CHAPTER 1

1.1 Introduction

The drive towards suicide is in no doubt influenced by many factors. However, in working with people who have suicidal feelings, it seems insufficient to conclude that this is merely to do with some external circumstance, such as redundancy or bereavement. Many other people find themselves to be in similar situations and yet are not suicidal. Hale and Campbell (1991) affirm that there are many common assumptions made about suicide, such as that it is a cry for help or that the person feels life is not worth living (Richards, 1999). Richards (1999) goes on further by stating that all such assumptions are only part of the truth and, if taken as the whole truth, are misleading. They fail to recognise that the feelings inherent in the suicidal state are related to, and affected by, unconscious processes. They also fail to recognise the violence inherent in the suicidal act. Lifton (1989) asserts: 'There is common ground to suicide, no matter who carries it out, as a violent statement about human connection, broken or maintained' (p. 460) (Richards, 1999).

Psychotherapists/trainee therapists, helpers, healers or counsellors often have different experiences in working with suicidal clients. According to Richards (1999), many of the therapists are experiencing their clients as attacking the therapy in a variety of ways. In terms of the therapeutic relationship, the suicidal clients are often felt to desire closeness and yet also to be frightened of it. This is understood as revealing in the transference something of the client's inner world and the relationships that existed therein. The work of therapists with suicidal clients seems to have many dimensions, and appears to be very unique in particular, relating it to other types of treatment approaches directed towards clients having other difficulties. In reference to client suicidality, Pope and Vasquez (1991) have made this point very succinctly. They have commented, "This aspect of our work focuses virtually all of the troublesome issues, questions of the therapist's influence, competence, efficacy, fallibility, over- or under-involvement, responsibility, and ability to make life-or-death decisions" (p. 153).

It also appears that this type of work seems to put the skills of a counsellor or therapist into test. There are also dangers involved, such as the possibility of the actual loss of a client by a therapist/counsellor to a successful suicide. Richards (1999) says that in her study, several therapists pointed out the dangers of working with suicidal clients whilst therapists are still inexperienced. In an ideal situation an initial interview would best be carried out by an experienced assessor. This is not always possible and the dangers cannot always be picked up in a brief assessment.

The emotional demands made on the therapists by such a nature of work seem to have received little, or not very extensive attention and documentation.
There also appears to be the assumption that professional helpers/therapists are adequately prepared at all times to handle and deal with the emotional demands and the uniqueness of each experience of working with a suicidal client. Trainee therapists/helpers are supposedly to be receiving support and guidance from supervision, but this cannot be always guaranteed, taking the uniqueness of each suicidal case into consideration.

1.2 A definition of suicide

According to Hatton and Valente (1984), suicide is the act of taking one's own life intentionally and voluntarily. Hatton and Valente (1984) also give Shneidman's (1971) definition of suicide. Shneidman (1971) defines suicide as the human act of self-inflicted, self-intended cessation. According to Erikson in Jacobs and Brown (1989), "the suicidal act must be viewed as a form of total self-destructive action in a *life-situation* in which positive alternatives of action seem to have lost their credence" (p. xi).

A more broad definition of suicide is given by Shneidman in Jacobs and Brown (1989), as he says that, "suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution" (p. 6).

Even though there may be clear definitions of suicide however, according to Hatton and Valente (1984), these definitions may be vague or imprecise. They maintain that

even when death is caused at one's own hand with a gun or poison, it is often difficult to specify if the act was accidental, or purposeful and intentional.
According to Hatton and Valente (1984), "the problem is that the term 'suicide' does not differentiate the level of intent, lethality, or the outcome of the act" (p. 33). However, they maintain that, "by definition, the death in suicide is the result of an intentional, self-destructive act" (Hatton & Valente, 1984, p. 34).

1.3 Methods and ways of committing suicide

Methods of taking one's life vary, but the three leading methods are firearms and explosives, poisons and gases, and hanging and strangulation. Their rank orders varies from state to state (Hatton & Valente, 1984).

One other method of suicide not mentioned by Hatton and Valente (1984), perhaps as they acknowledge the use of the methods they mentioned as varying from state to state, or from place to place, is the taking of overdose of pills or tablets, and mixtures of tablets.

1.4 Aim of the Study

In spite of the different theoretical training that therapists/trainee therapists have received or are still receiving, and the different approaches or positions in working with different problems presented by clients in therapy. The aim of this study was to:

Explore the different experiences, views and emotions that qualified and practising psychotherapists or trainee psychotherapists may encounter in working with suicidal clients.

1.5 Rationale

With regard to the practical training of psychotherapists regarding the suicidality of clients, the areas mostly focused on are in the assessment of the presence and intensity of suicidal state in terms of emotions, thoughts and behaviour, for example, Shea’s (1999), and Gilchrist’s (1995), contributions in this regard.

Gilchrist (1995) talks about the risk factors in adolescent suicide and suicidal behaviour, and Shea (1999) is giving a guide, for professional therapists and counsellors, of the practical steps taken in the assessment of suicidal behaviour.

Much literature on suicide, generally, is available, for example, (Lester, 1988) (Droge, 1992) (Lester, 1994); on suicide or suicidal behaviour in young people, (Gilchrist, 1995) (Read, 1996); on suicidal patients, (Bongar, 1991) (Truter, 1994) (Balakistnet, 1994) (Pretorius, 1992); as well as on other areas, such as the causes of suicide, (Ross, 1990); on the impact of suicide on family members, (Cleiren, 1991) (Wertheimer, 1991) (Cooper, 1999) (Kinsella, 1993); and on intervention strategies, (Gilliland, 1997) (Diekstra, 1989).

For the purposes of this study, the researcher came to have an awareness of the possibility that, therapists' and trainee therapists' work with suicidal clients seems to place huge demands on them. This is particularly in terms of appropriateness and timeliness of an approach and intervention of the therapist, in decision-making and also in the actual process of psychotherapy.

For the rationale of this study, not much is documented and emphasised in training in terms of the experiences and emotions or feelings of therapists/trainee therapists that they may have in working with suicidal clients.

This study attempts to highlight this need by thus seeking to make an exploration of therapists or trainee therapists in respect of their experiences and feelings or emotions in working with suicidal clients.

1.6 Format of the Study

In Chapter 2, a comprehensive review of literature on therapists' experiences in working with suicide cases is discussed, including the emotional experiences in this kind of psychotherapy work. Chapter 3 discusses the research methodology used. This includes a discussion on how the obtained data was analysed by the researcher. Chapter 4 gives the results of the study in a form of thematic analysis. Chapter 5 is a comprehensive discussion of results and the conclusion of the study.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

In the field of psychotherapy, it is apparent that working with a potential suicidal client is inevitable. This occurs both at training and professional levels. In their study, Kleespies, Penk, and Forsyth (1993) found that, during graduate training alone, nearly 97% of the psychologists have worked with clients who exhibited suicidal ideation or behaviour. One in four of those in their study had a client who made a suicide attempt and one in nine had a client who had committed suicide. It appears that Kleespies (2000) has taken a serious concern of this. In his attention to the exposure of the therapists to working with potential and real suicide cases, Kleespies (2000) firstly makes a distinction between a behavioural emergency and a behavioural crisis.

According to Kleespies (2000), a *behavioural emergency* will be taken to mean that a client has reached an acute mental state in which he or she is at imminent risk of behaving in a way that will result in serious harm or death of self or others unless there is some immediate intervention. Fortunately, there are only a few situations in clinical practice that meet this definition. They include serious suicidal states, serious violent states, and states in which a relatively defenceless victim is at grave risk of being exposed to harm or death (for example, a client with such impaired judgement that he or she might unknowingly walk in front of an oncoming truck or an abused child who remains in the custody of an abusing parent).

A *behavioural crisis*, on the other hand, will be taken to mean that a client has reached a state of mind in which his or her usual coping mechanisms are inadequate to restore equilibrium or to allow him or her to go on functioning in an adaptive way. A crisis may be a turning point for better or worse, but it necessarily does not lead to danger of serious physical harm or life-threatening danger. Clinical psychologists frequently need to deal with a variety of client crises, and sometimes these crises can contribute to or lead to emergencies. An important part of clinical work is

distinguishing between crises that may also be emergencies (and require emergency intervention) and those that are not (Kleespies, 2000).

This literature review section gives a focus on the emotional demands on the therapist in working with suicidal clients - which is a section which has not received much research attention and documentation, and in consideration of the fact that working with suicidal clients, or psychological intervention in suicide prone crisis situation is an inevitable part of the work of psychotherapists.
In the literature review section there is also a focus on the suicidal client's 'state of mind'. Maltsberger in Jacobs (1999) gives an explanation of a suicidal person's experience of psychache, and Hughes and Niemeyer (1993) describe the cognitive state of this client, which they view as a reliable predictor of suicidal behaviour.

On more specific focus of therapists' feelings in working with suicidal clients, Pope and Vasquez (1991) and Barr (1996) discuss the anxieties felt by therapists as inherent in this type of work. There is also an explanation of suicidal behaviour from the systems perspective and from the psychodynamic models.

Kleespies, Smith and Becker (1990); Kleespies et al., (1993); Carney and Hazler (1998); Milch (1980); and others such as Richards (2000), discuss the emotional impact of suicidal clients on the psychotherapist, as well as the therapists' emotional experiences and anxieties in working with these cases.

2.2 Therapists' exposure to suicidal events

According to Carney and Hazler (1998), mental health counsellors' exposure to suicidal events takes three basic forms: clients who commit suicide, clients who attempt suicide, and survivors of a loved one's suicide. According to Carney and Hazler (1998), each form carries its own separate set of circumstances and problems.

It seems as if, clients who attempt and commit suicide, are those mostly causing some emotional discomfort to therapists. This situation can involve some measure of immediacy in terms of thought and action (intervention) on the part of the therapist or counsellor. Pope and Vasquez (1991) seem to agree with this, and they believe that

few responsibilities are so heavy and intimidating for therapists as carefully assessing and responding to their client's suicidal risk. The need for attending to this lethal potential is pressing. The eventuality and response to suicidal risk is a source of extraordinary stress for many therapists.

2.3 A suicidal person: an overview

2.3.1 Acknowledgement of the psychological pain and suffering

According to Maltsberger in Jacobs (1999), suicide-vulnerable persons are well known to suffer from intolerable levels of mental suffering in which both anxiety and depression are mingled together. The anxious and depressive experiences of suicide vulnerable persons are extreme, unmodulated, and likely in themselves to be experienced as traumatic. Affective experiences that are so overwhelming correspond to early childhood, primitive, traumatic, or primary anxiety - these experiences are so incapacitating that clients are often rendered helpless. Some clients simply do not have the capacity to moderate and regulate painful effects. When the painful feelings are severe enough, no adaptation is possible and breakdown occurs.

Maltsberger in Jacobs (1999), in his explanation of this, continues to say that the psychological dimensions of almost every case of committed suicide (or serious completion) can be understood in terms of intensely felt psychological pain (called *psychache*), coupled with the idea of death (surcease, cessation, nothingness, oblivion) as the best solution to the problem of unremitting and intolerable *psychache* (Maltsberger in Jacobs, 1999). Maltsberger in Jacobs (1999) says that the unendurable psychache itself is generated by frustrated or thwarted psychological needs. The pattern of needs may be idiosyncratic for that individual. According to Maltsberger in Jacobs (1999), psychache is the hurt, anguish, or ache that takes hold of the mind. It is intrinsically psychological; it is the introspectively felt mental pain of negative emotions such as guilt, shame, anguish, fear, panic, angst, loneliness, helplessness. It is not the somatic pain of a toothache, an earache, or a headache; psychache is autonomously mental. It is "in" the mind; it is the pain of selfhood. When we feel it, its introspective reality is undeniable. Psychache is the introspective recognition of

perturbation. In general, the sources (or causes) of psychache are frustrated, blocked, or thwarted *psychological needs*.

With regard to suicide as a result of the experience of psychache, Maltsberger in Jacobs (1999) says that suicide occurs when the psychache is deemed to be unbearable and when death is actively sought in order to stop the unceasing of intolerable consciousness. The primary goal of suicide is to effect the cessation of painful mental life. Suicide is primarily a drama in the mind. In this view, suicide stems from heightened unbearable psychache. To understand suicide, according to Maltsberger in Jacobs (1999), we must understand suffering and psychological pain and various idiosyncratic (and culturally bound) thresholds for enduring it. To treat suicidal people (and to intervene against suicide), he says, we must address and then soften the psychache that drives it. The key question is, "Where do you hurt?" No psychache, no suicide. The major implication of this view would seem to be obvious: reduce the pain, and the raison d'etre for suicide will disappear.
The theoretical implication of this formulation is that if the psychache is mollified (by means of addressing the pressing needs), then the suicidality (or lethality) of the person will be sufficiently reduced so that the reason for suicide will no longer exist (Maltsberger in Jacobs, 1999).

The motive of a suicidal person is further explored and explained by Maltsberger in Jacobs (1999) as he says that, "the door to killing the body is further forced open when a client believes that physical self-destruction is not mental self-destruction. Many (suicidal clients) are convinced that the mental self will escape from that of the flesh, transformed and freed from suffering. My (Maltsberger's (1999)) experience suggests that such convictions are of resurgence are virtually universal in suicide, though they may not be entirely conscious, lurking only at the edge of awareness" (p. 74-75).

It seems as if unsuccessful attempts to meet intense or pressurising psychological needs bring about mental pain, which Maltsberger in Jacobs (1999) refers to as the psychache. Also, it appears as if suicide becomes an option to be seriously considered by a person suffering from mental pain, if there is hope of escaping from this mental pain through the killing of one's physical being.

2.3.2 The cognitive state of a suicidal person

Carney and Hazler (1998) provide a good description of a suicidal person's thinking or cognitive state. They claim that research seems to confirm that suicidal clients are typically pessimistic about the world and their relationships with others in a study of hospitalised psychiatric patients (Freeman & Reinecke, 1993). For example, Hughes and Neimeyer (1993) found that the cognitive predictors of hopelessness, self-negativity, and poor problem-solving performance functioned as reliable predictors of suicide risk (p. 103).

