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A phenomenological enquiry into the lived experience of Sandra Burlace - a psychotherapist working with suicidal ideation, privately and with the Samaritans.

Introduction

It can be argued that in this society our right to live is viewed as a most precious commodity. Conversely, the perceived morality around choosing to end our life is not as clear, is hard to define and is variable from person to person. The social and moral impact of such a choice can be wide ranging and this paper intends to explore that, from a psychotherapeutic perspective and at a phenomenological level.

Despite the abundance of evidence that suicide pervades our society and although as therapists we are surrounded by it, as a 4th year student at Masters level I have yet to encounter it at any point from a clinical training standpoint.

This interests me as an individual who has encountered suicide and considered it for myself. It also interests me as a mental health practitioner. My goal for this research will move away from a hard focus on the numbers and percentages around the choice to end our lives, since there are already a lot of those reports.

Here the focus will be on the personal impact of suicide on one person. My goal is to investigate what it means for one single individual to be a psychotherapist encountering death by choice regularly.

The literature review will focus on my understanding of the existing literature, and compare what views there are around the impact of suicide on clinicians. Before that I would like to expand on my personal experience and involvement with death.

My own experience of trauma informs this work in some ways. I have a long history with violent and sexual trauma in my personal life. This has given me over time a ‘thick skin’ to suffering - I’ve developed resilience.

Over my 2 year practice I have worked with 3 long term clients, each 1.5 years in length who have either experienced the death of a loved one by suicide and/or who were actively and seriously considering it for themselves. I have also experienced the attempted suicide of a client and the death of my brother Jonathan by suicide in 2014.

For me working with suicide has not been intimidating, but has carried with it a sense of gravity that I don’t find in any of my other work. Despite having this experience of my own, the understanding I gather from my peers is that many therapists are highly intimidated by the potential for suicide in their clients.

When discussing the subject casually with colleagues I hear that most would expect to find losing a client by suicide highly traumatic. On beginning this research my view on the matter is in agreement with my peers - that my exposure to many types of trauma has given me a shield against the trauma of suicide, but that out in the wider world relational attachments with suicidal clients will naturally result in a traumatic experience. I cannot, and don’t aim to assess

here what the broad impact of suicide on multiple practitioners is. What I aim to do is to find one other voice and explore what that person has experienced.

This piece of work gathers the response of Sandra Burlace who has also had long exposure to suicide and explores her emotional and professional reaction to it.

Literature Review

There are no books written specifically on the subjective experience of psychotherapists working with suicide. In light of this I have focused my attention on relevant scholarly articles on the impact of suicide work for clinicians, drawing strongly on the work **Eric W. Mcleod (2013)** amongst others. The following is a collation of those views intended to enrich understanding and provide a backdrop for the individual experience of my co-researcher **Sandra Burlace**.

Eric W Mcleod (p.33 2013 Michigan University) talks about the hazards associated with working as a psychotherapist, putting particular emphasis on the role of suicidal ideation as a cause of stress. Combining his own research and that of **Deutsch (1984)** he writes 'The hazards identified stem from the professional role and the social expectations associated with psychotherapy and the nature of working with clients. Among the most stressful experiences Deutsch found in her research, therapists considered clients' suicidal statements to be the most stressful, a stressor identified by 61% of her respondents.' Mcleod goes on to cite Deutsch further pointing to research in which practitioners report experiencing suicidal clients as regularly as once a week. Additionally to those reports, Deutch's own research found that suicidal statements were evidenced to be present in 11% of all client contact hours - twice a week for the average therapist at that time. Clearly this represents a significant finding with regards to the expected experience of the average therapist, suggesting that most individuals working in the field should fully expect to be exposed to suicidal ideation to a significant degree - perhaps something that is not expressed clearly enough at the onset of training.

Mcleod also cites **Kleespies, Penk and Forsyth (1993)**. Where Deutsch had focused on experienced clinicians, Kleespies et al focused on the related field of psychiatry and the impact upon inexperienced practitioners. In an environment where the US mental health relied on in-training clinicians extensively 'to treat many of the most impaired and difficult patients' **Kleespies et al (1993)** found that the impact on clinicians in training was considerable - equal in effect to how an actual suicide completion would impact upon experienced practitioners. Further to this, practitioners interviewed expressed that the only incidents trainee clinicians found more stressful than suicide attempts were actual suicidal completion and direct physical attacks upon their person by a client. Kleespies et al go even further to state that the impact of a suicide threat or attempt on a trainee clinician appears to induce a greater requirement for 'support and possibly intervention from the appropriate supervisory resources' and say that without such action clinicians may even be incapacitated for further work with suicide threat, attempts and ideation. This again holds significance for the purpose of this paper which inquires into the impact of work with suicidal clients upon the professional work of a psychotherapist.

Selakovic-Bursic (2001) discuss the explicit need for clinicians who are survivors of suicide to talk, they state that 'Upon establishing trust with their interviewers, survivors of suicide indicated feelings of guilt, remorse, doubt, and sorrow. Other reactions involved 35 blaming others and intellectualizing their reactions, a set of responses that were seen by the researchers as decidedly unhealthy.' Although not expressly referred to in that research, **Mcleod (2013 p35)** extrapolates the idea that this need to talk extends to clinicians who are faced with the threat, possibility and truth of suicide.

Within my own field of psychotherapy, supervision and personal therapy are considered essential - regardless of work with suicidal clients. In light of that the statement Mcleod makes here seems obvious, possibly even redundant. It will support the purpose of my inquiry to observe the experience of my co-researcher, who may or may not have felt the need to talk following work with suicidal clients.

Reflectively, Mcleod goes on to cite the work of **Rodolfa, Kraft, and Reilley (1988)**. Here Mcleod states 'The researchers found that while suicidal statements were stressful, they were not as stressful as other researchers had reported. They suggest this may be more of a product of differences in the perception of the degree of stress among professionals rather than the lack of stress itself. In essence, what one professional finds stressful may not be the most stressful event for another.' Indeed subjective experience is the focus of this paper and as such it will be my co-researcher who brings the facts of her experience working with suicide ideation.

The choice of psychotherapy and not psychiatry as my research focus hinges on the centrality of relationship in the psychotherapeutic alliance. My interest is in how the therapist *in relationship* with the suicidal client is impacted. **McAdams and Foster (2000)** have investigated the impact of suicide on those working as counsellors. In that study 23% of respondents reported having experienced the suicide of a client within their care and the response was recorded to be 'moderately to moderately high impact'. The writers go on to say that in comparison to psychologists and psychiatrists, counsellors reported more severe 'intrusive and avoidant thoughts' and that they 'universally reported the suicide of a client under their care was stressful'. As was the case earlier, the writers believe the impact of client suicide would be stronger for those in training than for those who are experienced. McAdams and Foster go on to say that for many of those who report experience of a client suicide the act has had a 'lasting impact on their personal and professional experience'. These findings meet with my own expectations that practitioners who engage more relationally with clients are exposed to greater risk of trauma should a client take their own life. This also combines well with Bernian theory of games and rackets, where intimacy represents the highest risk and highest reward of all the types of human interpersonal transaction **(Berne. E loc 215/225 of 2596)**.

Citing **Chemtob, Bauer, Hamada, Pelowski, and Muraoka (1989) McLeod (2013 p37**) postulates that although actively expecting the death of a client by suicide as part of a career in the field of therapy may seem fatalistic, it is 'a safer and more pragmatic viewpoint than a rather hazardous viewpoint of hoping it never happens and then experiencing significant emotional

damage if a client suicide does occur'. This combines well with my own views as a practicing therapist, and it is my aim to understand how this matches with that of my co-researcher. Chemtob et al share my view that relational investment with a client may increase the emotional impact of a suicidal event. In their study they found a direct correlation between the time spent with a client and the emotional impact of their suicide upon the clinician. Amongst the most reported reactions are feelings of disbelief, shame, vulnerability, guilt, loss of confidence, professional inadequacy and fears about reputation.

Methodology

A qualitative methodology was used in order to understand the subjective, existential experience of Sandra, rather than a statistical and quantitative approach. The work took the form of an unstructured interview with Sandra, allowing her to explore her feelings and experiences in the moment with me. Open questions were used to facilitate the process without leading Sandra towards concepts or ideas of my own - or excessively guiding the flow of the interview. I interviewed Sandra on the topic for just under 1 hour and used a dictaphone to record our conversation, transcribing it afterwards. On analysis of the transcript I observed the development of 3 key themes. I used these themes to form the headings for my findings comprising of a combination of Sandra's own words and any applicable theory or existing research. Sandra was given full access to this process, opportunity for input and consultation to ensure parity between her experience and what is reflected in my research.

The questions I asked Sandra were intended as a guide to allow her to expand and express herself. The questions followed the theme of impact and the intention was to support an understanding of Sandra's lived experienced. They were asked in the below order as follows:

1. What's the effect of working with suicidal individuals upon you emotionally?
2. What impact did the immediacy of the work with the Samaritans have on the way you worked with the individual in the moment?
3. How does your work with suicidal people affect you when you're working with other clients?
4. Tell me about your expectation to work with clients that considering suicide.

a) Co-researcher Involvement and Ethics

Prior to this work Sandra and I have been colleagues through Facebook, with very little interaction. We both studied at MIP under Bob Cooke and share the experience of that course. Sandra has recently graduated and had empathy for me in the process of this research, having done it herself. This aided the process in that Sandra knew what to expect, was relaxed and was not intimidated by the prospect of the interview.

I made contact with Sandra through Facebook, via an open invitation on the TA group, inviting anyone willing to share their experiences. I had several offers however Sandra seemed

by far the most appropriate with her mix of personal and professional exposure to suicide. I drafted a proposal document and following approval by Karen Burke at MIP I arranged a time to meet and interview Sandra. Sandra was open to having the interview at MIP or at my house and I decided to opt for my home. This enabled me to fully control the safety of the environment and ensure we had privacy, quiet and as much time as we might need. I advised Sandra of the following ethical points:

1. Her privacy was prioritised and the work confidential. Access would only be given to Bob Cooke and Karen Burke and students of MIP.
2. She was free to take a break at any point during the interview.
3. Sandra would retain the right to withdraw from the process at any point and the right to request I destroy any information or documentation relating to her.
4. The recorded interview would be destroyed following submission and after it had been marked.
5. Sandra had the right to access the work on demand.

