to differentiate between ‘good’ and ‘bad’ either within the self or others (Weinreich, 1992: 36).

Self-evaluation is closely linked with one’s beliefs and values system and is defined as ‘one’s overall assessment in terms of the positive and negative evaluative connotations of the attributes one construes as making up one’s current or past self-image, in accordance with one’s value system.’ One’s evaluation of another closely parallels this, in relation to how one assesses the other’s attributes, according to one’s own value system (Weinreich, 1992: 31).

Ego-involvement with oneself, or self-involvement – as one aspires to be, or as one is now or as one was in the past – is defined as ‘one’s overall self-responsiveness both in quantity and strength of the attributes of one’s ideal self-image (or current self-image or past self-image).’ Ego-involvement with another involves similar considerations in relation to ‘one’s overall responsiveness to the other in terms

of the extensiveness of both in quantity and strength of the attributes one construes the other as possessing' (Weinreich, 1992: 32).

4.7.5 Identity variants

The classification of identity variants is based entirely upon the underlying parameters of self-evaluation and identity diffusion, as defined above. It is therefore global in its application, ignoring 'individual characteristics indicated in detail by the full range of identity indices for the person' (Weinreich, 1992: 36). The classification of nine identity variants is based on Erikson's (1994) eight stage sequence for identity growth and on Marcia's (1966, 1980) four identity statuses – see Table 4.1 below. The most usual identity state is that classified as 'indeterminate', corresponding to moderate identity diffusion and moderate self-evaluation. This identity state is regarded as well adjusted. The term 'indeterminate' is used to direct attention to the underlying detail of the respondent's identity structure reflected in other identity indices. The identity state 'confident' reflecting high self-evaluation and moderate identity diffusion is also regarded as psychologically well-adjusted.

Table 4.1- Classification of Identity Variants

Classification of Identity Variants			
	IDENTITY DIFFUSION High (0.41-1.00)	Moderate (0.26-0.40)	Low (0.00-0.25)
SELF-EVALUATION High (0.81-1.00)	Diffuse high self-regard	Confident	Defensive high self-regard
Moderate (0.19-0.80)	Diffusion	Indeterminate	Defensive
Low (-1.00-0.18)	Crisis	Negative	Defensive negative

The remaining seven identity states are regarded as vulnerable as each represents a combination of identity diffusion and self-evaluation that is inappropriate. Those identity states classified as 'diffused' that reflect high and dispersed levels of conflicted identifications with others, are

- a) 'diffuse high self regard' – where self-evaluation is also high,
- b) 'diffusion' – where self-evaluation is moderate and
- c) 'crisis' – where self-evaluation is low.

It is suggested that individuals reflecting these states are unable to resolve their identification conflicts and consequently may have difficulty in making definite commitments.

The 'negative' identity state, with moderate identity diffusion and low self-evaluation, applies to individuals whose skills deficiency may preclude them from acting in accordance with their values and aspirations.

The remaining three identity states are classified as 'defensive' (or foreclosed) states with low identity diffusion, indicating a failure to acknowledge ordinary or usual levels of conflicted identifications. They are

- d) 'defensive high self-regard' – where self-evaluation is high,
- e) 'defensive' – where self-evaluation is moderate and
- f) 'defensive negative' – where self-evaluation is low.

It is suggested that people reflecting these states make undifferentiated appraisals of their social worlds and find it difficult to adapt to complex relationships and to changed circumstances (Weinreich, 1992: 22, 23, 36; Irvine, 1994: 102-109; and Black, 2000: 9-21).

4.7.6 Theory building using ISA

It was noted above (see par 4.4. above) that ISA is an open-ended metatheoretical framework of concepts relating to the structure, content and processes of identity development (Weinreich, 2003a: 5). Instead of a 'grand' or 'universal' theory', it should be regarded as a flexible framework built upon careful definition of theoretical concepts relating to aspects of identity and the presentation of theoretical process postulates concerning the development and redevelopment of identity. By applying this framework of concepts and postulates to data assembled by the use of focused identity instruments, investigators may arrive at new theoretical propositions 'about the socio-psychological processes of identity development in the socio-historical and biographical context under investigation' (Irvine, 1994: 109).

4.7.7 It was appropriate and convenient to include below at chapter 6, par.6.5, a discussion on ISA operationalisation in the context of the current study's research methodology.

4.8 Suicide, counselling and identity

This research study investigates identity development in clinician survivors. Its principal focus is to ascertain the actualité of the influence upon a clinician's sense of him/herself of this sudden, permanent loss of a client(s). Conventional approaches to the aftermath of client suicide are confused and uncertain. There is 'a poverty of care' for clinician survivors who face a paradoxical situation that leaves the needs of many suicide survivors only partially satisfied and therefore unmet to a greater or lesser extent:

'[Family] survivors [of the deceased client] have expressed desires to discuss their particular concerns and ask questions of the clinician. Clinicians, often conflicted by the need for self care, care for survivors and other internal and external constraints, are unsure of how to proceed' (Campbell, 2006: 460).

The aftermath of client suicide may expose clinician survivors to an enhanced risk of suicidal behaviour (Cain, 1972: 10; Campbell, 2006: 460). Exploration of clinician survivors' identity development could address this potential risk by facilitating more appropriate postvention strategies based upon research outcomes.

4.9. Theoretical postulates

Before describing the study's research methodology in chapter 6, below, relevant empirical literature presented in chapter 3, above, is synthesised to identify emergent themes and to articulate, next in chapter 5, theoretical postulates to provide focus and direction for the study.

Chapter Five: Theoretical Postulates

Chapter 5: The clinician survivor's experience: a survey of empirical data and emergent theoretical postulates.

5.1 Introduction

More than four decades of published research studies, albeit 'relatively sparse' (Foley and Kelly, 2007: 134) representing 'a collective avoidance' (Soderlund, 1999: 2) of the issue, has acknowledged both personal and professional responses by clinicians to loss of their client by suicide. Methods used in these studies were wide-ranging, including interview and content analysis (Litman, 1965; Kahne, 1968a; Henn, 1978; Goldman and Buongiorno, 1984; Kleespies, 1990 & 1993; Tillman, 2006), psychological autopsy (Litman, 1965), survey questionnaire (Kahne, 1968a; Holden, 1978; Brown, 1987a & 1989; Chemtob, 1988 a & b; Horn, 1995; Cryan et al., 1995; Grad and Zavasnik, 1998; Alexander et al., 2000; Dewar et al., 2000; Hendin et al., 2000; Gaffney et al., 2002; Ruskin et al., 2004; Hamaoka et al., 2007), literature review (Holden, 1978; Marshall, 1980; Jones, Jr., 1987; Horn, 1994; Farberow, 2001; Gitlin, 2006; Foley and Kelly, 2007), psychometric scales (Kleespies, 1990 & 1993; Horn, 1995), consensual qualitative research (Darden, 2008) and multiple methods (Hendin et al., 2004; Hendin et al., 2006).

5.2 Clinician's personal response

Personal responses by clinicians to client suicide were found to be similar to those experienced 'after such an event by family members' (Farberow, 2001: 12, 13) and 'equivalent...to the loss of a parent' (Soderlund, 1999: 2). The intensity of the clinician's relationship with their now-deceased client influenced their reactions (Litman, 1965) although clinicians' personal attributes including age (Farberow, 2001: 13) and gender (Grad et al., 1997) affected the intensity of some clinicians' responses.

5.3 Clinician's professional status

The clinician survivor's professional status strongly influenced their response. It was found that trainee clinicians' responses were often more pronounced than those of their more experienced colleagues (Henn, 1978; Brown, 1987a) following a similar loss by suicide. The more years a clinician was in practice, the less the level of their distress after a client's suicide (Hendin et al., 2004). However professional discipline, work setting and whether working with in-patients or out-patients were not factors that were found to be related to clinicians' levels of distress (Hendin et al., 2004).

5.4 Relationship quality

Jobes (2000) argued that ‘suicidality is essentially a relational phenomenon...the presence and/or absence of...key relationships can paradoxically be both suicide causing and suicide preventive’ (Jobes, 2000: 8). Further the quality of the clinician/client relationship was found to affect the clinician survivor’s reaction. Gaffney et al. (2002) confirmed the importance of this ‘key factor’ (Gaffney et al., 2002: 95). For example a clinician survivor’s feelings of grief and guilt were linked to their emotional connectedness and closeness of involvement with their client (Hendin et al., 2004).

Kahn (2001) believed that ‘in [psycho] therapy the therapist provides for the client a relationship unlike any the client has had before’ (Kahn, 2001: xi). He further held that ‘the relationship is the therapy’ (Kahn, 2001: 1) and urged counsellors to be ‘genuine, respectful, non-defensive and affirming of the client’s reality [and] to communicate to clients...empathy for their experience’ (Kahn, 2001: 18). When working with a client who expresses suicide ideation, the clinician’s approach was towards suicide prevention (Litman, 1996). But if the above mentioned attributes were diluted, diminished or absent in the clinician/client interaction, sub-optimal outcomes, up to and including client suicide, might be manifest (Stone, 1971; Firestone, 1997; Jobes, 2000; Orbach, 2001).

5.5 Case studies of clinician survivors’ experience of client suicide

A relatively small number of case studies devoted to client suicide were located by the investigator. Most involved clinician survivors writing about their personal experiences (Gorkin, 1985; Beatriz Foster, 1987; Phillips, 1995; Grad, 1996; Gitlin, 1999; Meade, 1999; Valente, 2003; Grad and Michel, 2005; Kapoor, 2008). Two clinician survivors (by proxy) wrote about the effect upon them of a colleague’s client suicide experience (Maltsberger, 1995; Misch, 2003).

What emerged from these studies was that which distinguished each of them from the others, as opposed to what they appeared to have in common. Unique aspects included each clinician’s personal and professional attributes, each client’s presenting and underlying issues, the quality of the ‘therapeutic alliance’ (Kahn, 2001: 151) and the influence, conscious or otherwise, of unaddressed countertransference hate (Maltsberger and Buie, 1974; Watts and Morgan, 1994; Jobes and Maltsberger, 1995).

5.6 The aftermath of client suicide

Writers on client suicide offered contrasting prognoses for clinician survivors. A majority of writers argued that clinician survivors may share similar experiences, albeit of varying intensity, including emotional distress, complicated grief or symptoms of acute stress response together with common professional consequences including feelings of failure, self-doubt and fears around censure and litigation (Cain, 1972; Goldstein and Buongiorno, 1984; Chemtob et al., 1988 a & b; Kleespies et al., 1993; Horn, 1994 & 1995; Cryan et al., 1995; Alexander et al., 2000; Farberow et al., 2001; Ruskin et al., 2004; Tillman, 2006; Gitlin, 2006; Foley and Kelly, 2007).

A minority of writers acknowledged that while many clinician survivors may experience a range of emotional and professional consequences, it was vital that individual differences were respected given the uniqueness of each client suicide event and consequently the appropriateness of tailored postvention responses (Marshall, 1980; Berman, 1995; Farberow et al., 2001; Gaffney et al., 2002). Hendin et al. (2000) referred to evidence of idiosyncratic processing by clinician survivors while Horn (1994) noted variations in clinician survivors' responses.

5.7 Coping with the aftermath

Some writers advocated organisational/institutional responses (Ruskin et al., 2004; Foley and Kelly, 2007). Others held that clinician survivors' postvention was the responsibility of each affected individual (Grad and Zavasnik, 1998; Meade, 1999; Campbell, 2006) at their own discretion (Soderlund, 1999) while Ruskin et al., (2004) referred to a minority of clinician survivors who were less resilient and therefore more vulnerable and who risked long-term adverse effects.

5.8 Emergent themes

A synthesis of this research produced the following themes:

5.8.1 Clinician survivors' response is dependent upon their respective levels of resilience and vulnerability;

5.8.2 The clinician survivor's response reflects the unique impact of their client's death by suicide;

5.8.3 Postvention for clinician survivors is the responsibility of each affected individual;

5.8.4 A collective avoidance concerning how clinicians deal with client suicide is reflected in the scarcity of research into this phenomenon;

5.8.5 The levels of emotional connectedness and closeness of involvement of clinician and client are the determinants of the clinician survivor's grief and guilt;

5.8.6 The relationship, or therapeutic alliance, is a key factor in facilitating benevolent outcomes for clinician survivors;

5.8.7 Unaddressed countertransference hate can adversely affect the therapeutic alliance resulting in sub-optimal outcomes when the client presents with suicide ideation;

5.8.8 The apparent imbalance in relation to the incidence of client suicide between trainee clinicians and their more experienced colleagues may be an avoidable consequence of an inappropriate case assignment strategy;

5.8.9 Clinician survivors (by proxy) will exhibit similar affects in the aftermath of client suicide but at reduced levels of intensity.

The above themes evidence multidimensional aspects of the client suicide phenomenon in relation to how it affects clinician survivors, both personally and professionally. Shneidman (1985) referred to suicide as 'a multidimensional malaise' (Shneidman, 1985: 203) and the form and content of each clinician survivor's response to client suicide evidences a similarly intricate configuration. Two further themes, emerging from Rubin's (1990) lists of personal and legal 'do's and don'ts' for clinician survivors when a patient dies by suicide, reflected some of this complexity:

5.8.10 Personal responsibilities: reach out to client's family and to colleagues; avoid discussion or appraisal of fault or blame; work with a trusted professional on own feelings.

5.8.11 Legal responsibilities: know relevant law and engage a private/institutional lawyer; keep accurate records about the prelude to and aftermath of client's death; do not alter any records: they are liable to discovery/subpoena in subsequent legal process; discuss case only in privileged settings; maintain client confidentiality.

Brown (1989: 426) described a related five stage process, based on Resnik (1969) and Cotton et al. (1983), specifically for trainee programmes which could structure institutional responses to patient suicide:

- i) Anticipation
- ii) Acute impact – within hours up to 8 weeks
- iii) Clarification and working through – 2 to 6 months
- iv) Reorganisation and addressing ongoing doubts – 6 to 18 months
- v) Preparation for reactivation and post-training practice.

To date no theoretical framework exists that attempts to understand and to integrate for the purposes of postvention, the dynamics of clinician survivors' responses to client suicide. In a recent study, Darden (2008) interviewed a small number (N=6) of clinical psychologist survivors and confirmed earlier findings (Kleespies et al.,1993) that these individuals experienced 'anguish' that met the criteria for complicated grief (Darden, 2008: 72).

Although none of the above mentioned themes are at odds with this inclusive finding, a complicated grief response to loss by client suicide represents one of several influences that impact the clinician's identity. Identity structure analysis facilitates measurement of individual research respondents' identity development, for example, in their appraisal and reappraisal of a key entity 'me when I am overwhelmed by life's cruelties' in a range of contexts. The current research will show that broad generalisations purporting to describe what happens to a clinician survivor's sense of self after client suicide are likely at best to be partially correct and that each clinician survivor's response is unique to them.

5.9 Clinician survivor's identity

Client suicide was described as 'possibly Freud's most intense personal experience of suicide' (Litman, 1970/1983: 567). Although Freud alluded to his patient's suicide three years after it occurred in mid-1898 (Freud, 1901/1976), Litman (1970/1983) believed that Freud's repression of the experience raised an 'important scientific problem':

'Is the taboo on suicide so intense that even psychoanalysts are reluctant to expose their case materials and personal experiences in this area?' (Litman, 1970/1983: 568)

For the following six decades, Freud's legacy may have impeded the accurate assessment of clinicians' responses in the aftermath of client suicide: they were not subject to scientific examination. The impact upon clinician identity as such was not specifically addressed in subsequent research. Researchers initially sought to estimate the frequency of client suicide before examining its potential impact on clinicians. The effect of such an event was estimated/measured using traditional psychological research approaches – interviews,

content/narrative analysis, survey questionnaire, statistical analysis and various psychological scales in particular Impact of Event Scale (IES) (Horowitz et al., 1979) and Acute Impact of Event Scale (AIES) (Kleespies et al., 1993).

Medical science underpins psychiatry and relevant research outcomes were presented in related terms, including the use of the Diagnostic and Statistical Manual (DSM-IV-TR) of Mental Disorders (2000) and its antecedents. For example, clinical levels of post-trauma symptoms were reported by most psychiatrist survivors (Chemtob et al., 1988a) and by a minority of psychologist survivors (Chemtob et al., 1988b), although Kleespies et al. (1993) suggested that acute stress response better described some psychologist survivors' experiences after loss of their client by suicide.

Subsequent research focused upon how improved clinical practice in relation to assessment, preparation and supervision might benefit trainee clinician survivors (Yousaf et al., 2002) while Foley and Kelly (2007) addressed the utility of a combination of personal (family and friends) and professional (colleagues and team members) support facilities for survivors. Gaffney et al. (2002) came closest to acknowledging each clinician survivor's identity development. They suggested that as each clinician survivor's experience was likely to be as unique as their client's suicide, consequently effective postvention should respect individual differences in relation to each clinician survivor's actual needs.

The current research will attempt to examine how the individual clinician's sense of identity might be reconfigured by the experience of client suicide. No research evidence exists that directly links client suicide with disruption of a clinician's sense of identity. Black (2002) observed that 'where a traumatic experience gives rise to disruption in the individual's internal world making way for ambiguity and choice, appraisals of self and others in the traumatic circumstance become included within the traumatic stress responses' (Black, 2002: 109). Client suicide may or may not be perceived by the clinician as a traumatic event (Green, 1990: 1638). Hence the current research seeks to assess each clinician survivor's identity development taking account of the traumatic stress potential of the client suicide event.

Each clinician survivor tries to attribute meaning to their client's suicide in their attempt to make sense of the event. The appraisal process facilitates the clinician in exploring their experience of client suicide within the continuity of their life experiences (Black, 2002). In particular, the clinician's past self ('me as I was before my client's suicidal behaviour')

and the clinician's aspirational self ('me as I would like to be') will influence the clinician's current appraisal of self ('me when I am overwhelmed by life's cruelties') in the aftermath of experiencing their client's suicide.

Weinreich (2003) emphasises 'the continuity of oneself experiencing the social world and one's activities...such that...significant...past [events] are reconstructions in the present...elicited by cueing into emotional residues of past experiences' (Weinreich, 2003: 22). Identity continuity involves reappraisals of self which, in the context of client suicide, will depend upon how the clinician survivor cues into psychological states, e.g. anger, guilt, sadness or acute stress symptoms, associated with previous experiences of suicidal behaviour by self and others. Examining the reappraisal experience and consequential modulations in the clinician survivor's identifications, beliefs and values system and interactions with other suicide-related experiences, will enable changes in the clinician survivor's identity to be studied (Black, 2002). This process will also illuminate the meaning that the clinician survivor attaches to client suicide in accepting and assimilating that experience into their identity.

The clinician survivor's life experience will include many biographical events that are also identity-defining including the formation of new relationships, changes in employment, achieving 'identity aspirations' (Weinreich, 2003: 23) or realising cherished ambitions. Some of these experiences may have positive outcomes for the clinician's wellbeing; others may bring anxiety and uncertainty. The current research, in the context of the clinician survivor's overall identity, will investigate their unique response to the client suicide experience and consequent changes to the clinician survivor's identity (Black, 2002).

ISA facilitates the investigation of the clinician survivor's experience in relation to identifications (empathetic and conflicted), beliefs and values systems, and the reverberations of other suicide-related experiences. ISA can record identity development and redefinition in these respects but also with regard to contextual and biographical experiences. In particular it can also analyse the clinician survivor's unique disposition to their social world, and in that context, to the clinician survivor's response to client suicide.

As an open-ended metatheoretical framework, ISA offers the prospect of deriving explanations in terms of theoretical propositions. These emerge from the exploration of concepts related to the issue being researched through the appropriate operationalisation of the ISA framework and the use of theoretical postulates (Weinreich, 2003: 109). In relation to

research in a clinical context, two essential features that are critical are now discussed with support from Black (2002: 111).

5.9.1 ISA makes subjective objective

The ISA framework allows the subjective clinical matter, e.g. the clinician survivor's experience of client suicide, and identity to be made explicit. ISA's operational procedures make the subjective issues related to identity and the clinician survivor's experience of client suicide, assessable and verifiable. This means that what could only be surmised in relation to the clinician survivor's experience is made objectively explicit 'by way of transparent procedures of assessment' (Weinreich, 2003: 2); and

5.9.2 Identity is not fixed

Identity is not an immutable phenomenon: it is subject to appraisal and reappraisal. This means that an individual's identity state is always open-ended and liable to change. ISA takes this fully into account whereas standard psychometric scalar assessments are limited in this regard, failing to consider modulations in identifications and the reinterpretation of beliefs and values on encountering new experiences.

Further to the above, emic elements – the loss experience, the socio-historical and cultural context and the clinician survivor's biographical development expressed in relevant discourses and interpretations – are integrated into the ISA conceptualisation. Also etic features, where psychological concepts and processes may be attributed universally across cultures and contexts, are inherent in the ISA conceptualisation (Black, 2002; Weinreich, 2003: 78, 79).

5.10 Theoretical postulates

In exploring how the clinician survivor's experience of client suicide changes their identity, several theoretical postulates are now presented that make identity redefinition meaningful and that describe how the clinician survivor makes sense of their client suicide experience. These postulates investigate the dynamic processes that engage the clinician survivor in their effort to understand the modulations in identifications with significant others and to learn from these issues that challenge the clinician survivor's beliefs and values system (Black, 2002).

5.11 The clinician's exposure to suicidal behaviour – immediate aftermath

Clinicians may or may not be aware of their client's level of suicidality. There is no foolproof method as yet that can predict suicide (Pokorny, 1983 & 1993) or accurately measure the lethality of a person's urge to self-destruction: the most sophisticated suicide assessment protocol (Meichenbaum, 2005) carried out by the clinician in session with their client present may be quite accurate and valid at that time. But suicide can occur 'out of the blue' as it were: a pilot study by Draper et al. (2008) showed that 60% of clients assessed at their final therapy session as 'not at risk' subsequently died by suicide (Pirkis and Burgess, 1998; Isometsa et al., 1995). The intensity of the clinician/client relationship will affect the clinician survivor's reaction (Gaffney et al., 2002; Hendin et al., 2004). The above-mentioned parameters – unexpectedness (Dewar et al. 2000) and relationship intensity – may be related to the following postulate:

Postulate 1: The clinician's direct appraisal of their client's suicide will differ from a colleague's experience by proxy of the same event.

The clinician's psychological response to client suicide will be unique to that individual:

Postulate 2: The clinician's direct appraisal of their client's suicide will be unique to the individual clinician.

5.12 The clinician's experience of client suicide

A clinician's orientation may be designated along a continuum from 'defensive' to 'open'. Defensiveness may be evidenced in relation to exposure to their client's perceived level of suicide risk, or with regard to experiencing discomfort or in keeping distant from their client, or in avoiding self-disclosure or in being closed to considering new ideas. Openness or genuineness or transparency is regarded as a core condition for an effective therapeutic relationship (Corey, 1996: 205). Openness is evidenced in the clinician's willingness to 'being really open to the flow of our experience of self and client such that we can be fully available and committed – in the moment – to using all our facilities to feel and understand our client's experience and world as if we stood in [their] shoes' (Janecka, 2004: 55).

Weinreich (2009) notes that 'while "defensive" has clear connotations, "open" in relation to the parameter of "identity diffusion" is more complex. While "open" has in general speech a favourable connotation, within ISA too great a magnitude of identity diffusion refers to an overwhelming dispersion of conflicted identification, when "openness" to further complication will be dysfunctional'.

Within the ISA conceptualisation, defensiveness and openness can be compared to the defensive and other states represented in terms of identity variant states (see chapter 4 above). The identity variants ‘indeterminate’ and ‘confident’ are considered psychologically well-adjusted identity states while other ‘defensive’ or ‘diffused’ identity variants are considered to represent vulnerable identity states. Identity vulnerability relates to the parameters ‘identity diffusion’ and ‘self-evaluation’ while vulnerability in relation to client suicide describes the clinician’s resilience in the face of this loss experience. Note that the clinician’s vulnerability as a result of client suicide will lead to reappraisal of the clinician survivor’s identity. This means that global identity variants represent an approximation of identity reappraisal after client suicide. The following postulate emerges from the above:

Postulate 3: The clinician’s orientation towards their social world, whether defensive or open, influences the extent and nature of their experience of client suicide.

Clinician survivors will dissociate from those affective characteristics in their deceased clients that challenge their ability to tolerate the despair that led them to suicide. The following postulate expresses this process:

Postulate 4: Clinicians, in appraising the psychache and lethality (Shneidman, 1996) that brought about their client’s suicide, will contra-identify with that client wishing to dissociate from those characteristics.