Client's cognitions of the future are also highly problematic. Hughes and Niemeyer (1990) noted that suicidal clients are extremely pessimistic and hopeless about the future even when compared to depressed clients. Research has demonstrated that the major precipitant of suicide is hopelessness (Beck, Steer, Kovacs, & Garrison, 1985). It seems that the suicidal person holds no hope of improvement and sees no reason to continue living (Weishaar & Beck, 1992) (Carney & Hazler, 1998).

It seems there is some serious disturbance with regard to seeing or the making of sense about the future in a suicidal person.
According to Carney and Hazler (1998), the certainty of having no hope is a characteristic that reflects suicidal people's proneness to dichotomous thinking (Neuringer, 1988). They think in terms only of good or bad as though there is no gradation along a continuum. This is particularly dangerous when life is seen as bad and death is seen as good. Compounding this dichotomous thinking is a tendency to have rigid patterns of thought which limit the development of alternative options to suicide (Neuringer, 1988).

According to Carney and Hazler (1998), there are five particularly faulty cognitions that suicidal individuals often have, and these are that: (1) suicide will be very disruptive for the surviving family, (2) acceptance and glory will be theirs after death, (3) suicide will give them control over others, (4) suicide will enable them regain contact with a deceased loved one, (5) suicide is a painless way of dying (Revere, 1985).

"These five faulty cognitions can make suicide an attractive option for clients who are physically suffering from feeling helpless, vengeful, or unrecognised. The suicide option may even provide an illusion of control for clients who feel that their lives are out of control" (Carney & Hazler, 1998, p. 30).

From the described cognitive state of a suicidal person, in particular reference to his or her hopelessness about the future, suicide again, appears to be considered as a strongly attractive alternative or option particularly with the subjective experience of mental anguish or suffering.

2.4 Working therapeutically with a suicidal person: the length a therapist can go

When talking about working with suicidal clients, Bruce Danto, a former director of the Detroit Suicide Prevention Center and former president of the American Association of Suicidology, states: "With these problems, you can't simply sit back in your chair, stroke your beard and say, 'All the work is done right here in my office with my magical ears and tongue.' There has to be a time when you shift gears and become an activist. Support may involve helping a client get a job, attending a graduation or play, visiting a hospital, even making house calls. I would never send somebody to a therapist who has an unlisted phone number. If therapists feel that being available for phone contact is an imposition, then they are in the wrong field or they are treating the wrong client. They should treat only well people. Once you decide to help somebody, you should have to take responsibility down the line" (Colt, 1983, p.50) (Pope & Vasquez, 1991, p. 162).

From the above statement, it seems as if psychotherapists have to make themselves to be very much available to, and emotionally supportive of their suicidal clients.
From what Colt (1983) in Pope and Vasquez (1991) is saying, availability of the therapist even in practical situations in the client's life is important, as long as this can be of benefit to the client.
The therapist's ability to be flexible, in this regard, that is, being able to make shifts to being available to the client on psychological and emotional support, as well as on practical support appears to be important. This also includes being always accessible

and available to the client, if need be, according to Colt (1983) in Pope and Vasquez (1991).

2.5 Therapists' avoidance of the suicide topic

It appears from the literature, for example, Menninger (1990; 1991) and Barr (1996), that psychotherapists, perhaps as a result of anxiety about working with such a problem or of some other reason, can be avoidant of the suicide topic when working with potential suicidal clients.

According to Pope and Vasquez (1991), this seems to be more prevalent among beginning therapists. "When we are inexperienced, we may be very cowardly regarding the mention of suicide in our initial interviews. We passively wait for the client to raise the subject and we may unconsciously communicate that the subject is 'taboo'. If the subject does come up, we avoid using 'hot' language such as 'murder yourself' or 'blow your brains out'. Our avoidance of clear and direct communication, our clinging to euphemisms implies to the client that we are unable to cope with his or her destructive impulses" (Pope & Vasquez, 1991, p. 165).

Norman Farberow, Ph. D., cofounder and former codirector and chief of research at the Los Angeles Suicide Prevention Center, believes that there are four main problem areas. First, therapists tend to feel uncomfortable with the subject; they find it difficult to explore and investigate suicidal risk; "We don't want to hear about it. We discount it. But any indication of risk or intention must be addressed." Second, we must appreciate that each client is a unique person: "Each person becomes suicidal in his or her own framework. The person's point of view is crucial." Third, we tend to forget the preventive factors: "Clinicians run scared at the thought of suicide. They fail to recognise the true resources." We fail to consult: "Outside opinion is invaluable" (Pope & Vasquez, 1991, p. 163-164).

2.6 Working with a suicidal client: the possibility of emotional damage to the therapist

According to Barr (1996), the heavy responsibility of these suicidal cases makes therapists reluctant to take them on. The reason practitioners shy away from the suicidal is because they have neglected to recognise the burden of caring for these clients and failed to give them the necessary supports. In this day and age of stated outcomes, clinicians hesitate to engage with a client whose purposes imply potential suicide. The absorption of experiencing a sense of profound failure leads even the most compassionate to question the process.

Barr (1996) asks a rarely asked question: "What do we have in place for the mental health practitioner who has lost a client to suicide? The answer appears to be: Little or nothing" (p. 1). According to Barr (1996), "as a result some very capable, sensitive practitioners are damaged because their healing needs have been left unattended" (p. 1).

Barr's (1996) reasoning is that "practitioners may move toward isolation, display a lack of vitality, waver in their professional judgements and, in general, show less confidence in voice and manner. These manifestations, if not tended to, harbour the potential for further emotional damage to the clinician. Inevitably, the clinician's practice will be affected by his or her diminished zest for the work" (p. 1). According to Barr (1996), there is a need to recognise that therapists might have been wounded by losing a client to suicide, that a significant loss has occurred for the clinician, that -- as with any abrupt halt to life -- there will be a period of questioning (Barr, 1996).

2.7 Are student/trainee therapists protected from the impact of client suicide?

Student therapists faced with client crises have historically been perceived as having a "protective advantage" by virtue of their student status when compared with professional therapists (Brown, 1987a, 1987b). According to Forster and McAdams III (1999), it is reasoned that the student can remove him-or herself from some burden of responsibility because he or she is working under the direction of a supervisor who

bears ultimate responsibility for the case. Current research has indicated that therapists in training may actually have a reaction to their client's suicide that is as strong if not stronger than that of their professional counterparts (Forster and McAdams III, 1999).

According to Kleespies et al., (1993), therapists in training may experience a reaction to their client's suicide that is as strong if not stronger than that of their professional counterparts. Following the suicide of a client, predoctoral interns in psychology have reported feelings of shock, disbelief, failure, sadness, self-blame, guilt, and shame that were significantly higher than those found in comparable studies of professional psychologists. Two studies involving psychiatric trainees reported responses including frequent feelings of guilt, sadness, anger, and increased fear in dealing with suicidal clients as well as various anniversary reactions to the event (Sacks, Kibel, Cohen, Keats, & Turnquist, 1987; Schnur & Levin, 1985). Brown (1987b) reasoned that when a client commits suicide, student therapists are more likely to feel that they have failed as persons than experienced professionals who are better able to separate personal failure from limitations of the therapeutic process. Consequently, the loss of a client to suicide may pose a greater threat to the self-concept of the student therapist than it does to the experienced professional who has a broader base of experience from which to process the event (McAdams III & Forster, 2000).

Forster and McAdams III (1999) mention that "what does seem clear, however, is that the premise of protective advantage apparently does not hold for some student therapists, and that for those students the impact of a client suicide can be considerable" (p. 23-24). Forster and McAdams III (1999) continue to claim that there is evidence that when such a crisis does occur, the impact of the event on the student counsellor, in particular, can be severe and have long-term consequences. They state that findings in the psychological and educational literature indicate that few clinical training programs have in place specific plans or models for responding to client suicide (Bongar & Harmatz, 1991; Brown, 1987a; Kleespies et al., 1993). Almost no information regarding attention given to client suicide in counsellor education programs (Myers & Hutchinson, 1994).

According to Kleespies (2000), compared to the psychiatry training program, with regard to working with suicidal clients, the psychology internship programs were found to lag behind the psychiatry residence programs in terms of utilising seminars, journal clubs, assigned readings, and case conferences for suicide related training. "The discipline of clinical psychology has not made the acquisition of a knowledge base and instruction in the management of behavioural emergencies a routine and required part of the educational preparation for those entering the profession. This fact has been documented for both client suicidal behaviour and client violence" (Kleespies, 2000, p. 1104).

Regarding the impact of client suicide on the student therapist, according to Forster and McAdams III (1999), Feldman (1987) noted that theoretical bias, personality, and history all influence a student's orientation and response to suicide. Ethical and legal requirements may differ in each case; the needs of the student counsellor will be specific to the details of the client-counsellor relationship, the nature of the working setting, counsellor experience level, and the counsellor's desires regarding how to respond to the event.

2.8 Impact of stress higher for student/trainee therapists than for professional therapists

McAdams III and Forster (2000) conducted a study, which was also looking into the frequency and impact of client suicide on the counsellor or therapist.

McAdams III and Forster (2000) report that "the frequency of client suicides among counsellors cannot be generalised from findings in psychiatry and psychology, because estimates differ substantially for the two disciplines. Generally the findings in psychiatry and psychology suggest that the professional and personal impact of client suicide on counsellors could be great; however without research data specific to the field of counselling, the exact nature of and extent of that impact are left to conjecture" (p. 9).

In the study of McAdams III and Forster (2000), of the 376 respondents, 23% had experienced the suicide of a client who was under their care. Within that group, 21

(24%) were student counsellors at the time of the suicide and 11 of the 19 items on the survey yielded mean responses indicating a moderate to moderately high impact of the client suicide, with symptoms comparable to those of clinical groups during the weeks following the event. Counsellors reported having intrusive and avoidant thoughts about the crisis that were higher than those of either psychologists or psychiatrists. Counsellors' ages were negatively related to the intensity of their reactions to clients' suicides. The severity and persistence of stress symptoms was greater for the counsellors who were students at the time of the client suicide than for those who were already in professional practice. The study indicates that the effects of client suicide have potentially negative and serious consequences for student and professional counsellors alike. Specific training pertaining client suicide should be a routine component of the counsellor educational process to effectively prepare students for this and similar clinical crises' and to encourage similar responses in professional practice settings (McAdams III & Forster, 2000, p. 107).

2.9 The personal and professional impact

It is of importance to note that the impact of working with suicidal clients can be felt by a therapist on either one or on both levels, which are: the personal and the professional levels.

According to Carney and Hazler (1998), the impact of client suicide is multiplied many times when the conservative estimate 240,000 - 600,000 annual attempts in the United States alone is considered (Diekstra, 1990). Five-million living Americans have attempted suicide at some stage in their lives (National Center for Health Statistics, 1996) which creates an enormous need for mental health counselling before and after suicide attempts for both clients and their loved ones.

On the personal level, the therapist's personal life seems to have been affected in a way by the suicide or suicide attempt of the client, as he or she may experience some or a variety of unpleasant emotions (McAdams III & Forster, 2000).
On the professional level, the therapist's practice, in terms of motivation, trust in his her abilities and functions, and dealing with future suicidal cases, and as well as other

areas of his or her professionalism, seems to be negatively affected by the suicide of the client (McAdams III & Forster, 2000).

According to McAdams III and Forster (2000), despite the apparent universality of client suicide, no information appears to exist regarding the frequency of suicides among the clients of student and professional counsellors. Nor does there appear to be any information available regarding the impact of clients' suicide on counsellors professionally and personally. The few studies that have been conducted on the frequency and impact of client suicides have focused almost exclusively on student and professional psychiatrists and psychologists (McAdams III & Forster, 2000).

Regarding the actual experience of client suicide by the therapist McAdams III and Forster (2000) say that therapists uniformly have experienced the suicide of a client as stressful, and for a substantial number the event has had a significant lasting impact on their personal and professional lives. In his study of psychiatrists, Brown (1987a) found that every individual he interviewed remembered the name of his or her deceased client, and details of the incident remained vivid even after 20 or 30 years.

McAdams III and Foster (2000) go on to explain their point by referring from other studies such as that of Chemtob, Hamada, Bauer, Torigoe and Kinney (1988b), and that of Maltsberger (1992). They say that "forty-nine percent of the psychologists surveyed by Chemtob et al. (1988b) reported symptoms of stress in the weeks after a client suicide that were comparable to those of people for whom the impact of parental loss were severe enough to necessitate treatment. More serious pathologic grief reactions to client suicide, including melancholia, atonement, and narcissistic avoidance, have been reported by Maltsberger (1992)" (p. 108).

2.9.1 Impact on counsellors

On the impact of client suicide on the professional and personal life of a therapist, in their study, McAdams III and Forster (2000) have something to say on this regard. They give a report which states that, in response to questions regarding the degree to which the therapists' professional and personal lives were affected by a client suicide, the counsellors reported that their lives were affected to a notable extent--11 of the 19

items on the questionnaire yielded mean responses in the middle to upper-middle third of the 7-point range indicating a moderate to moderately high impact of the client suicide. Professionally, respondents reported increasing their attentiveness to legal liabilities of their work, increasing their tendency to refer at-risk clients for hospitalisation, strongly increasing their focus on potential cues to client suicides, becoming more likely to seek peer and collegial consultation around high risk cases, becoming more conservative in their clinical record-keeping, and having generally increased concern for issues of death and dying. Personally, they reported feeling a loss of self-esteem, having intrusive thoughts and intensified dreams, and feeling both anger and guilt in response to their experience of a client's suicide.

Menninger (1991) reports that interviews of psychotherapists (Litman, 1965) revealed that they reacted personally to the death of a client in much the same way as other people do. In addition, they responded professionally in accordance with their special role as therapist. Litman (1965) commented, "The personal reactions depend, of course, on how the therapist viewed his client, how long and how closely they worked together, and the degree of his professional commitment to the other" (p. 572). The therapists' guilt feelings paralleled those expressed by relatives: "If only I had done such and such differently" (p. 573). The 200 therapists also emphasised concern about blame, responsibility, and inadequacy, including fears "of being sued, of being vilified in the press, of being investigated, and of losing professional standing" (p. 574). According to Bongar (1991), beyond the emotional consequences for the counsellor, legal issues also can arise in the form of malpractice liability. Clearly there are enormous stressors on counsellors whose clients have taken or threatened to take their own lives (Bongar, 1991).