Sandra agreed to all these points and on the day of interview signed the ethical consent form as provided by MIP.

b) Data collection

Sandra and I met in my home and talked for an hour. We sat in my living room with a dictaphone between us. The environment was casual, private, non-clinical and relaxed. Sandra expressed she was comfortable in the room. Before proceeding we spent a few minutes saying hello and making a drink of tea. This was to ease ourselves in as we had not met before, other than over internet discussions around the interview.

Sandra explained to me that she had a history with suicide personally, having considered it several times. I did not feel it was appropriate to ask if she had ever attempted to take her own life, although that could have been useful for the research. Sandra also expressed that suicide had been a theme in her family which had run throughout her life. I explained to her that it was a theme in my family also and we agreed that there could be interesting transferences in the room as well as shared experiences. We agreed that together we would care for both of our needs.

Sandra signed the ethical documentation and we discussed that if she needed or wanted to stop the interview process at any point then her wishes would be made paramount. I also made it clear that she will have access to the work created, the recordings made and have any input she wished into to the process.

I had several questions in mind for the interview and had showed these to Sandra in advance. Sandra advised she was happy with answering them and I explained that I may not use all of them in the interview and that spontaneous lines of enquiry might come up. Sandra expressed that she was OK with this. We agreed that we could both manage our boundaries as we went along.

My goal with the interview was to ask open questions focussed towards the theme of my research that would also allow Sandra free expression of her subjective experiences. We sat for the full hour and at one point there was a moment within the interview where I became aware that Sandra may well be vulnerable due to the personal nature of her involvement and past. I paused the interview but kept recording. I checked out Sandra's wellbeing and we agreed it would be OK to continue. When the interview did come to its natural end I expressed my thanks and ended the recording. We took a few minutes to come back into the here and now, reflect on our personal experiences of the interview and after a small chat, care taken that Sandra would be OK travelling home, we said goodbye.

Findings

Sandra spoke freely and with detail about her experiences personally and also clinically in her role at the Samaritans as well as in therapy sessions. It was clear that her experiences had moulded her and there were three key themes which emerged from her as we spoke, which I will outline below.

A profound experience, but not a negative one.

I asked Sandra what it was like for her emotionally to work with people who are suicidal and her manner was balanced and considered. Her main theme emerging on this was that although these experiences were profound, she was not afraid of these interactions and that her own exposure to suicide had provided her with a holding place internally. She gave clarity on what this meant to her clinically and personally in current practice and her explorations within supervision:

CR02 '...I want to use the word profound but that's not profound in a negative way particularly, it's impactful because I've had a long experience of suicide, personally, my maternal grandmother ...drowned herself. My mum tried ending her life lots and lots of times and it's something that I've struggled with ...long term and so when I'm with somebody else who is talking about suicidal thoughts... I feel connected with them because I think okay... I've been where you're sitting at the moment. ...I'm working with somebody at the moment and she's in my thoughts quite a lot ...she's actively suicidal, so I took it to supervision and we did some work on where I was coming from while working with her. The supervisor ...asked me a few questions and it was really clear that I was coming from a place of adult working with her.' (Transcript: p1, lines 8-20)*

**Changed from Paternal to be different from the transcript at Sandra's request.*

CR02 '...I feel very sure I've done so much work on my own don't exist, my own pull to suicide that ...mine isn't in the room at the same time but I guess that's what my supervision question is about to double check that it wasn't sitting in the room with me. (Transcript: p2, lines 33-36)

Sandra went on to express that her personal experience was a motivator for her and that she experienced excitement at the prospect of a chance to help a particular person through a process she had such knowledge of:

CR02 '...I felt very excited at working with this person, even though she was very suicidal...I know what that journey was like for me and although hers is going to be individual to her and not necessarily reflective of mine...I learnt a lot about working with suicidal individuals through my own journey, plus all the work at the Samaritans. ...that really is like at the coal face...'

CR01 'Hmm the front line is that what you mean?'

CR02 'Yes, yeah, although it's not face to face obviously but sometimes it is people turn up to the office but most of my personal experience [with the Samaritans] *was over the phone. (Transcript: p2, lines 41-50)*

Peace, Calm and Compassion

In her comments above Sandra focused on her immediate momentary response to the work. When asked about how it was for her to be working 'in that moment' with someone contemplating or intending to do suicide Sandra expressed calmness and compassion. There was a marked emphasis on human connection and also the importance of her own therapy:

CR02 'Yeah, in that moment. I'm in a place of calm support which is strange because my personality adaptation I would come from a histrionic place but I think a lot of the work I've done working through my own process has calmed that down and certainly when I was doing work with the Samaritans...' (Transcript: p2, lines 54-58)

When asked for clarity on whether she worried for her clients Sandra was unguarded and clear that her experience didn't contain fear and that in its place was care. She described her faith in human kindness and the importance of its role when connecting through suicide in progress:

CR02 '...no I don't think it is worry. It feels like some fond connection. I don't knowingly have one that suicided while I was on the phone, possibly one. It's very hard to know because they go quiet. So you don't really know but I certainly had a couple who were in progress and changed their minds and 3 hours later one of them, I could hear them, they'd gone back home. The kettle was boiling. ...I heard some toast pop up and ...that gives me a sense of reassurance that human kindness and connection with somebody, who is in the darkest moment of their life, can really make a difference.' (Transcript: p3, lines 67-75)

Sandra went on to express how compassion and connection are very potent tools and that also there is not a miracle cure for suicide. It is clear that hope and connection are the prevailing themes. In the excerpts below Sandra is clear that sadness isn't her main experience and yet her emotional and cognitive responses are rich to the point of physical experience:

CR02 '...that might only last ...12 hours. Perhaps they just slept that night and went back and did it the next day. I will never know but ...feelings change and perhaps 12 hours later some of their feelings would have changed and they didn't do it again. ...I will never know that bit but it's such a potent experience to be with somebody ...it took probably about 2 hours, 2 and a half hours but he made his way home and that our last bit of conversation, hearing the toaster pop up and he was going to eat this and go and get into bed and ...that's such a rewarding thing. (Transcript: p3, lines 83-90)

CR02 '...I could almost cry actually and yet it's a happy outcome but there was ...a really strong bond… somebody here who is sharing things with you ...it's unique ...it's sitting here at the top of my throat and I could easily cry and yet ...it's not sadness but I don't know what that is about. It could be relief. I could be marvelment at that strength of connection.' (Transcript: p4, lines 93-102)

Later in the interview Sandra extrapolated further on her experience of calmness in this work:

CR02 '...I have a big hurry up process ...that is one time where it doesn't come into play. As you ask that question I had a real sense of my stomach of lowering and flattening and being cold because I think it's that slow calmness that lets that connection take place and I can't think there would be anything helpful about being rushed in that. ...sometimes people ring and they are feeling a bit panicky. ...but perhaps what's happening is ...that's the adult coming in now thinking about it.' (Transcript: p6, lines 175-181)

CR02: 'It's a physical sensation that I would get when I had picked up the phone and I had heard somebody is a suicide in progress. ...I feel like everything inside me slows down and I'm focussing on that connection.'(Transcript: p7, lines 186-189)

CR02: 'Lots of nurturing ...because the interesting thing is ...The Samaritan's policy is the right to determine. ...it's not about talking anybody out of taking their own life it's about supporting them to make a decision and often they will change their mind in that process. ...lots of times people will decide not to end their life but there's the belief that they have the right to decide themselves. ...it's not like we're coming in cape crusader ...It's helping people explore their decision to end their life and then if they decide to do it then ...you are that person giving emotional support...so that they're not doing it alone.' (Transcript: p7, lines 196-205)

The right to choose.

I was emotionally struck by the signs of life described in Sandra's earlier story, and how she advocates for dignity. This gave me a sense of her empathic bond and her adamant belief in the right to choose despite her desire for these people to live.

When asked further about her compassionate response to what could be perceived as the darkness in these encounters. Sandra expresses her sense of privilege:

CR02 '...suddenly a bubble forms between me and the other and it almost doesn't matter. …I don't have much recollection of where I am or who else may be in the room ...it's just like me and that person are in this bubble ...I used to think ...what a privileged position I was in because for someone to reach out when they're in that place and say actually I don't want to die on my own ...it feels like it's a very privileged thing to be with somebody when they're ending their life ...if someone, in my family was to die I would want someone to be there with them and that was always my thought around these people who ring the Samaritans...' (Transcript: p4-5, lines 117-128)

CR02 'I had a similar experience with a young girl… she spoke to another Samaritan at my branch and asked her to send a message to me ...to say thank you for being there. It would have been lovely to have you as a mum, ...which I think in one way sounds bizarre but another way I think it's ...the level of the intimate connection you get while this is getting on.' (Transcript: p5, lines 137-145)

It was new for me to hear (Transcript: p7, lines 186-205) that the work of the Samaritans was around choice and not stopping people taking their own life. Sandra expressed that all sides can be true. When asked around her reactions to suicidal ambivalence Sandra reinforced the importance of time to think, feel and reflect:

CR02 'It makes sense...that it's about time and talking...around how that decision has been made, what worries they might have about it... Yes, I want to die, no I don't want to die, helps them clarify what's going on' (Transcript: p8, lines 222-225)

I asked Sandra if there was a 'no wonder' type response in her - a normalising response to this person's experience of life:

CR02 'Yeah, given that this is what is going on I'm not surprised you feel like that...that's a phase I've used in practice...and the Samaritans.' (Transcript: p8, 229-231)