5.13 Consequences for the clinician of experience of client suicide

Little empirical evidence exists that a client suicide experience leaves the clinician survivor’s sense of self unchanged (Phillips, 1995; Hendin et al., 2000). On the contrary, almost all clinicians, viz. 97.2%, fear the suicide of their client (Pope and Tabachnik, 1993). This defensive response by a clinician may mutate to passive anger during the counselling phase (Firestone, 1997) with potential to influence their post-client suicide affect. Getz et al. (1983) opined that ‘no one affiliated with the deceased [client] escapes some impact’ (Getz et al., 1983: 158; Berman, 1995). Horn (1994) suggested that psychological adaptation to client suicide involved alterations in the clinician’s identity arising due to the influence of their schemas (core beliefs and expectations of self) in coming to terms with the experience. These changes occur over a period of time and may involve altered approaches to future work practice with vulnerable clients (Horn, 1994; Gitlin, 1999; Alexander et al., 2000). A postulate that addresses these factors is:

Postulate 5: A clinician’s assimilation of a client suicide experience will give rise to a redefinition of identity that will be evidenced in modulations of identification conflicts and

self-evaluation, the extent of which will depend upon the clinician's orientation to their social world.

Empathy with a person in a therapeutic relationship differs from the ISA concept of empathetic identification. 'Empathy can be seen as an intellectual process that involves understanding correctly another person's emotional state and point of view' (Egan, 1998: 73). Empathetic identification with another is defined as 'the degree of similarity between the qualities one attributes to the other, whether "good" or "bad", and those of one's current self-image' (Weinreich, 2003: 60).

Increased empathetic identification with his client's suicidal behaviour occurs when the clinician attributes to self more of the characteristics that his client is experiencing in his suicidal state. So where the clinician empathetically identifies – to a greater degree by way of an open orientation or to a lesser degree via a defensive/closed orientation – with a suicidal client, this acknowledges their own suicidal tendency. More specifically, a client who dies by suicide will be perceived by a clinician survivor as having acted upon their psychache and lethality. Hence modulations in the clinician's empathetic identification with a deceased client will point to the extent to which the clinician ascribes to self characteristics of the client that are related to psychache and lethality. The following postulate is relevant:

Postulate 6: The clinician's experience of client suicidal behaviour will result in modulations of empathetic identification with a suicidal client from their past self, as appraised before the suicidal behaviour, to their current selves.

Conflicted identification with a suicidal client is defined as 'a multiplicative function of one's current empathetic identification and contra identification' with that client (Weinreich, 2003: 61). Contra-identification is defined as 'the similarity between the qualities one attributes to the other and those from which one wishes to dissociate (Weinreich, 2003: 58). Black (2002) explained the 'problematic circumstances' that conflicted identifications may cause for some clinicians. First, a clinician with conflicted identifications with clients will encounter difficulty in their professional appraisal of themselves, if they view 'acceptance' or 'unconditional positive regard' as a core condition that underpins the therapeutic alliance.

Second, a clinician working with a clients 'at risk of suicide' (Simon, 1998: 480) who has a conflicted identification with a suicidal client will be challenged on the one hand by the extent to which they are becoming more like their suicidal client whilst dissociating from them on the other (Black, 2002: 121). By definition, greater conflicted identifications with suicidal clients will be found in clinicians with an open orientation than with those whose

orientation is defensive. The latter clinicians will have lower conflicted identifications because of their low level of empathetic identifications with suicidal clients. It follows that clinicians' conflicted identifications with suicidal clients will, in general terms, point towards clinicians' own suicidality, but from which they wish to dissociate. The next postulate expresses this analysis:

Postulate 7: Conflicted identification with a client at risk of suicide (by suicide ideation, serious suicide attempt or death by suicide) will be indicative of the clinician's level of suicidality.

5.14 The clinician as 'a suicide survivor'

A key area of investigation herein is the clinician's experience as 'a suicide survivor'. Writing about the child's loss of loved ones Moriarty (1967) says 'of all the ways to lose a loved one, suicide must leave the most psychological reverberations' (Resnik, 1972: 169). At par. 2.8 above Patterson's (1996: 340) view of the client as a 'loved one' was mentioned. In this context, the clinician's experience of client suicide will reverberate with other suicide-related events within their life experience (Berman, 1995). Such events include the direct and indirect experience of suicide-related behaviours and predicaments involving self and others including family members and 'individuals close to (but not family members of) the suicide...roommates, employers, friends, lovers, co-workers, teachers, physicians, patients, students [who] can be and have been left with the warped and warping legacy of a suicide' (Cain, 1972: 16). The clinician's experiences as a suicide survivor will also include the aftermath of suicide reported in media, literature and history. Identifications with 'a suicide survivor' will influence the clinician's self appraisals in all seven situated contexts both past and current. Of particular relevance will be the influence of these identifications in the currently situated contexts of 'working' and 'relaxing' (see chapter 6 below). The next theoretical postulate is presented for exploration:

Postulate 8: Client suicide in conjunction with past experiences of suicidal behaviour in personal, collegial or societal contexts or as communicated in media, literature, or history will influence how clinician survivors appraise self and others, in a suicide-related context, when working and when relaxing.

5.15 Self-care in the aftermath of client suicide

The literature offers various ideas about how clinician survivors' personal and professional needs might be met in the aftermath. These range from structured, organisational responses such as quality assurance reviews (Misch, 2003), 'what went wrong' enquiries and survivors-

of-suicide groups (Sudak, 2007), through supervision / consultation forums with non-judgemental colleagues (Gorkin, 1985; Valente, 2003) to clinician survivors' self-help activities, including personal psychotherapy (Grad and Zavasnik, 1998; Misch, 2003; Campbell, 2006).

Potentially damaging effects of isolation upon the clinician survivor following client suicide may not be addressed (Gitlin, 2006). Colleagues who have not experienced loss of a client to suicide may be perceived as having limited understanding (viz. empathy) and therefore clinician survivors may be reluctant to approach them for support. Yet colleagues 'find out' and respond appropriately or otherwise. Survivors may withdraw, experience isolation and emotional aloneness in the face of institutional, societal, family and legal consequences of a client's death by suicide:

Postulate 9: Clinicians' experience of client suicide will result in decreasing empathetic identifications with colleagues accompanied by feelings of isolation arising from the absence of shared experience.

Clinicians will learn from the helpful (or otherwise) immediate and short-term response of colleagues including peers, supervisors and consultants such that they may develop closer and more interdependent relationships in the medium term:

Postulate 10: Clinician survivors' experience will result in closer empathetic identifications with professional colleagues – who also have experienced client suicide – and so provide an appropriate basis for assimilating their client suicide experience.

5.16 Beliefs and values systems

Horn (1994) suggested that the intensity of the clinician's attachment to their client will determine the strength of the impact upon schemas (core beliefs and expectations of self and others) of client suicide (Horn, 1994: 193). Black (2002) suggested that such impact upon, or disruption of a clinician's system of values and beliefs 'will engender the reappraisal of self and others resulting in new ways of evaluating one's social world' (Black, 2002: 125).

Weinreich (2003) explains that 'cognitions are what we can say about a person while affects refer to what one feels about that person...cognitions are rarely devoid of affective connotations' or implied meanings (Weinreich, 2003: 18). But when one's cognitions of others and their behaviours conflict with our feelings or affects towards them, then cognitive-affective incompatibility occurs. Weinreich (2003) holds that such incompatibilities are 'ubiquitous features of a social world that is far from perfect' (Weinreich, 2003: 18). ISA's

conceptual framework includes a structural pressure index. This arises from the cognitive-affective meanings attached to an individual's use of various discourses to express self and to appraise their social world in terms of their values and beliefs (Weinreich, 1989a).

The clinician's evaluation of self and others, using their system of values and beliefs, explores positive and negative connotations (viz. implied meanings) of discourses. The cognitive-affective meanings attached to the clinician's use of those discourses will vary from person to person. Where the connotations are negative, as indicated by cognitive-affective incompatibility, the outcomes are likely to be problematic for the clinician.

When evaluative connotations and affective associations relating to a construct become unstable and conflicted this is represented by a low structural pressure on that construct indicating a conflicted dimension of identity. Conflicted dimensions of identity point to areas of anxiety and stress for the clinician (Weinreich, 1992, 2003 a & b; Black, 2002). While conflicted dimensions of identity exist in most individuals, those that relate to suicidal behaviour will indicate the clinician's individual response to their client's suicidal behaviour. The following postulate expresses this process:

Postulate 11: Clinicians' experience of client suicide will affect their systems of values and beliefs and this will be evidenced in conflicted dimensions of identity.

Clinicians will contend with anxiety and stress, represented in conflicted dimensions of identity, through core evaluative dimensions of identity. The latter are evidenced in ISA through the stability and consistency demonstrated in positive or high structural pressures on relevant constructs. Stable evaluative connotations and compatible affective associations in appraisal of self and others with a relevant construct give rise to positive or high structural pressure (Black, 2002).

Clinicians who experience their client's suicidal behaviour, including their client's suicide will assimilate the impact of the experience by incorporating it within a developing sense of identity. Those core evaluative dimensions within the clinician's system of values and beliefs offer a perspective on how clinician survivors' contend with client suicide. The final theoretical postulate expresses this process:

Postulate 12: Clinician survivors' core evaluative dimensions of identity are indicative of their coping resources for integrating a client suicide experience.

These theoretical postulates offer a structure for the examination of the consequences for their identity development of clinician survivors' experience of client suicide.

5.17 Theoretical postulates, specific hypotheses and theoretical propositions.

In the spirit of Bouma and Atkinson (1997), the qualitative nature of this research enabled the study to proceed from theoretical postulates emerging from an analysis of relevant empirical literature, using key concepts that underpin identity structure analysis, specific hypotheses and through to empirically derived theoretical propositions based on current research. In chapter 6, Research Methodology, the current study's key objective and research aims, as understood at the outset, are articulated together with a key hypothesis [more precisely postulate] and four supporting hypotheses, followed by an elucidation of the study's methodology. Case study summaries and findings are then presented in chapter 7. Fuller versions of 11 target case studies are available at appendix 7, together with supplementary information at appendix 10.

Chapter Six: Research methodology

Chapter 6: Research Methodology

6.1 Introduction

This chapter examines the aims and objectives, strategy, approaches and methods employed to generate data, information and outcomes relevant to this investigation. The aims and objectives of this qualitative research study are stated together with key and supporting hypotheses. The latter are related to several theoretical postulates (see chapter 5) that emerge from an analysis of relevant empirical literature in the context of key concepts that underpin identity structure analysis. The idiographic (case study) approach is explained. The data collection and research instruments used contribute to a detailed and comprehensive consideration of the study's research design. The reliability and validity of this research approach, including the role of the researcher, is considered to ensure scientific rigour throughout.

6.2 Research design

6.2.1 Key objective and research aims

A key objective of this investigation is to explore what a professional duty of care might contribute to any influence, adverse or otherwise, of the suicidal loss of their client(s) upon the identities of the target group practitioners – psychotherapists/counsellors otherwise referred to as clinicians. The specific aims of the research are:

Specific Aim No1: To explore with respondent clinicians the extent to which interpersonal relationships with significant others are affected by the experience of being exposed to the suicidal loss of their client(s);

Specific Aim No 2: To investigate the influence on respondent clinicians of personal knowledge of the suicide phenomenon and of their experience of client suicide; and

Specific Aim No 3: To examine how the respondent clinicians' professional orientation is influenced with regard to their beliefs and values systems, by exposure to the client suicide experience.

6.2.2 Hypotheses

In qualitative research, which is 'more intuitive, subjective and deep', hypotheses [more correctly postulates] are usually developed as the investigation proceeds and not at its outset (Bouma and Atkinson, 1997: 208, 216). Consequently the following hypotheses are cited for scene setting and structuring purposes as well as to provide a necessary focus for the

investigation. At commencement of this project a key hypothesis and four supporting hypotheses were postulated.

6.2.3 Key hypothesis

The clinician has an established identity but they experience significant episodes that feature as elaborations of their existing sense of identity. The loss of a client by suicide is a traumatising event that is integrated within the clinician's identity in a uniquely disturbing and extraordinary way. If the clinician survivor's subsequent identity development is significantly disrupted, their supervision and aftercare needs will be distinctly different from those of clinicians without a client suicide experience.

6.2.4 Supporting hypotheses

Supporting hypotheses were suggested to some extent by speculative propositions that emerged from recent research (O'Keeffe, 2000: 242).

Hypothesis No 1: If being a suicide survivor is a lifelong identity-determining event then as a direct consequence, suicide survivors including clinician survivors, are threatened by unquantified trauma-related psychological pain, resulting in an enhanced risk of suicidal behaviour.

Hypothesis No 2: If appropriate counselling interventions have some prophylactic value for suicide survivors, it follows that clinician survivors would benefit positively from tailored counselling services following the suicidal loss of their client.

Hypothesis No 3: Clients, in the care of clinicians whose identity development was disrupted by client suicide, experience related transference and countertransference phenomena that interfere with resolution of issues that clients bring to the counselling room.

Hypothesis No 4: If a clinician's identity development was significantly disrupted by a client's suicide, the application of appropriate remedial strategies – individually, professionally and institutionally – would benefit the counselling and psychotherapy professions at all levels provided they focused primarily upon the clinician survivor's psychological health needs.

Note: Hypothesis No 4 was linked and consequential to the carrying through of Hypothesis No 2's promise.

6.2.5. Hypotheses testing

Case study evidence emerging from this research will be analysed with a view to reaching tentative outcomes including theoretical propositions regarding the above hypotheses, taking into account theoretical postulates, which may be incorporated within any overall conclusions.

6.2.6 Case study approach

An idiographic (case study) approach was adopted as a research strategy in order to obtain primary evidence from clinicians about their concrete, individual, personal, experiential responses to loss by suicide of their client(s). This approach is capable of recognising the totality of each clinician survivor's experience and is 'well suited to describing and making sense of the processes of change' (McLeod, 1997: 104). Lincoln and Guba (1989) held that mutual trustworthiness was an essential pre-requisite for the researcher and respondents (McLeod, 1997: 97). The case study approach permits an in-depth exploration of respondents' identity development, past, current and aspirational. When studied in depth and in detail, each clinician's suicidal loss experience is likely to be as unique to that person as their individual coping response. Consequently each clinician's assimilation of their client's suicide is similar to those of other clinician survivors only in the stark fact of their particular experience of a sudden, unannounced, potentially calamitous and catastrophic conclusion to the life of their client.

The case study is 'a distinctive form of empirical enquiry [but] as a research endeavour, case studies have been viewed as a less desirable form of inquiry than either experiments or surveys' (Yin, 2009: 14). Objections to this approach included lack of rigour, little basis for scientific generalisability, that they take too long 'and result in massive unreadable documents', and at times are used where quantitative methods might be more efficacious (Yin, 2009: 14-16). These potential issues may be addressed by 'systematic procedures', by acknowledgement of bias and prejudice where it exists, by applying emergent learning to theoretical propositions rather than to 'populations or universes', by awareness of the researcher's need to communicate with the reader using 'plain English', concisely and transparently, and by matching the case study method with the project's aims and objectives (Yin, 2009: 14). Earlier Yin (1989) listed criteria for 'a good case study':

- a) significance – unusual, revelatory or of general public or theoretical interest;
- b) completeness – reader enabled to understand the 'whole' of the case;
- c) alternative perspectives – case material facilitated alternative interpretations;
- d) sufficient evidence – case material adequate for study's purpose; and
- e) effective presentation – reader's interest engaged via researcher's enthusiasm.

(McLeod, 1997: 119).

McLeod (1997) added that there was 'increasing acceptance that the case study represents a legitimate approach to research in counselling and psychotherapy'. He suggested that 'central features' of this method were:

- f) multiple data sources;
- g) several perspectives on data;
- h) social context;
- i) consideration of competing interpretations;
- j) clear explicit data-collection techniques;
- k) conclusions backed up by data; and
- l) use of replication

(McLeod, 1997: 119)

Harré (2003) commented that the value, significance, influence and reputation of case study-based research that employed ISA as the underpinning (and more often than not the only) research instrument *par excellence* was increasingly being accepted in a range of research fields involving cross-cultural, societal and clinical contexts (Harré, 2003: xxii).

The researcher's goal must be to compose case studies that have significance and are complete, that consider alternative perspectives, that have sufficient evidence and that are 'composed in an engaging manner' (Yin, 2009: 185-190). Goffman's (1968a; 1968b) classic texts are regarded as models for qualitative research but he 'was light on method...yet it is clear that Goffman knew what he was doing and...he had something to say...virtues that we all might do well to cultivate' (McLeod, 2005: 209).

6.2.7 Identity Structure Analysis (ISA)

Identity Structure Analysis (ISA) is the principal research instrument used herein to investigate clinicians' identity development in the aftermath of their experiences of client suicide. ISA is ideally suited to the exploration of clinician's interpersonal relationships and their beliefs and values systems.

The exploration of potential psychological and related changes in clinician survivors following a client suicide experience requires a research instrument capable of examining the ongoing identity development in clinicians in the context of their social world, their personal and professional lives, and in relation to specific experience(s) of client suicide. ISA, operationalised through IDEXWIN software (Weinreich and Ewart, 1999a), as an open-ended conceptual framework, facilitates the application of custom-designed identity instruments, appropriate to the research project and both meaningful and of direct significance to respondents participating in the study.

ISA is capable of facilitating the exploration and conceptualisation of a clinician's direct experience of client suicide, as a clinician survivor, and a clinician's indirect experience, as a clinician survivor (by proxy) of the suicide of a colleague clinician's client,

in relation to clinicians' identifications and their beliefs and values systems. The suicide of a family member or friend of a respondent could also be influential life events. ISA was capable of monitoring identification modulations related to contextual variations and to respondents' biographical events, including their experience(s) of suicide outwith their professional lives.

ISA facilitated analysis of each respondent's idiosyncratic orientation to their social worlds and their component elements, including family members, personal friends and acquaintances, professional colleagues, clients and social groups in relation to assimilation of the experience of client suicide. It therefore supported a comprehensive exploration of the clinician's unique experience of client suicide, described variously as 'often a difficult event for therapists' (Jobes et al., 2000: 548), or as 'a traumatic experience for the therapist' (Grad et al., 1997: 380), or as a 'tragedy' (Jones, 1987: 141) or as 'surely among the most traumatic events in [the clinician's] professional life (Gitlin, 2006: 477).

6.2.8 Semi-structured and unstructured interviews

Each respondent was interviewed on audiotape by the researcher before they completed the ISA research instrument. Black (2002) described the rationale behind the use of data derived from semi-structured interviews to support ISA outcomes. He noted that this method is so familiar to clinicians that it would represent a medium through which many of them may already understand their human world. Morrow-Bradley and Elliot (1986) found that clinicians preferred discussion with other therapists above scientific enquiry such as reading research articles, as a way of keeping updated about issues related to clinical practice. Black (2002) explained that while using ISA's scientific methodology, operationalised in its idiographic mode, the addition of complementary semi-structured interviews provided the forum and a familiar mechanism by which such dialogue can take place. ISA in its idiographic mode supported by semi-structured interviews provided a comprehensive basis for case study analyses. Black (2002) was persuaded that semi-structured interviews allowed clinicians to discuss their own experiences in their own words (Black, 2002: 137).

An option existed to use an unstructured interview format with research respondents involving:

'no prepared list of questions...the interviewer decides what questions to ask from moment to moment depending upon the information volunteered by the informant' (Dyer, 1997: 59).

Such an ad hoc approach was deemed inappropriate because of the need to maintain focus during the interview upon the specific topic of the encounter – client suicide and its effect

upon a clinician survivor – as well as time, and other constraints. The procedure followed during the semi-structured interview is now described.

The interviewer explains at the outset in general terms what is to be explored and then raises the first theme or topic in the form of an open-ended question:

‘When the flow of ideas in answer to that first question comes to an end the interviewer may ask further questions to obtain clarification of some points or may raise a new topic (or theme) and the questioning repeats itself in a chain-like process in which one answer suggests the next question’ (Dyer, 1997: 59).

But respondents need to have their thoughts ‘gently guided by questions of some kind’ (Dyer, 1997: 59). Using a semi-structured format the interviewer works

‘from a number of prepared questions (or themes), while allowing the respondent plenty of opportunity to expand answers (or responses, including silence or emotional release) and pursue individual lines of thought...’ (Dyer, 1997: 59)

The respondent’s motivation is ‘the single most important factor in whether the interview is successful’. This is achieved by continuous contact with respondents throughout the interaction, expressing gratitude to individual respondents about the value of their contributions, detailed explanation of the aims and objectives of the research and assurances about confidentiality and anonymity, in relation to any published material (Dyer, 1997: 60). The other essential for successful interviewing is the establishment of solid rapport with the respondent.

In the current research investigation, a very high degree of rapport was sought through the researcher adopting the role of collaborator, rather than by remaining passive. Some self-disclosure by the researcher in relation to his own personal interest and commitment to the field of study under investigation was judiciously employed in order to enable respondents to identify with the researcher and the research goals (Dyer, 1997: 61).

In this research, respondents were offered the opportunity to reflect upon past suicidal loss event(s), other loss events resurrected by client suicide, their current feelings about the impact, or feared impact, of client suicide on their past, current and aspirational health, and what meanings, if any, they attached to the event when it happened and in its aftermath as the internalisation process proceeded. As Freud (1917/1973) observed:

‘in the process of mourning, the object (or the person) that is lost is replaced through the grief process by an inner representation of the same object. This process of internalising is one, which those who have worked through grief may be familiar with. The person they have lost in some sense now lives on in them. This internal presence is more than a memory of what the lost person was like, or what they said; it

is more like experiencing them in some sense as still part of the present, sometimes with a conscious or unconscious dialogue taking place with them' (Jacobs, 1998: 6).

Alternatives to audiotaped recordings that were rejected included short written notes, lists and headings summarising respondents' expressions of their recollections, opinions and propositions and explanations, during a preliminary discussion of the research project and its principal research instrument, identity structure analysis (ISA). The audiotaped interview approach was chosen as the most appropriate mechanism for facilitating each research respondent to disclose voluntarily that part of their personal biography that related to client suicide experience(s) and to enable accurate data access for research purposes.

A common schedule of themes was used by the researcher in interviews (see appendix 2) although minor variations were necessary to match the stated experiences of respondents in target, comparison and control cohorts. Some time before interview, each respondent was offered sight of the research proposal for this project (see appendix 1). At interview, target/ comparison respondents were invited to consider a list of themes – offered to them by way of a typed sheet – that included:

- a) counselling background, style, qualifications, experiences, etc.
- b) knowledge and experience of suicide in two contexts: personal life and professional life
- c) suicidal and non-suicidal clients
- d) actual experience(s) of client suicide
- e) consequences
- f) changes

After the interaction was completed, transcripts of interviews were prepared for possible use as illustrative narrative in related case studies.

An option to employ content analysis (Hickey and Kipping, 1996: 91) as a subsidiary research instrument similar to that used in the researcher's earlier study (O'Keeffe, 2000) was not exercised. It was not felt by the researcher to be necessary since ISA-related outputs together with illustrative narrative excerpts sourced from interview transcripts, was considered adequate.

6.2.9 Interviewer bias

The selection of the above-mentioned interview topics and the perceived exclusion of others had the unintended effect of restricting respondents' narratives. Lee (1993) cautions research interviewers 'that standardised interviewing allows experiences to be expressed in only

narrow and truncated ways' while noting Cannell's (1985) comment that 'the causes of bias are in some way located in the interviewer' (Lee, 1993: 117). The role of the researcher as a research instrument, including the presence of bias and prejudice is considered next.

6.2.10 The researcher as a research instrument

The researcher's exploration of identity development in clinician survivors is an idiographic research study that deploys two research instruments, namely identity structure analysis (ISA) and the self of the researcher as a research instrument.

In relation to this project, the researcher is a qualified and experienced psychotherapist / counsellor in private practice. Guba and Lincoln (1983) contend that the researcher as a research instrument should exercise adequate levels of competence in most of the reliable human instrument's requisite skills in observing, analysing, categorizing and careful listening as well as reasonably adequate personal qualities as a tolerant, patient, empathic, humane, honest and open human being (Guba and Lincoln, 1983: 139, 140). As the interviewer of respondents and facilitator for their completion of the ISA instrument, the researcher's reasonable competency in these skills was important for the successful completion of interactions with respondents. The researcher is an essential albeit subsidiary research instrument performing roles as instrument administrator, data collector, data analyst and data interpreter (Guba and Lincoln, 1983: 128). Responsiveness and adaptability and a holistic outlook are also regarded as key characteristics for investigators engaged in these research tasks. Other attributes considered of value to researchers are the ability to deploy both 'conscious and unconscious levels of awareness and kinds of knowing' that generate several 'knowledge products' including:

- i) conscious insights and apprehensions; and
- ii) unconscious hunches, impressions, feelings, vibrations (in response to nonverbal cues and unobtrusive indicators).