Both intrusive and avoidant responses to the client suicide clearly could impair professional competency. Kleespies et al., (1993) have suggested that those who have had a client suicide may be more likely to experience anxiety when subsequently treating suicidal clients. Also, it is possible that some counsellors may be intentionally avoiding their feelings related to the client suicide as a coping strategy (McAdams III & Forster, 2000).

2.10 Therapists' perceptions of suicidal clients: a psychodynamic approach

In her study, Richards (1999) mentions that in her investigation what has been elicited about the experience of clients and their suicidal impulses has come from the collections of their psychotherapists. This could be seen as a limitation in that what has been studied is the therapist's perceptions rather than the direct reports of the client. However, as was expected, the advantage of this method is that psychotherapists have been able to record their own observations of their clients as they have experienced them in the therapeutic relationship. The results have revealed a common pattern as their clients' internalised relationships were encountered in the transference relationship (Richards, 1999).

Through the transference relationship and their own countertranference responses, psychotherapists working with a suicidal client may be in a unique position. Their relationship with the client allows them to observe the nature, and ongoing process, of the client's internal and external object relations, and to explore the possible origins of these relations. The focal point is the therapeutic relationship itself and how the early experiences of the suicidal person are revealed in the relationship (Richards, 1999). According to Richards (1999) with regard to a suicidal client, it is probable that the inner world of such a person will be very bleak and impoverished. Instead of comforting and nourishing primary objects having been internalised, there is constant threat of psychological disintegration, arising from an intolerable experience of aloneness and emptiness. These clients are displaying a constant need to search for external sources of comfort and unconditional love. In Richards' (1999) study of the perceptions of therapists from a psychodynamic approach who have worked with suicidal clients, one interviewee described her client in this way:
'She has tried to make all of us (the professional carers) into parents who will take away the pain and look after her. She goes into hospital because she can't bear to be alone at home…When she was at home she kept ringing the hospital every evening and first thing in the morning' (p. 91). It seems that for those whose early experience of relationships has been poor, there is little sense of inner holding and security. They may feel that this can only come from other people outside the self. In contrast, death may be seen as promising to restore the perfect holding and nurturing mother forever

(Hale & Campbell, 1991). Low sense of self-worth may also be present as a result of the processes of splitting and projection (Richards, 1999, p. 91).

2.10.1 Suicidal trigger

Kohut (1971) postulates that the experience of an empathic, nurturing mother is a prerequisite for the individual to develop soothing introjects and the ability to comfort her/himself in times of loss. The data produced in the Richard's study (1999) appear to suggest that the experience of the suicidal person is such that a present experience of loss reactivates past rejections and feelings of emptiness. When these clients experience loss, it is likely that they feel a narcissistic insult. It is not the size of the insult that matters; rather it is the meaning given to the event in the person's inner world that is important (Richards, 1999).

2.10.2 Invasion/engulfment and abandonment

Many of the clients described as perceiving their parents as being involved with them in ways that had more to do with the needs of the parents than their own needs as a child. They felt themselves to have been intruded upon in various ways, both physically and emotionally, and yet their true feelings had been ignored.
There is fear both of being engulfed and taken over by an all-powerful, overwhelming object, and at the same time, of the true self being neglected, unseen, unheard and abandoned (Richards, 1999).

2.10.3 Rage

According to Richards (1999), it is likely that the child who has experienced abandonment, there has been no one available to either hear or receive his/her angry feelings. It is possible that in many of these cases the parents would be too self-absorbed to help the child deal with his/her rage. Without such help in infancy, the child cannot grow to believe that things are manageable and fails to develop adequate inner resources to deal with such feelings.

Richards (1999) claims that what seems to characterise the feeling of having to act out the rage is the perception that no other person is able to help and process the anger: it is impersonal. Viewed in this way, the suicide attempt can be understood as an angry attack or revenge but one that can only be carried out by killing the self's own body. The fear is: if I get in touch with the rage, I will annihilate the other, so I had better annihilate myself. The anger can only be expressed by turning it against the self and the internalised mother.

2.10.4 Differences between men and women

Even though it was a small sample, it is important to note that whilst a higher proportion of women were reported to perceive their parents as being rejecting towards them, a higher proportion of men were described as perceiving their parents to be indifferent. The use of this term to describe the experience of the male clients may indicate that they felt their parents to be uninterested in them. One therapist reported his client as saying: 'It didn't seem to matter whether I was there or not; they just didn't seem to notice.' This kind of experience may feel as much like abandonment as the rejection more often reported by the women in the sample (Richards, 1999, p. 90). However, in comparison, indifference may feel simply empty of any communication or recognition from the other person.
This accords with the findings of De Jong (1991), who discovered a strong gender effect in the relationship of levels of attachment to suicidality. De Jong (1991) noted that males with a history of suicidal impulses tended to have had less experience of parental and significant other attachment figures available to them when growing up than any other sex/group category in the study.

2.11 A systems approach

According to the systems approach, human problems are essentially interpersonal, not intrapersonal, and so their resolution requires an approach to intervention which directly addresses relationships between people (Carr, 2000).

Lyman Wynne believed that an individual's personality could be conceptualised as a subsystem within the larger family system. Thus, the ongoing transactions between

the individual and the family, if particularly deviant or abnormal, could initiate and maintain psychopathology (Carr, 2000, pp. 55-56).

The general explanation of the systems approach in this context is that which incorporates the family, as an immediate context (system) in which the individual person (subsystem) (who is a suicidal client, for the purposes of this study) lives, and to which he or she belongs.

According to Carr (2000), general systems theory and cybernetics, when applied to families, suggests a series of propositions or hypotheses.
What follows is a selection of some of the more important propositions entailed by a systems view of families.

2.11.1 The family is a system with boundaries, and is organised into subsystems (Colapinto, 1991).

According to the researcher's understanding, in this study, a suicidal client, in this regard, also belongs to this family system, and is a part of the various subsystems.

Within the structural family therapy tradition, distinctions have been made between the parental and child subsystems, male and female subsystems, and so forth (Colapinto, 1991).

2.11.2 The boundary around the family sets it apart from the wider social system, of which it is one subsystem

This broader system includes the extended family, parents' work organisations, the children's school, the children's peer groups, the involved health care professionals, and so forth. Within multisystemic family therapy, it is routine practice to work with the wider social system if it is involved in problem maintenance or could potentially be involved in problem resolution (Henggeler, Schoenwald, Bordin, Rowland & Cunningham, 1998).

The suicidal client, also, apart from belonging to the family system, participates in the wider social system, depending on his or her roles and positioning in this wider social system.

2.11.3 The boundary around the family must be semipermiable to ensure adaptation and survival

That is, a family's boundary must be impermeable enough for the family to survive as a coherent system and permeable enough to permit the intake of information and energy required for continued survival. Isolated families have impermeable boundaries and chaotic families have boundaries which are too permeable. (Colapinto, 1991).

2.11.4 Family member, and each family subsystem, is determined by the pattern of interactions that connects all family members

Everybody in a family is connected to everybody else and a change in one person's behaviour inevitably leads to a change in all family members (Carr, 2000).

According to the above statement, this means that suicidal feelings and a suicidal act of one member of a family is not an isolated event, as it is a very interpersonal situation or act, and affects all the other members of the family.

2.11.5 Patterns of family interaction are rule governed and recursive

These rules may be inferred from observing repeated episodes of family interaction. Identifying these recursive patterns, particularly those associated with episodes of problematic behaviour, is a core of family therapy skill common to many family therapy traditions (Carr, 2000).

2.11.6 Because these patterns are of the form 'A leads to B leads to C leads to A'

The idea of circular causality should be used when describing or explaining family interaction. Descriptions and explanations of families that involve linear (or lineal)

causality, of the form 'A leads to B', are probably incomplete and inaccurate (Carr, 2000).

Circular causality, in this regard, could be inclusive of the suicidal act of a family member. A suicidal acting family member may be trying to commit suicide 'because A does that, or because A does not do that'. It seems also that A will continue to do what he/she does, or not do what he/she does not do, this as part of the recurring family pattern. The suicidal acting family member is very likely to try another suicidal act again, so as to maintain the recursive pattern. Perhaps this explains the many repeated suicide attempts carried out by one person in a family.

According Carr (2000), the difficulty with the concept of circularity is that while members of systems exert mutual influence on each other, they do not all have the same degree of influence. That is, within family systems members are organised hierarchically with respect to the amount of power they hold, and this notion of hierarchy must be coupled with the concept of circularity, when working with cases involving the abuse of power (Carr, 2000).

2.11.7 Within family systems there are processes which both prevent and promote change

These are referred to as 'morphostasis' (or 'homeostasis') and 'morphogenesis'.

For families to survive as coherent systems, it is critical that they maintain some degree of stability or homeostasis. Thus, families develop recursive behaviour patterns that involve relatively stable rules, roles and routines, and mechanisms that prevent disruption of this stability. It is also essential that families have the capacity to evolve over the course of the lifecycle and meet the changing demands necessary for healthy development, adaptation and survival. Thus, families require mechanisms for making transitions from one stage of the lifecycle to the next and for dealing with unpredictable and unusual demands, stresses and problems (Carter & McGoldrick, 1989).

The suicidal act of a family member can be viewed within a systemic perspective as a way through which the stability of the family is maintained, particularly with unhealthy family interactions. In a way, the repeated suicidal acts of one family member maintain the stable family rules and routines of family interaction, and are very resistant to change.

2.11.8 Within a family system one member - the identified patient - may develop problematic behaviour when the family lack the resources for morphogenesis

According to Carr (2000), the symptom of the identified patient serves the positive function of maintaining family homeostasis.

When the integrity of the family system is threatened by the prospect of change, in certain instances one family member may develop problematic behaviour, which serves an important function in maintaining family homeostasis or stability (Carr, 2000).

2.11.9 Negative feedback, or deviation-reducing feedback, maintains homeostasis and subserves morphostasis.

In families referred for treatment, it is assumed that the symptom serves a positive function in maintaining the integrity of the family system, then it may also be assumed that when the identified patient begins to improve, and this is noticed by family members, this feedback may lead to patterns of family interaction that intensify the patient's problem and so maintain the status quo (Jackson, 1968a, b). For example, a child who develops emotional (including suicidal feelings and behaviour), psychosomatic or behavioural symptoms, or a child hospitalised for these or other types of problems, or a child taken into care for abuse or neglect, may become a united focus for concern in a family and halt the parents' involvement in either a symmetrical process of mutual blaming or a complementary process of care-giving and illness (Carr, 2000).

2.12 The emotional impact of a suicidal client on a therapist

However, even though therapists may be so much skilled and prepared from their training in working with suicidal clients, the emotional impact of this work on them also seems to be an inevitable component.

Referring again to Kleespies et al., (1993), in working with suicidal clients, they found that the emotional impact of such behaviour on psychology interns/trainees was as high, if not higher, than that found in comparable studies of professional level psychologists. These investigators also found a negative relationship between intrusive thoughts and images and the year in training in which a client suicide was experienced (i.e., the earlier in training that the trainee had a client suicide, the greater the reported acute emotional impact). They speculated that this heightened impact may be a function of less experience, less preparation, less security about one's role and ability, and/or greater proneness to surprise or shock over client suicidal behaviour. Again, Kleespies (2000) makes another emphasis on this aspect as he says that work with emergency cases can have an emotional impact on the clinician him/herself, especially if a client attempts or commits suicide.

2.13 Therapists' anxieties in working with suicidal clients

Carney and Hazler (1998) mention that no official statistics track suicides completed during a course of counselling, but many mental health counsellors have dealt with the reality of their clients committing suicide. Client suicide, in fact, has been referred to as one of the ultimate tragedies faced by the mental health treatment community.

According to Menninger (1991), client suicide is a source of considerable anxiety for psychotherapists. It is experienced by a substantial number of therapists, and has a significant emotional impact when it occurs.

Menninger (1991), when studying the impact of client suicide on the psychotherapist, reports that when 88 practising psychotherapists were surveyed in his study (Menninger 1990) about the causes of their anxiety, the most cited cause was client suicide. Two thirds (67%) of the respondents in Menninger's (1990) study,

acknowledged the presence of anxiety in such situations as a "feeling of imminent suicide in a client, "repeated suicide attempts, a "client threatening suicide on the phone but refusing to give his whereabouts, and "receiving a telephone call from the county medical examiner advising me of the suicide of a client" (p. 243).

The loss of a client by death is always troubling to the clinical practitioner because it represents an insufficiency of the treater's best efforts. Nonetheless, a fatal outcome is not unexpected in many medical and surgical conditions. In contrast, a fatal outcome is rarely expected in the psychiatric arena, in spite of the reality that some patients do commit suicide. When it does occur, a client's suicide is most often experienced as a therapeutic failure, and it invariably has a profound impact on the therapist (Menninger, 1991).

2.14 Therapists' feelings and experiences in working with suicidal clients

According to Milch (1990), the treatment of suicidal clients is often conducted with many reservations. "When these clients consult a therapist, they frequently stop treatment after a short time. When therapists see them for the first time, the intense suffering of these clients is apparent. Yet if the therapist communicates, during the initial conversation or the client's first several days on the ward, even the most minimal uncertainty about treatment success, these clients will withdraw and sever the therapeutic contact. They are likely to tell the therapist that everything is alright, that they can cope on their own, and that they want to go home. Unfortunately, if not treated, many of these clients will repeat the suicide attempt" (Milch, 1990, p. 384). Counsellors may respond to the disaster (client's suicide or suicide attempt) with feelings of shock, guilt, shame, denial, anger, and a sense of being blamed. They often find themselves in a battle with their own depression following a client's suicide (Kleespies, Smith, & Becker, 1990; Carney & Hazler, 1998).

Regarding the investigation of the impact of the client suicide or suicide attempt on a therapist, McAdams III and Forster (2000) carried out a study, which was to look into this issue. McAdams and Forster (2000) talk of their study by stating that, given the paucity of information available regarding the frequency of client suicides among counsellors and the apparent strong and pervasive impact of this event on therapists in

related disciplines, their study sought to examine the frequency and impact of client suicide among counsellors during training and practice.