I considered the idea that Sandra did not perceive receiving a phone call from a person who was in the process of suicide as dark (*Transcript: p4-5, lines 112-129*). I gained a sense of her vision of this as a choice for everyone - Sandra perceived receiving those calls as lucky. I was enlightened by her expression of feeling privileged, Sandra felt honoured to be there for someone in their last moments. The thank you note Sandra described struck me as evidence of success. When asked about her experiences around success Sandra explained that she feels highly rewarded:

CR01 '..that's enormous and ...I've kept the note. ...because it's a reminder of so many things. ...of our own fragility. ...of the strength of connection that we can create. ...of the value of

kindness ...it's a reminder of my own ...I hesitate to use the word potency but I guess… it's a reminder actually that I did that, that's really important... to me.' (Transcript: p5, lines 150-156)

When asked how her experience of suicidal clients affects her response to those who express severe needs, Sandra explored the idea of being desensitised:

CR01 'I've never considered that question ...I feel not... I don't see or feel any evidence that I do. When someone is talking about suicide ...they were thinking about it and we would explore it but there's not a plan. ...it's not an imminent danger. I'm not aware of any desensitisation but ...I wonder whether my background has desensitised me ...because of having lots of suicide in the family, ...if somebody close to me did take their life it would have a huge impact on me and yet as the same time suicide has become more normal given my environment...' (Transcript: p9, lines 260-269)

I asked whether rather than desensitisation, was it for her that suicide has had the venom taken out of it - was it no longer as frightening. Sandra's response was in line with her previous theme - that we all have the right to choose:

CR02 'Yeah ...it is a real option for everybody, all the time… Whether it's being considered or not it always is an option for any one of us.' (Transcript: p10, lines 283-285)

I asked what the statement around suicide being possible for everyone means for her. Sandra spoke about life as a balancing act:

CR02 '...I wonder whether that is a hardness inside me, that acknowledgment that actually we all have the potential to end our life if we chose and yet the reality of it is that I don't experience the hardness. If anything, it's the opposite, I experience the kindness of connection. ...the line I've got in my head is there for the grace of god go any of us.' (Transcript: p10, lines 299-304)

CR02 'We're all fine one moment and who knows...that house of cards can start to fall and then you're left with well that is some, that has become somebody's preferred option ...I remember it being a shock when I first found out that they don't actively stop people suiciding but actually, you know, I think life is about choice and perhaps death is about choice too...' (Transcript: p10, lines 307-314)

I asked Sandra for more detail around the shock of realising that Samaritans don't stop suicides:

CR02 '...part way in the training I suddenly realise that they have their...ethos...that everybody has the right to determine whether they live or die and that really caught me off guard...I really questioned whether I wanted to stay because I thought I'm not sure...this is aligned with what I'm feeling but ....as I lived with it and as I thought about it...I realised actually it was aligned with how I thought or perhaps I became aligned with their ethos… What came out of that is that I

believe that actually we do have the right to determine. ...that's not to say I wouldn't give all the support and ...the time to explore different options with somebody who is suicidal. ...I'm certainly not...ascribing to somebody handing out suicide potions…' (Transcript: p11, lines 325-338)

From a TA point of view this outlook matches well with 'I'm OK You're OK' **(Harris, T. 1967)**. I asked Sandra about whether her feeling was something along the lines of 'even in this you're OK':

CR02 'Even in this and actually I think… a lot of it is they felt they had no choices, ...for me, it would feel wrong to take away that choice ...it's something that I often think about when you read in the newspaper that somebody...dropped off a bridge onto the motorway and stopped the traffic and people miss flights ...there's all this irate stuff going on about how selfish that person was...but actually the thing that always goes through my head is perhaps their biggest impact in life was the way they died. ...I want to howl at that.' (Transcript: p11-12, lines 343-354)

I asked Sandra if by 'to howl' did she mean to howl in anger at those who persecute the suicidal:

CR02 'No, to howl with desperation for that person who makes the biggest impact with their death and there's an irony of language there...I'm using the same word but I don't mean the physical impact. I mean...the impact it has...on people in traffic...' (Transcript: p12, lines 356-361)

Again Sandra's vision of suicide as a human right, that we all have an entitlement to choose our own fate is emphasised here, mixed with her sadness. For some, when all other options seem impossible, even the choice of death is resisted somehow by the population. Sandra extrapolated on the role of others in this choosing:

CR02 '...the Arndale car park is well known for jumpers…(I) *saw somebody up on the car park, saw the police up there...doing the talking, passed him a green blanket to keep warm and that had a very big impact on me. ...there's somebody here who is about to jump and yet they're wet and cold and they're taking a blanket from somebody and that was like argh. I think a lot about that guy. He did jump and never without fail do I, excuse me [getting upset]. ...Never without fail do I walk past that place without thinking about him' (Transcript: p12, lines 366-378)*

It is apparent here that alongside Sandra's strong belief in the right to choose, her compassion for these individuals is considerable and the loss of life hurts her personally. The impact of it is not diminished by her exposure to it and she processes it in a healthy way.

CR02 '...I went to a conference on suicide...and one of the workshops was given by police negotiators and I...met the policeman who was working alongside the guy who was talking him hopefully down...I said that's what took me to join the Samaritans. ...the final push I needed to join ...I just wanted to let you know that there was some positive outcome from a really negative scenario...I wonder if you could let your colleague know and he said that was his very first

suicide... we all thought he was coming down and then he jumped and so it impacted everybody enormously there.'

CR01 'Including you.'

CR02 'Yeah, including me, yeah.' (Transcript: p13, lines 378-389)

I paused the interview here, to ensure wellbeing and safeguarding for Sandra. I expressed awareness of her personal experience of suicide and checked that she was OK. Sandra agreed to continue and said she was OK. Sandra expressed that the emotions involved are fundamental to her experience:

CR02 'Thank you for acknowledging that...I can take this stuff to therapy, if I need to but yes...in one sense that is our humanness...I feel I can't talk about this without being aware of the emotional impacts.' (Transcript: p13, lines 399-402)

I was aware of the costs involved in this work for Sandra and felt compelled to thank her for discussing this subject with me, which came with emotional costs for her:

CR02 '...yeah a cost and a gain. Pain at loss even though I didn't know that man but gain from the positive interventions...who have lived another 24 hours…' (Transcript: p13, lines 408-410)

CR02 'I didn't know the guy's name who jumped until I went to this workshop and I remember the officer saying he was called Gareth... it feels so really important about acknowledging the fact that now I know his name. ...I never walk past there without thinking about him.' (Transcript: p14, lines 414-419)

I understood Sandra's meaning to be that with this there is a trade off, she learned of a tragic death, gained motivation to help and subsequently had a positive effect on others. Later she met those who tried to help Gareth and learned his name - a powerful reminder that 'these people' are human beings with names, lives and loved ones.

My final question was around how much exposure to suicidal individuals she would expect to have in her work. Sandra described her ideas around the right to choose:

CR02 'That's interesting my answer is...this shows how much I normalise suicide... it feels like suicide is a normal part of our life and death ...people have those choices. ...I think I would have wondered what am I missing...if I'd had...my first 10 clients or 20 clients or something nobody had ever talked about suicide or had never said anything that made me think let's explore...I would be wondering what have I missed because it feels like a normal part of our human condition...' (Transcript: p14-15, lines 439-447)

When asked for clarity around the words ‘normalise’ and her expression of suicide as ‘just part of our human condition’ Sandra went further:

CR02 ‘...it’s part of our human dimension, I think. ...I hope that doesn’t make me hard but actually...I don’t see any hardness in practice. It’s the opposite. ...kindness and nurturing...but it does sound hard and flippant normalising suicide.’ (Transcript: p15, lines 454-460)

Here Sandra reinforced the point that there is a difference between honouring the right to choose and being cold to the act. Sandra’s discomfort around the idea that she may be ‘hard’ indicated a very compassionate, self reflection. This may well be the safe foundation an individual needs in order to go into this work and be effective.

Sandra continually emphasised her faith in choice, compassion, calmness and connection. Sandra made it very clear that there is no panic in it for her because of her belief in our right to determine. It’s clear that whilst she feels nothing but compassion and that although she believes in the sanctity of life, she’s also not pulled to rescue. The overarching theme revolves around the basic tenet ‘I’m OK You’re OK’. Sandra talks about this choice and how that you can observe change just by virtue of connection. She uses more TA language discussing the strengthening of the Adult ego:

CR02 ‘...I don’t want anybody to end their life on one level and yet at the same time, so many times in life we don’t feel we have the choices or we feel...shoehorned into choices we don’t want and I guess that’s where that privilege comes...it’s about exploring their options...and sometimes in that exploration you can hear things changing. ...one question that I’ve always found really useful...do you want to end your life or do you want to end the pain...that’s such a rich question and such a rich answer.’ (Transcript: p17-18, lines 523-533)

CR02 ‘...hope is in there as well...if the hope is diminished by the levels of pain because if we don’t have any hope then why do we get up in the morning. ....you so need that and that’s something, the suicidal client I am working with now it’s about strengthening her adult...making sure that she understands the value of building her resources around her and using them and that, for me, feels very exciting work to do as a therapist.’ (Transcript: p18, lines 543-550)

Sandra expressed excitement which is a link back to her earlier words around the profundity of the experience. I asked how it was exciting and she expressed that this was around witnessing growth:

CR02 ‘...to be alongside somebody as they are ...growing which is interesting ...because it is moving from child to adult ...and to be able to be the person that’s supporting them in that… I am very clear I can’t do the work for you but I’m going to be alongside you while you’re doing the work. (Transcript: p18, lines 555-559)

CR02 ‘...one of the things I think is really important, I needed to hear it when I was suicidal, is this isn’t insanity. You’re not going mad. This is lots of things all adding up…I so believe that to

be true and as I listened to her story I said to her I want to say something to you that no...It's not any of those things. This is like a message that you've had, a historical message that is playing out...and her relief to know that she's not going mad she sat there and just cried with relief and it's amazing the change that that one interaction had on her..' (Transcript: p19, lines 565-574)

The second quotation above reminds me of a bulls-eye transaction **(Tudor, K. 2002)**, a message to the child, the adult and the parent. Sandra's fundamentally TA based approach is showing here. It is a reflection of her rounded skill set that after an hour of conversation revolving around her emotional experience, Sandra could come so readily back to grounded practical theory. I was impressed by her balance of analysis and care.