(Guba and Lincoln, 1983: 135)

Another desirable quality, 'processual immediacy', enables the human instrument to respond immediately to presented data by reordering it, changing its direction, generating hypotheses on the spot and testing them with the respondent or in the situation as they are created. Also available are opportunities for clarification and summarisation (Guba and Lincoln, 1983: 136) and the ability to decide to explore atypical or idiosyncratic responses (Guba and Lincoln, 1983: 137, 138):

'Human inquirers...not only are open to the atypical response but encourage and seek it. The ability to encounter such responses and to utilize them for increased

understanding is possible only with human, as opposed to paper-and-pencil instruments' (Guba and Lincoln: 1983: 138).

In relation both to human respondents and the researcher, as a human instrument:

'...only human beings, depicting slices of their own lives in their own language, terms and visions can recreate reality' (Guba and Lincoln, 1983: 152).

6.2.11 Qualitative and quantitative elements

Barkham (1996: 23) suggested that 'the superordinate research approach should be methodological pluralism, incorporating both qualitative and quantitative methodologies' Black (2002: 137). The current research qualifies as pluralist, since it deploys two research instruments. ISA 'integrates qualitative analyses embodied in discourses with quantitative analyses represented in the empirical estimates of the parameters of identity' (Weinreich and Ewart, 1999a). In short, this research uses both qualitative and quantitative elements and satisfies Barkham's (1996) dictum at some level.

6.2.12 Scientific paradigm

This investigation obtained primary data and information directly from respondents in their own words. Audiotaped interviews captured, as potentially valuable primary research data, their responses to voluntary but focused reflections on their experience(s) of client and other suicidal loss. Completion of an ISA identity exploration research instrument by respondents facilitated inclusion of these responses as further primary research data. IDEXWIN software then facilitated analysis and presentation of identity indices for interpretation by the researcher within a case study format.

It was argued that the scientific paradigm was implicit where ISA was used. In the acquisition of new knowledge by means of research-based scholarship, the scientific paradigm relied on:

'experimentation as a fundamental technique, which views truth as confirmable; that is, truth is a hypothesis that has been confirmed by an actual experiment. The hypotheses are derived by deduction from an *a priori* theory; when enough hypotheses deriving from a particular theory have been verified, the theory itself is believed to have validity. Physics was a typical example' (Guba and Lincoln, 1983: 55).

This was the traditional method of the 'hard sciences' and the life sciences that had acquired 'a patina of orthodoxy' and was also widely adopted and emulated in the social-behavioural sciences as well (Guba and Lincoln, 1983: 56). The use of ISA as a research instrument in conjunction with identity exploration instruments devised by the researcher, in principle

amounted to theory testing, based upon the work of Weinreich (1988, 1992), Weinreich and Ewart (1997), Weinreich and Ewart (1999a) and Weinreich and Saunderson (eds.) (2003).

6.2.13 Validity and Reliability

Dyer (1997) holds that interview data are ‘inherently unreliable as a source of information about human behaviour or experience’ (Dyer, 1997: 64). To avoid being unwittingly misled, researchers seek ways to validate interview data. Potential techniques for ‘corroboration’ [in legal proceedings, this means first examination of a witness by the party calling the witness (Merrion-Webster online dictionary)] of respondents’ interview data are triangulation and ‘cross-examination’ [in legal proceedings, this means examination of a witness who has already testified in order to check or discredit the witness's testimony, knowledge, or credibility (Merrion-Webster online dictionary)]. The latter technique, cross-examination, is excluded not least because of the voluntary nature of research respondents’ contributions.

Triangulation, a term

‘borrowed from surveying, and used in evaluative research...means using two different views of the same thing: interview with observational data, open with closed questions or one researcher’s views with another’s’ (Coolican, 1990: 237).

Benefits may accrue from triangulation:

‘Triangulation forces the observer to combine multiple data sources, research methods and theoretical schemes in the inspection and analysis of behavioural specimens (Denzin, 1970) [and] depends upon exposing a proposition [the assertion of an informant] to possibly countervailing facts or assertions or verifying such propositions with data drawn from other sources or developed using other methodologies’ (Guba and Lincoln, 1983: 106, 107).

A further technique, called ‘phenomenon recognition’, involves ‘presenting the [researcher’s] “reality” to those who live it, and asking them whether it does, indeed, represent their common and shared experience’ (Guba and Lincoln, 1983: 186). McLeod (2005) explains a similar concept, viz. ‘credibility checks’ as a validation procedure that presents, for feedback purposes, what the researcher has produced to informants interested in and knowledgeable about the research. Although such an explicit check was not carried out in the current study, it was envisaged that respondents could, at some future time, be invited to comment on its conclusions, either individually or at a group discussion, following its completion. Communication of these results to respondents was necessarily tentative and done with careful regard for respondents’ wellbeing.

Bloor (1997) reflected upon the difficulty inherent in both triangulation and credibility checking as validation techniques:

‘...all validating techniques are social products, constituted through particular and variable methodological processes. The very methodological frailties that lead [researchers to seek]...validating evidence are also present in the generation of that validating evidence (Bloor, 1997: 49)’ (McLeod (2001: 187)

Participation by respondents in the current research was voluntary. It was anticipated that any significant withholding by respondents, consciously and unconsciously, during the time-limited, semi-structured audiotaped interview stage would be counterbalanced and informed by ISA-generated data.

Identity exploration using IDEXWIN software relied upon respondents’ focused response to an ISA research instrument. While analysis and interpretation of the outcomes of identity exploration was a skilled exercise by the researcher:

‘the identity indices...computed [within IDEXWIN software were] subject to the vagaries of instrument construction’ (Weinreich and Ewart, 1999a).

The only data analysed by the ISA software were the responses of respondents to ISA instruments, on paper copies or online. Furthermore, only transcripts of actual narrative of target respondents and the researcher are included for illustrative purposes in case study reports (see appendix 7 and appendix 10). The results obtained from each respondent are therefore based only upon data provided by them. Since the researcher designed the interview structure, participated in the interviews, designed the ISA instruments, supervised their application and carried out the entire project’s data processing, the degree of reliability of the investigation was dependent upon his trustworthiness, his integrity. Any and all bias or imbalance in the investigation’s design, execution or findings was the responsibility only of the researcher. The validity of the investigation rested upon the researcher’s objectivity: he was a university-recognised teacher of counselling and psychotherapy, and subject to police criminal records monitoring.

Research cohorts, as they were envisaged at the outset of the research, how respondents were recruited and their actual participation in research is considered next.

6.3 Research cohorts

Since the project was initiated (2001) additional professional literature on the incidence, frequency and impact of client suicide has appeared. Although further reliable data are needed, the ‘client suicide’ event has long been regarded as an inevitable ‘occupational hazard’ for clinicians (Chemtob et al., 1988a: 227; Chemtob et al., 1988b: 420; Alexander et

al., 2000: 1573). The American Association of Suicidology (AAS) issued a caution via their 'Clinician Survivor Task Force' website:

'the odds that [a clinician] will lose a client to suicide during [their] career are slim but they are not zero' (American Association of Suicidology (AAS), 2007)

At the outset, it was envisaged that the existence of taboo (Palmer, 2008: 134) and stigma (Cain, 1972: 15) in relation to death by suicide as well as potential legal ramifications including litigation fears, might inter alia restrict clinician participation in this research project. At commencement, the research proposal for the study (see appendix 1) envisaged a longitudinal approach exploring identity development in clinician survivors over two years and three phases employing two main research instruments: content analysis and ISA. [The longitudinal element was postponed indefinitely until the current project was completed]. Eligible respondents were to be recruited from the population of psychotherapists and counsellors in Northern Ireland, Ireland and Great Britain. It was hoped that the professional counselling organisations would facilitate contact with the researcher. From this anticipated sample of eligible respondents, two cohorts were envisaged:

- a) Target group : clinicians who experienced client suicide
- b) Comparison group : clinicians who have not experienced client suicide

Information about the project was communicated to local and national counselling organisations and to up to 70 individuals including counsellors and psychotherapists. An abstract of 'research work in progress' was uploaded to the 'BACP Research Directory' via the website (www.bacp.co.uk/research_directory) of the British Association for Counselling and Psychotherapy (BACP). No follow-up contact resulted. [Late in 2007 when this dissertation was being written up, the BACP advised the researcher that they could not locate the research abstract following redesign of their website.]

The project generated little interest from the counselling and psychotherapy professions. By early 2002 the researcher re-designated these cohorts in an attempt to broaden the project's appeal to clinicians, as follows:

- a) Target group: practising counsellors / psychotherapists
- b) Control group : non-practitioners

In late summer 2002 having made little progress in assembling eligible sample groups, the researcher decided to seek media publicity so as to engage with a wider population of counsellors / psychotherapists. A letter (see appendix 3) was sent to the editors of two Northern Ireland ('Irish News' and 'Belfast Telegraph') newspapers and one Irish ('Irish

Times', Dublin) broadsheet, that set out the research proposal and invited contact from interested practitioners. The letter appeared in the 'Irish News' in August 2002 under a 'banner' headline that was not without irony: 'Will anybody help a psychotherapist?' There were two responses only but neither correspondent was eligible to join the project.

Volunteer respondents who were eligible for target, comparison or control groups were ultimately identified by ad hoc methods including distributing summaries of the research proposal at meetings, seminars, workshops, etc. attended by counsellors, informal discussions with colleague counsellors and written invitations to individuals, groups and organisations that were thought to include potential research participants. Up to mid-summer 2006, a total of 22 eligible individuals made contact with the researcher, were interviewed on audiotape and completed an appropriate ISA identity instrument(s). One eligible counsellor working in addiction therapy expressed an interest but declined to participate in an audiotaped interview and was therefore excluded.

One individual was interviewed in 2002 as a control respondent (code C1) and again in 2005 as a target group respondent (code A17). A total of 11 clinician respondents were eligible for the target group having experienced client suicide(s). Of the remaining 11 respondents, six clinicians had not experienced client suicide but each expressed an interest in the research: they had worked closely with or had information about colleague practitioner(s) who had experienced client suicide(s). The researcher designated these six individuals as 'clinician survivors (by proxy)' (see also par. 3.1 above). A further five non-practitioner individuals who became aware of the research project volunteered as respondent members of a control group.

The final cohort structure was dependent upon eligibility criteria ascertained when interviews with each respondent were arranged:

- a) Target group: clinician survivors : 11 members (including code A17)
- b) Comparison group: clinicians survivors (by proxy) : 6 members
- c) Control group : 6 members (including code C1)

Target and comparison group respondents included counsellors employed in counselling agencies and in private practice, a trainee counsellor and clinicians employed in clinical psychology and medicine. Control group respondents included social workers and teachers. Before participating, all respondents completed a consent form (see appendix 4) in compliance with the requirements of the University of Ulster's Research Ethics Committee.

Three separate but related ISA instruments were designed by the researcher that took account of insights gained in earlier suicide survivor-related studies. The data collection instruments,

viz. ISA instruments that were supported by transcripts of respondents' audiotaped interviews are discussed next.

6.4 Data collection: design of ISA instruments

6.4.1 Bipolar personal constructs and entities are necessary constituents for constructing ISA identity instruments for analysis using IDEXWIN software. The former are characteristics or orientations used by a person to construe (or interpret) her/himself, other people and the social world in general; the latter are individuals and groups of people influential in the person's life. ISA is based upon measurement of 'identity' through the filter of a person's identification with or dissociation from significant others in her/his social world and 'situational selves' (*'me as I am now'*, *'me as I used to be'*, *'me as I would like to be'*, and so on). The term 'entity' is therefore given to people, groupings and issues of symbolic meaning to the individual. These entities include various perceptions of the self including ideal self image, viz. *'me as I would like to be'*, current and past self images, viz. *'me as I used to be'* and *'me as I am now'*, and various 'selves for others', viz. *'me as my family sees me'*, *'me as my colleagues see me'* and so on. An individual's ideal self-image, viz. *'me as I would like to be'*, 'provides the basis for designating [a person's] value system' (Weinreich, 1988: 10-12).

To ascertain a sample range of influential or significant people in the life of a clinician survivor and some events that may have influenced that survivor in important ways (Weinreich, 1992: 10) the researcher reviewed ISA instruments that were used in recent work with suicide survivors (O'Keeffe, 2000). This facilitated the generation of appropriate entity and bipolar personal construct lists for use with clinician survivors and clinician survivors (by proxy), viz. ISA Instrument A. An adaptation of these lists was used with the control group: ISA Instrument C. A variation of the latter was used with one respondent (code B1) early in the research: ISA Instrument B.

All respondents including controls were invited to complete paper-copies of relevant ISA instruments as they construed their social worlds and various aspects of their self-image, using a centre zero scale with nine points. They simply rated the extent to which one or other pole of the bipolar construct applied to a particular entity. The 'zero' point was used when the individual was either unable or unwilling to construe that entity with a particular construct.

6.4.2 Entities: instrument A

The respondents' list of 22 entities for ISA instrument A included five mandatory entities consisting of three 'minimal facets of self' and a minimal set of 'two significant others' (Weinreich, 1992: 10,11):

first, the ideal (or aspirational) self, e.g. '*me as I would like to be*', from which for each respondent, the desired pole of each construct may be determined and their aspirational (or role model) identifications may be made;

second, the current self 1 e.g. '*me when I am overwhelmed by life's cruelties*' from which a respondent's empathetic (de facto) identifications with others based in the current self may be estimated in relation to distressing life event experiences;

third, past self 1, e.g. '*me before I became a psychotherapist / counsellor*', from which estimates of empathetic (de facto) identifications with others in relation to the person's past self-image may be obtained;

fourth, an admired person, e.g. '*a person I admire*' and fifth, a disliked person, e.g. '*a person I dislike*', which, respectively, were additional anchoring features of identity that provided checks on the validity of the identity indices computed for each respondent.

An additional current self entity, e.g. current self 2: '*me when I feel enhanced by life's wonders*', from which a respondent's empathetic (de facto) identifications with others based in the current self may be estimated in relation to rewarding and enjoyable life event experiences;

Two specific past self entities, e.g. past self 2: '*me as I was before my client's suicidal behaviour*' and past self 3: '*me as I was after my client's suicidal behaviour*' facilitated estimates of empathetic (de facto) identifications with others in relation to a respondent's past self image in relation to a client's suicide.

Two additional current self entities e.g. current self 3: '*me when I'm working*' and current self 4: '*me when I'm relaxing*' from which a respondent's empathetic (de facto) identifications with others based in the current self may be estimated.

Two entities each incorporating a metaperspective: metaperspective 1 '*me as my colleagues see me*' and metaperspective 2: '*me as my clients see me*' facilitated a respondent's perception of the way that some other person/s or group viewed self, viz. 'my colleagues' and 'my clients'.

A further three entities included a range of individuals likely to be influential and significant in the respondent's social world: '*father*', '*mother*' and '*my partner/spouse*'. A further group of entities included five that related to the focal issues of this investigation, viz. the predicament of clinician suicide survivors. These were '*a client who died by suicide*', '*a*

client who recovered after serious suicide attempt, *'a client with suicide ideation*', *'a depressed client*' and *'a suicide survivor (person remaining alive after suicide death of individual with whom they had a significant relationship or emotional bond)'*. The final two (21st and 22nd) entities: *'a psychiatrist*' and *'my counselling supervisor*', represented an important occupational / professional and social grouping that was influential, positively or negatively, in relation to a respondent's self-esteem vis-à-vis her/his social world.

6.4.3 Entities: instrument B

The 22 entities for ISA instrument B were similar in all but four cases to entities for ISA instrument A. Reference to *'...I became a psychotherapist / counsellor'* in Past Self 1 (instrument A) was replaced in Past Self 1 (instrument B) by *'...my professional career experiences'*. *'A depressed client'* (instrument A) was replaced by *'An ambivalent client'* (instrument B). *'A client who recovered after serious suicide attempt'* (instrument A) was replaced by *'A client who made a serious suicide attempt'* (instrument B). Finally *'a suicide survivor (person remaining alive after suicide death of individual with whom they had a significant relationship or emotional bond)'* (instrument A) was removed and *'My closest friend'* (instrument B) was added. The reasoning behind these substitutions was to facilitate any respondents outwith the psychotherapy / counselling profession to join the research as controls. For example, it was (wrongly) thought that control respondents who were not therapists might not necessarily construe 'suicide survivors' appropriately. Second, and with similar reasoning, the reference to 'making a serious suicide attempt' was used instead of 'recovered after serious suicide attempt'. Lastly 'an ambivalent client' replaced 'a depressed client' to deepen the pool of potential respondent occupations from which controls might be recruited. [As noted in par 6.4 above ISA Instrument B was used by only one respondent (code B1)]

6.4.4 Entities: instrument C

Of the 20 entities for ISA instrument C, ten were similar to ten entities in ISA instrument A. The different entities were:

Past Self 1 *'me before I started work'* (instrument C) rather than *'me before I became a psychotherapist / counsellor'* (instrument A).

Past Self 2 *'me before I knew about suicide'* (instrument C) rather than *'me before my client's suicidal behaviour'* (instrument A).

Past Self 3 *'me after I knew about suicide'* (instrument C) rather than *'me after my client's suicidal behaviour'* (instrument A).

'A person who attempted suicide' (instrument C) rather than *'A client who recovered after serious suicide attempt'* (instrument A).

'A person with suicidal thoughts' (instrument C) rather than *'a client with suicide ideation'* (instrument A).

'A person who died by suicide' (instrument C) rather than *'a client who died by suicide'* (instrument A).

'my friend/partner/spouse' (instrument C) rather than *'my partner/spouse'* (instrument A).

Metaperspective 1 *'me as my work colleagues see me'* (instrument C) rather than *'me as colleagues see me'* (instrument A)

Metaperspective 2 *'me as my family see me'* (instrument C) rather than *'me as clients see me'* (instrument A).

'my parents or guardians' (instrument C) rather than *'mother'* and *'father'* (both instrument A)

One irrelevant entity excluded from instrument C was *'my counselling supervisor'* (instrument A) while two entities *'mother'* and *'father'* (instrument A) merged into one entity *'my parents or guardians'* (instrument C). The reasoning behind these substitutions was to facilitate possible respondents outwith the psychotherapy / counselling profession to join the research as controls: for example the word *'client'* (instrument A) was substituted with *'person'* (instrument C) where appropriate.

6.4.5 Bipolar personal constructs: instrument A

A list of 22 bipolar personal constructs for application of ISA with target group and comparison group respondents was prepared. Constructs were designed to:

'incorporate people's value and belief systems, and their "everyday ideologies" [and] include items that allow different people to opt for one or other pole as representing something to which they aspire (Weinreich, 1992: 12,13).

The current research investigation was about suicide, clinician survivors and identity development. Target group respondents were clinician survivors. Comparison group respondents were clinician survivors (by proxy). Access by respondents to the research proposal (appendix 1) and consent form (appendix 4) reminded them of the project's purpose. They were therefore prepared to some degree for the structure and content of ISA instruments.

They would be able to anticipate that several of the 22 constructs might include the words *'grief'* or *'suicide'*. Each construct was located within one or more of the following broadly defined categories: personal, suicide, professional, social, family, health and

‘existential’. The last mentioned category was a subset of the ‘personal’ category. The categories are detailed below. (Note: Summation of entities or percentages exceeded 22 or 100% due to overlapping membership of categories.)

(i) Personal Category:

12 out of 22, or approximately 54.5 % of personal constructs addressed respondents’ personal issues, as follows:

‘takes life for granted’ / ‘wonders what life is all about’;

‘carries a terrible responsibility for the fortunes or misfortunes of people with whom s/he had a significant relationship or emotional bond’ / ‘believes that people with whom s/he had a significant relationship or emotional bond are entirely responsible for their own circumstances’;

‘feels that safe expression of emotional feelings is always healthy’ / ‘feels that expression of emotions often indicates lack of control’;

‘questions who s/he is’ / ‘remains sure of who s/he is’;

‘I have warm feelings towards’ / ‘I loathe...’;

‘sticks rigidly to the values and beliefs of parents /guardians’ / ‘continues to develop personal values and beliefs’;

‘I feel a special responsibility for the well-being of others’ / ‘I don’t have any particular responsibility for the well-being of others’;

‘does not value some human beings very highly’ / ‘believes each human being is of irreplaceable value’;

‘I feel distressed by...’ / ‘I feel encouraged by...’;

‘continues to be the person s/he was into the foreseeable future’ / ‘feels that the person s/he was is dead’;

‘never feels lonely or uncomfortable when alone with self’ / ‘often feels the need for human company when alone with self’; and

‘was totally changed by suicide of person with whom s/he had a significant relationship or emotional bond’ / ‘was not much affected by suicide of person with whom s/he had significant relationship or emotional bond’.

(ii) Suicide Category

7 out of 22, or approximately 31.8 % of personal constructs addressed respondents’ issues in relation to the suicide phenomenon, as follows:

‘believes that suicide demands considerable bravery’ / ‘believes that suicide is the act of a coward’;

‘considers that most suicides could be prevented’ / ‘considers that most suicides are unavoidable’;

‘feels that grief following suicide is like any other’ / ‘feels that grief following suicide is uniquely painful’;

‘does not think about people committing suicide’ / ‘is highly sensitised to the issue of suicide’;

‘believes that suicide cannot be predicted by overt behaviour’ / ‘believes that suicide may be anticipated by perceptive observation’;

‘believes that depression and suicide are inextricably linked’ / ‘believes that suicide can occur ‘out of the blue’ without depression being evident’; and

‘was totally changed by suicide of person with whom s/he had a significant relationship or emotional bond’ / ‘was not much affected by suicide of person with whom s/he had a significant relationship or emotional bond’

(iii) Professional category

6 out of 22 or approximately 27.3% of personal constructs addressed respondents’ professional issues, as follows:

‘carries a terrible responsibility for the fortunes or misfortunes of people with whom s/he had a significant relationship or emotional bond’ / ‘believes that people with whom s/he had a significant relationship or emotional bond are entirely responsible for their own circumstances’;

‘I feel a special responsibility for the well-being of others’ / ‘I don’t have any particular responsibility for the well-being of others’;

‘believes that suicide cannot be predicted by overt behaviour’ / ‘believes that suicide may be anticipated by perceptive observation’;

‘does not value some human beings very highly’ / ‘believes each human being is of irreplaceable value’;

‘I feel distressed by...’ / ‘I feel encouraged by...’;

‘was totally changed by suicide of person with whom s/he had a significant relationship or emotional bond’ / ‘was not much affected by suicide of person with whom s/he had a significant relationship or emotional bond’

(iv) Social Category

Five out of 22, or approximately 22.7 % of personal constructs addressed respondents’ social/community issues, as follows:

'carries a terrible responsibility for the fortunes or misfortunes of people with whom s/he had a significant relationship or emotional bond' / 'believes that people with whom s/he had a significant relationship or emotional bond are entirely responsible for their own circumstances';

'I feel a special responsibility for the well-being of others' / 'I don't have any particular responsibility for the well-being of others';

'does not value some human beings very highly' / 'believes each human being is of irreplaceable value';

'withdraws from human contact' / 'seeks and develops human relationships';

'was totally changed by suicide of person with whom s/he had a significant relationship or emotional bond' / 'was not much affected by suicide of person with whom s/he had a significant relationship or emotional bond'.

(v) Family Category

5 out of 22, or approximately 22.7 % of personal constructs addressed respondents' family issues, as follows:

'carries a terrible responsibility for the fortunes or misfortunes of people with whom s/he had a significant relationship or emotional bond' / 'believes that people with whom s/he had a significant relationship or emotional bond are entirely responsible for their own circumstances';

'sticks rigidly to the values and beliefs of parents /guardians' / 'continues to develop personal values and beliefs';

'I feel a special responsibility for the well-being of others' / 'I don't have any particular responsibility for the well-being of others';

'relies on family support at times of threat or crisis' / 'does not need family support at difficult times';

'was totally changed by suicide of person with whom s/he had a significant relationship or emotional bond' / 'was not much affected by suicide of person with whom s/he had a significant relationship or emotional bond'.

(vi) Health Category

4 out of 22, or approximately 18.2 % of personal constructs addressed respondents' health issues, as follows:

'feels that safe expression of emotional feelings is always healthy' / 'feels that expression of emotions often indicates lack of control';

‘relies mainly on prescribed medication to relieve psychological pain’ / ‘always uses complementary / alternative remedies where possible’;
‘believes that depression and suicide are inextricably linked’ / ‘believes that suicide can occur ‘out of the blue’ without depression being evident’; and
‘feels momentary bouts of psychological discomfort’ / ‘suffers unendurable psychological pain’.

(vii) Existential category

4 out of 22 or 18.2% of personal constructs addresses respondents’ existential issues, as follows:

‘takes life for granted’ / ‘wonders what life is all about’;
‘questions who s/he is’ / ‘remains sure of who s/he is’;
‘continues to be the person s/he was into the foreseeable future’ / ‘feels that the person s/he was is dead’; and
‘never feels lonely or uncomfortable when alone with self’ / ‘often feels the need for human company when alone with self’.