McAdams and Forster (2000) report the results of their study by stating that, relatively speaking, the counsellors showed somewhat lower levels of intrusion and avoidance in response to their client's suicide than did reference groups of individuals who had survived the homicide of a family member or who had sought counselling following the recent death of a parent (Horowitz, Weiss, Kaltreider, Krupnick, Marmar, Wilner, & Dewitt, 1984). However, greater levels of intrusion and avoidance were reported by this sample than noncounselling-seeking survivors of the death of a parent (Horowitz et al., 1984) and either psychiatrists and psychologists who had experienced a client suicide. The levels of intrusion and avoidance reported in that study mostly closely resembled the levels reported previously by individuals who had experienced the recent death of a parent but who had not sought counselling in the aftermath of the loss.

In Menninger's (1991) study, the themes that therapists most commonly cited in describing their reaction to news of a client's suicide were shock (feeling stunned or surprised), sadness (feeling loss or grief), anger, a sense of guilt (regret), anxiety (feeling worried or fearful of criticism), and doubt about competence (questioning their skills, feeling inadequate). "The actual words most frequently used were 'anger,' 'sadness,' and 'shock'" (Menninger, 1991, p. 217).

Along the same lines, Goldstein and Buongiomo (1984) interviewed 20 psychotherapists and found reactions similar to those reported by Menninger (1991). "All the psychotherapists described initial responses of guilt feelings, anger, disbelief, and shock, followed by grief, shame, despair, and a loss of self-esteem and self-confidence. Then came a period of renewal and a process of 'working through.'" (Menninger, 1991, p. 220).

Kolodny, Binder, Bronstein and Friend (1979) reviewed the experience of four psychotherapists in training whose clients had committed suicide. They described the aftermath as "a process of mourning. It occurred over time and required time; we could not rush it, circumvent it, or avoid its various aspects" (p. 43). They believed

that the circumstances of being the therapist of a client who died by suicide intensified their own sense of threatened omnipotence and self-esteem and their feelings of shame, guilt, vulnerability, and self-doubt. They experienced an intense need for support, understanding, and absolution, but they also felt isolated (Menninger, 1991)

According to Menninger (1991) the impact of a client's suicide can also be viewed as a traumatic experience to the therapist who has "lost control" of the therapeutic process. The reactions of the therapist may parallel other posttraumatic psychological responses -- shock, numbness, denial, and intrusion-and-avoidance responses (Menninger, 1991).

2.15 Suicidal person's way of communicating in therapy: projective identifications

2.15.1 A Developmental view/perspective

In the course of ordinary development, reshaped and transmuted, introjects take up their places in the ego (where "neutralisation" is most complete) and superego. (Here ego and superego are used to refer to the faculties of mental function as in Freud's structural theory [1923]). The introjective origins of the superego are always betrayed by its quality of watchful otherness; it is built up from internalised parental experiences of censure and approval. Structurally it is the seat of conscience. Persons successful in development achieve adulthood with more or less loving and reasonable consciences, an indication that the superego has been built up out of good proportion of loving experiences (libidinal energy) and not too many aggressive ones, and that it has been open to amelioration by good corrective experiences through the course of development (Freud, 1923; Schafer, 1960; Maltsberger, 1999).

Less fortunate are those children whose development is overcharged with feelings of hate and anxiety. These cannot develop normally. Certain vital functions of the ego fail to consolidate, and in the matter of identity and character formation, the ego itself tends to break into compartments. Vulnerability to psychosis and suicide are thus built in (Freud, 1940, especially pp.201-204; Kernberg, 1966 & Fairbairn, 1952). Introjects of an intensely hostile nature take their places in the mind, and the minds of such

clients are structurally fragile. Whereas the superego-ego systems of the mentally well remain more or less stably integrated through adulthood, very aggressive introjects are difficult to neutralise and bind down into one structure or another. They tend to be structurally itinerant, in the sense that at one moment they appear to assert themselves in the superego system, at another to dominate in projection-susceptible object representations. At still other moments, hostile introjects tend to become entangled with the self-representation, especially the body-representation. This makes the client's body loathsome to him and causes it to feel alien. When the body is experienced in this way and identified as a source of suffering and torment, suicidal self-attack can occur. Sometimes the hostile introjects seem to dominate both the conscience and large proportions of the self-representation (Maltsberger, 1999).

2.15.2 The suicidal client in therapy

"The client's destructive behaviour can be seen paradoxically as both an offer of contact and a creative achievement in which she created her childhood situation. In the same way, clients' self-injuries can be seen as reruns of their childhood injuries. Similar to the way self-injurious clients secretly harm their bodies, suicidal clients can be subtly insulting in their interpersonal interactions. The therapist becomes a self-object that regulates narcissistic equilibrium" (Kohler, 1984; Kohut, 1984; Reiser, 1986) (Milch, 1990, p. 387).

Pope and Vasquez (1991) quote James Chu, a psychiatrist in charge of Codman House at McClean Hospital, as commenting: "When you deal with suicidal people day after day after day, you just get plain tired. You get to the point of feeling, 'All right, get it over with'" (p. 162). According to Pope and Vasquez (1991) the potential for fatigued, boredom, and negative transference is so great that we must remain constantly alert for signs that we are beginning to experience them. Maltsberger and Buie (1974) discuss therapists' repression of such feelings. A therapist may glance often at his watch, feel drowsy, or daydream - or rationalise referral, premature termination, or hospitalisation just to be rid of the patient.

2.15.3 Suicidal clients' use of projective identification

According to Richards (2000), the idea of projective identification has been developed and extended (Bion, 1967). It is now also thought to be a means by which, unconsciously, some clients attempt to communicate their feelings and experiences to another person. In this way they may actually make the other feel and know what it is like inside their inner world. To some extent everyone will unconsciously employ this mechanism at times. However, suicidal clients are amongst those who rely heavily upon projective identification (Malin & Grotstein, 1966) both as a defence and as a means of communication. Thus they are able to arouse very intense emotions within their counsellor or therapist (Maltsberger, 1984-1985). The therapist can, in this way, become a receptacle for the difficult feelings which are a part of the patient's inner world (Modestin, 1987)

Maltsberger (1999) says that "in psychotherapy, the client, projecting his hostile inner presences (introjects) onto the therapist, may become convinced that the therapist wants to get out of him, or that he even harbours the secret wish the client would go ahead and kill himself" (p. 77).

Wolk-Wasserman (1987) interviewed 40 suicide attempt clients, members of their families and their therapists. He observed that clients were often aggressive and negative or ambivalent towards their treatment as a defence against a possible separation from the therapist and in order to avoid feeling hurt or rejected. Holidays and other interruptions in therapy were particularly problematic. According to Wolk-Wasserman (1987), it emerged from the material that termination, or threatened termination, of therapy may have been one of the factors precipitating a new suicidal action in seven cases. The therapist was often confronted by the aggressive, provocative and demanding side of the client. The primitive defence mechanisms, such as denial of reality, idealisation, disparagement and projective identification were hard for the therapist to take. Wolk-Wasserman (1987) believes that in some of the clients studied, the suicide attempt clearly expressed aggression towards the therapist. Repeated threats of suicide could provoke fear or anger in the therapist, since such an action involved a failure in his or her work (Richards, 2000).

Modestin (1987) concludes that clients with a higher suicidal risk generate more anxiety and more feelings of anger. Due to the suicidal clients ability to project strong emotional feelings, he or she is particularly more prone to provoke counter-transference reactions within the therapist (Richards, 2000).

In Richard's (2000) study, six (17%) of the participants spoke specifically of the way in which their clients had been able to make use of the therapist and the therapy process in order to contain and process destructive feelings. Eleven therapists (31%) observed that the client had developed considerable dependence within the therapeutic relationship, and seven (20%) described the client's need and longing to be loved and valued. However, it was striking that many of these clients were described as also having a fear and a hatred of the dependent relationship upon the therapist. They could only perceive it as ending in abandonment, either in the form of rejection or engulfment. This reflected the way that many of the clients had been described as feeling in relationship in significant figures early in life. Thirty-two participants (91%) said that, to a greater or lesser degree, they did consider that their client had been able to make use of the link or connection to them, nine of these (26%) described their client also as attacking the therapy and attempting to sabotage the process. Some clients attempted to avoid reality in the therapeutic relationship by splitting and first of all idealising and then disparaging the therapy and the therapist (Richards, 2000). Richards (2000) reports that the results indicate that clients displayed both a desperate need and yet, at the same time were very frightened by the closeness of the therapy relationship. This sometimes meant that clients attempted to destroy the therapy as well as showing signs of wanting it. The therapists tended to believe that the closeness with them simply felt too dangerous to these clients. It seemed that the prospect of facing this inner threat and pain of annihilation was so terrifying for some clients that they could only find ways of avoiding it.

Some of the therapists felt the suicide attempt contained an aggressive message from the client to them (Richards, 2000).

2.15.4 Narcissistic injury to the therapist

At the beginning of treatment, the client may idealise the therapist. But at the slightest insecurity, the client's resistance breaks down and the destructive aspects of the relationship surface. Suicidal clients are particularly quick to notice the therapist's own magical expectations and then to expect a miracle cure. When this cure is not forthcoming, these clients may attack the therapist's feelings of self-worth (Maltsberger & Buie, 1974; Winnicott, 1949). Thus the therapist may have to endure a client's rejection for long periods during treatment while still providing adequate holding functions. The therapist therefore becomes the rejecting, cold, destructive mother (Milch, 1990).

According to Pope and Vasquez (1991), one therapist - *Jesse Geller* - stated that one of the two main problems in treating suicidal clients is our own anger and defensiveness when confronted by someone who does not respond positively - and perhaps appreciatively - to our therapeutic efforts. It can stir up very primitive and childish feelings in us - we can start to feel vengeful, withholding, and spiteful. The key is to become aware of these potential reactions and not act them out in our relationship with the client.

During the interactions in the therapeutic relationship, the therapist can develop a negative countertransference: The client becomes a rejecting, cold parental figure. In this situation, the therapist can experience unbearable, "inhuman" feelings of rage and revenge, and may even prefer to see the client dead rather than to continue treatment. The therapist feels incapable, helpless, and guilty. Because such latent aggression is seldom permitted in the helping professions, these impulses are transformed into various forms of defensiveness. Sometimes the therapist has guilt feelings that lead to acts of revenge (Searls, 1979; Milch, 1990).

"Not only do clients seek the vitalisation of a self-object experience from therapists; therapists also seek confirmation of their own worth from clients--through a self-object experience centering on the client's improvement. And clients who themselves respond to every hurt, to every loss of dignity no matter how slight, know quite well how to inflict hurts and wounds on the dignity of their therapists" (Milch, 1990, p.

388). According to Milch (1990), the unconscious of the therapist understands the unconscious of the client. This rapport on a deep level can express itself in slips of the tongue, in functional symptoms, or in certain countertransference feelings. The therapist experiences the client as a part of the self in the sense of a self-object countertransference (Kohler, 1984; Wolf, 1979). "The therapist's volatile feeling of self-worth mirrors the client's self-object relationship. By making themselves more aware of these processes, therapists can prevent the development of such transference and countertransference patterns" (Milch, 1990, p. 388).

2.15.5 The effect on the psychotherapist

The effects upon therapists shown in Richard's (2000) study are comparable with those discovered by Menninger (1991). The data support his conclusions that this is not by any means an unusual occurrence in the practice of psychotherapy (Richards, 2000).

The themes that therapists most commonly mentioned in describing their reactions were: a lack of surprise; feelings of hopelessness and helplessness; a sense of failure; feeling upset, distressed and sad; anxiety in the weeks that followed and increased concern about the client's self-destructiveness. One participant explained: 'I experienced something of his desperation and feelings of helplessness and hopelessness'. (Richards, 2000).

Several therapists felt angry with the client and also angry with the referring psychiatrist or the psychiatric system. For many participants it had a profound effect causing self-doubt and a loss of confidence. For example: 'He presented with strong contempt for self, for other helpers, for psychiatry and for me. I probably would have felt some of his contempt.' (Richards, 2000)

Six participants felt that therapists should never duck the issue of suicidal feelings or threats and should always take them seriously, discussing them fully with the client. Linked with this, three people particularly mentioned the need to work through and understand with clients their own destructiveness, and one person talked about the

importance of understanding the specific internal meaning of the suicidal act to the client (Richards, 2000).

Five people talked about holding the boundaries firm and containing the demands and pressures to come out of role. One person commented upon the importance of this for the therapist as well as for the client: 'Containment and structure feels very important to one's own identity and to enable one to deal with very strong projections of the client's persecutory internal world into one's own'. Five therapists pointed out that it is important to keep things in perspective. They felt it necessary to accept that, in spite of all the best efforts, suicide is a possibility (Richards, 2000).

2.15.6 Attacks on the therapy: some countertransference aspects

One participant described her own feelings during the time that she worked with her client: 'I felt at times completely useless, hopeless as a therapist and a human being, always doing and saying the wrong things. I also had strong feelings of her dependence and panic at the degree of it. Sometimes the feelings were acknowledged by her to be hers, at other times I carried them all' (Richards, 2000).

Richards (2000) states that Maltsberger and Buie (1989) have described how different components of countertransference hate, particularly malice and aversion, may even play a part in promoting a suicidal outcome. They comment that countertransference struggles frequently repeat a significant part of the childhood of clients who later become suicide prone. They describe an example of a client who had engaged in such a struggle with his therapist: 'In retrospect it seemed that the client had needed to provoke a rejection from the therapist. Once satisfied that no one really understood or cared he could turn away from other people and destroy himself' (p. 286). In this way the client externally confirms his or her internal perception of how the world is (Richards, 2000).

About her study, Richards (2000) claims that this study revealed various ways in which clients attempted to provoke or to prod the therapist into acting upon their countertransference feelings. Several participants reported feeling angry and furious with the client, even to the point of considering whether to continue working with that

client. Other reactions included frustration and contempt. Some participants said that they felt helpless and wondered if the client would be better off working with someone else. For example: 'She makes everybody feel helpless, totally … The GP and the psychiatrist have given up on her. I do feel a sense of despair sometimes. Do I say to her, "I can't help you, you'll better go and find somebody who can"? But again I think that's something to do with her despair, that's how she wants to make me feel, that's what it's like for her' (Richards, 2000, p. 7).