Discussion

Sandra's relationship with suicide and her exposure to it in the workplace make for an interesting set of findings when placed alongside the observations made in the literature review.

(Mcleod E.W 2013) talks about exposure to suicidal statements as being the most stressfully impacting upon psychotherapy practitioners, quoting (**Deutsch, 1983)** to say that 61% of responders reported this way. Sandra's experience is in many ways counter to that.

Sandra does express impact, but makes it clear that her deep understanding of the meaning of suicide and her faith in the right to choose enables her to disengage with the 'rescue' position in the drama triangle (**Karpman, S. 1968)** placing her in a position of connected nurturing. This compassionate and resiliently engaged approach to the choice lessens the stress for her, to the degree that in some places she wonders around the ideas of being 'hard' or desensitised.

This is more in keeping with the work of **Rodolfa, Kraft, and Reilley, (1988)** who talk about differing perceptions in the degree of stress by professionals. This potential for subjective variance was something I anticipated in the literature review and the juxtaposition between Deutsch's research and Sandra's personal experience supports the idea of these differences.

Interestingly **Deutsch's (1984)** research around the level of exposure to these themes (11% of all contact hours) does match with Sandra's expression that if he she wasn't encountering suicide then she would be wondering what she hadn't done right.

When I initially read the percentage I was shocked by the frequency that I might expect to encounter suicide. Now having spoken with Sandra it seems obvious that suicide would be a common theme in my work. This has meaning in that it casts a tentative light on a possible need in the TA training environment. These brief findings support the idea that trainee psychotherapists may well have a largely un-met need to be robustly prepared to encounter suicidal people regularly. **Chemtob, Bauer, Hamada, Pelowski, and Muraoka, (1989)** support this idea as outlined in the literature review.

I proposed that a strong relational connection with an individual might raise the possibility of trauma through their suicide or attempted suicide.

Chemtob et al supported this stating that the most reported reactions were feelings of disbelief, shame, vulnerability, guilt, loss of confidence, professional inadequacy and fears about reputation.

Sandra reports none of these experiences. She is very clear that when true contact is made and there is genuine regard for human choice then the absolute truth of our ability to choose protects her from any trauma. Sandra is effected, feels sadness and loss but can move on with life knowing that she cared for the other and did not attempt to deny their right to decide on the time and manner of their own death.

As with earlier, for me this finding now appears more obvious having absorbed some of Sandra's views as an individual who is extremely experienced in the subject.

Where the literature I reviewed goes into significant detail regarding the statistics and expectations around suicide in the psychotherapy workplace, there is a distinct lack of literature around the subjective experiences of it. With that I will now move through the themes of the analysis and present my discussion of them.

A profound experience, but not a negative one:

Sandra described the emotional impact as 'profound'. I understood her in the common meaning - that she was greatly impacted emotionally and intellectually by her work. My feelings as we spoke were deeply compassionate and careful, I experienced in my body the sense of a level of compassion which is beyond my usual experience.

I'm certain that in this I was experiencing Sandra through transference and felt privileged to know something of that connection she described as being in 'the bubble' *(Transcript: p10, lines 117-120)*. I had a glimpse of her subjective experience through this which I won't forget.

Sandra's words were often from a TA perspective and she explored around awareness of her transference and awareness of her Adult ego state. In the literature review I raised a question regarding Sandra's emphasis on supervision whilst working with suicide. Sandra refers to her commitment to this several times in the interview *(Transcript: p1, lines 17-27).* Interestingly her work in supervision was not around any trauma of her own in the work, but more about care taken to ensure she was coming from a positive and individuated state. The importance she placed on supervision, self reflection and understanding the other brought my thoughts to **Mark Widdowson's** citing of **(Stark, 2000)** and the exploration of 'difficult empathy'. The depth of her connection reminded me sharply of Erskine et al's Integrative theory around attunement **(Erskine R, Moursund, J and Trautman, R. 1999)**.

In her body language and words Sandra appeared congruent and deeply invested in the experiences of these individuals, the stories she told held personal value for her and this is where I experienced her commitment to life. Sandra's discussion of the suicide in the Arndale car park *(Transcript: p12, lines 364-376)* gives a very strong personal account of the experience and is evidence of the value she puts on human life. This is juxtaposed with her belief in the right to choose death.

When combined with her statements around not worrying for clients, feeling a fond attachment and being impacted in a non-rescue way we receive a clear picture of her emotional

reaction to suicide. This informed my discussion around the differences between Sandra's experiences and my proposal around relational impacts in therapy - as well as the research of **Chemtob et al (1989).** In the findings Sandra cleary expresses impact, she discusses it from the perspective of gain and loss, she also expresses the lasting nature of the impact. We receive a very clear message from Sandra that her experience is indeed profound, multi-faceted and not exactly traumatic.

Peace, Calm and Compassion:

With understanding that Sandra's past had involved suicide, I was interested to know about her emotions around individuals experiencing suicidal thoughts and intentions. Sandra described a nurturing approach chosen from an Adult place. Instead of the trauma described in the research and which I had imagined in my literature review, Sandra expressed in the findings again very clearly - her feelings are of fond connection, not worry *(Transcript: p3, line 67)*. Her own therapy and Samaritans experience have brought her a long way to understanding that people in that emotional space are not to be convinced or rescued, a hurry up process has no value and there's no miracle cure. Sandra talked of physically feeling the cathexis of her Nurturing Parent ego state (Transcript: p7, lines 190-205), a place of calmness which is all important in the storm of emotion the person is often facing. She can't express enough that the tools for this work are compassion and connection and we are brought close to the work of **Erskine et al (1999)** and the Integrative approach. What's clear to me as I review the data is that Sandra approaches the work from her Adult/Nurturing Parent, her work with the client is not only about strengthening their Adult, but more importantly nurturing the Child and holding them long enough for them to find some peace. From there they may find a semblance of their Adult with which to think through their options. In this, Sandra appears to be a person first and a therapist/Samaritan second - I'm reminded of a well repeated anecdote about how the type of therapy is statistically un-important, and that success is found in the bond created. Ultimately Sandra is *there.* Whether that is to help find emotional and mental space, or to be that person who is present as another chooses their own death is out of her hands.

The right to choose:

The most powerful message Sandra had to deliver was that death is a choice and a human right for her. The idea pervades the findings and informs every facet of her approach. Sandra describes her original shock to have found that as a Samaritan she wasn't to be saving anyone's life and how that through thought and discussion she has absorbed that view into her own. Her views were changed and whilst discussing the idea of desensitisation she clarified that she has come to appreciate the ending of life as a real option for everyone, all the time. She makes this clear when discussing her ideas around desensitisation:

CR02 '...I appreciate it is a real option for everybody, all the time, because it is. Whether it's while it's being considered or not it always is an option for any one of us.' (Transcript: p10, lines 283-285)'

This conveys a level of humanism which to me seems to go beyond what is common in our current British society, putting the existential rights of the individual person at the top of the priority list. Sandra sums this up with the famous quote *'there but for the grace of god go any of us' (Transcript: p10, lines 303-304)*. We are all human and we can all hurt, we can all succeed or fail, we can all choose. Sandra goes further to make it clear that it's choice she supports, not acts of self destruction. She brings the TA concept of 'I'm OK, You're OK' **(Harris, T. 1967)** to it's ultimate truth - If you choose to die, you will still be OK with me.

It isn't lost on Sandra that for many people who are considering suicide this may be the only choice they've ever been able to have. Her story about Gareth who jumped from the Arndale car park gains colour when you share this part of her view - Gareth had people around him, a warm blanket and encouragement. He had options and at that point, in that moment, he made a choice. Perhaps with more discussion or a different circumstance he may not have, but ultimately it was his right to choose.

Sandra went on to extrapolate about her discomfort when people are derisive about suicide, for instance labelling those who have died as selfish. When I asked for further details she expressed vividly her sense of despair that for some the act of death may be the only act they are noticed for *(Transcript: p11-12, lines 347-352)* and clarified further *(Transcript: p12, lines 357-359).* I was continually struck by how despite this pain which she expressed, Sandra still advocates the right to choose. She also fully expects to encounter suicide in her work, as a part of normal life. It is clear to me that Sandra's approach to the subject provides her with everything she needs to survive and thrive in an environment that contains such loss. I speculate that without this tempering to her world view, Sandra may well have been traumatised and impaired in the ways in which I had expected in the literature review.

Summary and Conclusion

The weight of subjective experience

The goal has been to explore Sandra's personal experience and view that against my expectations and the backdrop of the literature available. It would be remiss not to remember that Sandra's views are the result of her very personal experience of suicide combined with her professional work around it. Although Sandra applies TA theory to her practice and speaks with that language, her descriptions draw mainly on her feelings and views around integrity, the right to choose and the power of compassion and connection. It is important to note that she does not bring any depth of theory around these concepts in the interview, and that the questions were not designed to invite that. Sandra speaks from a purely phenomenological space and her views may only be seen authentically in that light. It's a limitation of this particular study that Sandra hasn't been invited to explicitly back up her views with theory. That same limitation gives also gives the work it's strength - a rare opportunity to view without dilution, the intimate experience of one person.

Projection and Transference

Embracing that Sandra's are unique to her requires us as clinicians to accept that they come with a high potential for transference and projection. For example when Sandra talks about the individual right to choose, she tells us that her views were influenced by the Samaritans and that she feels honoured to be with individuals whilst they are in 'that place' (Transcript: p4, lines 112-124). Sandra doesn't give any further details for the basis of these views. The 'place' she speaks of could be any emotional state or physical place and through an unspoken sense of mutual understanding we are left to make assumptions.