6.4.6 Bipolar personal constructs: instruments B and C

Instrument B: A list of 22 bipolar personal constructs was prepared for completion by control group respondents. These replicated personal constructs in instrument A (see par.6.4.5 above) for target group respondents except for their ordering and polar positioning. For example, instrument A construct 10: *‘does not think about people committing suicide’/ ‘is highly sensitised to the issue of suicide’* was replaced in instrument B by construct 1: *‘is highly sensitised to the issue of suicide’ / ‘does not think about people committing suicide’*. Otherwise instruments A and B were identical. In the event, instrument B was inappropriate for use with control respondents. Only one control respondent (code B1) completed it and it was replaced by instrument C for remaining control respondents.

Instrument C: A list of 20 bipolar personal constructs was prepared for use with control respondents. Taking into account ordering, polar positioning and minor verbal differences, instrument C’s constructs replicated instrument A’s constructs with the following exceptions:

In instrument A *‘never feels lonely or uncomfortable when alone with self’ / ‘often feels the need for human company when alone with self’* became *‘can usually be alone without feeling lonely or uncomfortable’ / ‘cannot be alone for long without the need for human contact’* in instrument C;

In instrument A *'was totally changed by suicide of person with whom s/he had a significant relationship or emotional bond'* / *'was not much affected by suicide of person with whom s/he had a significant relationship or emotional bond'* was excluded in instrument C.

In instrument A *'carries a terrible responsibility for the fortunes or misfortunes of people with whom s/he had a significant relationship or emotional bond'* / *'believes that people with whom s/he had a significant relationship or emotional bond are entirely responsible for their own circumstances'* was excluded in instrument C.

Instrument C was used with five respondent controls.

6.4.7 ISA instruments overview

A dynamic process influenced the current research both positively and negatively as outlined at par 6.3 above. Obstacles to respondent access were eventually overcome and adequate data was assembled for analysis. Design of three ISA instruments, A, B and C, was straightforward and their respective content, balance and spread – across categories – sought to avoid common errors (Weinreich, 1992: 15) and aimed to achieve effectiveness and efficiency in deriving analytical outputs. How ISA functions in processing instrument content for identity analysis is discussed next.

6.5 Operationalisation of ISA

6.5.1 As noted at par. 4.7.7 above, it is meaningful to locate this discussion here, rather than in chapter 4, as it relies upon information concerning ISA instruments (bipolar constructs and entities) included earlier in chapter 6 above.

6.5.2 Weinreich (2003: 77-110) offers a detailed and convincing description concerning how ISA concepts, outlined above in chapter 4, may be made functional using ISA IDEX software (Weinreich and Ewart, 1999a), when the identity structures of individuals are empirically investigated. Weinreich (2003) devised a number of algorithms so that inputs from ISA instruments may be represented numerically as 'assessable parameters of identity' (Weinreich, 2003: 77) when relevant algorithms are computed. In short, ISA IDEX software (Weinreich and Ewart, 1999a) outputs for research respondents are quantitative parameters that may be interpreted by the researcher to highlight certain attributes of the identity structures of individual respondents. The technology that underpins this process need not be elaborated here as detailed, comprehensive expositions (Black, 2002; Weinreich, 2003b) may be consulted as necessary. In the current research, relevant attributes as defined by Weinreich (2003) are interpreted by the researcher 'to tell the story' of each research respondent in case study narratives.

6.5.3 Scale ranges and cut off points

A schedule of scale ranges for ISA indices and suggested cut-off points were calculated by Weinreich (1992) for practical application to interpret ISA outputs for individuals. The schedule is set out at table 6.1 below. The ranges used are based upon definitions and their algebraic representation. One example may suffice to explain this process.

When a person idealistically identifies with a significant other (i.e. regards them as a positive role model) and simultaneously empathetically identifies with that person (i.e. perceives similarities between characteristics good or bad of oneself and that other) the outcome is likely to be a positive one, which enhances one's perception of one's self (Weinreich, 1989a: 52).

However when one contra-identifies with another (i.e. regards them as a negative role model) while at the same time one empathetically identifies with that person, the outcome is likely to be a negative one, i.e. a conflicted identification.

As stated at par 4.7.2 above, a conflicted identification with another, designated K_i is defined as follows:

'In terms of one's current self-image, the extent of one's identification conflict with another is defined as a multiplicative function of one's current empathetic identification and (one's) contra-identification with the other' (Weinreich, 2003b: 100).

The algebraic representation of the current conflict in identification with entity E_i is represented as follows:

$$K_i^c = \sqrt{((\text{emph identifn})_i (\text{contra -identifn})_i)}$$
$$= \sqrt{(\Psi_i^c \Phi_i^I)}$$

where Ψ_i^c and Φ_i^I are given by the empathetic and contra-identification with the other respectively.

Weinreich (2003: 100) notes that the square root of the product is taken so that the index for identification conflict K_i^c remains in dimensional terms a measure of identification, not (identification)^{squared} (Weinreich, 2003b: 100).

The range of values for a person's conflict in identification with another is zero to unity (table 6.1), that is, from no conflicted identification with that other to the maximum theoretically possible, though psychologically unlikely (Weinreich, 2003b: 100).

In like manner, Weinreich (1992) elucidated scale ranges for ISA indices and suggested cut-off points for the ISA concepts for ego-involvement, evaluation, identification and identification conflict indices: identity diffusion, identification conflict, idealistic-identification, contra-identification, empathetic identification and structural pressure. These are set down at table 6.1 below.

It is important to state that cut-off points are by their nature arbitrary. Weinreich (1992) based the cut-off points on statistical criteria for a sample of 546 respondents (Weinreich, 1992: 36). The indices should be regarded as estimates of the underlying parameters, which may be subject to bias, as a result of over-inclusion or omission of certain kinds of bipolar constructs and entities and to error as a result of rating-scale response failures (Weinreich, 1992: 35).

6.5.4 Common errors in identity instrument construction

The instruments used in the current research are detailed above at par 6.4. Their outline content was based upon instruments designed for ISA investigation of postvention approaches for suicide survivors in earlier research (O’Keeffe, 2000). The differences between the latter instruments and those deployed (particularly ISA instrument A) in the current research addressed the shift in focus from suicide survivors to clinician survivors. For example, the entity ‘a person who has taken her/his own life...’ (suicide survivors’ study) was replaced by ‘a client who died by suicide’ (clinician survivors’ study). Situated selves ‘me as I was before / after I found out about the suicide’ (suicide survivors’ study) were replaced by ‘me before / after my client’s suicidal behaviour’ (clinician survivors’ study).

Additional current situated selves – ‘me when I’m overwhelmed by life’s cruelties’ (CS1) and ‘me when I feel enhanced by life’s wonders’ (CS2) augmented current research into clinician survivors’ identity development. They served to facilitate exploration of aspects of identity development related to ‘despair’ (CS1) and ‘contentment’ (CS2). Further it was essential to acknowledge professional aspects of clinicians’ identity development. These were recognised in new entities ‘my counselling supervisor’ and ‘a psychiatrist’.

It was also fundamental to include several suicide-related entities including ‘a depressed client’, ‘a client who recovered after serious suicide attempt’ and a ‘client with suicide ideation’ so that psychological pathways to suicide and their implications for clinicians’ identity development were clearly and adequately represented. Finally the new entity ‘a suicide survivor (person remaining alive after suicide death of individual with whom they had a significant relationship or emotional relationship)’ was essential and required its elaborate description. This term is not in common usage by clinicians. Although a standard

text (Cain, 1972) has been available for almost four decades, commentators confuse a person who “survived” a serious suicide attempt with ‘a suicide survivor’, as clearly articulated above. It is worth adding that Reber and Reber (2001) make no reference to the term ‘a suicide survivor’ but do explain at length ‘survivor guilt’ (Reber and Reber, 2001: 728) in several contexts that exclude suicide.

6.6 Research ethics

6.6.1 Research ethics: health, safety and comfort of respondents

All respondents were healthy volunteers, women and men, aged 18 and over, normally resident in their own homes. Collecting qualitative data from respondents ‘for example through interviews, can be intrusive and demanding’: this raises ethical issues around respondents’ health and safety (McLeod, 2005: 15). Most research in psychotherapy adopts the moral view that the researcher’s ‘primary responsibility to research participants is to prevent harm to them (non-maleficence)’ (McLeod, 1997: 175). Taking careful account of the potential sensitivity (Lee, 1993: 4) of this project, the researcher judged that anyone currently taking medication prescribed by a medical practitioner for the treatment of depression and/or related conditions should be excluded from participation: ‘Depression or anxiety disorders usually produce quite subtle distortions...making their influences on [decision-making] difficult to detect’ (Raymont, 2002 : 203) . All respondents were invited to inform their general practitioners of their voluntary participation in this research project (see appendix 4).

At the outset it was acknowledged that there was a risk, unquantifiable but probably low, to the health of respondents through their participation in the current research. Client suicide was described, in a case study, as ‘a personal and professional nightmare’ for a clinical psychologist (Jobes et al., 2000: 549). Consequently it was prudent to take reasonable precautions to protect respondents from health risks associated with their participation.

Some indeterminate potential for re-traumatisation existed, for example, for respondents who had been subject to acute stress symptoms after a client suicide experience, when they re-visited this during the audiotaped interview or while working through the IDEX software (Weinreich and Ewart, 1997). Proctor (2004: 1) described how discrete elements of trauma, fear and distrust in the recent and distant past interacted with the present forming a re-traumatising environment with ongoing psychosocial stressors and changes in mental distress.

All respondents were volunteers who had the opportunity to discuss the investigation, its objectives and format with the researcher. But it was surmised that respondents, during their active participation at interview and/or the ISA instrument via IDEX software stage, might exhibit mild discomfort if unresolved grief feelings were thereby aroused. The expression of such feelings in a safe, supportive environment was acknowledged to be both therapeutic and healing:

‘It will come as no surprise that we feel that the most important way to learn to respond to a suicide is through talking. Keeping silent, hiding your feelings about the suicide, punishing yourself, only perpetuates the grief. Expressing grief and pain, anger and guilt is healthy’ (Lukas and Seiden, 1990: 144).

The researcher sought to provide such an environment. All respondents were free to withdraw from the audiotaped interview before it commenced and also at any time during the interview. Before the interview started subjects were so informed and when the interview commenced, a statement reiterating this ‘freedom to withdraw at any time without adverse or any inferences being drawn’ was repeated during the researcher’s introductory remarks on tape. The researcher was available to respondents, by telephone, after the conclusion of the interview/ISA instrument via IDEX software session, if short-term advice and/or support were sought. If and when requested, by an individual respondent, the researcher was able to offer relevant help and advice, including counsellor referral information related to longer-term support.

6.6.2 Research ethics: Confidentiality

Some writers took the view that confidentiality in counselling, and by extension in counselling research, was ‘an absolute principle’. For example, Einzig (1989), in a text designed to help potential clients, held that ‘all counselling is totally confidential’ (Bond, 1998: 122). An opposing view cited the importance of client autonomy, related to ‘the client’s values, personal resources and capacity for self-determination’ (Bond, 1998: 122). In the research context, ‘respondent’ replaced ‘client’ but the same considerations applied. Perhaps the common sense position was best summed up as ‘the client [or respondent] should know where s/he stands in relation to confidentiality’ (Bond, 1998: 122). A major Irish counselling organisation offered the following guidance:

‘B.6.1 The IACT Code of confidentiality applies for research purposes’ (Irish Association for Counselling and Therapy (IACT), 1998: 6).

Conditional confidentiality was offered to all respondents in the current research with three caveats related to:

- i) information about or intent to commit serious criminal offence/s including offences against or involving children, terrorism and drug trafficking;
- ii) serious intent to self-harm;
- iii) information required under sub-poena by any properly constituted court of law (Bond, 1999: 8-10).

This was discussed fully with respondents before they commenced any interview or ISA instrument application and completion.

6.6.3 Research ethics: Personally identifiable material

A major British counselling organisation offered researchers in counselling the following guidance:

‘B7 Research:

B.7.1 The use of personally identifiable material gained from clients or by the observation of counselling should be used only after the client has given consent, usually in writing, and care has been taken to ensure that consent was given freely.

B.7.2 Counsellors conducting research should use their data accurately and restrict their conclusions to those compatible with their methodology’ (British Association for Counselling (BAC), 1996: 8).

A major Irish counselling organisation offered researchers precisely the same guidance (Irish Association for Counselling and Therapy (IACT), 1998: 6). Consequently the researcher undertook that all material published in the dissertation associated with this investigation would be anonymised in order to protect respondents’ privacy.

6.6.4 Research ethics: Written explanation and consent form

All respondents had access to the research proposal. Any questions that they had were addressed before each completed a consent form (see appendix 4). Each element of the respondent’s involvement – interview and ISA instrument – was completed consecutively and a time commitment by respondents of up to two hours (approximately) was agreed in advance. By conveying their written consent, respondents agreed that material obtained through audiotaped interviews/IDEX software could be used for research purposes subject to the above caveat concerning ‘personally identifiable material’.

6.6.5 Research ethics: Protection for the researcher

By obtaining in advance from respondents their informed written consent, the researcher secured reasonable protection for respondents’ anonymity and from possible adverse health consequences for them due to participation. The researcher accepted moral responsibility for any negative impact on respondents and made arrangements to help respondents in this

regard (see par 6.6.1 above). The researcher's counselling practice and research activities were professionally supervised by a chartered clinical psychologist and he carried relevant professional indemnity insurance. He is a member of the British Association for Counselling and Psychotherapy (BACP) and was formerly an elected member of the Irish Association for Counselling and Therapy's (IACT) Regional Committee for Northern Ireland. He is a current member of the Irish Association of Suicidology. He has access to professional colleagues for personal therapy as necessary. This combination of professional and therapeutic resources offered him an adequate level of support for the duration of this investigation.

6.6.6 Research Ethics Committee

The Research Ethics Committee of the University of Ulster approved the study.

6.7 Results

Case study summaries and findings are presented in chapter 7. Fuller versions of 11 target case studies are available at appendix 7 together with supplementary material at appendix 10.

Table 6.1 Scale Ranges for ISA Indices.

Scale Ranges for ISA Indices			
Ego-involvement			
Range	(0.00 to 5.00)		
Very high:	Above	4.00	
Low:	Below	2.00	
Evaluation ("standardised") & Self Esteem			
Range	(-1.00 to +1.00)		
Very high:	Above	0.70	
Moderate:	0.30 to	0.70	
Low:	-0.10 to	0.30	
Very low:	Below	-0.10	
Identification & Identification Conflict Indices			
Identity Diffusion			
Range	(0.00 to 1.00)		
High:	Above	0.40	
Moderate:	0.20 to	0.40	
Low:	Below	0.20	
Identification Conflict			
Range	(0.00 to 1.00)		
Very high:	Above	0.50	
Moderate:	0.35 to	0.50	
Low:	0.20 to	0.35	
Very low:	Below	0.20	

Idealistic-identification

Range (0.00 to 1.00)
High(+ve role): Above 0.70
Low: Below 0.50

Contra-identification

Range (0.00 to 1.00)
High(-ve role): Above 0.45
Low: Below 0.25

Empathetic Identification

Range (0.00 to 1.00)
High: Above 0.70
Low: Below 0.50

Structural Pressure

Range (-100 to +100)
"Core")**** Above 80
evaluative)*** 70 to 79
dimensions of)** 60 to 69
identity)* 50 to 59

"Secondary")+++ 40 to 49
evaluative)++ 30 to 39
dimensions of identity)+ 20 to 29

"Conflicted",)
inconsistently, or)
non-, evaluative)
dimensions of identity) -20 to +20

Consistently)
incompatible) Large
evaluative dimensions) negative

Note

It is stressed that cut-off points are by their nature somewhat arbitrary. The indices themselves should be regarded as estimates of the underlying parameters, which may be subject to bias as a result of over-inclusion, or omission, of certain kinds of constructs or entities, and to error as a result of rating-scale response failures. Caution should be exercised in their interpretation.

Chapter Seven: Case Study Summaries and Findings

Chapter 7: Case study summaries and findings

7.1 Introduction

This investigation was concerned with identity development in clinicians consequential to their involuntary status, as survivors of client suicide or clinician survivors. Litman's (1965) seminal article on 'patient suicide' described conclusions from interviews with 200 psychotherapists 'shortly after one of his (sic) patients committed suicide'. Litman was familiar with psychological autopsy (Litman et al., 1963) as a major investigative approach of the coroner 'to ascertain who commits suicide and under what circumstances' (Litman, 1965: 571). During the execution of such investigations, survivors – 'relatives...friends, employers, physicians, and especially when available, psychotherapists' were interviewed (Litman, 1965: 572). Litman identified two types of reaction:

'therapists react to such deaths personally as human beings much as other people do and also according to their special role in society.'

Litman (1965) and Litman et al. (1963) were limited in their conclusions.

Almost half century later, the current research used ISA to investigate clinician survivor status in a scientific approach that contrasted with Litman's (1965) apparently anecdotal methodology. ISA facilitated comprehensive exploration of clinicians' individual responses, whether personal, professional or otherwise to client suicide in the context of their appraisals of their identifications with their social world. It focused upon client suicide as a unique event in each clinician's personal and professional autobiography. Its objective was to ascertain, in the context of their duty of care and through the window of their clinician survivors' experiences, the impact of the loss of a client(s) through suicide on clinicians' identity development and, concomitantly, to illuminate their coping strategies and mechanisms. Accordingly and, in particular, respondents' identifications with 'a suicide survivor' and with 'a client who died by suicide' were key parameters in each case study. All target respondents voluntarily completed a consent form before interview.

The outcomes from 11 target case studies are presented in detail in Appendix 7 and Appendix 10. These idiosyncratic, descriptive interpretations formed the evidential basis for target case study summary findings. ISA outcomes for 6 comparison group respondents and 6 control group respondents are incorporated (see pars 7.3 and 7.4 below) as appropriate to highlight and illuminate the extent and

degree of any significant differences in identity development of these individuals in the absence of direct client suicide experience(s) in their autobiographies.

Conclusions that might be drawn are detailed in Chapter 8. A caution is essential regarding the validity of ‘summaries’ of case studies and the evidential value of ‘conclusions’ that attempt to derive insights, possibly leading to new knowledge, from comparison of cases studies. Accordingly the 23 summaries below are self-contained: case comparisons and insights derived therein are discussed in Chapter 8.

7.2 Target case study summaries

7.2.1 Case study A1 – ‘Paula’

Paula was a counselling director of a rehab unit for men with homelessness issues. Paula’s client suicide experience over a year before interview was a very highly influential life event for her. This was evidenced by very high empathetic identifications (emp idfcn CS1 0.68; CS3 0.73) with ‘a client who died by suicide’. She saw within herself in the context of ‘life’s cruelties’ and more so when ‘working’ with vulnerable clients, many of the characteristics that she perceived when reflecting upon her deceased client. The dual relationship that she participated in when working as a counsellor with the sibling of her deceased client was not without some negativity. It generated countertransference responses containing ‘a lot of anger [and] very complicated emotions’ connected back to Paula’s family suicide experience with her cousin around 15 years before interview.

All of Paula’s global identity variants were vulnerable in various ways. Her personal and professional life was permeated by problematic identifications with suicidal clients (con idfcn range CS3/CS4 0.39/0.47) and with ‘a suicide survivor’ (con idfcn CS3/CS4 0.47/0.42) when ‘working’ and when ‘relaxing’. Paula also recognised aspects of herself that were at odds with her values and beliefs in her identical problematic identifications with ‘a suicide survivor’ and with a ‘client who recovered after serious suicide attempt’, before she became a counsellor and before her client’s suicide (PS1/PS2) and when ‘enhanced by life’s wonders’ and when ‘working’ (CS2/CS3): (PS1 0.47; PS2 0.45; CS2 0.45; CS3 0.47).

Paula’s empathetic identifications, when working with vulnerable clients, with ‘a suicide survivor’ (CS3 emp idfcn 0.45) and with ‘a client who died by suicide’ (CS3 emp idfcn 0.73) pointed towards her distancing herself from her dual suicide survivor status while embracing, albeit subconsciously, key characteristics of her

deceased client. This sub-conscious use by her of the psychological defence of denial clouded Paula's appreciation of her suicidal aspirations that were evidenced in how she acknowledged surprise and shock but also respect and admiration for those who acted on suicidal impulses.

Paula's conflicted dimensions of identity via low structural pressures (SPs) on constructs pointed to areas of uncertainty including that suicide could not be predicted, feeling momentary bouts of psychological discomfort, wondering what life was all about, being totally changed by the suicide of her client, being highly sensitised to the issue of suicide and feeling that the person she was is dead.

It was unclear whether Paula's system of values and beliefs was capable of addressing her areas of uncertainty with regard to suicide. She attempted to contend with these by pursuing her aspirational beliefs by way of her core evaluative dimensions of identity, indicated by high SPs on constructs, including her preference for alternative/complementary remedies, continuing to develop her personal values and beliefs, believing grief following suicide was uniquely painful, that each human being was of irreplaceable value and that most suicides are unavoidable and can occur 'out of the blue'.

Paula construed herself as having consistently high empathetic identifications with her counselling supervisor in all counselling contexts and with regard to life's 'cruelties' and 'wonders' (range emp idfcn PS2/PS3/CS1/CS2/CS3 0.64/0.86) pointing to an anchor for her in her professional life. Such support was not replicated in non-counselling contexts in her personal life with family members, viz. partner/spouse, mother or father (range emp idfcn CS1/CS2/CS4 0.27/0.59).

All in all, Paula's ways of contending with the aftermath of client suicide, were concerning not least because her ongoing relationship with her deceased client evidenced strong empathetic identifications, as above, relatively high evaluation (eval 0.43) and intense ego-involvement (ego inv 4.26) but also because of her own potential vulnerability in relation to suicidal behaviour.

7.2.2 Case study A2 – 'Basil'

Basil was a part-time counsellor whose full time employment was in an educational institution. Basil's life experience until date of interview included several client suicides and he was designated a 'serial clinician survivor'. His most recent client suicide experience occurred up to five years before he upgraded his academic

qualifications and commenced full-time employment in an educational setting and part-time activity as a counsellor.

In the current context ‘me when I am overwhelmed by life’s cruelties’ (CS1) his global variant was ‘crisis’, a vulnerable state. In this context Basil’s very low self-evaluation (eval – 0.07) indicated failure to achieve his aspirational values and beliefs, in the irreplaceable value of each human (SP 92.08) when the ‘cruelties’ of armed conflict devalued his therapeutic pastoral contributions in support of self and vulnerable others. Basil contended successfully with his own propensity towards suicidality in the transition from ‘cruelties’ to ‘wonders’, evident in the very high self-evaluation (CS2 eval 1.00).

Basil’s areas of uncertainty, evidenced in low SPs on constructs, included several aspects of suicide – whether it could be anticipated, whether it was brave or cowardly, whether grief after suicide was uniquely painful, whether depression and suicide were inextricably linked and in relation to the suicide survivor’s predicament. He aspired to contend with stress around these problematic considerations by way of his core evaluative dimensions of identity, evidenced in high SPs on constructs, including his above-mentioned belief in the irreplaceability of each human being, the safe expression of emotion, having warm feelings toward others, taking life for granted and being open to human relationships. Basil in his narrative said that he believed it was best for him to focus upon more positive, healthier options for change and progress than the terminal one of suicide.

When working, Basil did not construe himself as ‘a suicide survivor’ (CS3 emp idfcn 0.38) but rather recognised much more strongly the characteristics of his ‘partner/spouse’ (CS3 emp idfcn 0.94) in that identity state even than those of his counselling supervisor (CS3 emp idfcn 0.81). His current academic activities were more dominant in his life than his counselling activities (CS3 ego-inv 3.37) although his experiencing of ‘wonders’ and ‘relaxing’ were the predominant identity states by far.

The outcome of Basil’s case was an insightful rejoinder to the notion that client suicide, or even serial client suicide, predisposed a counsellor to an indefinite hypervigilant future dominated by awareness of the possibility of client suicide. On the contrary even when ‘overwhelmed by life’s cruelties’ (CS1) Basil was less ‘a suicide survivor’ (CS1 emp idfcn 0.64) being more as his ‘mother’, ‘a depressed client’ and his ‘father’, respectively, (CS1 emp idfcn 0.79, 0.79, 0.71).

As intimated par 7.2.10 in Appendix 7, Basil ‘came through’ identity determining experiences that were permeated with ‘suicide and the pain of suicide’. He succeeded in resolving difficult and potentially disabling identity conflicts in achieving his aspirations to ‘seek and develop new relationships’ (SP 70.05), to relegate ‘thinking about people committing suicide’ (SP 70.34) to a lower priority in his cognitive agenda and to deal with existential issues around life and death, first by remaining ‘sure of who he is’ (SP 67.15) and then by continuing ‘to be the person he was into the foreseeable future’ (SP 59.98). Stimulating educational opportunities availed of in re-training for a new career met his aspirations to continue to develop personal values and beliefs’ (SP 57.11).

7.2.3 Case study A5 – ‘Michael’

Michael worked full-time as a counsellor in private practice. He was ‘shocked’ by loss of his client ‘out of the blue’ in a unique ‘first time in 20 years’ of counselling practice client suicide event.