Another reaction was to want to intrude upon the client: 'I found myself pleading with her to have something to eat, some sustenance.' 'She makes me want to become invasive and overpowering. I think. I think, "Right, give me your money. I'll keep all your money and give you pocket money and then we'll get you sorted out." I feel terrifically tempted to do this' (Richards, 2000, p. 7). One participant recounted being aware of countertransference in the wish to attack like the abusive parental object. Another interviewee described being overwhelmed by tiredness in the sessions with a suicidal client: 'I have on occasions really thought I would fall off my chair with wanting to go to sleep, it's been so powerful. I'm convinced that it's something to do with the countertransference, it's something she's doing to me, she doesn't want me to be there or something. There's something mind numbing about what's going on, she's just wiping me out' (Richards, 2000).

According to Richards (2000), the data demonstrate that it was a common experience for the therapists not only to be confronted with a high degree of despair, anxiety and aggression but also to find themselves invaded by such feelings. The clients could be both extremely demanding and disparaging. In the transference the clients would frequently attempt to make the therapist act in a way that accord their inner perception of self and other in relationship.

2.16 Conclusion

From the reviewed literature it seems that therapists' work with suicidal clients presents with a situation of a number of possibilities. Therapists experience a variety of emotions when working with suicidal clients, and the emotional demands of the

work seem to be intense. In this way, what therapists emotionally and psychologically experience is subjective.

The research framework of this study is post-modern. It is then seeking to explore these subjectively experienced emotional impacts and feelings that therapists have in working with suicidal clients.
The next chapter discusses the research methodology of this study.

CHAPTER 3

METHODOLOGY OF THE STUDY

3.1 Methodology of the study

3.1.1 Introduction

This research study took the form of a qualitative design, as the main aim was to make an exploration of the experiences of therapists in working with suicidal clients. A qualitative research design seems to have distinct advantages, and fits in perfectly with this study, and also with the social constructionist position that the researcher took.

In mentioning the strengths of qualitative data, Miles and Huberman (1994) state that well collected qualitative data has the following importance:

"A major feature is that the focus is on naturally occurring, ordinary events in natural settings, so that insight can be gained into what 'real life'. Because the data are collected in close proximity to a specific situation, rather than through the mail or over the phone, influences of the local context are taken into account. The possibility for understanding latent, underlying or non-obvious issues is thus strong" (p. 10).

According to Green (1999), qualitative data inherently "are filled with richness and holism, which holds the potential for revealing complexity; such data provide 'thick descriptions' that are vivid, nested in real context, and have a ring of truth that has strong impact on the reader. The data is typically collected over a sustained period of time, which makes it powerful for studying any process (including history)" (p. 107).

Green (1999) explains this further by stating that the inherent flexibility of qualitative studies (data collection times and means of collection can be varied as a study proceeds) gives further confidence that we've really understood what has been going on. The emphasis is on people's 'lived experience' and as such is fundamentally well suited for finding meanings which people place on the events, processes, and structures of their lives; their "perceptions, assumptions, prejudgements,

presuppositions" and for connecting these meanings to the social world around them (Green, 1999).

"Three other claims for the power of qualitative data, are that qualitative data is the best strategy for discovery, exploring a new area and for developing hypothesis" (Green, 1999, p. 107).

3.1.2 Sampling

3.1.2.1 Method of Sampling

As the aim of the study was the development of an understanding of some concept, this through the subjective experiences of individuals, it became much relevant to determine the sample from a group of people who were likely to provide the relevant theoretical insights (Breakwell, 1995). The group of respondents in this study was one qualified therapist and three trainee therapists, and a theoretical sampling procedure was chosen as a method of sampling.

3.1.2.2 Procedure

To have access to participants/respondents for this study, which were - an already qualified therapist and three trainee therapists - the necessary permission was to be obtained from the “gatekeepers” (Breakwell, 1995), if necessary, particularly with regard to those participants that are linked to institutions in their daily work.
Time also, was taken to explain the aims and background of the research project in terms which the listeners (respondents) were likely to understand. Great care was taken to say just why that particular person was requested to participate, (otherwise they may be left wondering ‘why me?’), (Dyer, 1995).
Explanation of what was going to happen to the information (both as rough notes and in the final report) once it was obtained, was given, and that all information was to be protected by a confidentiality rule. In addition, respect, and any further assurances about confidentiality, which would have been demanded would have been given (Dyer, 1995).

Also it was ensured that the right of every informant to withdraw from an interview at any time is clearly stated, repeated, if necessary at intervals, and acted on promptly. According to Dyer (1995) “the nature of the interview is such that the possibility always exists that an informant will wish to withdraw, especially if it approaches matters which are of deep personal significance” (p.61).

3.1.3 Participants

A group of respondents who were a psychotherapist and three trainee therapists was recruited and they voluntarily participated in the study.

No intended restrictions in terms of work experience, theoretical orientation, gender, race, age, or marital status was imposed in any way, and participation in the study was voluntary, and termination could be made at any time during the study (Rosenthal & Rosnow, 1991) should a participant wished so.

3.1.3.1 Information on the obtained participants

Four participants were obtained in this study. All of the participants voluntarily participated in this study.
The following is a background biographical information about the participants at the time of the holding of the interviews with them:

Participant A is a female intern psychologist at a public hospital (Helen Joseph Hospital). She was in her early thirties, and at the time of this interviewing had already had contact and exposure in working with suicidal clients at the general Medical Wards, the Outpatient setting and the Inpatient Psychiatric Ward of this hospital.

Participant B is also a female intern psychologist serving simultaneously at two public hospitals (this intern was known as a 'floating intern' at Helen Joseph and Coronation Hospitals). She was also in her thirties. As a 'floating intern' she had had constant contact and exposure to suicidal clients at the Medical Wards of Coronation Hospital and the Medical Wards of the Helen Joseph Hospital, had seen regularly suicidal

clients at the Outpatient clinic, and the Inpatient Psychiatric Ward of Helen Joseph Hospital.

Participant C is a qualified and practising female psychologist, with about three years of experience. She was in her late twenties at the time of the interviewing for this study. She had had her main contact and exposure with suicidal clients while she was in her psychology internship year at a public hospital (King Edward Hospital). This was mainly through referrals from Medical Wards, and then through subsequent follow-up meetings with clients on an Outpatient basis.

Participant D is another female intern psychologist, who was in her late twenties. She was doing her psychology internship at Sterkfontein Hospital, which is strictly a state psychiatric hospital. She had had her exposure with suicidal clients in the 'Lock-up Ward' of this hospital.

3.1.4 Method of Gathering Data

Because this is a qualitative study, the interview method of obtaining data was used with the four participants.
With regard to the interview method, according to Dyer (1995), research cannot provide the mirror reflection of the social world that positivists strive for, but it may provide access to the meanings people attribute to their experiences and social worlds. While the interview is itself a symbolic interaction, this does not discount the possibility that knowledge of the social world beyond the interaction can be obtained. In fact, it is only in the context of non-positivistic interviews, which recognise and build on their interactive components (rather than trying to control and reduce them), that ‘intersubjective depth’ and ‘deep-mutual understanding’ can be achieved (and, with these, the achievement of knowledge of social worlds).

Dyer (1995) goes on to say that those of us who aim to understand and document others’ understandings choose qualitative interviews because it provides us with a means for exploring the points of view of our research subjects, while granting these points of view the culturally honoured status of reality.

3.1.4.1 The semi-structured interview

The researcher in this study used a semi-structured interview. According to Dyer (1995), “a semi-structured format, is the one in which the interviewer works from a number of prepared questions, while allowing the respondent plenty of opportunity to expand answers and to pursue individual lines of thought seems to offer the best approach” (p.59). According to Smith in Smith, Harre, and van Langenhove (1995), "in general, researchers use semi-structured interviews in order to gain a detailed picture of a respondent's beliefs about, or perceptions or accounts of, a particular topic. The method gives the researcher and respondent much more flexibility than the more conventional structured interview, questionnaire or survey. The researcher is able to follow up particularly interesting avenues that emerge in the interview and the respondent is able to give a fuller picture" (p. 9). "Post-modernism rejects the idea that a single objective and rational account of the world can be reached. It accepts the existence of the world (people), but this can never be accurately known. Rather, through perception and language, the world is socially constructed by communities" (Carr, 2000, p. 119). According to Gergen (1994), social constructionists argue that an individual's knowledge of the world is constructed within a social community through language. This 'community' in the context of this study is the researcher and the research interview participant.

It seems there are much more advantages in using the semi-structured interview in gathering data. Smith in Smith et al., (1995) continues to explain the advantage of using semi-structured interviews by saying that with semi-structured interviews, the investigator will have a set of questions on an interview schedule but the interview will be guided by the schedule rather than dictated by it.
"Semi-structured interviews facilitates rapport/empathy, allows a greater flexibility of coverage and enables the interview to enter novel areas, and it tends to produce richer data" (Smith in Smith et al., 1995, p. 12).

3.1.4.2 The Interview Schedule

As the researcher had decided on using a semi-structured interview, an interview schedule was thus needed in this regard, which was to help guide the interview, rather than dictate it (Smith et al., 1995).
The formulation of the questions of the interview schedule had come about with a review of the literature that the researcher had used in this study. The main areas that the literature had touched on, together with the aim of the study, had resulted in the formulation of questions that became part of the semi-structured interview.

Because the reviewed literature was wide, and the researcher not wanting to dictate to the research participant in the actual interview, but rather to help guide, the researcher saw it fit to use a few questions, which formed the interview schedule. This was in addition to obtaining the biographical details of the participants.
Thus the number of questions that were compiled for the interview schedule were only ten, as more of expanding and explanation was to be done by the participant during the interview, being helped by the interview schedule.

3.1.5 Method of Data Analysis

As this is a qualitative study, the researcher decided on using the qualitative method of content analysis as a method of analysing data.
Singleton (1993) mentions that content analysis should be seen as a set of methods for analysing the symbolic content of communication. According to Rosenthal and Rosnow (1991), content analysis, forces a researcher to scrutinise the material he is evaluating and classifying it by specifying, the category, the criteria and assessing their success in measuring qualitative phenomenology.

Weber (1985) states that the central idea in content analysis is that the many words of the text are classified into fewer categories. Each category may consists of one, several, or many words. Words, phrases, or the other units of text classified in the same category are presumed to have similar meanings (Weber, 1985).

The data that was obtained from each of the interviews was transcribed, and thereafter subjected to the analysis of its content according to the method explained above. With the formulation of categories, and the resulting word frequencies, the various themes which appeared, were then identified, and are fully discussed in the following chapters.

CHAPTER 4

RESULTS OF CONTENT ANALYSIS

4.1 Introduction

This chapter shows the results of this study. The processes that the researcher engaged in when analysing the results are discussed in details, and the themes that emerged from the obtained data are shown.

The researcher decided on analysing the interview results individually because of the possibility of their uniqueness, and of variation from one interview to the other. Below, the researcher shows the various steps he took in the analysis of data following the content analysis methodology.

4.2 The process of data analysis

According to Weber (1985), the central idea in content analysis is that the many words of text are classified into fewer categories.
According to Weber (1985), each category may consist of one, several or many words. Words, phrases, or the other units of text classified in the same category are presumed to have similar meanings.

To come to this stage of the research results, the recorded interviews were firstly transcribed. The method of data transcribing worked by going through the tape recorded verbal responses of each research participant and transformed them into a typed verbatim. As with the method of content analysis, words, word senses and phrases are of particular importance.

Content analysis forces the researcher to scrutinize the material he is evaluating and classifying it by specifying the category, the criteria, and assessing their success in measuring qualitative phenomenology (Rosenthal & Rosnow, 1991). The formulation of categories from the obtained data was done as soon as the data was in a typed format. These categories consisted of several or many words.

From there the researcher could classify in the same category those words, phrases, word senses or units of texts which were presumed to have similar meanings (Weber, 1985). As these were classified into their respective categories, the system of enumeration was also being defined and applied (Singleton, 1993). By system of enumeration this refers to a number of times that a certain word, word sense or phrase that was put into its respective category, as it appeared in the text, was being recorded in terms of its number of times of appearance. This led to the formulation of *frequencies.*

The Table below represents the codes and frequency of particular categories of words, word senses and phrases that were obtained in the transcribed interviews.

CODES	CATEGORIES	FREQUENCIES
101	Suicidality because of finance, job place to stay, etc	5
102	Suicidality because of emotional pain/problems	4
103	Sucidality because of depression	10
104	Suicidality because of a personality disorder, e.g. borderline personality disorder	10
105	Suicidality as a result of relationship problems	6
106	Suicidality as a result of family problems	4
107	Suicidality as a result of a crisis situation in a client's life and context	3
108	Suicidal client as very emotionally needy	7
109	Suicidal client as needing support	3
110	Suicide attempt as not really wanting to die, but something else, such as a way of coping or of seeking attention	17
111	Suicide attempt as an attempt to communicate something to others, or as a need to be heard	10
112	Suicide attempt as inability to cope	4
113	Suicide attempt because one is 'lost'	6
114	Suicide attempt as a functional symptom in the client's family or context	4

115	Therapist having one, single, or generalised perception of suicidal clients	1
116	Therapist not having one, single or generalised perception of suicidal clients	4
117	Therapist's feelings of exhaustion/tiredness	14
118	Therapist's feelings of anxiety	5
119	Therapist's feelings of empathy	7
201	Therapist's feelings of sadness	6
202	Therapist's feelings of being demanded by the suicidal or suicide attempting client	6
203	Therapist's feelings of being personally invaded and engulfed by the suicidal client	16
204	Therapist's feelings of being rejected by client	14
205	Therapist's feelings of being manipulated by client	20
206	Therapist's feelings of being inhumane with client	1
207	Professional responsibility (boundaries) as opposed to needing to act in an humane way	3
208	Therapist's feelings of confusion about her role	1
209	Therapist's feelings of professional liability	12
210	Suicidal client found to be desperate	13
211	Suicidal client found to be feeling abused	1
212	Suicidal client found to be eliciting dependency onto the therapist	4
213	Suicidal client found to be eliciting feelings of avoidance from therapist	6
214	Suicidal client found to be frustrating by therapist	6
215	Suicidal client found to be having withdrawal and avoidance tendencies	6
216	Suicidal client found to be evading responsibility	3
217	Suicidal client found to be always drawing in the therapist	9
218	Suicidal client perceived as angry	14
219	Suicidal client perceived as tired	5