For me her tone and delivery, my transferential experience of Sandra and my own views combine to tell a story. Through this I interpret her 'place' in a specific way. It seems clear to me that she means a place of despair and vulnerability, a place of crisis where no hope seems available and the individual is at their last resort. The feeling of privilege that Sandra describes also makes sense to me personally - I receive a sense of the honour to be able to care of another life which is in crisis, to help rationalise, to support and enable true choice. This however is only what seems clear to me.

Sanda's understanding of the emotional space of her callers and clients appears to come through transference, projection, empathy and attunement. So too then has come my understanding of her - I have similar experiences and draw on my internal world to bring life and imagination to the story she relates. From this viewpoint it would be unwise to understand the work done here as proof that this is the only or best manner with which to view and work with suicide. Better to view the work as intended - an insight into a person who works in this area extensively, ultimately an insight into Sandra.

Critical Evaluation

Sandra expresses very specific views which pivot around the right to choose, the integrity of all life and the value of compassion and connection in healing. We accept the limitations of the phenomenological enquiry and look at the pros and cons of what we know about Sandra's approach.

Sandra states that compassion shows respect, supports integrity and enables choice. These main tenets of Sandra's work are its best attributes. We see that Sandra aims to bring calm and space to those she works with. She respects their rights, helps them see their options and crucially doesn't judge. This view appears to bring the benefit of inviting emotional autonomy whilst providing a holding space. From this vantage point the benefits are obvious, the client is left in an 'I'm OK You're OK' position, the therapist does not engage in rescue and should the client choose to end their own life it is a tragedy - yet one ultimately in the hands of the individual.

Although I feel inclined to share Sandra's view, we must view it in balance. From another perspective we may see flaws. If Sandra's approach is grown from her experience then as discussed earlier it is prone to transference. This raises questions which were not answered in this research:

- How much of what Sandra shares with these individuals is truly there and what is projected?
- What might be the impact of this potentially unseen disparity between the projected self and the true client on the work?
- Is it possible that in this approach we might miss a client in their unspoken need for a nurturing controlling parent voice? A strong and assertive 'Don't Do It!'?

Sandra does talk indirectly about projection in her interview (Transcript: p1-2, lines 16-47). There's a clear focus on her effort and responsibility to remain in the Adult ego state, which if successful would automatically ensure a separation of self from the other. As for the impact of disparity and the chance that we may miss the other - this research did not ask those questions, something which I regret.

Critical Application

This research is phenomenological and as such is not intended to directly impact the way I or anyone else may work. What is gained from this study is a very clear understanding of the way one individual works successfully (as far as we know) in the area of suicide. In terms of the impact of that on my own practice I take some reassurance that my approach around empathy and attunement works for another more experienced clinician. More than this I feel the study may enrich the moral options and offer a broadening of the clinical world for those who read it. This work provides one person's view, its strengths and a brief exploration of its limitations. There are enlightening insights into the spiritual life, theoretical arenas and emotional rationale of Sandra and they can been digested for what they are. Importantly, they are not to read as clinical suggestions or deeply researched methods.

A summary of the lived experience of Sandra Burlace working with suicide

Sandra values human beings, is impacted by their actions, feels deep complex emotions for them and crucially, she can separate herself from them. Tellingly the supervision Sandra has taken around the matter has been focussed on her appropriate approach to the work, rather than any trauma induced. It's clear to me that Sandra's upbringing around suicide, her personal experience of it and her formative years as a worker on the Samaritans helpline has given her an exposure to the life ending decision which is rare. Because of this Sandra provides a very potent insight into the life of one human being who is regularly encountering the choice to end life.

This insight is sharply contrasted with the literature I reviewed and the feelings I had around the possible impact. Where my own expectations and the majority of literature suggests deep trauma, Sandra describes deep empathy. Where the literature and I expected questions around guilt, competence and blame, Sandra describes privilege, connection, dignity and acceptance. I had originally interpreted the work of **Rodolfa, Kraft, and Reilley (1988)** as a cold view, perhaps resulting from the less relational clinical approach of those interviewed. I leaned

closer to the views of **Selakovic-Bursic (2001), McAdams and Foster (2000)** and drew upon the ideas of the implicit risk in intimacy that TA **(Berne, E. 1964)** advocates. My thinking and feelings were around how a therapist might work more closely with a person, develop a closer bond and invest more of themselves in an individual than perhaps any other mental health practitioner. For me it stood to reason that this would increase the impact of suicide on the practitioner.

What Sandra tells us is that if the bond is genuine and created with a dignified and true respect for the other, then the choice to end life remains entirely in the hands of the other. Guilt from this view doesn't make sense, but a sense of loss does. This is precisely what Sandra reports as her experience.

To remove choice would be an affront to the rights of the person, who in many cases is left experiencing no other options. Sandra views her place in this work as a human with which to talk through the decision or alternatively as a connection to make, through the final hours of life. Which of these things she will be is not her decision, but that of the dignified human being she is connecting with.

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Appendices

The appendices are ordered as follows:

A: Research Proposal
B: Participant Consent
C: Transcript

Research Proposal Form

Name: Colin David Ogdon

Research topic/focus:

A phenomenological enquiry into the lived experience of Sandra Burlace an individual working with suicidal ideation.

The purpose of this research is to understand from one practitioner's perspective, the impact of working with individuals who present with suicidal ideation. The overarching question here relates to the emotional impact of this work, specifically how the context of severe and shocking potential might be reflected in the work and life of the person.

Intended Methodology:

A qualitative methodology will be used in order to understand the subjective, existential experience of the co researcher, rather than a statistical and quantitative approach. This work will take the form of an unstructured interview with the co researcher. Open questions will be used to facilitate the process.

How will you prepare your participant and minimise any risks of harm to your participant?

To ensure the participant is fully informed regarding what to expect they will receive an informed consent document as provided by MIP. This document outlines the participant's rights and the general nature of the co researching process. Key areas for the participant's information are:

- The purpose of the research
- How they will be involved - questionnaire,interview, recording/video
- What steps will be taken to protect their identity
- Will their identity be known to anyone other than the therapist and if so who?
- Will any other person have access to personal information other than the therapist? If so, who?
- Arrangements to secure all records relating to the client and information as to what will happen to all records
- Procedures for withdrawing consent and for making complaints against the researcher
- Any possible negative impact upon them, for example reliving past traumas

To ensure confidentiality the interview will take place in a private, relaxing and safe environment away from intrusion. All records taken will be kept locked in a safe to which only I hold the key. Personal information will be destroyed once it is of no use to the investigation, which is expected to be when research project is typed into it's final form and submitted for marking. The only exception to this is that the finished project itself will be seen by Bob Cooke and Karen

expected to be when research project is typed into it's final form and submitted for marking. The only exception to this is that the finished project itself will be seen by Bob Cooke and Karen Burke of MIP and kept as part of the MIP Clinical Research Library. Information stored will be held in compliance with the principles of the Data Protection Act 1998 which state data is to be:

- Processed fairly and lawfully
- Obtained only for one or more specified lawful purposes
- Adequate, relevant and not excessive for their purpose
- Accurate and kept up to date
- Not kept longer than is necessary
- Processed in accordance with the rights of data subjects
- Protected against unauthorised use or loss
- Not transferred outside the European Economic Area unless subject to similar levels of data protection.

In addition to this further protections are in place due to compliance with confidentiality and ethical codes of MIP, UKCP and BACP which can be provided on request.

The interview will be undertaken from an I'm OK, You're OK perspective with the focus on the dignity and the participant's right to care and respect. The participant has a right to see the finished transcript as well as make adjustments during its creation to how their contribution is reflected. Once the interview is over I will then debrief the individual, taking careful precautions that they are emotionally and physically OK to end the process and part ways. The participant will retain the right to withdraw consent at any time and stage of the process.

I have read 'The Manchester Institute Guidelines for Research in Psychotherapy' and I agree to abide by them.

Signed: [signature] Date: 6.8.17

Approval given by: [signature] Date: 4th August 2017

Manchester Institute for Psychotherapy

Research Project Participant Consent Form

I Agree to be interviewed about my personal experience as:

A psychotherapist or counsellor working with suicidal individuals.

I understand that the interview will be transcribed and this will form the basis of data which will be analysed more generally as part of a research project for the researcher's training as a psychotherapist. I understand that course tutors will read the final research report and that it is possible the data/ finding/ report may be disseminated more widely (e.g it may be published in some form later) while my particular details will remain strictly confidential if I so choose.

I understand that this interview will be conducted in accordance with ethical standards laid down by the Manchester Psychotherapy Training Institute (In line with the United Kingdom Council for Psychotherapy Ethical Committee Report Ethical Guidelines for Research)

I understand this to mean that:

1. I have the right to withdraw from the interview at any point and I can refuse to answer any questions which might make me feel uncomfortable
2. The interviewer will do all she can to treat me with respect, care and sensitivity.
3. I can make a choice about confidentially. If I so choose, the contents of this interview will be kept entirely confidential. There will be no record of my name anywhere (a pseudonym will be used) everything I say will remain anonymous.
4. I will have access to the transcript of the interview and that I have the right to ask that any data (tape and transcript) be destroyed after it has been analysed.
5. I have the right to ask for particular quotes not to be used in any published work.

I ~~do~~/do not wish my real name to be used. I wish my pseudonym to be

Signed [signature]

Date 3/12/17

Interviewed by Colin Ogdon
07741244801
colindavidogdon@gmail.com

CR01: Fine. It's recording.

CR02: Excellent.

CR01: I'm not going to make notes or anything Sandra because I've got you here and I will spend hours transcribing it.

CR02: You will.

CR01: So, the first question is what's the effect of working with suicidal individuals upon you emotionally?

CR02: Okay. I mean I suppose I want to use the word profound but that's not profound in a negative way particularly, it's impactful because I've had a long experience of suicide, personally, my paternal grandmother she drowned herself. My mum tried ending her life lots and lots of times and it's something that I've struggled with, you know, long term and so when I'm with somebody else who is talking about suicidal thoughts, suicidal feelings I suppose the first thing is like I feel, I feel connected with them because I think okay, you know, I've been where you're sitting at the moment. It's interesting I'm working with somebody at the moment and she's in my thoughts quite a lot and I was thinking about, she's actively suicidal, so I took it to supervision and we did some work on where I was coming from while working with her. The supervisor was brilliant, asked me a few questions and it was really clear that I was coming from a place of adult working with her.