His global identity variants were vulnerable except in the context of ‘life’s cruelties’ when he was regarded as ‘well adjusted’. This apparent stoicism was overlaid with anger at ‘being conned’ by his client’s suicidal behaviour. The fact that his deceased client was a practitioner counsellor deepened Michael’s negative response to being deceived.

Michael’s uncertainties, by way of low SPs, were dominated by suicide-related issues, including being totally changed by his client’s suicide, belief in an inextricable link between depression and suicide, being highly sensitised to the issue of suicide and feeling that grief after a suicide was uniquely painful. He contended with these problematic areas by aspiring to implement his core evaluative dimensions of identity, by way of high SPs, including belief in the irreplaceable value of each human being, continuing to develop personal values and beliefs, expressing his emotions safely, having warm feelings for others, believing people he was close to were entirely responsible for their own circumstances (SP 56.42) and an almost equally strong aspirational belief, despite his ‘out of the blue’ experience of client suicide, that suicide could be anticipated by perceptive observation (SP 55.28)

Michael’s view of self around his client suicide experience and the intensity of his engagement with it in this transition: (PS3/CS3 eval 0.87/0.88) and (PS3/CS3 ego-inv 4.48/4.31) evidenced its impact upon his identity in the context of his working

life. Although in the context of life's cruelties (CS1 emp idfcn 0.62) Michael construed himself as a clinician survivor, there was less in him of 'a suicide survivor' after client's suicide (PS3 emp idfcn 0.55) or when working (CS3 emp idfcn 0.58). The moderate level of his clinician survivor status indicated that while there was something of 'a clinician survivor' in him when he was with vulnerable clients, there was much more in him of a highly regarded person ('admired person': emp idfcn 0.95), a professional colleague ('counselling supervisor': emp idfcn 0.84) and a family member ('partner / spouse': emp idfcn 0.74).

Michael was predominantly defensive when contending with stress but he may not have been able to cope effectively. There were clues in his highly conflicted identifications with 'father' (PS1 con idfcn 0.49), with suicidal thoughts (PS1 con idfcn 0.52) and with death by suicide (PS1 con idfcn con 0.51) before he trained as a counsellor. His defensive stance about his own sense of identity blocked effective assimilation of and learning from his experience of the shock of suicide 'out of the blue' that was reinforced by his anger at being deceived.

Michael's psychological engagement comprised anger projected at the female client who took her own life and also directed towards himself because he allowed himself to believe all was well while she was planning to kill herself. The impact of this suicide led him to review his counselling approach and to re-consider implementing a procedure for formal suicide assessment of all clients.

7.2.4 Case study A6 – 'Frank'

Frank was a psychotherapist working in the NHS with vulnerable clients. His sole client suicide experience occurred two years before interview. He had a brief psychotherapeutic relationship with the deceased and learned, by way of a seemingly casual remark in passing by his former supervisor, of his client's suicide up to three months after therapy ended.

Across all seven past and current contexts his identity variants were considered well-adjusted. Frank's personal experience of 'recovering from a serious suicide attempt' in his teens (PS1) was a gateway into his current employment. The prelude to his related experience as a client in an effective therapeutic relationship facilitated his career choice as 'a wounded healer': Frank's 'search for wholeness and integration' (Spurling and Dryden, 1989) was generated by 'the pain of his negative life experiences into a resource for helping others' (McLeod, 1998: 354). He took a

psychology degree and worked with vulnerable people, first as a Samaritan volunteer, and latterly as a therapist qualified to doctorate level.

Frank recognised the clinician survivor part of himself when ‘working’ (CS3 0.75) and acknowledged strongly many characteristics of this person in both past and current contexts (range PS2/CS2 emp idfcn 0.77/0.73). Frank’s view of self around his client suicide experience and the intensity of his engagement with it in this transition: (PS3/CS3 eval 0.81/0.86) and (PS3/CS3 ego-inv 4.41/4.26) evidenced the event’s deep impact upon his working identity. But the most dominant part of his current identity was ‘me when I’m enhanced by life’s wonders’ (ego-inv 4.85).

On balance, his stronger positive role model was ‘a client who recovered after serious suicide attempt’ (ideal idfcn 0.95) rather than ‘a suicide survivor’ (ideal idfcn 0.82) and he valued the former (eval 0.90) much more highly than the latter (eval 0.68). Whereas his ‘survivor’ status was thrust upon him by his vulnerable client’s suicide, his own achievement was evident in ‘recovery’ from an attempt on his own life and his subsequent positive therapeutic endeavours on behalf of others.

Frank’s aspired to value each human as irreplaceable, to feel responsible for others well-being, to feel strongly about issues around suicide including its special grief, to believe that suicide might be anticipated and thus prevented, and to accept that he was ‘totally changed’ by suicide of persons linked to him. These evaluative identity dimensions, by way of high SPs, helped him to contend with distresses around problematic identity dimensions, recognised in low SPs, including ‘out of the blue’ suicide, i.e. unanticipated suicide not foreseen by a psychotherapist, his feeling of responsibility for those close to him and any momentary bouts of psychological discomfort linked perhaps to absence at time of human support. He aspired nonetheless to continue to develop personal values and beliefs.

Frank’s interest in and commitment to the current research was evidenced in his remark to the researcher ‘You’ve taken on quite a challenge’. He exemplified achievement earned through overcoming the dual adversities of his adolescent vulnerability and more recently his client’s suicide. His clinician survivor status transformed crisis into opportunity: paradoxically, the experience was an asset to him rather than a burden: it enhanced his awareness of his own and his clients’ vulnerability and offered insights that deepened his psychotherapeutic knowledge and skills in the psychology of suicide.

7.2.5 Case study A9 – ‘Dorothy’

Dorothy was a practitioner counsellor employed full-time in a counselling agency following several years as a volunteer counsellor. Her client took his own life following up to five sessions and after cancelling two appointments. She learned of his death in a brief telephone call to her home from a senior agency colleague. This was an ‘out of the blue’ suicide by a client who presented with issues (alcohol / gambling / relationships) around addictive behaviour with implications for suicide risk (Frank et al., 1991).

Her global variants were well-adjusted except in three contexts: pre-counselling career (PS1) ‘crisis’, when working (CS3) ‘defensive high self-regard’ and when relaxing (CS4) ‘defensive’. Her PS1 identity variant was linked to her marriage breakdown and divorce proceedings. Defensiveness was evident when Dorothy was either working or relaxing when problematic identifications with suicidal clients predominated over issues in her family or professional worlds.

Dorothy’s identifications with suicide in counselling were quite problematic in the context of life’s cruelties (CS1: four suicide-related persons, con idfcn, range 0.46/0.53) and this status was replicated across all current contexts. However when ‘working’, while she construed some of herself as ‘a suicide survivor’ (CS3 emp idfcn 0.68), she recognised personally many more of the characteristics of ‘my counselling supervisor’ (CS3 emp idfcn 1.00), ‘an admired person’ (CS3 emp idfcn 0.77) and ‘mother’ (CS3 emp idfcn 0.73).

Dorothy’s past encounter with suicide by way of her friend’s suicidal behaviour was indicated in her highly problematic identification: ‘a client with suicide ideation’ (PS1 con idfcn 0.77). She significantly resolved this in other situated contexts, including ‘life’s cruelties’ (CS1 con idfcn 0.53).

Dorothy’s positive role models were professional colleagues, and those in her personal and family worlds: her counselling supervisor (ideal idfcn 1.00), a psychiatrist (ideal idfcn 0.82), an admired person’ (ideal idfcn 0.77) and ‘mother’ (ideal idfcn 0.73).

Dorothy aspired to relieve some distress around her uncertainty, via low SP on the construct, about ‘suicide demanding bravery’ (SP 26.04) in a person taking their own life: she did this by way of her core evaluative dimensions of identity, by way of high SPs, with regard to suicide. These included aspirations to believe that suicide caused uniquely painful grief, that suicide could be anticipated and prevented, that she

was highly sensitised to the suicide issue and that suicide caused survivors to change totally. Low values placed upon the suicidal, alive and dead, challenged Dorothy's aspirational belief system: a client deceased by suicide (eval – 0.53) was among her most negatively valued persons set against one of her most highly esteemed: 'me as I would like to be' (eval 0.94).

Some of Dorothy's aspirations appeared mutually opposed: that suicide could occur 'out of the blue' (SP 42.03) while it could also be 'anticipated' (SP 82.00) and 'prevented' (SP 78.23). Dorothy's other aspirational beliefs included inter alia the irreplaceable value of each human and having a special responsibility for others' well-being. Existential issues about life's purpose: 'wondering what [it's] all about' (SP 63.18), and life and death: 'continuing to be the person she was' (SP 79.29) and 'remaining sure of who she is' (SP 76.23), were also important core aspirational beliefs for Dorothy.

Her 'out of the blue' experience of client suicide challenged and deeply affected her sense of herself and others. The support of professional colleagues was essential for her continuing engagement with this recent 'nightmare' including education about well-researched connections between pathological addictions and suicide leading to helpful insights about effective psychotherapy with addicted and potentially suicidal clients.

7.2.6 Case study A11 – 'Hannah'

Hannah was a practitioner counsellor employed full-time in a counselling agency following work experience in psychiatric nursing and in counselling for HIV/AIDS and substance abuse. Two clients had taken their own lives: one was an ex-psychiatric patient several years ago in England and more recently, a current client was found hanged after 6 months in counselling with Hannah and 4 days after his last appointment. Two of Hannah's immediate family had killed themselves: an uncle 30 years ago and a cousin a few years before interview but after her ex-psychiatric patient's suicide. She learned of her client's suicide on returning from a brief period of annual leave to keep her appointment with this now deceased client.

Hannah's seven global variants were regarded as well-adjusted. But her problematic identifications with suicide were very high in two contexts: after client suicide (PS3: four suicide-related persons, con idfcn, range 0.54/0.58) and when overwhelmed by life's cruelties (CS1: four suicide-related persons, con idfcn, range

0.49/0.58). Hannah's problematic identifications with active suicidality via 'ideation' and 'depression' in clients were more intense than with the aftermath of suicidal behaviour via 'recovered', 'survivor' or 'client who died by suicide'. When 'working' she construed herself as 'a suicide survivor' (CS3 emp idfcn 0.68) while recognising herself more so in the characteristics of 'an admired person' (CS3 emp idfcn 0.95), of professional colleagues (e.g. 'supervisor' CS3 emp idfcn 0.91) and of family members (e.g. 'my partner/spouse' CS3 emp idfcn 0.82).

Hannah's past encounters with family suicide emerged in her highest pre-counselling problematic identification with 'a recovered after suicide attempt client' (PS1 con idfcn 0.52) which intensified in 'life's cruelties' (CS1 con idfcn 0.58) but remained at its pre-counselling level when Hannah worked with vulnerable clients (CS3 0.52). This pattern was repeated for 'actively suicidal' clients in these transitions: (PS1/CS1/CS3 'actively suicidal' [depressed and ideation] con idfcn 0.49/0.58/0.49). Family suicide during her adolescence heightened an awareness that was intensified through more recent patient and family suicides. It was evident that Hannah's most problematic current issues would be with 'suicide in counselling', its potential, its actualité and its aftermath while she continued to have substantial issues with her family, e.g. 'mother' (all contexts, range, con idfcn 0.44/0.51).

Hannah's positive role models spanned her professional, personal and family worlds with her strongest models being 'an admired person' (ideal idfcn 1.00) and 'my counselling supervisor' (ideal idfcn 0.95). Her negative role models were suicide-related depressed/suicidal clients (contra-idfcn both 0.68).

Hannah aspired to contend with distress, pointed up by low SPs, including existential issues, levels of responsibility for certain others and suicide-related concerns: suicide being a brave act, 'out of the blue' suicide and whether suicide can be anticipated. She did this by way of implementing core evaluative dimensions of identity, by way of high SPs, about suicide including: that grief after suicide was uniquely painful, being highly sensitised to the issue of suicide, that suicide could be prevented and that suicide totally changed survivors. Other strong aspirational beliefs included developing personal values and beliefs, the irreplaceable value of each human, developing human relationships and continuing to be the person that she is.

The ISA instrument was unable accurately to discriminate between Hannah's evaluation of her deceased relatives (uncle and cousin) and her deceased clients (patient and client). So it was not immediately possible for the researcher to identify

‘family’ as an evaluative influence in this regard. Yet an apparent paradox existed for Hannah: she appraised four suicide related clients as people that she valued least (eval: four suicide-related clients, range: – 0.03 / – 0.27), her deceased client being least valued. These data contrasted overwhelmingly with Hannah’s highest aspirational self-evaluation ‘me as I would like to be’ (eval 1.00). Yet the single most essential component for effective counselling was the quality of the relationship between client and counsellor:

‘There is an increasingly wide acceptance of the importance of the relationship between the client and therapist as the agent of therapeutic efficacy... something about the process between therapist and client and the way they relate...is much more important to successful outcome than...content of sessions...or the knowledge, skills and techniques of the practitioner’ (Wilkins, 2003: 73)

Hence the paradox: negative evaluation of the suicidal, or any, client by a counsellor conditioned some potential for an ineffective outcome. The related notion of ‘countertransference hate’ is examined at par 8.3 below. Whether there was any identifiable connection between low client evaluation and client suicide in any individual case required further research.

7.2.7 Case study A12 – ‘Ruth’

Ruth held a senior post involving both management and practitioner roles in a counselling agency following periods working in mental health and community development. She lost two clients by suicide within one month about four years prior to interview. One deceased client, a young single mother, was her client intermittently for about three years. Attempts to admit her to a psychiatric ‘place of safety’ during the last three weeks of her life failed. She was found hanged. Later Ruth worked briefly with a male client who was found hanged before the date scheduled for his third session.

Ruth’s global variants were vulnerable except ‘me before client’s suicidal behaviour’ (CS2) which was ‘indeterminate’, a well-adjusted state. Six remaining identity variants were ‘diffusion’ or ‘diffuse high self-regard’ pointing to co-existing high levels of unresolved problematic identifications with varying levels of self-evaluation.

Problematic identifications with suicidal-related clients deepened after her clients' suicides, most noticeably with 'a client who recovered after serious suicide attempt' (PS2/PS3 con idfcn 0.40/0.53) and least with 'a client who died by suicide' (PS2/PS3 con idfcn 0.40/0.47): both clients had executed their suicidal intent, one fatally. When based in 'life's cruelties' Ruth's problematic identifications modulated most with 'client with suicide ideation' and with 'a depressed client' (PS3/CS1 both con idfcn 0.59/0.68): both clients were actively suicidal and at risk. In contrast, her identifications with 'a suicide survivor' were not problematic in any of the seven contexts.

When working, Ruth construed herself highly as 'a suicide survivor' (CS3 emp idfcn 0.86) but also recognised in self almost as many of the attributes of 'an admired person' (CS3 emp idfcn 0.82) in that context. She also recognised in herself as much of 'a suicide survivor' 'when relaxing' (CS4 emp idfcn 0.86) while recognising more attributes of 'an admired person' (CS4 emp idfcn 0.91) therein. The implication was that Ruth did not easily discriminate between working and relaxing, this being a hallmark of the workaholic.

Ruth's multiple encounters with suicide, in mental health and in community and social work, were evidenced in her highest (jointly with 'father') pre-counselling, problematic identifications with 'a client who recovered after serious suicide attempt' (PS1 con idfcn 0.60), followed closely by 'suicidal/depressed people' (PS1 con idfcn both 0.59). However, when working with the suicidal, her problematic identifications were largely resolved (CS3 four suicide-related clients range con idfcn 0.40/0.46), the highest level being with a 'recovered client' (0.46). It was noted that when working, she evidenced highly problematic identifications with her parents (CS3 con idfcn mother 0.51; father 0.52). These parental issues were in evidence across all contexts (PS1/CS4 con idfcn range 0.50/0.58).

Ruth's positive role models included entities from her social, professional and personal worlds but most strongly 'a suicide survivor' (ideal idfcn 0.91), whom she valued very highly (eval 0.78). This reflected her social, community and counselling engagement with 'survivors': as a clinician survivor she aspired towards their qualities and attributes. Her most negative role models were suicide related clients.

Ruth aspired to contend with distress and uncertainty, pointed up by low SPs, around suicide prevention, the negative effect of suicide on survivors and existential issues by implementing her core evaluative dimensions of identity, via high SPs.

These included her aspirations to believe that grief after suicide was uniquely painful, that suicide and depression were inextricably linked, that suicide could be prevented, and so on. Ruth contended with the vagaries of her counselling and other lives by aspiring inter alia to use alternative remedies, family support, having warm feelings for other people and believing in the irreplaceable value of human beings.

The paradox of counselling the suicidal, mentioned above in par 7.2.6, was also evident in Ruth's case. She evaluated suicidal clients at a very low level (eval: four suicidal clients, range – 0.10 to – 0.48) and her deceased clients were valued least. Yet effective counselling relied upon the quality of the relationship for all therapeutic approaches. The investigator was unable to explain this finding and did not speculate about any link between client suicide and deficient counsellor/client relationship. (See also par 8.3 below for further examination.)

7.2.8 Case study A14 – ‘Eric’

Eric was a hypnotherapist in private practice working with a psychodynamic orientation. He experienced the loss by suicide of two clients and subsequently a patient's natural death in a hostel from a terminal illness. The significance of the latter bereavement was its contribution to reactivating unresolved aspects of Eric's two client suicide losses.

Eric's global identity variants were vulnerable except for 'me when I feel enhanced by life's wonders' (CS2), which was 'confident', a well-adjusted state. Six remaining identity variants were 'crisis' (PS1 & PS2), 'diffusion' (PS3, CS1 & CS3) and 'diffuse high self-regard' (CS4), signalling high levels of unresolved identification conflicts and varying levels of self-evaluation.

Eric's problematic identifications discriminated between clients in relation to their perceived levels of suicidality or suicide risk. Depressed, suicidal and deceased clients (con idfcn all contexts range 0.42 to 0.70) were generally more complicated for him than clients who remained alive after their own – 'client who recovered after serious suicide attempt' (con idfcn all contexts range 0.34 to 0.40) – or another's suicidal behaviour – 'a suicide survivor' (con idfcn all contexts 0.43 to 0.51). Eric's self-evaluation was context based, being much higher (eval 0.92) in 'wonders' (CS2) than when burdened by 'life's cruelties' (CS1 eval 0.26).

Eric recognised in himself many of the characteristics of 'a suicide survivor' following the loss of his clients (PS3 emp idfcn 0.82), but less so when working (CS3

emp idfcn 0.68) or relaxing (CS4 emp idfcn 0.65). However at work he construed himself as possessing more of his mother's qualities (CS3 emp idfcn 0.73) while when he was away from work the characteristics of 'an admired person' (CS4 emp idfcn 0.80) were more predominant in his construal of self.

Eric's strongest positive role models included those from his social and professional worlds while depressed, suicidal and 'deceased by suicide' clients represented his most negative exemplars.

Eric aspired to contend with distress, pointed up by low SPs, around existential issues, accessing family support, suicide being the act of a coward and the impact of suicide upon survivors, by implementing aspirational beliefs, identified by high SPs. These included convictions that depression and suicide are inextricably linked, that suicide could be anticipated and prevented and that grief after suicide is uniquely painful. In addition Eric contended with life's vagaries by expressing his feelings safely, by belief in the irreplaceable value of each human being, by using alternative/complementary remedies and being encouraged by others.

Some apparent ambiguity was evident, in Eric's very low evaluation of depressed, suicidal and 'deceased by suicide' clients (eval range – 0.42 to – 0.30) while aspiring to believe in the irreplaceable value of each human being – see also par 8.3 below.

7.2.9 Case study A15 – 'Debbie'

Debbie was trainee clinician on placement in a rehabilitation hostel for men in recovery from drugs and alcohol-related addictions. Her first client died by suicide after completing four weekly counselling sessions and having agreed to attend further session/s. When interviewed Debbie availed of the opportunity to express her feelings of shock and distress. She also benefitted from expert supervision and the support of trainee colleagues and tutors.

All seven of Debbie's identity variants were considered vulnerable. They revealed deficiencies in her self-evaluation in each context and the wide range and magnitude of her conflicted identifications with family members and vulnerable clients. Unsurprisingly her attention, as assessed by the ego-involvement parameter, was very highly focused upon her deceased client and upon that part of herself, the trainee clinician survivor.

Debbie's consistently highly conflicted identifications with suicide-related people reflected her recognition of the negative influence upon her of the suicide phenomenon, regardless of the guise in which it was manifested to her. Her experience of suicide-related behaviour in others before and after her interest in psychotherapy developed, heightened her self-awareness of the characteristics of 'a suicide survivor'. Her dual status as a family suicide survivor and as a trainee clinician survivor influenced her view of herself when she was working or relaxing. However she also sensed in herself characteristics of family, professional and social others that were as close as those of 'a suicide survivor'. This explained to some extent her otherwise remarkable ability to move forward reasonably quickly following the loss of her client.

Debbie's strongest positive role model was her counselling supervisor (ideal idfcn 0.91) whom she wished to emulate and whose influence supported her transition in the aftermath of her client's suicide. Her most negative exemplar was 'a client with suicide ideation' (contra-idfcn 0.68).

She aspired to contend with distress and uncertainty, indicated by low SPs, around being totally changed by her client's suicide which generated a hypervigilance regarding the issue of suicide, causing her to feel the need for human contact and family support, while being uncertain about herself and how to relate with others. Debbie's core dimensions of identity via high SPs, represented aspirational beliefs in the safe expression of her emotional response to her serious loss, relying on alternative/complementary remedies, believing that suicide demanded considerable bravery while continuing to develop personal values and beliefs and feeling that grief after suicide was uniquely painful.

Debbie experienced the paradox of counselling clients with suicide-related issues, in her low evaluations (eval four suicide-related clients range – 0.04 to – 0.42) of these vulnerable people – see also par 8.3 below. Such attributions of relative disfavour were not outwardly apparent in her conscious behaviour as a trainee counsellor. However Debbie's secondary aspirational beliefs shed some light upon her qualified attitude to others: these included 'belief in the irreplaceability of human beings' (SP 31.24) together with a degree of uncertainty in her about feeling responsible for others' circumstances (SP 26.56), perhaps including clients that she might be close to in the therapeutic relationship.

7.2.10 Case study A16 – ‘Mark’

Mark was a highly qualified clinician with high-level therapeutic competencies based upon postgraduate education and training allied to extensive psychotherapeutic practice. He was the survivor of the recent suicide of a former school mate in addition to three client suicides over a period of four years before being interviewed for current research.

With one exception, Mark’s global identity variants were considered well-adjusted. When ‘overwhelmed by life’s cruelties’ (CS1) very low self-evaluation (eval – 0.09) linked to problematic identifications were greatest in relation to suicide-related clients (CS1 con idfcn range 0.45 to 0.54) producing a vulnerable identity variant. Only when he was overwhelmed by life’s cruelties was Mark’s engagement with suicide in his professional work considered to be less than well-adjusted.

Mark’s conflicted identifications with ‘a suicide survivor’ were more intense across the remaining six contexts (con idfcn 0.46 to 0.57) than with suicide-related clients (con idfcn range 0.22 to 0.42). He recognised in that entity characteristics with which he was uncomfortable and wished to dissociate. When working Mark recognised some qualities in himself that he appraised in ‘a suicide survivor’ (CS3 emp idfcn 0.65). But in this context there was much less in him of the clinician survivor than of a professional clinician, evidenced in his recognition of many more of his own characteristics in ‘a psychiatrist’ and in ‘my counselling supervisor’ (both CS3 emp idfcn 0.80).

The intensity of Mark’s engagement and evaluation of clients was dependent upon how he appraised them: he exercised professional discrimination perhaps paradoxically by focusing most highly upon clients that he valued least. His positive role models included people in his professional, social and family worlds, with his strongest being his professional supervisor (ideal-idfcn 0.77). Clients with suicide-related issues represented his most negative exemplars.

Mark’s low SPs pointed to areas of stress, discomfort and uncertainty for him including levels of responsibility for certain others, personal and existential issues and suicide-related concerns: suicide being the act of a coward, post-suicide grief and its effects upon survivors and being highly sensitised to suicide issues. Mark contended with these issues by way of his core evaluative dimensions, identified by high SPs, including his conviction that suicide was preventable, especially when anticipation was informed by perceptive observation, although ‘out of the blue’ suicide did occur

when seriously suicidal individuals did not access expert, effective therapeutic support. Other aspirational beliefs that Mark benefitted from included his resilience in continuing to be the person that he is, contending with momentary psychological discomfort and developing relationships with and warm feelings towards other people.

Although Mark was a multiple clinician survivor, he was not overly influenced by that part of himself during his engagement with vulnerable clients. However there was little doubt that he was hugely affected by the experience of losing several clients by suicide. A paradox was evident in Mark's case, as in some other cases herein, related to his low evaluation of some suicidal clients while aspiring towards believing in the irreplaceability of all human beings (SP 57.50) – see also par 8.3 below.