301	Suicidal client perceived as selfish	2
302	Suicidal client perceived as afraid of themselves	2
303	Countertransference issues	4
304	Suicidal client's therapy found to be a learning process by therapist	8
305	Therapist drawing from previous personal experiences	6
306	Therapist taking of responsibility over the client	3
307	Therapist's experiences of emotional impact	5
308	No therapist's experiences of emotional impact	-
309	Therapist's perceptions of something positive about suicidal client	9
310	Client's regret and humiliation over suicide attempt	5
311	Therapist's need to do a good therapeutic job	2
312	Therapist's feelings of surprise and shock following client's suicide attempt	1
313	Therapists feelings of personal inadequacy and self-blame as a result of client's suicide attempt	4
314	Therapist not feeling bad about oneself as a result of client's suicide attempt	-
315	Therapist's feelings of anger as a result of client's suicide attempt	13
316	Therapist's feelings of helplessness following suicide attempt of client	2
317	Para-suicides and repeated suicide attempts not taken seriously by therapist	2
318	Impact on therapist because of not knowing what client is going to do	2
319	Client's socio-economic problems found to be inhibitory to the process of psychotherapy	8
401	The ambivalence of the therapeutic relationship	5
402	The closeness of the therapeutic relationship	6
403	Therapist's feelings of needing to care about client	2

404	Therapist's feelings of guilt	2
405	Therapist's feelings of having done her part	6
406	Desensitisation and bluntness as emotional impact in working with suicidal clients	11
407	Time as a subjectively experienced stressor	4
408	Therapist's feelings of feeling like giving up on working with suicidal clients	1
409	Therapist as providing with psycho-education and or coping skills to client	16
410	Establishment of trust and rapport in the therapeutic relationship	3
411	Need for follow-up sessions for the client	8
412	Therapeutic intervention at client's family/relationship level	5
413	Therapist's need for intense support from supervision	7
414	The need to put down boundaries with clients	1
415	The need to enter into a suicide pact or contract	4
416	The hospital system found by therapist to be a stressor	4

Table representing the Categories and Frequency of Word Senses and Phrases

4.3 Themes that emerged from the interviews

As gathered from the various categories, which consisted of the frequencies of word senses and phrases, the following themes were then formulated by the researcher as having emerged from the interviews. These were viewed by the researcher as overall common themes, which were found in the text document from each of the respondents in the interviews.

The researcher came to the decision of formulating themes taking from categories which had the highest frequencies. In this regard, the researcher decided on formulating themes from those categories which had a numerical appearance in terms

of word senses, phrases and units of texts having common connotations from ten times upwards.

4.3.1 Suicidality because of depression

Therapists have found that other people try to commit suicide mainly because of depression, as Interviewee B has said that *"Also clients I work with in long-term, clients with …depression that attempted suicide during this year."*
She had this perception with one of her suicidal clients: *"I could see that she was terribly depressed, and she's feeling awful."*

This therapist also sounds as if able to make deductions between a real intention to die, and just a manipulation by client, *"If you want to die, then you are terribly desperate, depressed and alone."*
Perhaps also there is serious intentionality with regard to suicide amongst depressed clients. Interviewee B states, *"With the ones who are depressed…have them admitted and medicated."*

4.3.2 Suicidality because of a personality disorder, for example, borderline personality disorder

It appears as if borderline clients present themselves to therapists as having more of a personality problem, which then present itself with many suicide attempts.
From the borderline clients that she has seen, Interviewee B stated that, *"All wanted to kill themselves for all the bad reasons, all because of personality disorder."*

Whereas Interviewee C's experience with borderlines is that which also had an impact on the therapy relationship. She said that, *"It's like a borderline personality disorder who presented underlying dynamics of the good object and bad object."*

4.3.3 Suicidal client found by therapist to be desperate

Because of their inability to cope with problems, suicidal clients have been found to be very emotionally desperate.

"It's like they desperately need you." - Interviewee A

Once a therapeutic relationship has been established, Interviewee B mentions that *"Sometimes I can feel their desperation, it's a desperate person who needs something badly."*
The process of therapy as well helps the therapist to get more into this emotional desperation, *"When they do get involved, when they do come back for group and stuff then you do get involved and you actually pick up their desperation and depression and whatever stuff"* - Interviewee B.

4.3.4 Suicide attempt as not really wanting to die, but something else, such as a way of coping or of seeking attention

The interviewed therapists, through their exposure and experience in working with suicidal clients, have come to view some suicidal actions as not really a wish to die. They view these rather more as a way that people find and use to cope within their contexts, and also as a way of getting attention from their significant others. Interviewee A said that, *"I get the sense that they don't want to die. It's a case of they want a way out or they don't know what else to do."*

"I know that they can potentially die but somehow they never do, they are just para-suicides." - Interviewee B. She sees a para-suicide as: *"It's a desperate person, who wants to get attention and needs something badly. Some are doing it because there's no other way to get attention."* This is in line with Interviewee C's way of thinking that para-suicides *"thought it's a way of coping, getting attention from their spouses and people who want to leave them."* This therapist says that for a personality disorder, such as the borderline, through suicide attempt, *"there's a feeling of relief, that 'look I am alive, I have pain, I bleed.'"*

4.3.5 Suicide attempt as an attempt to communicate something to others, or as a need to be heard

According to Interviewee A, because of their anger, people who are attempting suicide *"they want that person to know they are angry. It's only an attempt to say,*

'Look, I am angry, and I need you hear that. " "They thought it's a way of getting attention," - Interviewee C.
This is also the same feeling with Interviewee B, *"How far must they go…how far must they go before people hear them?"* She continues by saying that, *"Then the way to get out of it…you are really in trouble interpersonally, your way to elicit reaction is to take an overdose."*

4.3.6 Suicidal client perceived to be angry

Therapists seem to have a common view of suicidal clients as people who are angry, and the suicidal act as an act out of anger.

"I get the sense that they are angry! It's like an act of anger, they feel angry with somebody, and they want that person to know they are angry." - Interviewee A.

"With all there is anger, so deep seated anger." - Interviewee D.
According to Interviewee B, *"It's like an institutionalised way of solving problems. It's part of their sculpture, when you don't feel well, when you are angry, when you fight with your boyfriend or with your parents or whatever, then the way to get out of it…"*
According to Interviewee C there are *"…different things that get people to be angry enough…to consider an option like that."*

It appears as if the anger has led to an irrational thinking and decision making with suicide been considered as an option. As to the nature of the anger itself interviewees did not give description. But it seems much of it is interpersonal rather than intra-personal. *"I could be wrong, but a lot of anger directed at other people, and I also think that suicide is internalised anger"* - Interviewee D.

4.3.7 Therapist's feelings of professional liability

In dealing with suicidal clients therapists seem to experience a certain amount of pressure, professionally, *"You really not want to stuff up because of huge implications."* - Interviewee A.

Interviewee B said, *"I can't say you can prevent them from doing it. I am going to be liable, in a way. I feel like I am a bit responsible for the ones I'm really involved in,"* and, *"they stay my responsibility."*

"Other stressors like checking out that you really make sure that this patient is really not suicidal." - Interviewee B. For Interviewee C: *"I need to check out, and make sure I have covered the different areas that I think could be dangerous in this person's life."*

According to Interviewee C, *" I kind of assess the situation in terms of responsibility, and I try to access all the avenues in terms of my responsibility. "* This seems to be a felt professional pressure. This also includes, *"Making sure you do appropriate counselling."*

4.3.8 Therapist's feelings of being manipulated by client

Therapists have found suicidal clients, particularly those with personality disorders such as borderlines, to be very manipulative of them as therapists, of therapy, and of other people.

For example, Interviewee number A said, *"It's like they desperately need you and really want you there, but then they sort of push you away, or think that you don't care, or test the boundaries"*. This therapist recalled a certain client of hers whom she said that, *"she's always playing a game of kind of seeming to always really need me, but not wanting to be in that position."*

Even though she had some therapeutic relationship with her one borderline client, interviewee B said that, *"you never know what she is going to do, it's like a manipulation thing…"*

With her borderline client, Interviewee D remembers that this client used to *"threaten me all the time, you know, with the suicide,"* and that this client used to blackmail her. This therapist has personally discovered that *"borderline clients are the ones who try to manipulate the situation more than any other client. Like at any one stage they'll be quite okay, and 'I don't need any help', the next stage they'll put on the 'I need help, everybody help me and I am going to die right now'. "*

4.3.9 Therapist's feelings of being personally invaded and engulfed by suicidal client

When working with suicidal clients, particularly those attempting suicide in the middle of therapy, therapists have felt that their personal lives were being taken over by these clients, as these therapists felt a sense of needing to be always available to them, both emotionally and practically. Interviewee A has expressed this in this way, *"Because you have to make a judgement cause in a way about someone's life, like do they need to go into the ward or should you make a suicide pact, and it sort sit into your mind"*. She had expressed her involvement with her one suicide attempting client in this way, *"I feel like I'm her family almost"*.
Interviewee B's experience was, *"I had to keep my phone on next to my bed in case she wants to phone, so I must be there for her all the time. …you think about them a lot"*.
It appears as if suicidal clients are very demanding in all ways in working with them in therapy. The demands vary from being emotionally available to them, decision making and in taking appropriate practical actions.

4.3.10 Therapist's feelings of being rejected by suicidal client

Therapists have found suicidal clients to be very rejecting, both of them, and of the therapy relationship.
" I think there is ambivalence, they are needy, and they rely on you, and they really rely on you and you become very important, but at the same time they want to push you away, or not wanting to be in that situation." - Interviewee A.

"It feels like they don't really want to be helped, so for me to go into a relationship would mean rejection from them," and also, *"With long-term ones… a sense of desperation, and also rejection."* - Interviewee B.

Interviewee D mentions a client which *"disqualifies everybody who tries to help him, including me. Maybe that's where my irritation comes from because he blocks me from helping him."* She describes this situation also with another client of hers: *"I*

tried to get closer but she would always stop me with some sort of action or something."

According to Interviewee B, with suicidal clients, there is *"something between anger stuff and rejection."*

It appears as if suicidal clients have a serious emotional difficulty in admitting, to self and to others, their need for help from others.

4.3.11 Therapist's feelings of exhaustion/tiredness

Regarding personal experience of working with suicidal clients is: *"One of the many experiences you find that is the exhaustion because this client kept on threatening and kept attempting suicide."* - Interviewee A.

This experience is also which is felt as an emotional impact in working with suicidal clients.

This is also another therapist's experience with a client who was also very dependent on her. She mentions having to cope with this client's dependency, and *"but at the same time I am getting very exhausted."* - Interviewee B.

Interviewee D's experience is that of being physically and emotionally drained. *"I found that by just talking to him, and noticing how drained I was at a certain time when we started talking about his family and his suicidal nature, how drained I felt However, when I was talking about the aspects of the other life I was getting more energetic."* - She goes on to say that, *"Having to be disturbed like twenty-four hours a day just became too much for me. I was tired constantly."* - Interviewee D.

4.3.12 Desensitisation and bluntness as emotional impact in working with suicidal clients

Over some time working with suicidal clients, *"The surprise element goes away after a while"* - Interviewee C.

"You get sort of desensitised for working with them. I can see that now I get so desensitised and blunt. Now I feel if they are going to do it they do it…I did my part." - Interviewee B.

A similar process with Interviewee D, *"So for me I think I have shut down a little bit more than when I came to the ward. Not that I am not as open, it's just…I'm different."*

4.3.13 Therapist's feelings of anger as a result of client's suicide attempt

The interviewed therapists expressed a feeling of irritation and anger as a result of a client's suicide attempt. This was more so especially with clients that they were already in therapy with.

Interviewee B was already in therapy with her long-term client who was prone to bio-chemical depression and suicide attempts. When this client attempted suicide in the middle of the process of therapy, Interviewee B felt *"angry with her for doing that. Not phoning me after contracting that she would do that!"*

This is very similar to Interviewee A's response toward a client for having attempted suicide during the therapy relationship.

Interviewee D was angered by a client who started acting out and threatening with suicide as the therapy session was drawing to close. *"She's making me angry by going on like this, and it's not going to help her." S*he felt more angered as she could deduct that the client's actions were more of manipulation than having a feeling of wanting to die. This therapist also thinks that she would respond to a client's suicide attempt during the therapy process with more anger as an initial response.

It looks like therapists experience more of the betrayal of the therapeutic relationship when a client attempts suicide during the process of therapy, and they feel very angered by this act of the client. This seems more so particularly if the client did not forewarn or inform them at least, before attempting another suicide.

This act of the client seems to also intensify the therapist's feelings of rejection of the client of her as a person, and of therapy.

4.3.14 Therapist as providing with psycho-education or coping skills to suicide attempting client

A major theme that appeared also during the interviews, particularly with Interviewee C is the role of the therapist in working with a suicidal client, which is mainly that of psycho-educative work. This is to help the client cope, both with his or her emotional state and with his or her environment.
"So what I find as my role, apart from being supportive in that environment (therapeutic environment), would be re-educative, where I would provide them with other options of coping." - Interviewee C. Her therapy would be mainly about *"using the basic principles of hearing the person, containment, the need to do the re-educative stuff…talking about learning other ways of coping, dealing with the emotions relating to that, and basically learning about feelings. You are helping him with skills."*

4.4 Conclusion

In this chapter, the researcher gave a detailed discussion of how he had gone about with the analysis of data. The themes that emerged were also briefly discussed. In the following chapter there is a detailed discussion of the results (the themes that were obtained) in light of the reviewed literature.

CHAPTER 5

DISCUSSION OF RESULTS AND CONCLUSION OF THE STUDY

5.1 Introduction

The study yielded results that particularly emerged from the subjective experiences and perceptions of a therapist and trainee therapists in their individual capacities, that is, as experienced and felt by each therapist. Common themes were identified, and hence formed major themes which are discussed in this section as the results of this study.

As the study is from a post-modern, social constructionist position in particular, the identified common themes from interviews held by the researcher with the participants are thus understood as 'truths', which have been socially constructed. The construction of these 'truths' happened during the conversation (semi-structured interviews) between the researcher and the participants.

According to Carr (2000), "for social construtionists, truth is not discovered but constructed. However, it is not constructed by isolated individuals; rather, it is constructed by communities of people in conversation" (pp. 117-118).