CR01: Emotionally do you mean?

CR02: Yes, yes.

CR01: Okay.

CR02: Which felt really important. My question was, you know, am I okay to work with somebody that is suicidal, although I knew I was I thought I want to get some professional opinion on this and so that was a really good piece in supervision. So, I guess it's strange because that was just last week and having this today, this interview today makes me think being very aware of which ego state I'm in.

CR01: Now or with the clients.

CR02: No, when I'm working with somebody who is suicidal.

CR01: I hear you.

CR02: Because I feel very sure I've done so much work on my own don't exist, my own pull to suicide that that isn't, mine isn't in the room at the same time but I guess that's what my supervision question is about to double check that it wasn't sitting in the room with me.

CR01: It's a kind of explore with me together whether or not my own stuff is in this room at the same time as …

CR02: As there's.

CR01: Yeah and I could see why you want to.

CR02: Yes and it was a very good session, supervision session because I felt, I felt very excited at working with this person, even though she was very suicidal I have felt and I do feel very excited about working with her because I think I know what that journey was like for me and although hers is going to be individual to her and not necessarily reflective of mine I think I learnt a lot about working with suicidal individuals through my own journey, plus all the work at the Samaritans. You know that really is like at the coal face. It's …

CR01: Hmm the front line is that what you mean?

CR02: Yes, yeah, although it's not face to face obviously but sometimes it is people turn up to the office but most of my personal experience was over the phone.

CR01: It sounds very in the moment, you know, that perhaps some of these people are in crisis when they call up, at the moment of crisis, which I'm interested in that, you know, how it is for you, in that moment.

CR02: Yeah, in that moment. I'm in a place of calm support which is strange because my personality acquisition I would come from a histrionic place but I think a lot of the work I've done working through my own process has calmed that down and certainly when I was doing work with The Samaritans and somebody comes through and actually is suicide in process well in progress, in progress is the right word.

CR01: Okay so that's the thing is it suicide in progress?

CR02: In progress yeah and those people still sit with me now and I stopped doing that 2 years ago and I probably came across them 3 or 4 years ago but there's a bit of them still sit with me now.

CR01: Do you carry them with you still?

CR02: Yeah.

CR01: Do you worry for them?

CR02: No, no I don't think it is worry. It feels like some fond connection. I don't knowingly have one that suicided while I was on the phone, possibly one. It's very hard to know because they go quiet. So you don't really know but I certainly had a couple who were in progress and changed their minds and 3 hours later one of them, I could hear them, they'd gone back home. The kettle was boiling. I could hear the kettle boiling. I heard some toast pop up and that's like, that gives me a sense of reassurance that human kindness and connection with somebody, who is in the darkest moment of their life, can really make a difference.

CR01: Yeah.

CR02: It might not but it can really make a difference.

CR01: Yeah and thanks for that because it's those personal experiences of it that I actually I want to write about and you're saying to me that you are on the telephone with this person but who was in the progress of suicide and through that connection that you've got faith in the next thing you know there's toast being made, signs of life and comfort.

CR02: Yeah and that might only last, you know, 12 hours. Perhaps they just slept that night and went back and did it the next day. I will never know but you know feelings change and perhaps 12 hours later some of their feelings would have changed and they didn't do it again. You know I will never know that bit but it's such a potent experience to be with somebody and it was a young lad and it took probably about 2 hours, 2 and a half hours but he made his way home and that our last bit of conversation, hearing the toaster pop up and he was going to eat this and go and get into bed and that, that's such a rewarding thing.

CR01: I really got a feeling for the warmth, for the warmth in that story, in that memory of yours and in you.

CR02: Yeah, I could almost cry actually and yet it's a happy outcome but there was a really strong, a really strong bond.

CR01: That bond.

CR02: Yeah, you know, somebody here who is sharing things with you, it's just it's unique.

CR01: I remember your word profound and I had a sense of what you meant when you said it but I can hear it for definite now, you know.

CR02: Yeah, it's sitting here at the top of my throat and I could easily cry and yet it's, it's not sadness but I don't know what that is about. It could be relief. I could be marvelment at that strength of connection.

CR01: Wonder.

CR02: Yeah, yeah.

CR01: I experience you as in wonder and relief and all of those things that you've said actually all combined and that's my sense of it because I feel it a bit too down because I imagine myself in that, as you.

CR02: Yeah, yeah, you know it's late at night and the room that I was sitting was dark and the places he was, the physical place he was at was very dark, very cold, very alone.

CR01: What's it like for you to hear that when you are on the telephone?

CR02: Well I always imagined when I was doing my training, my Samaritan training that if that happened to me I would be oh my god, you know, waving to someone across the room saying come here you need to help me or whatever because you always have other people on shift but actually the reality of it was so different from what I had imagined it would be like. It's the sense I had and I have had several phone calls like this is that suddenly a bubble forms between me and the other and it almost doesn't matter. You know I don't have much recollection of where I am or who else may be in the room or who is coming and going it's just like me and that person are in this bubble and the thing I used to think about is that what a privileged position I was in because for someone to reach out when they're in that place and say actually I don't want to die on my own and it's you like I picked up the phone as opposed to any other operators but still it feels like it's a very privileged thing to be with somebody when

they're ending their life and that's what I think about. I can't remember if I've spoken about it while you've been recording or before but, you know, if someone, in my family was to die I would want someone to be there with them and that was always my thought around these people who ring The Samaritans is that.

CR01: A sense of honour, like it's an honour.

CR02: Yes, yeah.

CR01: Yeah, I get a strong sense of your feelings on the sanctity of a person, a person's life.

CR02: Hmm, yeah, yeah, very much so. So, you know, the impact of those interactions with those people they're still with me now. You know, I mean I have to look around for it. It's not like I'm living with it all the time but this kind of conversation really makes me think about it. I had a similar experience with a young girl and she didn't take her life at that session and what she did ring, what she did do is she rang up about a week or so later and asked to speak to me which isn't possible the way the system works and she spoke to another Samaritan at my branch and asked her to send a message to me of thanks to say thank you for being there. It would have been lovely to have you as a mum, something like that, which I think in one way sounds bizarre but another way I think it's that, the level of the intimate connection you get while this is getting on.

CR01: It sounds like if somebody is saying that to you that you've done, you've done what you needed to.

CR02: Yes, yeah.

CR01: And what's that like for you? The experience of that success and that gratitude.

CR02: Oh that's enormous and the Samaritan who took the message wrote a note and I've kept the note. So that's 4 years old now but I've kept that note because it's a reminder of so many things. It's a reminder of our own fragility. It's a reminder of the strength of connection that we can create. It's a reminder of the value of kindness, you know, it's, and it's a reminder of my own, oh I hesitate to use the word potency but I guess it is, it's a reminder actually that I did that, that's really important, really important to me.

CR01: Yeah, I hear that. A person who has done that work that you've been doing could report and talk differently about the work but with you and your personality I got a real sense of the investment that you've got.

CR02: Yeah and I think that investment is part of what is needed to create that connection. You have a phone call with someone you've never met and you might be on the phone for an hour, it might be two but it's very short.

CR01: With that in mind, another question about your experience, with that does your knowledge of this timescale affect the way you are emotionally on the phone when you know that you don't have much time. I get suddenly this sense of …

CR02: Yeah, it's like a quick assessment to work out what it is that's going on.

CR01: And how are you emotionally with that, in that place?

CR02: While that's happening?

CR01: Yeah.

CR02: I don't really understand the question.

CR01: That's okay. I have this imaginary scenario in my mind where you pick up the phone and there is somebody who is suicide in progress and this idea that then there's a sort of, there's a timescale to this. I have to be fast and I am wondering what your emotional reaction to the pressure and the time to small timescale is.

CR02: It's interesting because I have a big hurry up process but I've, that is one time where it doesn't come into play. As you ask that question I had a real sense of my stomach of lowering and flattening and being cold because I think it's that slow calmness that lets that connection take place and I can't think there would be anything helpful about being rushed in that. I mean sometimes people ring and they are feeling a bit panicky. I, but perhaps what's happening is that the adult, that's the adult coming in now thinking about it.

CR01: I hear that actually, like a self-soothe, soothe, yeah.

CR02: Yeah, yeah.

CR01: And would that happen in the moment as well do you think then? I know that you're saying that you can feel your stomach flatten and a …

CR02: Yes, that's a sense that I, that's the feeling. It's a physical sensation that I would get when I had picked up the phone and I had heard somebody is a suicide in progress. It's like I feel like everything inside me slows down and I'm focussing on that connection.

CR01: I have this mental image somehow, vague mental image, of you somehow physically summoning your nurturing parent.

CR02: Yes, yeah.

CR01: Like a transformation.

CR02: Yeah, that's what's needed.

CR01: A transformation, for you to transform.

CR02: Lots of nurturing, yeah lots of nurturing because the interesting thing is also and it is relevant The Samaritan's policy is the right to determine. So, it's not about talking anybody out of taking their own life it's about supporting them to make a decision and often they will change their mind in that process. So, you know, lots of times people will decide not to end their life but there's the belief that they have the right to decide themselves. So, it's not like we're coming in cape crusader to stop people ending their life. It's helping people explore their decision to end their life and then if they decide to do it then, you know, you are that person giving emotional support on the end of the phone so that they're not doing it alone.

CR01: I'm still quite profoundly earlier when you said about how you when you were talking about when you felt privileged that this person was calling up because they don't want to die alone and it never occurred to me that that's why they were calling. I, in my mind, they're calling because they want you to stop them. So, you've given me a clarity that I didn't have actually.