7.2.11 Case study A17 – ‘Matthew’

Matthew's case facilitates exploration of identity development in a respondent during the transition from ‘control’ status to ‘target group’ member. He was interviewed initially while employed as community worker and a second time, some years later when working as an agency counsellor following his client's suicide.

Matthew's global identity variants reflected his transition from a well-adjusted identity state to a more vulnerable identity state and illustrated how the experience of a family suicide and/or that of a client contributed to identity development.

A key finding evidenced Matthew's higher levels of conflicted identification with ‘a suicide survivor’ in the context of ‘life's cruelties’ when the suicide (2002) was that of a family member rather than that (2005) of a client (CS1 con idfcn 2002 – 0.54; 2005 – 0.43). When working as a counsellor Matthew shared some characteristics that he recognised in ‘a suicide survivor’ (CS3 emp idfcn 0.60). But he identified at a much higher level with other entities including ‘an admired person’ (CS3 emp idfcn 0.90) and ‘my counselling supervisor’ (CS3 emp idfcn 0.85). Hence Matthew's engagement with vulnerable clients was not excessively influenced by his clinician survivor experience.

Matthew's positive and negative role models changed following his client suicide experience. Professional colleagues were more prominent than family members as Matthew's positive exemplars while ‘a client deceased by suicide’ joined ‘a client with suicidal thoughts (ideation)’ as his key negative role models.

Matthew's system of aspirational values and beliefs was affected to a limited extent by his experience of client suicide, most significantly in relation to existential and meaning of life issues: afterwards (2005) he 'remains sure of who he is' (Inst 'A' construct #6 SP 56.49) while previously (2002) he 'questions who he is' (Inst 'C' construct #3 SP 15.60); afterwards (2005) he 'wonders what life is all about' (Inst 'A' construct #1 SP 40.43) while previously (2002) he 'takes life for granted' (Inst 'C' construct #2 SP – 33.86). However his aspirational belief that suicide could be anticipated, perhaps through the presence of client depression, was stronger (Inst 'C' construct #17 SP 54.14; Inst 'A' construct #13 SP 64.98) while his aspirational belief that suicide could be prevented was less strong (Inst 'C' construct #14 SP .73; Inst 'A' construct #5 SP 42.66).

Matthew exhibited characteristics of some colleague clinician survivors, for example, low evaluation of the suicidal client while aspiring to believe that each human is irreplaceable – see also par 8.3 below – and when working, the limited influence of his clinician survivor status following his client suicide experience. As a dual family and clinician suicide survivor, Matthew remained convinced that uniquely painful grief followed suicide. However he appeared only marginally more 'sensitised to suicide issues' after his client suicide experience (SP 47.72) than before it (SP 44.97).

7.3 Comparison case study summaries

The following case study summaries explore the influence, if any, upon a clinician's identity development of a colleague clinician's experience of client suicide. In general, the former clinicians are referred to as clinician survivors (by proxy). In the comparison case study A7 – 'Barbara', the suicide death of the latter clinician's line manager/counselling supervisor is deemed to confer 'clinician survivor (by proxy)' status upon her, when the counsellor's suicide generates an equivalent, serious loss event comparable to, and representative of, a client's suicide (by proxy). Findings by Calhoun et al. (1984) – see also par 3.6.2 above – suggested the existence of a psychological response of unknown dimensions in those bereaved by such losses as those experienced by clinicians survivors (by proxy). The following case studies offer insights into the nature of this response in terms of identity development of clinician survivors (by proxy), as defined. All comparison respondents voluntarily completed a consent form before interview.

7.3.1 Comparison case study A3 – ‘Tamara’

Tamara was a highly qualified clinical psychologist working in private practice as a counsellor and counselling supervisor. One of her supervisees contacted her by telephone following the loss of her client by suicide following four counselling sessions. The bereaved counsellor had not (yet) brought her client’s work to Tamara for supervision prior to the client’s death. Tamara’s encounter with this clinician survivor conveyed upon her the status of clinician survivor (by proxy). Tamara’s appraisal of her supervisee’s client suicide experience pointed up a miserable perspective on the person Tamara used to be ‘before she became a psychotherapist’ (PS1). She construed herself then as having the qualities of ‘a client who recovered after serious suicide attempt’ (emp idfcn 0.77), ‘a suicide survivor’ (emp idfcn 0.77) and ‘a client with suicide ideation’ (emp idfcn 0.68).

Tamara’s identity variants were regarded as well-adjusted i.e. ‘confident’, in three current contexts – CS2, CS3 and CS4 – and one past context – PS2. Tamara’s global identity variants are regarded as vulnerable in the remaining three contexts: two are ‘crisis’ (PS1 and CS1), while the third is ‘diffusion’ (PS3). The latter variants were linked to low levels of self-evaluation and wide dispersion of high identification conflicts in these contexts.

Tamara experienced stress and uncertainty, indicated by low SPs on constructs, with regard to suicide related discourses, including being totally changed by suicide, believing that suicide demands considerable bravery and being highly sensitised to the issue of suicide. She contended with these problematic aspects of suicide by implementing her core evaluative dimensions of identity, identified by high SPs on constructs, including continuing to develop personal values and beliefs, feeling that safe expression of emotions is healthy and believing in the irreplaceability of each human being.

Her identification conflicts further confirmed that Tamara was strongly influenced by aspects of suicide in her counsellor-client and supervisor-supervisee relationships. This was exemplified in her past biographical history (PS1 conf idfcn range 0.53 to 0.70) with regard to clients with suicide-related issues. This pattern was replicated when she appraised herself currently in the context of ‘me when I’m overwhelmed by life’s cruelties’ (CS1 conf idfcn range 0.44 to 0.76) with regard to suicide-related clients.

Tamara's self-appraisal in all identity states evidenced her self-construal as 'a client who recovered after serious suicide attempt' (all contexts emp idfcn range 0.55 to 0.81) although in three current contexts she also recognised in self significant qualities of her father and partner (CS2, CS3, CS4 emp idfcn range 0.71 to 0.94). Her encounter with her supervisee reminded her of these major elements of her current sense of self.

Tamara's engagement with her clinician survivor supervisee alerted her, in the sense of a wake-up call, regarding possible deficiencies in her understanding of the psychology of suicide. This experience was not so much a 'client suicide (by proxy)' event for her as a shock that she perhaps had not thought through before how she would contend with such an eventuality – the loss of her client by suicide – should such a misfortune occur.

7.3.2 Comparison case study A4i – 'Lucy'

Lucy was a Jungian-trained psychotherapist and counselling supervisor. Her fellow student was a colleague counsellor who died by suicide some months before Lucy's interview. Although she had not experienced client suicide, she supervised a counsellor who was a clinician survivor. This relationship conveyed to Lucy the status of clinician survivor (by proxy).

Lucy idealistically identified with her supervisor (ideal idfcn 0.73) who represented her key positive exemplar. She contra-identified strongly with depressed and suicidal clients (contra-idfcn 0.73 to 0.91) but she dissociated rather less from 'mother' (contra-idfcn 0.68).

Currently Lucy highly empathetically identified with her supervisor when working and relaxing (CS3, CS4 emp idfcn both 0.77). Lucy's previous suicidality levels were indicated by the characteristics of 'a client who recovered after serious suicide attempt' that she recognised in past senses of herself (emp idfcn PS1, PS2 both 0.55; PS3 0.64) and even more so currently when working (emp idfcn CS3 0.68).

Lucy's highly conflicted (i.e. problematic) identifications with depressed and suicidal clients before she became a counsellor (PS1 con idfcn range 0.44 to 0.76) modulated in other contexts (PS2 to CS4 incl con idfcn range 0.26 to 0.67) evidencing Lucy's resolution of some identification conflicts during her counselling career. However Lucy's identification conflicts with 'a client who recovered after serious

suicide attempt' were consistently high across all current contexts (CS1 to CS4 incl con idfcn range 0.46 to 0.49).

Overall Lucy's identity variants indicated well-adjusted 'indeterminate' states when she was experiencing life's wonders (CS2) and when working (CS3) and vulnerable states in other contexts: 'diffusion' (PS2, PS3, CS1 and CS4) and 'crisis' (PS1). These states pointed to Lucy's widely dispersed and high levels of identification conflicts.

Lucy's problematic dimensions of identity (low SPs on constructs) included uniquely painful grief following suicide, being totally changed by suicide of a significant other, relying on family support in crises, considering most suicide could be prevented and feeling momentary bouts of psychological pain. She contended with stress and uncertainty related to these issues by implementing her core evaluative dimensions of identity including aspirational beliefs in the irreplaceable value of each human being, continuing to develop personal values and beliefs, questioning who she is and feeling that safe expression of emotions is always healthy.

It was clear that Lucy's own level of suicidality, her experience as a clinician survivor (by proxy) and her recent loss of a colleague counsellor by suicide were highly significant influences on Lucy's identity development. There were good indications that her systems of value and beliefs could match her needs in relation to the aftermath of a significant other's suicide. She did not construe herself as 'a suicide survivor' when working (CS3 emp idfcn 0.45) while that part of her resembling 'a client who recovered after serious suicide attempt' (CS3 emp idfcn 0.68) was less significant than her 'counselling supervisor' or 'an admired person' (CS3 emp idfcn both 0.77) in that context.

7.3.3 Comparison case study A7 – 'Barbara'

Barbara was a trainee counsellor in her mid-20s with some experience of one-to-one work and telephone counselling in an agency setting. Her father died by suicide when Barbara was four years old while she made a serious attempt on her own life several years before interview. Her interest in the current research related to her personal experiences and also to the violent suicide (by hanging) of her agency line manager, a practitioner counsellor, some months before interview. In the context of the current research, her colleague counsellor's suicide was representative of 'a client who died by suicide', conferring upon Barbara the status of a clinician survivor (by proxy).

Barbara was unable or unwilling when completing ISA instrument ‘A’, to construe or to appraise either ‘Father’ or ‘a client who died by suicide’. This pointed up her failure to come to terms with her early experience of her father’s suicide, her own attempted suicide and the recent suicidal loss of her line manager. She adopted the position of refusing to contemplate the meaning of her father’s suicide or that of a client who died by suicide, represented by her colleague counsellor’s suicide.

Barbara defined herself as ‘a suicide survivor’ with whom she was most intensively involved (current emp idfcn all 0.95; ideal idfcn 0.95; ego-involv 5.00). Other possible notions of identity that she might have adopted such as her mother, her partner and her counselling supervisor are excluded as in these results:

Barbara A7	current emp idfcn range	ideal-idfcn	ego-involv
Mother	0.65 – 0.68	0.68	3.10
Partner	0.60 – 0.65	0.64	3.54
my counselling supervisor	0.32 – 0.35	0.32	0.86
a psychiatrist	0.10 – 0.18	0.32	1.12

She minimally empathetically identified with her depressed and suicidal clients (current emp idfcn range 0.10 to 0.18) and also substantially contra-identified with these clients (contra-idfcn 0.41 to 0.59).

Barbara had resolved her problematic identifications with depressed and suicidal clients to a degree (max ‘past’ con idfcn 0.41; max ‘current’ con idfcn 0.34). She achieved this by further dissociating from these clients (max past emp idfcn 0.29; max current emp idfcn 0.18) failing to recognise anything of herself in them. Her highly favoured identity as ‘a suicide survivor’ allowed for no other characteristic of herself by others.

Barbara had very nearly fulfilled her identity aspiration of being ‘a suicide survivor’, across all current contexts, her global identity variants being ‘defensive high regard’.

Barbara’s system of values and beliefs as revealed in her core evaluative dimensions of identity, via high SPs on constructs, suggested that she aspired to continue to develop personal values and beliefs, to feel that grief following suicide

was uniquely painful, to believe that depression and suicide were inextricably linked, to continue to be the person she was, to rely on family support and never feeling lonely or uncomfortable when alone. But Barbara's identity processes indicated little development of personal values and beliefs and it was unlikely that she could rely on family support at times of crisis given her family history. Overall her aspirations appeared somewhat unrealistic.

Areas of stress for Barbara, via low SPs on construct, included issues around being responsible for others' fortunes or misfortunes, whether suicide could be prevented or was unavoidable and the role of perceptive observation in preventing suicide. She remained uncertain in relation to these issues.

Barbara's core aspirations represented her unrealistic attempt to achieve personal certainty in the face of these unresolved dilemmas that demonstrated her failure to resolve her experience of her father's suicide, her attempt to end her own life and her line manager's suicide. Currently she adopted the defensive position of 'a suicide survivor' being as yet unable or unwilling to understand the possible meanings and implications of these suicidal activities.

7.3.4 Comparison case study A8 – 'Sheila'

Sheila was an experienced and highly qualified counselling psychologist working in an agency setting. Two years before interview, her client died suddenly: Sheila was advised that her client's family were unsure whether or not her client had died by suicide. A year later a coroner's inquest found that the client's death was accidental: the client had overdosed on prescribed medication but no firm evidence existed of suicidal intent. Sheila worked currently with a client who was a clinician survivor, having lost a client by suicide. Consequently Sheila was considered to be a clinician survivor (by proxy). Sheila had also experienced family suicide three years before interview when a family member was found hanged. Hence Sheila's experience of others' suicidal behaviour was considerable but absent in relation to self.

Sheila was unable or unwilling to appraise either 'a client who died by suicide' or 'mother'. In the former case, she wrote 'N/A' against all ISA instrument 'A' entries. In the latter case she wrote 'deceased' against the initial ISA construct '...takes life for granted' / '...wonders what life is all about' and left all subsequent entries blank. Sheila did not wish to contemplate the meaning of her mother's death or

that of 'a client who died by suicide', the latter being represented by her clinician client's loss of their client by suicide.

Sheila was intensely ego-involved with 'a suicide survivor' (ego-inv 5.00) but did not recognise herself in that entity's characteristics in any current context (emp idfcn range 0.32 to 0.50). Indeed she highly dissociated from this person (contra-idfcn 0.59) and regarded them very unfavourably (eval – 0.28). Her three encounters as 'a suicide survivor', viz. family, accidental death of client where suicide was ultimately ruled out, and clinician survivor (by proxy), focused her attention on the entity in the context of current research but not more pervasively in her life.

Sheila placed a very low evaluation upon depressed and suicidal clients (eval range – 0.12 to – 0.32) and upon a suicide survivor (eval – 0.28). Although she was currently working in trauma-related psychotherapy following work experience abroad devoted to suicide assessment of vulnerable clients, Sheila believed her clients valued her very highly (eval 'me as clients see me' 0.77) and almost as highly as her colleagues (eval 'me as colleagues see me' 0.83). Countertransference dynamics, as demonstrated in pars 2.8 and 3.9.5 above may be influential here.

Sheila's identity processes revealed that she construed herself quite strongly in the characteristics of her counselling supervisor (all contexts emp idfcn range 0.64 to 0.77), her partner (all contexts emp idfcn range 0.55 to 0.73) and, less emphatically, her father (all contexts range 0.41 to 0.59). Sheila's past problematic identifications with depressed and suicidal clients (past conf idfcn range 0.47 to 0.60) were only partially resolved in the current contexts of life's wonders (CS2), working (CS3) and relaxing (CS4) (current conf idfcn range 0.40 to 0.54) as she distanced herself only slightly from these people (max past emp idfcn 0.57). However these parameters of conflicted identification maintained high or very high levels.

All Sheila's identity variants were regarded as vulnerable except when she was relaxing (CS4 'determinate'). High levels of identity diffusion reflected her high and widely dispersed conflicted identifications across all but one context (CS4) with all entities except her partner and an admired person.

Sheila's system of beliefs and values as revealed in core evaluative dimensions of identity, via high SPs on constructs, indicated aspirations to continue to develop personal values and beliefs, to seek and develop human relationship, to believe that each human being was of irreplaceable value, to continue to be the person she was into the foreseeable future, to feel that safe expression of emotional feelings

was always healthy and never feeling lonely or uncomfortable when alone with self. Sheila's low evaluation of depressed and suicidal clients (eval range – 0.15 to – 0.32) suggested that her aspirational belief regarding the 'irreplaceability of each human being' was somewhat unrealistic. See also par 8.3 below.

Areas of stress for Sheila, by way of low SPs on constructs, included existential issues around questioning who she is and taking life for granted, whether she could rely on family support at times of crisis and being highly sensitised to the issue of suicide while believing that suicide demanded considerable bravery. Her core aspirations represented her attempt to achieve personal certainty in the face of these unresolved dilemmas.

Sheila did not construe herself strongly as 'a suicide survivor' following her client's suicidal behaviour (PS3 emp idfcn 0.55). She was reluctant to explore, via the ISA instrument, the meaning of her mother's death or of her clinician survivor (by proxy) status via her client's clinician survivor experience. When asked whether she believed herself prepared for the possibility of a client's suicide she replied:

'I don't feel I am anyone's saviour... if someone kills themselves...it's their choice...counselling is not for everyone...counselling does not save everyone...and that's why it doesn't surprise me...clients of reputable therapists have killed themselves and I wouldn't put the blame on them or see them or their work as having failed.' She added that she would not 'put blame on [a clinician survivor] or see them or their work as having failed.'

7.3.5 Comparison case study A10 – 'Alison'

Alison was a qualified, experienced agency counsellor working in addictions and with vulnerable young people for over 10 years. She changed career after recovering from traumatising injuries suffered in a road traffic accident.

Three months before interview Alison's husband's youngest brother was found hanged in a public park. He was later identified as a client of a counsellor who was Alison's agency colleague. Her colleague's loss experience and its context meant that Alison was regarded in current research as a clinician survivor (by proxy). Alison disclosed that a family member was shot dead some years prior to interview and that a second sibling of her husband was murdered when the deceased client was a young child.

Alison was most intensely ego-involved with 'a client who died by suicide' whom she evaluated negatively (ego-inv 5.00; eval – 0.64). Across all contexts she saw very many characteristics of herself in her counselling supervisor (emp idfcn

range 0.81 to 1.00), her father (emp idfcn range 0.76 to 0.90), her mother (emp idfcn range 0.71 to 0.90) and less emphatically in her partner (emp idfcn range 0.57 to 0.68). She did not construe herself in the characteristics of 'a suicide survivor' in any context (emp idfcn range 0.15 to 0.23) notwithstanding her dual suicide survivor status in family and clinician survivor (by proxy) contexts. Indeed she very highly dissociated from this individual (contra-idfcn 0.82) and regarded them unfavourably (eval – 0.42). It was as if she acknowledged the fact of her dual survivor status in interview but not its influence upon her sense of herself.

Her past conflicted identifications were somewhat resolved in relation to depressed and suicidal clients (past conf idfcn range 0.36 to 0.48; current conf idfcn range 0.32 to 0.38), a suicide survivor (past conf idfcn range 0.38 to 0.45; current conf idfcn 0.35 to 0.40) and a client who died by suicide (past conf idfcn 0.42 to 0.48; current conf idfcn 0.39 to 0.44). She achieved this by dissociating from these individuals (max past emp idfcn 0.32; max current emp idfcn 0.25), and failing to construe characteristics of herself in them.

Alison had achieved her identity aspirations to be as close as possible in her characteristics to her counselling supervisor particularly when working (CS3 emp idfcn 1.00). All of her identity variants were regarded as well-adjusted being either indeterminate or confident.

Her aspirational values and beliefs by way of core evaluative dimensions of identity (via high SPs on constructs) indicated that she felt that grief following suicide was uniquely painful, that she sought to develop human relationships, that she believed in the irreplaceability of each human being, that safe expression of emotion was healthy and that she continued to develop personal values and beliefs. Alison's aspirations included being highly sensitised to the issue of suicide, believing suicide could be anticipated and being totally changed by her client's suicidal behaviour.

Areas of uncertainty for Alison, indicated by low SPs on constructs, included existential issues (wondering what life is all about and remaining who she is), whether she had a particular responsibility for others and, in relation to suicide, whether suicide demanded considerable bravery and whether suicide could be prevented. Her core dimensions of identity representing her approach to minimising problematic areas were realistic and authentic. She adopted the professional example of her supervisor in her therapeutic work contending well with countertransference issues. Exceptions remained in her very low evaluations of depressed and suicidal clients

(eval range – 0.43 to – 0.48) and in the tension between the dominant influence of ‘a client who died by suicide’ (ego-inv 5.00), representing her deceased brother-in-law, and her low evaluation of that unfortunate individual (eval – 0.64).

7.3.6 Comparison case study A13 – ‘Terry’

Note: Terry did not fully complete ISA instrument ‘A’ as follows: final 8 discourses for constructs #4 ‘safe expression of emotion’ and #7 ‘grief following suicide’, respectively, and first 14 discourses for constructs #5 ‘suicide prevention’ and #8 ‘pain relief’, respectively. Terry also employed ‘0’ ratings in ISA instrument ‘A’ more frequently than any other respondent.

Terry was a graduate professional working in industry for many years before a career change when he entered the counselling profession. When interviewed he was a practitioner with 15 years experience in voluntary, agency and independent settings. He used eclectic, humanistic approaches in one-to-one work supporting clients, as he phrased it, ‘to find their own answers’. Terry could be considered a ‘wounded healer’:

‘The wounded healer theory...proposes that the power of the healer (the priest or shaman in primitive societies, the therapist in modern society) derives from [their] inner experience of pain, loss and suffering...a ‘wound’ in the healer gives [them] an excellent basis from which to understand and empathise with the wounds of clients.’ McLeod, 1998: 354).

He benefitted from psychotherapy in relation to adverse consequences of his own life events and issues. This experience led him to train in psychotherapy.

Terry confirmed that his response to life issues had in the past taken him to ‘a dark depression’ including suicide ideation. Terry’s personal encounter with suicide ideation occurred before he became a psychotherapist and commenced working with similarly vulnerable clients. He confirmed his awareness that, in the past, a counsellor colleague had lost a client to suicide. Terry offered to be available to support this clinician survivor. But this offer was not taken up. Terry described the bereaved counsellor’s response as an ‘extraordinary reaction’ when they totally ‘closed down’. They were not helped when told about the loss of their client ‘in an inappropriate way’. As a clinician survivor (by proxy), Terry described his feeling that client suicide, although he had not yet experienced it, would be ‘the nightmare that continues after you wake up’.

Terry was most highly involved with ‘me when I feel enhanced by life’s wonders’ (ego-inv 5.00; eval 0.88) and also with ‘me as colleagues see me’ (ego-inv

4.90; eval 1.00), each of whom he valued very highly. He recognised his counselling supervisor as his most positive role model (ideal-idfcn 0.77), followed by 'father' and 'a suicide survivor' (ideal-idfcn both 0.68).

When at work, Terry recognised in himself most of his characteristics of 'father' and 'a client who recovered after serious suicide attempt' (CS3 emp idfcn both 0.85) while he also construed himself as sharing many aspects of 'a suicide survivor' in this context (CS3 emp idfcn 0.80), and less emphatically, 'a depressed client' and 'my counselling supervisor' (CS3 emp idfcn both 0.75). It was as if Terry behaved, while engaged in client work, with a very high degree of awareness of, and responsiveness to suicidal behaviours and outcomes for self and others. His appraisals of depressed and suicidal clients following his client's suicidal behaviour (PS3) and when at work (CS3) were identical (PS3/CS3 emp idfcn range 0.50 to 0.85). Terry's most highly conflicted identifications in these contexts followed a similar pattern (PS3/CS3 conf idfcn range 0.42 to 0.48).

These data pointed to the ongoing influence upon Terry of his personal encounter with suicide ideation and his repeated engagement with clients whom he perceived to be at risk of suicidal behaviour. The latter entities were as dominant if not more so (depressed/suicide ideation/recovered clients ego-inv range 3.37 to 3.94) than his supervisor (ego-inv 3.37) in his professional life. Terry's appraisals of 'a client who died by suicide' representing his colleague's deceased client, are informative by way of his relatively high evaluation of this person (eval 0.64), which is the same as his evaluation of his counselling supervisor (eval 0.64), and the low ego-involvement he has with this deceased person (ego-inv 1.92).

It appears that Terry valued his depressed and suicidal clients according to their proximity to death by suicide (eval: ideation 0.10; depressed 0.44; recovered after serious attempt 0.53; died by suicide 0.64).

Terry's global identity variants were regarded as well-adjusted except in the contexts of life's cruelties (CS1 'negative') and before he became a psychotherapist (PS1 'crisis'). The latter vulnerable identity states were linked to his very low self evaluation and high identity diffusion therein.

His core evaluative dimensions of identity (via high SPs in constructs) confirmed his aspirational system of values and beliefs including development of personal values and beliefs, belief in the irreplaceable value of each human being, warm feelings for others, feeling encouraged by others and being highly sensitised to

suicide, believing suicide can be anticipated. Terry's areas of uncertainty were dominated by issues around suicide including its occurrence 'out of the blue', whether suicide demanded bravery, being affected by suicide of others and how suicide could be prevented.