This means that the presence of the researcher, together with the conversation held with the participants of the study, had helped the participants to come to make useful constructions of how they have individually experienced working with suicidal clients. "The usefulness of a construction is judged by a community in terms of the degree to which it facilitates problem-solving, adaptation to the environment, need-fulfilment and survival" (Carr, 2000, p. 118). Thus the researcher has come to accept the themes which emerged in this study as socially arrived at 'truths' through the conversations held with participants. These 'truths' had also helped the participants to have a perception of their therapeutic work (conversations) with clients who are troubled by suicidal feelings and behaviour.

5.2. A discussion of themes

The common themes, as obtained from the individual interviews with the therapists are: *suicidality because of depression*; *suicidality because of a personality disorder, for example, borderline personality disorder*; *suicidal client found by therapist to be desperate*; *suicide attempt as not really wanting to die, but something else such as a way of coping or of seeking attention*; *suicide attempt as an attempt to communicate something to others, or as a need to be heard*; *suicidal client perceived as angry*; *therapist's feelings of professional liability*; *therapist's feelings of being manipulated by client*; *therapist's feelings of being personally invaded and engulfed by suicidal client*; *therapist's feelings of being rejected by suicidal client*; *therapist's feelings of exhaustion/tiredness*; *desensitisation and bluntness as an emotional impact in working with suicidal clients*; *therapist's feelings of anger as a result of client's suicide attempt*; *therapist as providing with psycho-education or coping skills to suicide attempting client*.

5.2.1 Suicidality because of depression

According to Hughes and Neimeyer (1993), the cognitive predictors of hopelessness, self-negativity, and poor problem solving performance function as reliable predictors of suicide risk. Hughes and Niemeyer (1993) also found that suicidal clients are extremely pessimistic and hopeless about the future even when compared to depressed clients.

In this sense, depression appears as a precipitating factor to suicide. Most commonly also is the hopelessness found in depressed clients, which is also found in suicidal clients. According to Neuringer (1988), they think only in terms of good and bad. This is particularly dangerous when life is seen as bad and death is seen as good. As is found in most depressed and suicidal clients, Freeman and Reineke (1993) state that such clients are pessimistic also about the world and their relationships with others. Interviewee B had mentioned loneliness found in depressed suicidal people, *"If you want to die, then you are terribly desperate, depressed and alone."* Weishaar and Beck (1992), and Carney and Hazler (1998) view a suicidal person as holding no hope of improvement and seeing no reason to continue living.

Emotional desperation, or having a sense of finding significant others to be emotionally unavailable seems to be one strong contributing variable to suicide being considered by emotionally troubled persons.
In this situation, intensive hospitalised treatment was considered as important by Interview B, *"…have them admitted and medicated."*

5.2.2 Suicidality because of a personality disorder, for example, borderline personality disorder

According to Kaplan and Sadock (1994) borderline personality disorder patients are…characterised by extraordinarily unstable affect, mood, behaviour, object relationships and self-image.

Borderline personality disorder patients almost always appear to be in a state of crisis. Mood swings are common. The patients can be argumentative at one moment and depressed at the next and then complain of having no feeling at another time (Kaplan & Sadock, 1994),

According to Kaplan and Sadock (1994), the painful nature of their lives is reflected in repetitive self-destructive acts (suicidality). Such patients may perform wrist slashing and other self-mutilations to elicit help from others, to express anger, or to numb themselves to overwhelming affect.

Richards (1999) state that it is probable that the inner world of a suicidal person (with a borderline personality problem) will be very bleak and impoverished.
Instead of comforting and nourishing primary objects have been internalised, there is constant threat of psychological disintegration, arising from an intolerable experience of aloneness and emptiness. These clients are displaying a constant need to search for external sources of comfort and unconditional love (Richards, 1999).

According to Interviewee B, she found the reasoning for suicide attempts by her borderline clients to be unsound, as they *"all wanted to kill themselves for all the bad reasons."* This is simply because of their personality structure, which contains serious

emotional and mood instabilities, accompanied with the affected person's (borderline) inability to control these.

With these clients, according to Interviewee C, *'…the dynamic there of self-injury is different from the act of suicide, because in a borderline case like that there is a feeling of relief, that, 'Look I am alive, I have pain, I bleed.'"* The borderline client in this way may be viewed also as attempting to communicate many issues pertaining to the self at one time, inside and outside of the therapy contexts.

5.2.3 Suicidal client found by therapist to be desperate

Also what came out in the study was, from both the perception and the emotional experience of the therapists of the suicidal clients as emotionally desperate persons. It appeared as if suicidal people had reached a point of despair and of hopelessness.

From a level of intellectual understanding, therapists came to perceive the desperation of their clients, and of having a very raw sense of needing the other for help, that is, they were found to be emotionally needy. According to Interviewee A, *"It's like they desperately need you and really want you to be there."*

Through working with them, Interviewee B came to find them as extremely needy and desperate, *"I have come to perceive them as needy. Some are doing it because they are very desperate. ….you know it's a desperate person who wants to get attention and needs something badly…"*

Interviewee B, in particular, has been emotionally sensitive and close to her clients' emotional neediness and desperation during the process of therapy, *"When they do get involved, when they do come back for group and stuff then you do get involved and you actually pick up their desperation and depression and whatever stuff"*

According to Maltsberger in Jacobs (1999) the psychological dimension of almost every case of committed suicide (or serious completion) can be understood in terms of intensely felt psychological pain (called *psychache*) coupled with the idea of death

(surcease, cessation, nothingness, oblivion) as the best solution to the problem of unremitting and intolerable *psychache* (Maltsberger in Jacobs (1999)).

Emotional desperation could as well be explained as a felt psychological pain, which Maltsberger mentions as *psychache.* As desperation and psychological pain becomes unbearable to a person, then a suicide attempt seems to be an option (only option) that a mentally distressed person sees as available.

5.2.4 Suicide attempt as not really wanting to die, but something else, such as a way of coping or of seeking attention

Working empathetically with suicidal clients had led therapists to find their clients' one other way of coping in demanding situations, and also of seeking the attention of others, which is by the attempt to commit suicide.
According to Milch (1990), the patient's destructive behaviour can be seen as …an offer of contact. According to Richards (2000), suicidal clients are amongst those who rely heavily upon projective identification both as a defence and as a means of communication.

One therapist said that she gets the sense that suicide attempting clients do not really want to die. According to this therapist, *"they seem to have very little coping skill, they seem they can't deal with things. …It's a case of they want a way out or they don't know what else to do."* - Interviewee A. *"It's a way of coping. It helps them cope if they go through that point in time… that's for them their way of coping, their way of dealing with it."* - Interviewee C.

This links with the point of desperation that suicidal clients often seem to quickly reach in their lives, and in attempts to cope with their situations.

"I think some use it to get attention. I can think of a boy who got a lot out of it and another client who … a borderline client who got a lot of attention from it." - Interviewee A. Para-suicides, in this regard, were viewed as such by therapists, that is, as mainly a way of getting attention from others, *"…it's a way of coping, getting attention from their spouses and people who want to live them."*

Interviewee B recalls a client in this way: *"…I could see the function of his system because he does suicidal stuff because he wants to get attention. To get people closer to him and stuff… your way to elicit reaction is to take an overdose, because you know the ambulance is going to fetch you, and is going to be a big trauma, and everybody is going to visit you in hospital, they'll send you flowers and food and cards, they'll have a lot of sympathy with you, and you'll forget it because how can they be so nasty with you and …the symptom is really functional in a way that they return to the family, they integrate with the family again. And I feel like…well…you don't actually need that much from me, it's not that you actually want to die."*

Perhaps the need to be accepted by significant others unconditionally and to be attended in a way that is emotionally beneficial urges suicide attempting people to view and accept suicide attempt as an option to call for attention, and to cope with problems.

5.2.5 Suicide attempt as an attempt to communicate something to others, or as a need to be heard

As through the attempt, suicide-attempting people have been perceived by therapists as having another important need in their lives, the need to be heard, particularly of their overwhelming emotions to be understood by others.

"They want that person to know they are angry. It's only an attempt to say 'Look, I am angry, and I need you hear that."

According to Richards (2000), they have felt themselves (suicidal people) to have been intruded upon in various ways, both physically and emotionally, and yet their true feelings had been ignored.

5.2.6 Suicidal client perceived to be angry

In Richard's (1999) study, many of the suicidal clients perceived their parents as being involved with them in ways that had more to do with the needs of the parents than their own needs as a child.

It is likely that the child who has experienced abandonment, there has been no one available to either hear or receive his/her angry feelings. ... the parents would be too self-absorbed to help the child deal with his/her rage. Without such help in infancy the child cannot grow to believe that things are manageable and fails to develop adequate inner resources to deal with such feelings (Richards, 1999).

According to Richards (1999) what seems to characterise the feeling of having to act out the rage is the perception that no one other person is able to help and process the anger: it is impersonal. The suicide attempt can be understood as an angry attack or revenge but one that can be only carried out by killing the self's own body. The fear is: if I get in touch with the rage, I will annihilate the other, so I had better annihilate myself (Richards, 1999).

In this study, therapists had a view of their suicide attempting clients to be very angry. *"With all there is anger, so deep seated anger."* - Interviewee D.
According to Interviewee B, *"It's part of their sculpture."*

One therapist, Interviewee A, regarding her clients' suicide attempts, found out that, *"It's like an act of anger, they feel angry with somebody, and they want that person to know they are angry."* It seems therapists also had an understanding that suicidal clients also tend to communicate their feelings of anger as a result of interpersonal troubles and problems in a way of self-mutilation or destruction, that is, problems encountered interpersonally are being dealt with by suicide attempts. *"A lot of them are primarily relationship problems, …their boyfriends and girlfriends had threatened to leave them or had ended off the relationship and they are with somebody else, or they have problems with families."* - Interviewee C. One therapist even commented that, interpersonally, they are *"easily made sad, and easily hurt, or angered…"* - Interviewee D, and then they act out their feelings by attempting suicide.

5.2.7 Therapist's feelings of professional liability

Therapists in this study had also felt pressure coming from the professional responsibility of working with suicidal clients.

Client suicide [or its possibility] is a source of considerable anxiety for psychotherapists. It is experienced by a substantial number of therapists, and has a significant emotional impact when it occurs (Menninger, 1991).
….the presence of anxiety in such situations as a "feeling of imminent suicide in a client," "repeated suicide attempts," "a patient threatening suicide on the phone but refusing to give his whereabouts,"… (Menninger, 1991, p. 243).

According to Barr (1996), in this day of stated outcomes, clinicians hesitate to engage with a client whose purposes imply potential suicide.
McAdams III and Forster (2000) talk of the impact on the therapist due to client suicide, on the professional level in terms of the therapist's practice, motivation, trust in his or her abilities and functions, and in dealing with future suicidal cases, and as well as other areas of his or her professionalism. McAdams and Forster (2000) view client suicide as negatively affecting these areas.

In McAdams and Forster's (2000) study, professionally, therapists reported increasing their attentiveness to legal liabilities of their work, increasing their tendency to refer at risk clients for hospitalisation, strongly increasing their focus on potential cues to client suicides, becoming more likely to seek peer and collegial consultation around high risk cases, becoming more conservative in their clinical record-keeping, and having generally increased concern for issues of death and dying.

One therapist said that working with suicidal clients, for her, her experience of working with suicidal clients, *"It's quite challenging and there is an extra variable of … really not wanting to get hurt yourself, or you really not want to stuff up because of huge implications."* - Interviewee A.

Under crisis and very pressurising situations, the therapist's feeling can be *"dreadful, terrible, like I really have to help this person and I felt very responsible."* - Interviewee B.
For interviewee C, *"It makes me more alert…I need to check out, and make sure I have covered the different areas that I think could be dangerous in this person's life. That's when I think of things like the signing of the [suicide] contract…. So those sort of things - signing the suicide contract, making sure you do appropriate counselling,*

checking out on the environment that causes or stimulates such behaviour, and then making sure that's dealt with as well " - Interviewee C.

5.2.8 Therapist's feelings of being manipulated by client

Personality disordered clients, borderlines in particular, were found by therapists in this study to be very manipulative.

They are likely to tell the therapist that everything is alright, that they can cope on their own, and that they want to go home. Unfortunately, if not treated, many of these clients will repeat the suicide attempt (Milch, 1990). *"Very needy and attention seeking, manipulative… they can put on many faces, you know."* - Interviewee C.

Therapists in this study had found themselves to be not knowing what the suicidal client will do, and in this way felt out of control regarding the treatment process, it seems. According to one therapist, regarding her borderline client, *"you never know what she is going to do."* - Interviewee B. *"She used to threaten me all the time with the suicide, and so I think it was in our third or fourth session, I told her no, that she shouldn't blackmail me."* - Interviewee D.

Threats with suicide attempts were also found as one way in which suicidal clients would use to control the therapist and the therapy. *"I would be like very tense all of the time, like whether this client would die or not. Afterwards I realised how much she kind of get me in her caring in a way, …like how much she did everything in her power to get me in that situation."* - Interviewee A. In order to describe the manipulative situation, she went on to describe this patient in this way, *"She does not have anyone else and she's always playing a game of kind of seeming to always really need me but not wanting to be in that position, and yet at the same time I am."*

It appears as if therapists would generally find it demanding and difficult working with suicidal clients with borderline personality problems, this because of the manipulation that happens during the process of therapy.

5.2.9 Therapist's feelings of being personally invaded and engulfed by suicidal client

Some clients attempt to communicate their feelings and experiences to another person. In this way they may actually make the other feel and know what is like inside their inner world (Malin & Grotstein, 1966). According to Richards (1999), it seems that for those whose early experience of relationships has been poor, there is little sense of inner holding and security. They may feel that this can only come from other people outside the self.

With suicidal clients, Richards (1999) mentions that they have felt themselves to have been intruded in various ways, both physically and emotionally. There is fear both of being engulfed and taken over by an all-powerful, overwhelming object.
It is because of these experiences of these clients that they have, and they come to project them onto their therapists. In a way they take over the lives of these therapists. This is in accordance with Interviewee B's experience, *"I went home but it doesn't leave me when I went to sleep…I couldn't stop thinking about them as a way to control my feelings towards them. The suicidal ones are definitely having an impact due to you feel like you can't let go of them, they stay with you all the time. So that is the discomfort in a sense that it feels like they are never leaving me".*
With this kind of situation, the therapists gets to be involved in many very demanding ways, with the client, such as cognitively, emotionally, and practically.