CR02: I think all can be true. I think about, I don't know if you know Tony White's work on suicide and …

CR01: Yeah, I do actually. I talk to Tony quite a lot on Facebook. He's great.

CR02: Yeah and that's what suicide ambivalence and you know and I think that's something, I think that's something that you find anywhere working with people who have been suicidal. I want to die, no I don't.

CR01: Yes.

CR02: Hmm.

CR01: How do you react when you are, how, I know that it could be different every time, so we do have to speak broadly but when you're faced with that ambivalence how does that feel?

CR02: It makes sense. It makes sense and it's worth, always my thoughts on that it's about time and talking, you know, around how that decision has been made, what worries they might have about it, you know, sometimes expressing that. Yes, I want to die, no I don't want to die, helps them clarify what's going on.

CR01: And the sense of you having, there's a few things, there's an invitation into an adult ego state. There's that sense and that apparently which is normalising them, sort of a new wonder.

CR02: Yeah, given that this is what is going on I'm not surprised you feel like that. Yeah, that's a phase I've used in practice and I mean in my practice and The Samaritans.

CR01: In The Samaritans.

CR02: Yeah.

CR01: Have you come across suicidal ideation in your therapy practice?

CR02: Yes and I think that's where my personal history of suicide and it's like the stuff at The Samaritans that's been very helpful because I mean there's, as far as I'm concerned there's no shame about clients talking about their thoughts, you know, thinking through some things and I don't feel affronted or don't feel scared by any of it. You know I can be curious and explore some of those things and it feels like it's not coming, for me, there's no panic here. It's okay. You know it's all alright. I can be curious without any sense of panic and I'm sure, I'm sure that's picked up in the room, well with transference and counter-transference we know it is don't we?

CR01: Yeah.

CR02: So, it's okay for them to talk about it and we can explore it.

CR01: Yeah, I feel reassuring to hear that you move into a calm, the way that you've described to me into a calm place emotionally.

CR02: Yeah.

CR01: And thank you again because it is that personalised, I know I keep saying it but it really is your personal and emotional responses to this that's key for the research I'm doing. I've got another question. I just want to choose which one to do next. So, we work with a range of clients, don't we in the work that we do? I have this, I know my personal experience but I also have this imagination in my mind about how sometimes when you go to hospital the nurses seem a bit cold and desensitised and so that thinking led to my next question which is how and or if your work with suicidal people affects you when you're working with other clients who are not in the same life threatening type of crisis. That question is around do you ever feel desensitised or do you think that it has any impact at all on the way that you work with other people?

CR02: That's interesting I've never considered that question could I get or do I get desensitised. I feel not, no. I don't see or feel any evidence that I do. When someone is talking about suicide in a, you know, in sort of 2 or 3 things removed, you know, they were thinking about it and we would explore it but there's not a plan. So it's something that is there but it's not an imminent, it's not an imminent danger. I'm not aware of any desensitisation but actually this is interesting I wonder whether my background has desensitised me perhaps because of having lots of suicide in the family, don't get me wrong, if somebody close to me did take their life it would have a huge impact on me and yet as the same time suicide has become more normal given my environment, my family, my family environment it has become more normal. So, if there has been any desensitisation perhaps it came at that level.

CR01: Hmm you really just enlightened me actually because maybe it's what you're describing, would you tell me if this fits?

CR02: Hmm.

CR01: It's not really about that you've been desensitised but maybe the suicide has had sort of the, the idea has maybe had some of the venom taken out of it for you, like it's not as frightening.

CR02: Yeah.

CR01: So, is it better to say rather than that you've become desensitised, which would describe you as losing feeling, which doesn't seem right to me, I can sense your compassion but to say instead you understand suicide and now you're not frightened of it.

CR02: Yeah and I appreciate it is a real option for everybody, all the time, because it is. Whether it's while it's being considered or not it always is an option for any one of us.

CR01: I see what you're saying to me there's a profound truth in that that exists in our minds, in our physical corporal capability.

CR02: Yeah, yeah absolutely, so yeah.

CR01: Would you tell me a little bit about what when you make that statement, which is so profound, what that means emotionally for you?

CR02: Say the question again.

CR01: I go all around the houses sometimes Sandra. So, you just made quite a profound statement about let's be real, the statement is something like this in real terms suicide is possible for everybody. It can happen. Let's accept it. Let's see it, you know, why would we ignore it. Is there an emotional impact with that knowledge. You know this profound knowledge, some people don't make that awareness because they've not had your experience and I wonder what if there's a unique emotional response to that that I could hear.

CR02: Yeah, well I wonder whether, this isn't a feeling, this is a thought but I wonder whether that is a hardness inside me, that acknowledgment that actually we all have the potential to end our life if we chose and yet the reality of it is that I don't experience the hardness. If anything, it's the opposite, I experience the kindness of connection. I suppose it, yeah, the line I've got in my head is there for the grace of god go any of us. I don't have any religious beliefs but that's a really good line.

CR01: So, a very human, a very human response.

CR02: Yeah, is that, you know, we're all ticking along. We're all fine one moment and who knows, you know, that house of cards can start to fall and then you're left with well that is some, that has become somebody's preferred option and I do, whether that's the training I've had which The Samaritans ascribed to the right to determine and perhaps I've taken that on, you know, through that training because I remember it being a shock when I first found out that they don't actively stop people suiciding but actually, you know, I think life is about choice and perhaps death is about choice too.

CR01: Again, a very real and profound awareness and I was wondering if you could tell me a bit about that shock?

CR02: Which shock?

CR01: When you found that people weren't to be saved.

CR02: Oh when they, yes because you know I went to The Samaritans because I'd had so much therapy. I live with a permanent call to suicide but I still don't exist which, you know, I manage and I manage using resources as well. As I started in The Samaritans because I thought I want to give something back especially to people who can't necessarily access therapy-based support. So I started my training at The Samaritans, went through huge hurdles to get in, quite a rigorous recruitment process and then part way in the training I suddenly realise that they have their, their ethos is that everybody has the right to determine whether they live or die and that really caught me off guard and I remember, we used to have training every weekend and between one weekend and the other I really questioned whether I wanted to stay because I thought I'm not sure, I'm not sure this is aligned with what I'm feeling but actually as I lived with it and as I thought about it went back to training that following weekend, talked to people about it. I realised actually it was aligned with how I thought or perhaps I became aligned with their ethos. I don't know. I don't understand quite the process that went in there but I know what came out of that. What came out of that is that I believe that actually we do have the right to determine. So that's not to say I wouldn't give all the support and, you know, the time to explore different options with somebody who is suicidal. You know I'm certainly not, I'm not ascribing to somebody handing out suicide potions and stuff like that. You know it's not that.

CR01: I've just heard a very pure, it's your right to choose. I'm okay, you're okay.

CR02: Yes, it is actually, yeah that's exactly what it is.

CR01: Even in this.

CR02: Even in this and actually I think sometimes even in this is the, my experience is sometimes when people are talking about what had taken them to that point where they were ending their life, a lot of is they felt they had no choices, you know, and so, for me, it would feel wrong to take away that choice and it's something that I often think about when you read in the newspaper that somebody jumped off a motorway bridge, but dropped off a bridge onto the motorway and stopped the traffic and people miss flights and stuff and there's

all this irate stuff going on about how selfish that person was and stuff but actually the thing that always goes through my head is perhaps their biggest impact in life was the way they died. You know and I want to howl at that. I don't know that's true of course but the possibility that that might be true leaves me wanting to howl.

CR01: To howl at those that rave.

CR02: No, to howl with desperation for that person who makes the biggest impact with their death and there's an irony of language there, you know, falling impact but it's, I'm aware that that's bizarre. I'm using the same word but I don't mean the physical impact. I mean the …

CR01: The emotional impact.

CR02: And the impact it has, you know, on people in traffic and …

CR01: I hear you, I hear you, you're saying that their biggest marker that they made was to disappear.

CR02: Yeah, yeah and that leaves me to think about one incident that was the thing that made me actually wing off an application form for The Samaritans. I used to live in the city centre and the Arndale car park is well known for jumpers and they've put barriers up and everything but it was just before Christmas and I'd been doing some shopping, was walking back to the flat, saw somebody up on the car park, saw the police up there and they'd cordoned off the road underneath and I watched from a distance, just for a moment and I remember seeing there I guess the guy doing the talking, the police officer doing the talking, passed him a green blanket to keep warm and that had a very big impact on me. I thought there's somebody here who is about to jump and yet they're wet and cold and they're taking a blanket from somebody and that was like argh. I think a lot about that guy. He did jump and never without fail do I, excuse me [getting upset].

CR01: That's okay.

CR02: Never without fail do I walk past that place without thinking about him and I went to a conference on suicide last month in Manchester and one of the workshops was given by police negotiators and I went to that and met the man, met the policeman who was working alongside the guy who was talking him hopefully down and I went up to him at the end, I said that's what took me to join The Samaritans. That was the final push I needed to join and I said I just

wanted to let you know that there was some positive outcome from a really negative scenario and I said and I wonder if you could let your colleague and he said that was his very first suicide he said and we all thought he was coming down and then he jumped and so it impacted everybody enormously there.

CR01: Including you.

CR02: Yeah, including me, yeah.

CR01: I just want to pause the questions for a moment to check out with you that's all because I saw you were getting upset and what I hadn't, I'm aware that you have a personal connection with suicide and that we're talking about it a lot. So I'm just checking in with you that you're okay.

CR02: Yeah, I am okay.

CR01: Because there's emotional content here.

CR02: Yeah, there is yeah.

CR01: And so my first paramount priority is your well-being. I don't care about this interview.

CR02: Yeah, yeah, no and that's good. Thank you for acknowledging that Colin and you know I am in therapy and I can take this stuff to therapy, if I need to but yes and in one sense that is our humanness. We can't talk about this, you know, I feel I can't talk about this without being aware of the emotional impacts.

CR01: Well then thank you because and I really mean thank you not just that platitude because there's, for you, there's a cost in terms of emotional an emotional cost …

CR02: Well yeah I guess actually.