This belief system was realistic in view of his experiences of suicidal behaviour, both personal and professional. His core aspirational beliefs appeared appropriate to the task of contending with many of these problematic areas around suicide.

Overall Terry's experience as a clinician survivor (by proxy) did not of itself unduly influence his professional engagement with vulnerable clients although his personal encounter with suicide ideation when depressed before becoming a counsellor appeared likely to have informed and empowered his professional therapeutic relationships.

7.4 Control case studies

These control case study summaries explored the influence of suicidal behaviour in self and others on identity development in non-clinicians. Two instruments, 'B' and 'C', were used, the former with respondent B1 – 'Kevin' and the latter with five respondents C1 – Matthew, C2 – Jack, C3 – Robert, C4 – Adam and C5 – Danny. All control respondents voluntarily completed a consent form before interview.

7.4.1 Control case study B1 – 'Kevin'

Kevin was a senior social worker who completed a postgraduate counselling qualification for personal and professional development. He did not work with clients as a counsellor and was regarded in this research as a non-clinician. ISA instrument 'B' that was used here, excluded the entity 'a suicide survivor': it was not therefore possible to explore Kevin's identity development in relation to this entity. Findings that did emerge are detailed below.

Kevin had no personal/family experience of suicidal loss and did not consider that he was a suicide survivor. As a social worker, his clients included family members whose neighbour died by suicide. Kevin was aware that a professional colleague's client died following prolonged alcohol abuse. Some of Kevin's clients disclosed self-harm, as a coping mechanism rather than as a prelude to suicidal behaviour, or a failed or botched suicide attempt.

Output from Kevin's ISA instrument 'B' showed he was most intensely involved with 'an admired person' whom he valued very highly (ego-inv 5.00; eval 0.98). Other relevant entities were 'me as I would like to be' (ego-inv 4.90; eval 1.00) and 'my closest friend' (ego-inv 4.90; eval 0.77). He recognised in himself many characteristics of suicidal clients after his client's suicidal behaviour (PS3) and in the context of life's cruelties (CS1): (emp idfcn range: PS3 0.57 to 0.81; CS1 0.68 to 0.74). But when he was working or relaxing there was more in him of his mother's attributes (CS3/CS4 emp idfcn 0.91/0.85) and of his closest friend (CS3/CS4 emp idfcn 0.86/0.85). Family and friends represented Kevin's positive role models (ideal-idfcn range 0.82 to 0.86) while suicidal clients represented his most negative role models (contra-idfcn range 0.45 to 0.50).

Kevin's levels of conflicted identification were relatively high and stable in the transition from the past, after his client's suicidal behaviour (PS3 range 0.53 to 0.60) to life's cruelties currently (CS1 range 0.55 to 0.61), easing in other current contexts (CS2/CS3/CS4 range 0.43 to 0.54). He resolved his past conflicted identifications as he distanced himself currently from suicidal clients, evident in decreased levels of empathetic identification.

Kevin's global identity variants were regarded as well-adjusted being 'indeterminate' in all seven contexts. His metaperspectives revealed little difference in how he appraised himself either as colleagues or clients saw him. He adopted a professional position, where colleagues were a more dominant influence (ego-inv 4.13) than clients (ego-inv 3.85).

His core evaluative dimensions of identity, by way of high levels of SPs, included aspirations to feel that grief following suicide was uniquely painful, to believe in the irreplaceable value of each human being, to feel that safe expression of emotions was healthy, to seek and develop human relations and to think that suicide demanded considerable bravery. Kevin's problematic areas, indicated by low SPs, included whether suicide could be anticipated by perceptive observation, whether suicide caused a survivor to change totally, being sure of who he is, feeling the need for human company when alone and the use of alternative / complementary remedies.

Kevin's uncertainties were capable of being addressed by his professional orientation towards his work and in his openness to engagement with others in building human relationships. There is an absence of evidence here to confirm or otherwise Kevin's attitude to the predicament of 'a suicide survivor', except perhaps

his uncertainty (SP – 12.58) about suicide being linked with total change for a survivor.

7.4.2 Control case study C1 – ‘Matthew’

‘Matthew’ was a non-clinician when he completed ISA instrument ‘C’. Some years later having qualified as a clinician, his client died by suicide and as a clinician survivor, he completed ISA instrument ‘A’. He was an eligible member of both target group, as A17, and control group, as C1. A single integrated case summary, ‘Case study A17 – Matthew’, at par. 7.2.11 above, considered issues relevant to his identity development before and after his clinician survivor experience.

7.4.3 Control case study C2 – ‘Jack’

When interviewed, Jack was employed as a support worker in a rehabilitation (otherwise rehab) centre for homeless men. He had an interest in and knowledge of counselling, having studied to university certificate level. Jack disclosed six discrete experiences of suicidal behaviour during several years’ service in rehab work. He felt that rehab residents were a particularly vulnerable group for whom suicide ideation was seldom far away. Jack was a former rehab resident and a recovering alcoholic.

Jack’s experiences included two ex-residents who died by overdose and hanging, respectively, a family member who died by monoxide poisoning, two attempted suicides via overdose and severed wrists, respectively, and an attempted murder linked with these suicide attempts.

Jack was most intensely involved with ‘me when I feel enhanced by life’s wonders’ whom he valued highly (ego-inv 5.00; eval 0.83). He was almost as highly involved with ‘a person who attempted suicide’ whom he valued negatively (ego-inv 4.93; eval – 0.36). He did not recognise in himself characteristics of depressed and suicidal clients in any current context (CS1 to CS4 emp idfcn range 0.05 to 0.50). In the past, there was much in his self construal, respectively, of ‘a depressed person’ and ‘a person who attempted suicide’ (emp idfcn PS1/PS2 range 0.65 to 0.74), reflecting his own suicidal behaviour, before working in rehab and as a recovering alcoholic. There was little of ‘a suicide survivor’ in Jack in any context, past or current (PS1 to CS4 emp idfcn range 0.26 to 0.56) except perhaps when he was overwhelmed by life’s cruelties (CS1 emp idfcn 0.56).

He did not differentiate ‘work’ from ‘relaxation’: that part of him, recognised in the characteristics of ‘a psychiatrist’, was very influential (CS3/CS4 emp idfcn 0.75/0.78) although not as much as ‘an admired person’ (CS3/CS4 emp idfcn 0.95/0.94) and, less so, his friend/partner/spouse (CS3/CS4 emp idfcn 0.85/0.83). An admired person and his friend represented his positive role models, respectively (ideal-idfcn 1.00; 0.90) just ahead of ‘a psychiatrist’ (ideal-idfcn 0.80). Depressed and suicidal people were Jack’s most negative role models (contra-idfcn 0.60 to 0.70).

Jack’s very high levels of conflicted identification with depressed and suicidal people before he started work and before he knew, personally, about suicide (PS1/PS2 conf idfcn range 0.53 to 0.72) were somewhat resolved when he engaged with the existence/reality of suicide (PS3 conf idfcn range 0.37 to 0.49) as he distanced himself from such people, evident in decreased levels of empathetic identifications in this context. Only when overwhelmed by life’s cruelties did these indicators intensify (CS1 conf idfcn range 0.52 to 0.59), before easing in other current contexts (CS2 to CS4 conf idfcn range 0.19 to 0.49).

His global identity variants were well-adjusted currently, viz. confident or indeterminate, except when he was ‘overwhelmed by life’s cruelties’: global variant ‘diffusion’, pointing to high and widely dispersed conflicted identifications and moderate self-evaluation. Jack’s identity variants were ‘crisis’ in two past contexts (PS1 & PS2) before he worked in rehab, reflecting his low self-worth therein (PS1/PS2 eval – 0.18/0.03). The beneficial effect of his rehab experience was evident in his well-adjusted global variant ‘indeterminate’ (PS3 eval 0.75), reflecting his enhanced self-image.

Jack’s metaperspectives revealed the crucial importance to him of his life and work in rehab, evidenced in much higher appraisals of his colleagues’ view of him compared with those of his family (meta eval: colleagues 0.67; family 0.23).

His system of values and beliefs, indicated by core evaluative dimensions of identity showed that he aspired to believe in the irreplaceable value of each human being, feeling that safe expression of emotions was healthy, considering that most suicides could be prevented, continuing to develop personal values and beliefs, remaining sure of who he is and having warm feelings for others. Problematic areas, included feeling that grief following suicide was uniquely painful, being highly sensitised to the issue of suicide, relying upon family support and feeling a special responsibility for others.

Jack was capable of addressing these stresses in his ongoing relationship-building in his rehab residents' support activities, although the task of developing a satisfactory personal and family-oriented life was a work in progress. Jack's multiple survivor status did not impinge negatively on his work with vulnerable residents.

7.4.4 Control case study C3 – 'Robert'

Robert was a retired college lecturer with extensive experience in education and community involvement. He had previously worked as a school teacher. He recalled four discrete events involving suicidal behaviour in others including two former school pupils, a neighbour and a former teacher colleague each of whom was found hanged. Robert volunteered for 10 years with a suicide prevention organisation, until about 15 years before interview. He said he was most affected by the suicide of his teacher colleague:

'...it challenged the beliefs that I have...how I believe I ought to live in terms of being a member of a faith community...caring for other people ... recognising the impossibility of keeping house for all the 'Big Issues' sellers in the world...it's there...beyond that the man's death will always be with me in the sense that he died around this time of year...anniversary...and I remember him in my prayers and that's all I can do...there's nothing else.'

Robert was most involved with 'an admired person' (ego-inv 5.00) and 'my partner' (ego-inv 4.76) each of whom he valued extremely highly (eval both 0.99). Robert did not currently recognise in himself any characteristics of depressed or suicidal people (CS1 to CS4 emp idfcn range 0.12 to 0.44). In the past, he recognised in self slightly more characteristics of depressed and suicidal people (PS1 to PS3 emp idfcn range 0.13 to 0.50). However in the past and currently he recognised in self most if not all the qualities of 'an admired person' and 'my partner' (all contexts emp idfcn range 0.78 to 1.00). These data reflected absence of any suicidal behaviour by Robert.

There was little of 'a suicide survivor' in Robert in any context, past or current (PS1 to CS4 emp idfcn range 0.28 to 0.44).

Robert did not differentiate work and relaxation: that part of him that recognised characteristics of 'an admired person' and 'my partner' were extremely influential in both contexts (CS3/CS4 emp idfcn both 0.94). These people also represented his positive role models: 'an admired person' (ideal-idfcn 0.90) and 'my partner' (ideal-idfcn 0.85). Depressed and suicidal people (contra-idfcn 0.40) were Robert's most negative role models other than 'a person I dislike' (contra-idfcn 0.45).

His moderately high levels of conflicted identification with depressed and suicidal people in the past (PS1 to PS3 con idfcn range 0.28 to 0.45) eased slightly when modulating currently (CS1 to CS4 con idfcn range 0.27 to 0.42). This was reflected in diminished empathetic identifications with these people (past: emp idfcn range 0.28 to 0.50; current: emp idfcn range 0.22 to 0.44). This resulted from Robert distancing himself from the suicidal behaviour of others while a volunteer and in being a multiple survivor in relation to four fatal suicidal episodes.

Robert's global identity variants were regarded as well-adjusted before he started work (PS1) and before he knew about suicide (PS2): both were regarded as 'indeterminate'. In the remaining contexts Robert was either 'defensive' (CS1) or 'defensive high self-regard' (PS3; CS2 to CS4 incl) which were regarded as vulnerable identity states, evidenced in very high levels of self-evaluation and low identity diffusion.

Robert's metaperspectives revealed the gulf between his work, now that he was retired, and his family life, evidenced in hugely higher appraisals of his family's view of him, as compared with that of his (former) work colleagues (meta eval: colleagues – 0.06; family 1.00).

His core evaluative dimensions of identity confirmed aspirational beliefs and values including the irreplaceable value of each human being, continuing to be the person he was into the foreseeable future, relying upon family support at times of crisis and believing grief following suicide was uniquely painful. Problematic areas for Robert included belief that suicide demanded considerable bravery, reliance upon prescribed medication to relieve psychological pain and being able to be alone with self without feeling alone or uncomfortable.

These uncertainties were capable of being addressed to some extent through family support although his defensiveness in all four current contexts pointed to Robert's relatively closed attitudes to suicide and suicide prevention, evident in his narrative:

'...I believe anyone who intends to take their own life will do it...ultimately or proximately...there's no way to prevent it...'

Robert's multiple suicide survivor status did not endow him with the characteristics of a suicide survivor nor did it influence him currently when 'working' (CS3) or 'relaxing'(CS4), albeit in retirement.

7.4.5 Control case C4 – ‘Adam’

Adam was an experienced, highly qualified lecturer in the social sciences at a local college. He did not know, personally or professionally, anyone who died by suicide or attempted suicide. He was aware, at some remove, of the circumstances surrounding the deaths by suicide of two students, one male and one female, who both attended a local school and were known to each other. Otherwise his knowledge of suicide was confined to his professional work as a college lecturer.

Adam’s dominant influences were ‘a person who attempted suicide’ and ‘a suicide survivor’ (ego-inv both 5.00) but he valued the latter (eval 0.69) more highly than the former (eval 0.12). He recognised in himself many of the qualities and characteristics of depressed and suicidal people in the context of being ‘overwhelmed by life’s cruelties’ (CS1 emp idfcn all 0.70) and less so, when ‘working’ (CS3 emp idfcn all 0.55). At the same time, Adam recognised, when construing himself, many of the characteristics of ‘a person I admire’ and ‘my partner’ (CS1 to CS4 emp idfcn range 0.70 to 0.85). Before starting work (PS1) and not knowing about suicide (PS2) he construed in self some aspects of depressed and suicidal people (PS1/PS2 emp idfcn 0.63) and, more strongly, qualities of his parents (PS1/PS2 emp idfcn 0.74).

After he knew about suicide (PS3), Adam construed in self most, if not all, of the characteristics of parents, a psychiatrist, an admired person and my partner (PS3 emp idfcn all range 0.95 to 1.00). These data echoed the sudden violent death of his father when Adam, an adolescent and the eldest among several siblings, took on at least partially some of his late father’s attributes, represented strongly in the qualities of those above-mentioned adults.

There was something in Adam of ‘a suicide survivor’ in both past contexts (emp idfcn range 0.53 to 0.80) and, less emphatically, currently (emp idfcn 0.60 to 0.70) although this could not be readily linked with Adam’s narrative.

His positive role models were located among family and friends (ideal-idfcn range 0.90 to 0.95) and, less so, ‘a suicide survivor’ (ideal-idfcn 0.75). Adam’s negative exemplars included depressed and suicidal people (contra-idfcn range 0.45 to 0.60).

Adam’s high levels of conflicted identification with depressed and suicidal people (past: conf idfcn range 0.44 to 0.56; current: conf idfcn range 0.44 to 0.59)

confirmed his consistently robust dissociation from characteristics of these people when recognised in self.

Adam's global identity variants were regarded as well-adjusted (PS1, CS2, CS3, CS4: 'indeterminate'; PS3: 'confident') except 'when overwhelmed by life's cruelties' (CS1) and 'before he knew about suicide' (PS2), both variants being 'diffusion' and regarded as vulnerable identity states. In the former context (CS1) this related to his moderate self evaluation therein (eval 0.40), pointing to tragic loss events, including his father's premature death and its negative effect upon achievement of Adam's aspirational goals.

His metaperspectives revealed little difference between how he believed his work colleagues saw him compared with how his family viewed him. This perhaps reflected his ongoing involvement as parent to his own children and to his role in loco parentis with college students.

Adam's core evaluative dimensions of identity confirmed aspirational beliefs and values including feeling a special responsibility for the wellbeing of others, believing in the irreplaceable value of each human being, having warm feelings toward others, believing that suicide may be anticipated by perceptive observation and that grief following suicide is uniquely painful and being able to be alone without feeling lonely or uncomfortable. Problematic areas included believing that suicide demands considerable bravery and that depression and suicide are inextricably linked, continuing to develop personal values and beliefs, using alternative/complementary remedies to alleviate psychological pain and feeling encouraged by others.

Several of Adam's key life events and the consequences thereof, including in his early teenage the violent death of his father, the meaning that he attached to this loss, his subsequent predicament in having to 'grow up very quickly' as his deceased father's eldest surviving son, and his current family life and status as an educator of the young, are mirrored in his aspirational core values and beliefs. The suicides of two young people albeit at some remove, generated uncertainty for him not least in developing personal values and beliefs in the premature and tragic absence as an exemplar of his deceased father.

7.4.6 Control case C5 – 'Danny'

Danny was a highly qualified college lecturer in the social sciences for over five years, having previously worked for seven years as an approved social worker

following periods of community work. He also previously volunteered for a period with a suicide prevention organisation.

He disclosed four past incidents involving suicidal behaviour by others including a former social work client who died by suicide some time after Danny changed career, less than five years before interview. He had also worked professionally with the partner of a person who died by suicide following discharge from a psychiatric unit and with a mother, whose son and his best friend were found hanged together. The fourth incident involved the self-reported attempted suicide by drowning of Danny's social work client. Danny also recalled from memory up to eight social worker colleagues whose clients had taken their own lives. His lecturing work included presentations involving learning resources related to suicide prevention, intervention and postvention.

Dominant influences for Danny were 'me when I'm overwhelmed by life's cruelties' (ego-inv 5.00), 'a person who died by suicide' (ego-inv 4.70) and with 'me as I would like to be' (ego-inv 4.60). He valued the last-mentioned much more highly (eval 1.00) than the others, respectively (eval 0.08, 0.22). His positive role models were located in family and friends (ideal-idfcn range 0.70 to 0.95) while negative exemplars included depressed and suicidal people (contra-idfcn 0.45 to 0.50).

He recognised in himself many of the characteristics of depressed and suicidal people in the context of being 'overwhelmed by life's cruelties' (CS1 emp idfcn range 0.60 to 0.80) and less so when working (CS3 emp idfcn range 0.30 to 0.60). In these contexts, Danny construed in self, respectively, many of the qualities of 'a person I admire' (CS1, CS3 emp idfcn 0.65, 0.85) and 'my partner' (CS1, CS3 emp idfcn 0.55, 0.85) which were highest when Danny was working. In the past, when Danny knew about suicide (PS3), there was much more in him, respectively, of the qualities of 'my partner', 'a person I admire' and 'my parents' (PS3 emp idfcn range 0.75 to 1.00) than of depressed or suicidal people (PS3 emp idfcn range 0.35 to 0.65). These data show that the influence on Danny's sense of self of suicidal behaviour in others, when working or volunteering is moderated by his experiences with friends and family.

Danny's conflicted identifications were currently highest with depressed and suicidal people in the context of life's cruelties (CS1conf idfcn 0.55 to 0.60). When working, Danny's lower levels of empathetic identification effected a reduction in his levels of conflicted identification with depressed and suicidal persons (CS3 conf idfcn range 0.39 to 0.47) pointing to an appropriate resolution of his conflicted

identifications in the transition from ‘cruelties’ to ‘working’. Danny’s dissociation currently from past ‘suicide survivor’ characteristics (past emp idfcn range 0.55 to 0.61; current emp idfcn 0.33 to 0.60) were evident in the partial resolution of related conflicted identifications with ‘a suicide survivor’ (past conf idfcn range 0.47 to 0.49; current conf idfcn 0.36 to 0.49).

This respondent’s global identity variants were regarded as vulnerable except when he was ‘relaxing’ (CS4: ‘indeterminate’), a well-adjusted identity state. Danny’s very low levels of self-evaluation, in the past (PS1 eval 0.06; PS2 eval 0.16) and currently (CS1 eval 0.08) allied with high identity diffusion resulted in identity variants ‘crisis’ in these context. Danny’s remaining vulnerable identity states were ‘diffusion’, based in moderate self evaluation and high identity diffusion (PS3, CS2, CS3: eval range 0.59 to 0.77; diffusion range 0.42 to 0.43).

His metaperspectives pointed to higher involvement with colleagues (meta ego-inv 3.50) than family (meta ego-inv 3.10) while feeling less valued by the former (meta eval 0.27) than by the latter (meta eval 0.52). This pointed to his commitment to his profession while his family role contributed more significantly towards achievement of his aspirations.

Danny’s core evaluative dimensions of identity confirmed aspirational values and beliefs including wondering what life is all about, believing in the irreplaceable value of each human being, continuing to develop personal values and beliefs, feeling a special responsibility and having warm feelings for others and believing safe expression of emotion is healthy. Areas of uncertainty for Danny included feeling momentary bouts of psychological discomfort, being alone without feeling lonely and uncomfortable, using alternative/complementary remedies, being sensitised to the issue of suicide and its prevention, developing human relationships and continuing to be the person he was into the foreseeable future.

Danny’s core values and beliefs were capable of addressing problematic areas to a limited extent because of some contradictory areas concerned with human relationships, existential issues and suicide prevention. His identity development was strongly influenced by his past experiences of others’ suicidal behaviour during his previous career as an approved social worker. While he exhibited some current characteristics of ‘a suicide survivor’ in his college lecturer role, there were many more qualities in him of family, friends and colleagues when working (CS3 emp idfcn range 0.65 to 0.85).

7.5 Discussion and conclusions

ISA indices relating to all 23 case studies are set out in several tables of data at Appendix 8. In Chapter 8, below, these data are analysed in the context of empirically based theoretical postulates that were described in Chapter 5, above. Derived theoretical propositions evidence the significance of this research, enabling and informing its conclusions and implications.

Chapter Eight: Discussion and Conclusions

Chapter 8: Discussion and Conclusions

8.1 Introduction

Following Black and Weinreich (2003), the results of current research presented as case studies are idiosyncratic in nature. They reveal ‘the complex of processes...by which respondents construct and reconstruct their identities’ when exposed to suicidal behaviour in self and others (Black and Weinreich, 2003: 345). Warnock (1987) pointed to the ‘value of a [case] study which by probing further and further into the individual, attempts to tap something not only rich and unique, but also relatively universal or shared (Smith et al., 1995: 60). It was also noted that ‘the claims of case study and idiographic workers are typically cautious, highly detailed and grounded in data’ (Smith et al., 1995: 63).

Hermans (1988) held that ‘an additional strength of the idiographic approach is that the personal meaning and personal relevance of a more or less general finding can be assessed in intensive idiographic research’ (Hermans, 1988: 808). He suggested a combination of ‘nomo-concepts enabling [us to] understand the particular world of the individual’ in proposing the integration of nomothetic and idiographic methods (Hermans, 1988: 785). However Lange (1989) considered that:

‘ISA is a clever hybrid between qualitative [idiographic] and quantitative [nomothetic] approaches which enables the researcher to transform almost purely idiographic information into normalised quantitative indices. The nature of these indices makes it possible to perform comparisons between individuals, however idiosyncratic the material from which the indices are derived may be...ISA anchors the analysis in the value system of the individual, the latter being determined from data almost entirely provided by the individual [respondent]’ (Lange, 1989: 170).

It is now proposed to consider theoretical postulates (see also Chapter 5) in the light of research outcomes, summarised and tabulated at Appendix 8, and, taking account of the study’s originating hypotheses, aims and objectives (see also Chapter 6), to derive theoretical propositions that enable and inform the study’s conclusions and implications.

8.2 Theoretical postulates, empirical outcomes and derived theoretical propositions

Postulate #1 A clinician’s direct appraisal of their client’s suicide will differ from a colleague’s experience by proxy of the same event.

The current research did not include respondents, who experienced precisely the same client suicide event directly as clinician survivors and indirectly as clinician survivors (by proxy). However tables 8.10 and 8.11 compare ISA data for target group ‘clinician survivors’ and comparison group ‘clinician survivors (by proxy)’ in relation to their self construal when ‘working’ (CS3). The former group (82%) are seen to empathetically identify much more strongly with ‘a suicide survivor’ than the latter group (33%): there is much more of ‘a suicide survivor’ in a clinician survivor than in a clinician survivor (by proxy). It can therefore be concluded that postulate #1 contributes an evidential basis for a related theoretical proposition. See also par 8.4.2 below.

Postulate #2 A clinician’s direct appraisal of their client’s suicide will be unique to the individual clinician.

Identification processes for each target group respondent demonstrate, in the aftermath of their client’s suicide (PS3), varying levels of context-based indices of current empathetic and conflicted identifications with ‘a suicide survivor’ and with ‘a client who died by suicide’. Tables 8.28, 8.29, 8.30 and 8.31 illustrate these data. The responses of each clinician survivor, represented in these appraisals may appear in some cases to be numerically similar, e.g. respondents A14 and A15 for ‘a suicide survivor’, while being quite different in relation to ‘a client who died by suicide’. In short, each respondent’s appraisal of their client suicide experience is particular to that respondent. It can therefore be concluded that postulate #2 contributes an evidential basis for a related theoretical proposition. See also par 8.4.2 below.

Postulate #3 A clinician’s orientation towards their social world, whether defensive or open, influences the extent and nature of their experience of client suicide.

Tables 8.1, 8.2 and 8.3 summarise global identity variants for target, comparison and control group respondents. These classifications are based only on the underlying parameters of identity diffusion and self-evaluation, as detailed at par 4.7.5 above. The above mentioned tables reveal which respondents are considered to be psychologically well-adjusted (i.e. ‘indeterminate’ or ‘confident’) and which are regarded as vulnerable (i.e. remaining seven variants – see table 4.1 above).

Inspection of variants in table 8.1, target group, clinician survivors, and table 8.2, comparison group, clinician survivors (by proxy), across both past and current selves reveals little difference in the frequency of vulnerable identities in the former group (56%) and the latter group (57%). Vulnerable identities in the control group

(see table 8.3) are much less evident (43%). Considering current selves only, vulnerable identities are most frequent in the target group (57%), less so in the comparison group (50%) and least evident in the control group (42%). It can therefore be concluded that postulate #3 contributes an evidential basis for a related theoretical proposition. See also par 8.4.2 below.

Postulate #4 Clinicians in appraising the psychache and lethality (Shneidman, 1996) that brought about their client's suicide, will contra-identify with that client, wishing to dissociate from those characteristics.

Table 8.32 illustrates levels of contra-identification with 'a client/person who died by suicide' by members of each respondent group. These levels are 'high' for 82%, 75% and 50%, respectively, of target, comparison and control groups indicating more frequent dissociative responses by clinician survivors to such perceived characteristics than by clinician survivors (by proxy) or by control group members. It can therefore be concluded that postulate #4 contributes an evidential basis for a related theoretical proposition. See also par 8.4.2 below.

Postulate #5 A clinician's assimilation of a client suicide experience will give rise to a redefinition of identity that will be evidenced in modulations of identification conflicts and self-evaluation, the extent of which will depend upon the clinician's orientation to their social world.

Inspection of tables 8.1, 8.2, 8.3 and 8.33 confirms that redefinition of identity, indicated by changes in global identity variants (GIVs) from past to current contexts, is a consequence when target and comparison group respondents appraise client suicidal behaviour.

Referring to table 8.33, 'defensive' variants, including 'defensive', 'defensive high self regard (def HSR)' and 'defensive negative' are evident more frequently in this transition for all groups but at varying levels. 'Open' variants, including 'diffusion', 'diffuse high self regard (diff HSR)' and 'crisis' are slightly less evident in this transition for the target group while being much reduced for the comparison group. 'Well-adjusted' variants, including 'confident' and 'indeterminate' are influenced much less for target group respondents than for comparison group respondents. It is clear from table 8.33 that control group respondents also experience identity redefinition resulting from their knowledge and awareness of others' suicides.

Changes in identity variants based on associated adjustments both in identity diffusion as a measure of extent and incidence of identification conflicts, and in self-

evaluation, represent evidence of identity redefinition. Postulate #5 therefore represents an evidential basis for a theoretical proposition. See also par 8.4.2 below.

Postulate #6 A clinician's experience of client suicidal behaviour will result in modulations of empathetic identification with a suicidal client, from their past self, as appraised before the suicidal behaviour, to their current selves.

Empathetic identification may be understood as a 'de facto state of affairs in which ego's recognition and comprehension of the other may refer to a compassionate understanding of shared values, vulnerabilities and eccentricities as well as shared aspirations and desired qualities' (Weinreich, 1989b: 223). Tables 8.7, 8.8 and 8.9 illustrate modulations in respondents' empathetic identifications with 'a client who died by suicide' in the transition from 'me before my client's suicidal behaviour' (PS2) to 'me when I'm working' (CS3).

These results show that 73% (N=8) of clinician survivor respondents and 67% (N=4) of clinician survivors (by proxy) experience modulations, either increasing or decreasing, in the levels of ascription to self of characteristics of a deceased client, related to psychache and lethality. Postulate #6 therefore represents an evidential basis for a theoretical proposition. See also par 8.4.2 below.

Postulate #7 Conflicted identification with a client at risk of suicide (by suicide ideation, suicide attempt or death by suicide) will be indicative of the clinician's level of suicidality.

It could be considered highly likely that, when currently working, clinicians' identification conflicts with depressed or suicidal clients, including a client who died by suicide, may be the most challenging in a psychotherapeutic context (Pope and Tabachnik, 1993; Simon and Hales, 2006). Recall that identification conflict represents the degree of self's dissociation from qualities that one attributes to the other that are also present in one's current self-image.

Analysis of respondents' conflicted identifications with depressed and suicidal clients in tables 8.4, 8.5 and 8.6 confirms that similar proportions of target (82%) and comparison (83%) group members experience high or very high levels. Almost all control group (94%) members, i.e. non-clinicians, share similar levels of identification conflicts with depressed or suicidal people, i.e. non-clients. Again similar proportions of target (73%) and comparison (75%) group members experience high or very high conflicted identification levels with 'a client who died by suicide'. Fewer control group members (50%) experienced high or very high conflicted identifications with 'a

person who died by suicide’.

These data resonate with survey findings by Rogers et al. (2001) that 20% of counsellors ‘have seriously considered suicide’ (Rogers et al., 2001: 368). Current research data confirm that some clinician survivors and clinician survivors (by proxy) could have an, as yet, unquantified propensity towards such behaviour. Postulate #7 therefore represents an evidential basis for a theoretical proposition. See also par 8.4.2 below.

Postulate #8 Client suicide in conjunction with past experiences of suicidal behaviour in personal, collegial or social contexts or as communicated in media, literature or history, will influence how clinician survivors appraise self and others in a suicide-related context when working or when relaxing.

Tables 8.10, 8.11 and 8.12 illustrate respondents’ empathetic identifications with ‘a suicide survivor’ when working or relaxing. It is evident that considerably more clinician survivors construe in self many of the attributes of ‘a suicide survivor’ in both contexts, respectively, CS3 82% and CS4 73%, than either clinician survivors (by proxy) (CS3, CS4 both 33%) or non-clinician controls (CS3 60% and CS4 20%).

Direct experience of client suicide is seen to represent a more predominant influence upon clinicians than other suicidal behaviours in these contexts. Postulate #8 therefore represents an evidential basis for a theoretical proposition. See also par 8.4.2 below.

Postulate #9 A clinician’s experience of client suicide will result in decreasing empathetic identifications with colleagues accompanied by feelings of isolation arising from the absence of shared experience.

Postulate #10 A clinician survivor’s experience will result in closer empathetic identifications with professional colleagues – who have experienced client suicide – and so provide an appropriate basis for assimilating their client suicide experience.

Clinicians do not advertise their client suicide experiences. This was evidenced inter alia by the modest participation level by clinicians in the current research. Analysis of modulations in clinician survivors’ empathetic identifications with colleagues demonstrated the existence and extent of their dissociation from colleagues in the aftermath of client suicide, represented currently as one of ‘life’s cruelties’ (CS1).

Metaperspectives of self are defined as self’s perception of the other’s view of self (Weinreich, 2003: 9). Clinician survivors were able to recognise in colleagues, self’s attributes that decreased significantly in the transition from ‘me before my

client's suicidal behaviour' (PS2) to 'me when I'm overwhelmed by life's cruelties' (CS1) before being restored in the current contexts of 'working' (CS3) and 'relaxing' (CS4).

Table 8.13 illustrates that each clinician survivor experienced decreased levels of closeness to colleagues that ranged from 6% (case A6) to 54% (case A2). Table 8.14 shows clinician survivors (by proxy) experienced similar modulations ranging from 6% (case A10) to 70% (case A3), excepting case A7 where no modulations occurred. Control group members modulations, per table 8.15, in levels of closeness to work colleagues did not follow an observable pattern with increases (12% to 60%) and decreases (8% to 32%).

Postulate #9 therefore represents an evidential basis for a theoretical proposition. See also par 8.4.2 below. Note that postulate #10 cannot readily be tested against current research's empirical data because metaperspectives of professional colleagues who have experienced client suicide are not available.

Postulate #11 Clinicians' experience of client suicide will affect their systems of values and beliefs and this will be evidenced in conflicted dimensions of identity.

Postulate #12 Clinician survivors' core evaluative dimensions of identity will be indicative of their coping resources for integrating a client suicide experience.

Weinreich (2003) distinguishes between the notions of 'contending with stress' and 'coping with stress':

'During one's biographical history one will...have developed constructs that characterise psychologically stressed arenas, these being conflicted dimensions of identity, and other constructs that represent routes for contending with stress in line with core and stable dimensions of identity...some at least of one's core identity aspirations will represent orientations that one has developed in order to contend or maybe cope with distressing experiences...whether or not *contending with stress* translates into *coping with stress* (italics in original) is another matter for analysis' (Weinreich 2003: 365, 366).

However the above postulates concern the identity consequences for clinicians of a client suicide event, in relation to their beliefs and values systems. Whether a survivor's coping resources were deployed effectively or otherwise would require longitudinal consideration such as Harris (2003) discussed in relation to monitoring identity development over time.

Examination of high structural pressures (>70) on constructs in three cohorts facilitates 'an overall representation of how respondents construe their social world

while appraising themselves and others in the context of [current] research' (Black and Weinreich, 2003: 353). This offers insights into the impact of client suicide on their systems of beliefs and values.

There are commonalities with regard to selection of constructs that represent respondents' core evaluative dimensions of identity. Tables 8.19, 8.20 and 8.21, for example, showed that 64% (N=7) of target group members, 83% (N=5) comparison group members and 100% (N=6) of control group members placed a strong emphasis upon the belief that 'each human being is of irreplaceable value'. Further, 64% (N=7) of target members, 50% (N=3) of comparison group members and 50% (N=3) of control group members felt that 'safe expression of emotion is always healthy'. Again 45% (N=5) of target group members, 33% (N=2) of comparison group members and 33% (N=2) of control group members felt that 'grief following suicide is uniquely painful'.

Data in the above tables illustrated these and other commonalities in target, comparison and control groups that range across aspects of respondents' beliefs and values systems, represented in current research under seven categories: personal, professional, suicide, social, family, health and existential. It is evident from table 8.34 that target and comparison group members were close in the composition of some core elements of their beliefs and values systems while control group members share fewer of these. Control group respondents were invariably impacted by the suicidal deaths of colleagues, family members, neighbours and/or acquaintances but not by client suicide, either directly or indirectly. In this context, Berman's (1995: 86) ideas are illuminating on the universality and idiosyncrasy of suicide survivors' responses whether by clinician survivors or by deceased client's family members. Identity development resulting from experiences as a clinician survivor, as a clinician survivor (by proxy) or as any other suicide survivor are found to be similar ('universality') while also being unique ('idiosyncrasy') to each respondent.

Tables 8.16, 8.17 and 8.18 illustrate the incidence of conflicted evaluative dimensions of identity for respondents in all three research cohorts. Target group members are largely associated with suicide-specific (24%) and personal (24%) constructs and less emphatically, family (14%) and existential (14%) constructs. Comparison group members' conflicted dimensions of identity are associated largely with suicide-specific (48%) constructs, and less so, personal (19%), existential (19%) and family (14%) constructs. Results for clinician survivors and clinician survivors

(by proxy) are similar in structure while control group members' conflicted dimensions of identity reflect much more wide-ranging categories.

Postulates #11 and #12 therefore each represent evidential bases for a related theoretical proposition. See also par 8.4.2 below.

8.3 Clinicians' attitudes to suicidal clients

At par 3.9.5 above, the existence of unaddressed countertransference hate (CTH) (Maltsberger and Buie, 1974; Watts and Morgan, 1994; Jobes and Maltsberger, 1995) was briefly discussed. In current research, the negative mixture of aversion and malice that CTH contains was evident when some respondents' attitudes were explored.

Observation of respondents across three cohorts in their evaluation of and ego-involvement with depressed, suicidal and 'deceased by suicide' clients and with suicide survivors, offers possible insights regarding the presence of CTH in clinicians' attitudes to clients with suicide-related issues. Weinreich (2003: 89) defines one's evaluation of another as 'the extent to which another is favoured or disfavoured [involving] one's overall assessment of [that other] in accordance with one's value system'. The existence of CTH in clinicians towards their vulnerable clients may therefore be indicated by consistently low or very low evaluation levels.

Table 8.22 illustrates the above-mentioned evaluations by respondents. All control group respondents make broadly comparable low or very low evaluations of all ambivalent/depressed, suicidal, suicide attempters or 'deceased by suicide' people. Target group members' evaluations are seen to be low or very low for 95% of depressed or suicidal clients, for 91% of clients deceased by suicide and for 55% of clients who recovered after serious suicide attempt. Comparison group members' evaluations for these clients are, respectively, 83%, 50% and 83%. These evaluation data show that the influence of varying levels of client suicidal behaviour, directly (target group) or indirectly (comparison group) upon clinicians is somewhat less than the more uniformly baleful influence that knowledge and awareness of others' suicidal behaviour has for non-clinicians.

In explaining ego-involvement, Weinreich (2003) defines this parameter as a measure of one's 'intensity of involvement' (Weinreich, 2003: 48) with self, others, institutions or emblems, including behaviours or actions, that may 'have [an] unusually powerful impact despite being quite removed from the person's daily encounters' (Weinreich, 2003: 88). As defined, respondents' degree of ego-

involvement with an entity will measure how dominant, influential and powerful its impact is. The question now arises regarding the meaning, in relation to identity development, of respondents' high ego-involvement with suicide-related clients when coincident with very low, low or higher evaluation levels of these individuals.

From table 8.23, 82% of target group respondents are very highly ego-involved with 'a client who died by suicide'. Comparison (50%) and control (67%) group members are also ego-involved with that key entity but at reduced levels. From table 8.24, 55% of target group members are both highly ego-involved with 'a client who died by suicide' and place a very low value on that entity. Comparison (50%) and control (50%) group members evidence this specific relationship but somewhat less so. Table 8.25 illustrates a parallel relationship with regard to 'a client with suicide ideation' but at reduced levels for the three groups, respectively, 45%, 33% and 33%. Analysis of results for depressed/ambivalent and attempted/recovered entities show much weaker relationships, if any, linking low evaluation and high ego-involvement levels.

Table 8.23 reveals that 64% (N=7) of target group respondents and 67% (N=4) of comparison group respondents are very highly ego-involved with 'a suicide survivor'. However table 8.26 shows that 36% (N=4) of target group members are both very highly ego-involved and place a moderate or better evaluation upon this entity. This contrasts with 17% (N=1) and 33% (N=2) respectively for comparison and control groups. This indicates that some target group clinician survivors experience lower CTH levels with regard to suicide survivors.

Considered collectively, these results confirm that clinicians' responses to their vulnerable clients are related to their perceptions of clients' levels of suicide risk. Higher levels of suicide risk are associated with suicide ideation and previous suicide attempts (Simon and Hales, 2006: 586) while suicide survivors are believed to be at increased risk for suicidal behaviour (Cain, 1972: 10; Campbell, 2006: 460). Fawcett (2006: 256) notes that, while suicide is not predictable in any individual (McKinnon and Farberow, 1976; Pokorny, 1983, 1993), assessment for suicidality in a depressed client seeks to assign them to risk groups, in relation to lethality, ranging from a) acute high risk of suicide in the immediate future, to b) chronic high risk of suicide over a period of years but moderate immediate risk and c) low risk of suicide for the foreseeable future.

Clinicians' perceptions will be critically informed by their knowledge, experience and competency in assessment for suicide. It seems evident that, where it exists, CTH and its potentially debilitating effects might best be addressed by enhancing clinicians' ability, insights and expertise in assessing clients for suicide. This could alleviate clinicians' fears (Pope and Tabachnik, 1993), anger (Dressler et al., 1975) and antipathy (Scheurich, 2001) towards vulnerable clients at risk of suicide (Simon, 1998: 480).

8.4 Conclusions

8.4.1 Introduction

The researcher made clear (see par 6.2.2 above) that the study's hypotheses were stated at the study's commencement for scene-setting and structuring purposes and to provide necessary focus for research. Furthermore, the study's key objective (see par 6.2.1 above) was the investigation of clinician identity development following client suicide in the context of a professional duty of care. Its specific aims referred to clinicians' relationships with significant others, personal knowledge of suicide, experience of client suicide and the influence upon clinicians' beliefs and values of exposure to client suicide.

Research outcomes at the study's conclusion take account of the above-mentioned hypotheses, the key objective and specific aims in arriving at a sequence of empirically-grounded theoretical propositions, derived from theoretical postulates emerging from analysis of empirical literature. The derived propositions are firmly based in evidence provided by analytical synthesis of case study findings and any implications, both theoretical and clinical, for clinician identity development in the context of client suicide.

8.4.2 Empirically derived theoretical propositions

Theoretical propositions stated below were developed from theoretical postulates. A further theoretical proposition emerged from an analytical synthesis of case study findings about clinician attitudes to clients at risk of suicide. See also par 8.3 above. In par 8.4.3 below, the significance of research findings is discussed.

Proposition #1 A clinician's direct appraisal of their client's suicide will differ from a colleague's experience by proxy of the same event and will be unique to that clinician.

Proposition #2 A clinician's orientation towards their social world whether defensive or open will influence the extent and nature of their experience of client suicide.

Proposition #3 Clinicians, in appraising the psychache and lethality (Shneidman, 1996) that brought about their client's suicide will contra-identify with that client, wishing to dissociate from those characteristics.

Proposition #4 A clinician's assimilation of a client suicide will give rise to a redefinition of identity evidenced in modulations of identification conflicts and self-evaluation the extent of which will depend upon the clinician's orientation to their social world.

Proposition #5 A clinician's experience of client suicidal behaviour will result in modulations of empathetic identification with a suicidal client, from their past life, as appraised before such behaviour, to their current selves.

Proposition #6 A clinician's conflicted identification with a client's propensity to suicide (by way of suicide ideation, serious suicide attempt or death by suicide) will be indicative of that clinician's level of suicidality.

Proposition #7 A clinician's direct experience of client suicide, in conjunction with past experiences of suicidal behaviour in personal, collegial or social contexts or as communicated in media, literature or history, will influence how clinician survivors appraise self and others in a suicide-related context, when working or relaxing.

Proposition #8 A clinician's experience of client suicide will result in decreasing empathetic identifications with colleagues accompanied by feelings of isolation arising from the absence of shared experience.

Proposition #9 A clinician's experience of client suicide will affect their system of values and beliefs, evidenced in conflicted dimensions of identity. In this context, a clinician survivor's core evaluative dimensions of identity are indicative of their coping resources as they contend with integration of a client suicide experience.

Proposition #10 Clinicians' perceptions of suicidal clients will be critically informed by their knowledge, experience and competency in assessment for suicide. Relevant ability, insights and expertise will therefore address, where present, adverse consequences of unaddressed countertransference hate including malignant alienation from the client, so as to moderate CTH's potential for undermining and weakening the therapeutic relationship.

8.4.3 Significance of research findings

Each clinician survivor's response to a client suicide experience was shown to be idiosyncratic, being unique to that individual clinician, as stated in proposition #1, above. Case study findings, detailed in Appendix 7 and summarised in Chapter 7, demonstrated the individuality within each respondent's identity development in the aftermath. In particular, the extent to which clinician survivors believed themselves to possess the attributes of 'a suicide survivor', while working or relaxing, differed for each individual, ranging from low to very high. (See table 8.10 Target Group – Current empathetic identifications with 'a suicide survivor'.) This key finding indicated that for effective postvention, each clinician survivor's particular needs, as perceived and expressed by that individual, should be addressed. Remaining empirically derived theoretical propositions, stated at par 8.4.2 above, represent equally significant research outcomes. Each is a discrete statement based in analysis of respondents' identification modulations.

Propositions #2 and #4 emphasise the strong influence upon the clinician survivor of their orientation towards their social world, whether 'defensive' or 'open', as elucidated in par 8.4.2 above.

Propositions #3 and #10 evidence the crucial influence upon the quality of the therapeutic relationship of the clinician's skills in assessment for suicide while maintaining core conditions of empathy, congruence and respect (Wilkins, 2003: 64-84).

Propositions #5 and #7 show that a clinician survivor's engagement with past suicidal behaviour in self and others will affect how they respond currently to a client at risk of suicide.

Proposition #6 resonates with Orbach's (2001: 171) view – see also par 2.9 above – that the clinician's own level of suicidality is a critical factor in relation to facilitating effective psychotherapy with suicidal clients.

Proposition #8 confirms the empirical evidence that debilitating isolation for the clinician survivor may intensify in the absence of non-judgemental access to colleague clinician survivors' shared experience of client suicide (Gitlin, 2006; Hendin et al., 2000; Hendin et al., 2004).

Finally proposition #9 suggests that the clinician survivor's system of values and beliefs may be so disrupted by their client suicide experience, that their coping ability will be challenged and tested.

The overall significance of this research rests primarily in related consequences for postvention protocols and procedures particularly in organisational settings. Incorporation of these propositions within the design and delivery of postvention support frameworks for clinician survivors, whether directly or by proxy, offers potential to positively transform existing ad hoc practices. This work explains diversity in clinicians' responses when faced with this serious loss experience, as evidenced in each clinician survivor's identification processes, while paying due regard to acknowledged differences based inter alia in their gender (Grad et al., 1997), therapeutic experience (Hendin et al., 2004) and theoretical orientation (Tillman, 2006).

8.4.4 Limitations

Current research would have benefitted from comparable quanta of target, comparison and control group members. Thus a total of 33 respondents should ideally have been recruited, 11 for each cohort, instead of 11, 6 and 6 respectively. This limitation was due to a combination of recruitment difficulties and time constraints.

Grad et al. (1997) investigated gender differences in clinicians' responses to patient suicide. Current research respondents were 43.5% (N=10) female and 56.5% (N=13) male. Target group membership was 45.4% (N=5) female and 54.5% (N=6) male; comparison group was 83% (N=5) female and 17% (N=1) male while control group was 100% male. Although respondent gender was not a variable in current research, gender balance for all cohorts might have been preferred.

One respondent (A17; C1; 'Matthew') featured as an eligible member of both target and control groups. This could have adversely influenced research findings although balancing advantages – see case study A17 at Appendix 7 and Appendix 10 and case summary at par. 7.2.11 – are also evident.

Only one control group member, viz. B1 'Kevin', completed ISA instrument 'B' which did not include the entity 'a suicide survivor' thereby potentially diluting resultant findings.

Late in current research following completion of respondent interaction, the researcher noted that the inclusion of an entity 'a clinician survivor', in addition to 'a suicide survivor', in ISA instruments might have been helpful. This possible deficiency was acknowledged although the ISA model for research investigations is always constrained by the vagaries of instrument construction (Weinreich, 1992).

Current research did not investigate longitudinal aspects. Its findings are therefore restricted to respondents' identity development at the time of interview.

8.4.5 Directions for future research

Current research did not investigate longer term identity development in clinician survivors. Several respondents had experienced more than one client suicide. A possibility existed for renewing contact with target and comparison group respondents to investigate identity development in the interim.

Postulate #10 referred to empathetic identifications with colleague clinician survivors. This dynamic is a potential research topic although practical difficulties are acknowledged in recruitment of eligible respondents

The rarity of suicide – 'a very low frequency event (Gitlin, 2006: 477) – combined with relatively few suicides per clinician means that 'the topic [client suicide] never becomes one that demands an agreed-upon set of coping skills that has been shaped and taught over the generations' (Gitlin, 2006: 478). Further research, in addition to the current study, to address this deficiency is suggested.

8.4.6 Implications of research findings

Each clinician survivor's identity development in the aftermath of their client's suicide was shown to be idiosyncratic, evidencing unique personal, professional and other elements. Consequently their assimilation process for the experience will reflect elements that are peculiar to each clinician survivor. This means that available individual, family, social and organisational resources should be configured so as to match each clinician survivor's distinct, ascertained, support needs. Proposition #8 (above) in conjunction with postulate #10 (see par. 5.15 above) points to potential benefits for clinician survivors of a networking facility for mutual, therapeutic interaction. A clinician colleague of a survivor, described in current research as a clinician survivor (by proxy) will also have an idiosyncratic response to their colleague's loss. Their identified needs should also be similarly addressed.

It is not possible to predict suicide in any individual (Fawcett, 2006). However there is some evidence that a clinician survivor's propensity to suicidal behaviour may match the increased risk for suicidal behaviour in non-clinician survivors (Cain, 1972; Campbell, 2006). The evident implications for effective provision of clinician survivors' support resources should be noted and actioned.

A traumatising aftermath of ‘out of the blue’ client suicide was experienced in a uniquely personal way by several respondents including Michael, Hannah, Ruth, Debbie and Matthew. It is indisputable that for vulnerable clients during each clinician/client interaction, appropriately documented and effective assessment for suicide risk, is essential to protect both clinician and client. Each of these bereaved clinicians benefitted from family, collegial and organisational support. But essential self-support to reinforce that crucial human support in the aftermath also depended upon each clinician’s competency in effective approaches to assessment for suicide.

Education and training in suicide assessment protocols and procedures should therefore be mandatory for trainee clinicians and prioritised in continuous professional development programmes for clinicians.

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