CR01: In this conversation so I don't want that to go missed.

CR02: No, yeah a cost and a gain. Pain at loss even though I didn't know that man but gain from the positive interventions, you know, from people who have lived another 24 hours so …

CR01: And those that hopefully lived and continued to live.

CR02: Yeah, yeah.

CR01: Do you want another question?

CR02: Hmm. If, one thing before you move on. I didn't know the guy's name who jumped until I went to this workshop and I remember the officer saying he was called Gareth, I think he was called Gareth and that feels like really important but you can take that bit out if you want to I don't mind but, it feels so really important about acknowledging the fact that now I know his name. You know I never walk past there without thinking about him.

CR01: And it's I certainly won't take it out but thank you because what you're telling me here is that this person's identity has emotional meaning …

CR02: Yes.

CR01: And I don't want to call him this person anymore and I am glad that he was Gareth.

CR02: Yeah yeah so …

CR01: Not related to the interview but I will show you something, remind me to show you a client before you go, you'll like it but okay we've got Gareth now.

CR02: Yes, yeah.

CR01: I've got Gareth as well. Alright [silence] I tend to pull my nose when I'm thinking.

CR02: [Laughs] That's okay.

CR01: We might have answered this already. I will ask you the question. So, would you tell me about your expectation, I know that it's different actually because you did Samaritans before you were a therapist I will ask the question the way it's written and if we want to tweak it, we can. Could you tell me about your expectation to work with clients that are suicidal when you began your career as a therapist? And what I really, what I'm going towards there is did you expect to have to encounter this much in the therapy room?

CR02: That's interesting my answer is oh that shows how much, this shows how much I normalise suicide is that it feels like suicide is a normal part of our life and death but life choices and we have people in therapy and people have those choices. So, I think I would have wondered what am I missing if, if I'd had, you know, my first 10 clients or 20 clients or something nobody had ever talked

about suicide or had never said anything that made me think let's explore, you know, have you ever had these thoughts? Have you ever harmed yourself? Then I would be wondering what have I missed because it feels like a normal part of our human condition, you know, that sort of self-harm, suicide stuff. I think it's part of the human condition.

CR01: Hmm I hear it actually and you say normalise, this is how much you normalise suicide but I think your message, your message, tell me if this is right or wrong again is well suicide is just part of the world.

CR02: Yeah.

CR01: And so you expect it. You expect to encounter it.

CR02: Yeah, it's part of our human dimension, I think.

CR01: So, I'm in the right zone with you.

CR02: Yeah, yeah, yes, you know and then again I'm thinking okay well I hope that doesn't make me hard but actually in practice I don't see any hardness in practice. It's the opposite. You know kindness and nurturing, and you know when a client is at a place that they need that but it does sound hard and flippant normalising suicide.

CR01: Are you asking, I couldn't tell if you were asking me how it sounded to me.

CR02: Am I asking …

CR01: You know what that was like a therapy question that Sandra because I'm so used to doing that.

CR02: Yeah, yeah.

CR01: I'm sorry you don't need to answer it, just leave it. I was aware when I knew that I was doing this that there's a possibility for cross over.

CR02: Yes, yeah of course.

CR01: So I'm glad that pulled …

CR02: That's okay. My confusion, I went to a place of confusion, that's interesting yeah.

CR01: We're both therapists and we're both clients. So, we just go to those places so naturally and we could just do that.

CR02: And actually we're talking about something, you know, which is about loss and pain.

CR01: Yeah and that's why I really wanted and still do to make sure that you're okay because you, I'm sure, well I know because you've told me that you've taken your response to suicide to therapy.

CR02: Yes, yeah.

CR01: There could be plenty of opportunity for those waters to be muddied and we will make certain that you're okay before you leave.

CR02: No, I am absolutely fine. I am okay. I'm not sure I've answered that question.

CR01: Which the one that I just asked?

CR02: Yes.

CR01: I don't think you need to. It was like a therapy. I think just let that one go because I don't think it's okay for me to bring you into that emotional space of where that question took us. I kind of erased it from my mind.

CR02: Okay but the question you actually asked me from your phone have I actually answered that question?

CR01: Oh that question?

CR02: Yeah.

CR01: Sorry, tell me about your expectation to work with clients that are considering suicide. Yeah, you've answered it resoundingly.

CR02: Yes, yeah.

CR01: I and tell me if this is a good paraphrase of what you've said.

CR02: Yeah.

CR01: I expected it to such a degree that I'm surprised at how I embrace suicide as part of life.

CR02: Yeah, I suppose it's not that I expect it as such a degree, I think if I hadn't have seen it I would have questioned myself around what am I missing?

CR01: Yeah, yeah. So if that didn't come up what, like I'm I can't be doing this right.

CR02: Yeah, what am I missing?

CR01: Yeah, what are you missing? What haven't I done in this therapy in order to come across this truth?

CR02: Hmm.

CR01: Because I say so is it because the truth should be apparent in hmm don't need to ask, don't need to ask, I understand. I already understand you. I've got this pull to do a full hour and we've got 15 minutes left but we've done the questions so …

CR02: Is there anything else you are curious about?

CR01: [Silence] You know, I've just got this complete sense of this compassion that you bring to this work and your spirit. I don't know if I have any questions because you've made it so clear what your relationship with suicide is that I couldn't miss it, you know. That it's about, I can check it out with you can't I?

CR02: Yeah.

CR01: I read it that this is about human compassion for choice and that the panic is almost taken out of it by your ability to give the individual their right to determine and whilst you feel nothing but compassion and you believe in the sanctity of their life you're not pulled to rescue. You're not pulled to some panicked rescue. It's about I'm okay, you're okay.

CR02: Yeah, yeah.

CR01: I mean, do I understand?

CR02: Yes, I think so. I mean it feels I don't want anybody to end their life on one level and yet at the same time, so many times in life we don't feel we have the choices or we feel we are shoe-horned into choices we don't want and I guess that's where that privilege comes from whether that by I suppose it's slightly different if you are working in therapy with somebody then on The Samaritans. The Samaritans is very time limited. So, yes it's about exploring their options, who, what, where, why and sometimes in that exploration you can hear things

changing. Now one question that I've always found really useful and I've used that in therapy with a client as well on the phone with The Samaritans is do you want to end your life or do you want to end the pain. You know and that's such a rich question and such a rich answer. I don't know whether Tony has written in his book but my guess is he has. I can't remember.

CR01: Tony White?

CR02: Yeah.

CR01: I think he has and I've read it in that and there's another one the making peace with suicide. It's a famous book isn't it and it's in there too. My fiancé Denise, who that you have met, she once said to me just out of profoundness, I think, out of her own head that she thought that the suicide decision can happen when your pain is more than the resources you have or the resources you believe you have for dealing with it.

CR02: Yeah, yeah and hope is in there as well. You know if the hope is diminished by the levels of pain because if we don't have any hope then why do we get up in the morning.

CR01: Yeah.

CR02: You know you so need, you so need that and that's something, the suicidal client I am working with now it's about strengthening her adult. You know making sure that she understands the value of building her resources around her and using them and that, for me, feels very exciting work to do as a therapist.

CR01: Exciting.

CR02: Yes, yes.

CR01: That's something that I'm interested in actually. So would you tell me a bit about how it's exciting. I can imagine but I would love to hear it from you.

CR02: How it's exciting, to be alongside somebody as they are, I suppose growing which is interesting actually because it is moving from child to adult but, you know, it's going through a process of growing and to be able to be the person that's supporting them in that, you know. I am very clear I can't do the work for you but I'm going to be alongside you while you're doing the work.

CR01: You take me back to your original analogy which is your holding hand, holding hands.

CR02: Holding hands, yeah, yes and it's interesting actually because this week, last week I saw a brand new client who is actively suicidal. We had our first session and at the end of the session we stood up, I stood up to go to the door with her and she stood up and she said one of the things I think is really important, I needed to hear it when I was suicidal, is this isn't insanity. You're not going mad. This is lots of things all adding up. That's not the same as insanity. I so believe that to be true and as I listened to her story I said to her I want to say something to you that no this isn't madness. You're not going mad. You're not losing the plot. It's not insanity. It's not any of those things. This is like a message that you've had, a historical message that is playing out and I could so clearly hear it and her relief to know that she's not going mad she sat there and just cried with relief and it's amazing the change that that one interaction had on her. I could physically see loads of differences going on and so we stood up and so we finished the sessions, stood up and she went to the door and she said to me thank you for that session. I could hug you and it's really interesting because with my first therapist I contracted with him that I would like a hug at the end of the session. So we checked in every week and we would hug or would not hug and so I thought is this what she is asking. So although we'd actually stood up I thought she's still in the room so I said we'd talked a little about on contracting earlier and I said would you like us to contract for a hug now and she said very much and so we hugged.

CR01: How did that feel for you?

CR02: It felt good because it was boundaried. It was contracted for. It was something she had asked for. It's something I am very happy to give.

CR01: I really meant her gratitude …

CR02: Oh her gratitude.

CR01: How did it, yeah which is sort of encapsulated by the hug isn't it?

CR02: Oh yes, yeah oh that was brilliant. That was brilliant.

CR01: Yeah.

CR02: And we will work well together I just know we will and that's where the excitement is I suppose to see somebody who is sitting where I was sitting

perhaps 6 years ago or something. I don't know how long ago now but to see someone who is sitting, who is sitting where I was sitting and think, you know, I know this journey can be done.

CR01: I imagine you bring such rich [deep sigh] I don't want to use the word guidance, I know that that's not the right word but for those people you would be such a rich experience, you know, a healing person.

CR02: Yes, I hope so, yes.

CR01: I feel that's what you are.

CR02: Yeah, thank you Colin. Thank you.

CR01: I think we're finished.

CR02: Okay, it's gone really quick.

CR01: It's flown by as well. 58 minutes. What a wonderful person you are. Thank you so much for this.

CR02: Thank you.

CR01: I think you've been very courageous.

CR02: I know and that's why sometimes I wonder about oh is it ….