5.2.10 Therapist's feelings of being rejected by suicidal client

The therapy relationship has been found by therapists as having been filled with ambivalence.

In Richard's (2000) study, therapists described their clients as displaying a need and longing to be loved and valued. However, it was striking that many of these clients were described as also having a fear and a hatred of the dependent relationship upon the therapist. They could perceive it as ending in abandonment, either in the form of rejection or engulfment.

Richards (2000) reports that some therapists also described their clients as also attacking the therapy and attempting to sabotage the process.
The results of Richards' (2000) study indicate that clients displayed both a desperate need and yet, at the same time were very frightened by the closeness of the therapy relationship. This sometimes meant that clients attempted to destroy the therapy as well as showing signs of wanting it.

The suicidal clients' experience of therapeutic closeness feels as too much for them, and they tend to display making shifts away from it, yet at the same time therapists found this as rejection.
According to Milch, (1990), these clients may attack the therapist's feelings of self-worth. Thus the therapist may have to endure a client's rejection for long periods during treatment while still proving adequate holding functions.

This situation, during the process of therapy, could be experienced as difficult by the therapist and also as frustrating. The experience of Interviewee A was: *"But then they sort of push you away, or think you don't care, you know or test the boundaries. It's kind of…there is ambivalence."*
"They don't come back for therapy and stuff like that. It feels like they don't really want to be helped, so for me to go into a relationship would mean rejection from them." - Interviewee B.
A more frustrating experience of Interviewee C was with a male client who *"disqualifies everybody who tries to help him, including me…because he blocks me from helping him."* This is similar to Richard's (2000) study, wherein a therapist mentioned that, at times she felt completely useless, hopeless as a therapist and as a human being, always doing and saying the wrong things. Maltsberger and Buie (1989) noted a client who was in a struggle with a therapist. The therapist noted that 'it seemed that he had needed to provoke a rejection from the therapist. Once satisfied that that no one really understood or cared he could turn away from other people and destroy himself' (p. 286). According to Richards (2000), in this way the client confirms his internal perception of how the world is.

It seems the suicidal client's inability of self-acceptance leads to rejection of the self, which is then accompanied by the client's need to confirm this with others, that is, by

provoking rejection from others, the therapist included. According to Milch (1990), thus the therapist feels incapable, helpless, and guilty.

5.2.11 Therapist's feelings of exhaustion/tiredness

When working with suicidal people, according to Pope and Vasquez (1991), there is a great potential for fatigue, boredom, and negative transference.
Maltsberger and Buie (1989) mention that a therapist may glance often at his watch, feel drowsy, or daydream or rationalise referral, premature termination, or hospitalisation just to be rid of the client.

In this study, therapists have mentioned intense feelings of exhaustion and tiredness when working with their suicidal clients. These feelings of tiredness having come about because of the clients' threats of suicide, and also during the treatment process, as therapy seemed to be not really helping, and have been felt as an emotional impact in working with suicidal clients. According to Pope and Vasquez (1991), a psychiatrist commented that when one is working with suicidal people day after day, one just gets plain tired. One gets to the point of feeling, 'All right, get it over with.'

Therapist A said that, *"Sometimes I feel very tired, I get very tired, very demanded." "They elicit motherly feelings from me* [dependence on the therapist] *but at the same time I am getting very exhausted."* - Interviewee B.
Interviewee D also had a client who elicited dependency on her, and having to cope with it, *"but at the same time I am getting very exhausted. I found that by talking to him, and noticing how drained I was at a time when we started talking about …suicidal nature, how drained I felt. But when I was talking about the aspects of other life I was getting more energetic"*
Interviewee B describes herself as feeling *"empathy for some, but exhaustion for others."*

Because of the nature of their emotional dependency, and of their circumstances, suicidal clients can very much elicit feelings of dependency on the therapist, and these could lead to therapists feeling very demanded, and subsequently very exhausted.

5.2.12 Desensitisation and bluntness as emotional impact in working with suicidal clients

Over time therapists get to be emotionally blunt and desensitised with working with suicide cases.

Kleespies et. al. (1993) found that the emotional impact of a client's successful suicide on psychology interns/trainees was as high, if not higher than that found in comparable studies of professional level studies. Kleespies et, al. (1993) speculated that this heightened impact may be a function of less experience, less preparation, less security about one's role and ability, and or greater proneness to surprise or shock over client's suicidal behaviour.

In Menninger's (1991) study, the themes that therapists most commonly cited in describing their reaction to news of a client's suicide were shock (feeling stunned or surprised), sadness (feeling loss or grief), anger, a sense of guilt (regret), anxiety (feeling worried or fearful of criticism), and doubt about competence (questioning their skills, feeling inadequate).

It should be borne in mind that the findings in the above mentioned studies were those which tempered around therapists' feelings following the *success of a client's suicide attempt*, and not about therapists' general feelings in working with suicidal clients.

In this study, it has been found out that when working with suicidal clients over some time, especially on a regular basis, *"the surprise element goes away."* - Interviewee C. According to Interviewee B, *"you get sort of desensitised for working with them. I can see that now I get so desensitised and blunt. Now I feel if they are going to do it they do it…I did my part.*

Talking of her experience of emotional bluntness after having spent time working regularly with particularly borderline clients, Interviewee D said that, *"Frustration, sadness, irritation,… I think it has lessened to a large degree over the time…So for me I think I have shut down a little bit more than when I came to the ward. Not that I am not as open, it's just that…I'm different…I don't know if I have shut myself off, but I can shut my emotions down and close off. "*

It seems as if emotional bluntness and desensitisation is as a result of a function of experience and time in working with suicidal clients on a regular basis, particularly with the para-suicides, as Interviewee B said that, *"You hear the same stories over and over…"*

5.2.13 Therapist's feelings of anger as a result of a client's suicide attempt

Therapists have mentioned feelings of anger as a result of a client who attempted suicide while they were still in therapy with them.

According to Wolk-Wasserman (1987), the suicide attempt clearly expressed aggression towards the therapist. Repeated threats of suicide could provoke fear or anger in the therapist, since such an action involved a failure in his or her work. Milch (1990) refers to this - client's suicide attempt while in therapy as a narcissistic injury to the therapist.

Pope and Vasquez (1991) states that one of the two main problems in treating suicidal clients is our own anger defensiveness when confronted by someone who does not respond positively - and perhaps appreciatively to our therapeutic efforts.

This has also been the experience of interviewees in this study. Once her client tried to commit suicide while in therapy with her, Interviewee B was *"sort of shocked, because she said she would phone me whenever she wanted* [or feeling like] *doing it, and she didn't phone me. I was angry with her for doing that! Not phoning me after contracting that she would do that!"*
Interviewee D had talked of her narcissistic injury because of her client's suicide attempt, in this way: *"I think it angered me…and when she kept on saying she wants to kill herself…and the position she put me in. I was angry! Later on I realised my own need to control things and the realisation that I couldn't, and being put into that position. For somebody to be…I mean to actually do that to me, because I am there to help them and how can they want to help me…The impact was so great."*

Therapists felt betrayed by their clients' suicide attempts in the middle of therapy. The suicide attempts in the middle of therapy also seem to intensify feelings of rejection of the therapist, and of manipulation by the client.

5.2.14 Therapist as providing with psycho-education or coping skills to suicide attempting client

One of the findings of this study was that, in addition to their supportive function to suicidal clients because of their desperation and emotional neediness, therapists experienced their role as very psycho-educational to their clients. This came out of the therapists' perceptions of their suicidal clients as very much lacking of the actual emotional resources, psychological coping skills, and of the actual practical problem solving skills.

According to Colt (1983), once a therapist decides to help somebody [a suicidal client], a therapist should have to take responsibility down the line. There has to be a time when you shift gears and become an activist. Support may involve helping a client get a job, attending a graduation or play, visiting a hospital, even visiting a hospital (Pope and Vasquez, 1991). This then, once a therapist had discovered the client's limitations in terms of coping skills, may involve psycho-education as another way of helping the client learn and put into practice the necessary skills to cope with demanding situations.

According to Interviewee C, *"So it wouldn't be necessarily a constructive and insightful stuff. It would be more re-educative and psycho-educative. …You need to do psycho-education work with the client."* She further states that, *"Give them options if they are ready to look at other options. But make them available to the person…you can almost use decision-making trees. So you teach them that skill. And I find that works, because you communicate to the person* [suicide-attempting young person] *that, 'listen, you are old enough to make responsible decisions now, that's number one, number two - I'm not going to make them for you, but I'm going to suggest, recommend, based on my experiences, but the decision is still out to you'. So you are communicating…it's almost like a safety net. You kind of work as a safety net."*

5.3 Conclusion

The obtained themes in the results of this study are viewed by the researcher as 'truths' that therapists have come to make through subjective experiences in their work with suicidal clients. Suicidal clients, as shown in the discussion of results, present with a variety of feelings and emotional experiences onto the therapists. The therapy relationship itself has been felt in various ways by therapists, and also the actual process of therapy, which has been found on many occasions to be very difficult, and to be emotionally demanding.

The socially arrived at 'truths' or social constructions appear to have been made in this study through the semi-structured interviews. As the epistemological position of this study is social constructionims, the truths in the study were "constructed by … people in conversation" (Carr, 2000, p.118). The researcher together with each research participant engaged in this conversation, in order to help therapists (research participants) to formulate meaningful statements about their work with suicidal clients, as experienced by each individual therapist.

The reviewed literature in this study had indicated, for example, that suicidal clients are hopeless and generally pessimistic about the future (Hughes & Neimeyer, 1993); that therapists find it to be emotionally exhausting to work with suicidal clients (Pope and Vasquez, 1991); the emotional rejection felt by therapists on the personal and therapeutic levels (Richards, 2000); therapists professional liability to a suicidal client in therapy (Menninger, 1991); as well as on the other areas as comprehensively shown by the discussed results of this study.

The co-constructors of 'truths' with the researcher in the study (the participants), had verbalised these experiences on the personal and professional levels. The formulated 'truths' had led to the conclusion that therapists find it therapeutically uniquely challenging when working with suicidal clients, as compared to clients with other presenting problems in therapy.

5.4 Limitations of this study

5.4.1 Shortcomings

This study has certain shortcomings in a sense that a very small sample size was chosen and used, and the results of the study were obtained from this sample. The results of this study are mainly obtained and based on the experiences of a very small group of respondents, and although very useful in proving insight into the question investigated, can not be accepted as a representation of psychotherapists' experiences in general.

Also regarding the question which was investigated by the study, and the conduction of interviews, voluntary participation was the main criterion and the sample was not that which represented the larger therapists.

The results that have been reported and discussed in this study are based only on the major themes that were obtained from the interviews. Minor themes as well did appear, as were shown in the table of the results of content analysis, which also seem to have valuable indications of therapists' experiences in working with suicidal clients.

5.4.2 Strengths

Despite these shortcomings, this study, with the results that it yielded, has contributions in the field of therapy, particularly in working with suicidal clients. As this study shows, therapists' experiences in working with suicidal clients is one other important area that must be investigated, and further and a more wider research in this area is needed.

5.4.3 Recommendations for future research

The comprehensively discussed results of this study were only those of the major themes which emerged from the analysis of the obtained data.

Future research can focus on the identified minor themes as well, as they also have valuable research contributions in the area of the work of the therapists in working with suicidal clients.

This study focused on the general experiences of therapists in working with suicidal clients, and it yielded results which indicated therapists' concerns on the therapy and professional levels. Future research can specifically focus on either of these, that is, on therapists' experiences on professional concerns, or experiences on the level of the process of psychotherapy. Contextual areas of working with suicidal clients (for example, a medical ward, lock-up ward, or an out-patient setting), is another focus that can be recommended for future research.

REFERENCES

Anderson, H. & Goolishian, H. (1988). Human systems as linguistic systems: evolving ideas about the implications for theory and practice. *Family Process, 27,* 371-393.

Balakistnet, P.M. (1994). *Seasonal trends in parasuicide: an investigation of Admissions to a Port Elizabeth General Hospital (1988-1992).* Unpublished Master's Dissertation. Port Elizabeth: University of Port Elizabeth.

Barr, B. (1996). After an adolescent's suicide, who consoles the therapist? *Brown University Child & Adolescent Behaviour Letter, 12 (1),* 1-2.

Beck, A.T., Steer, R.A., Kovacs, M., & Garrison, B. (1985). Hopelessness and Eventual suicide: A 10 year prospective study of patients hospitalized with suicide ideation. *American Journal of Psychiatry, 142,* 559-563.

Bion, W.R. (1967). *Second Thoughts*. New York: Aronson.

Bongar, B. (1991). *The suicidal patient: clinical and legal standards of care*. Washington, D.C.: American Psychological Association.

Bongar, B. & Harmatz, M. (1991). Clinical psychology graduate education in the study of suicide: Availability, resources, and importance. *Suicide and Life Threatening Behaviour, 21,* 231-244.

Breakwell, G.M. (1995). *Research Methods in Psychology*. London: Sage Publications.

Brown, H.N. (1987a). The impact of suicide on psychiatrists in training. *Comprehensive Psychiatry, 28,* 101-112.

Brown, H.N. (1987b). Patient suicide during residency training (1): Incidence, implications, and program response. *Journal of Psychiatric Education, 11,* 201-206.

Carney, J.V. & Hazler, R.J. (1998). Suicide and Cognitive-Behavioural Counselling: Implications for Mental Health Counselling. *Journal of Mental Health Counselling, 20 (1),* 28-40.

Carr, A. (2000). *Family Therapy: Concepts, Process and Practice.* U.S.A.: John Wiley & Sons, Inc.

Carter, B. & McGoldrick, M. (1989). *The Changing Family Lifecycle. A Framework for Family Therapy,* 2nd ed. New York: Gardner.

Chemtob, C.M., Hamada, R.S., Bauer, G., Torigoe, R.Y. & Kinney, B. (1988b). Patient suicide: Frequency and impact on psychologists. *Professional Psychology: Research and Practice, 19,* 416-420.

Cleiren, M.P. H.D. (1991). *Adaptation after bereavement: a comparative study of the aftermath of death from suicide, traffic accident and illness for next of kin*. Leiden: DSWO Press.

Colapinto, J. (1991). Structural family therapy. In A. Gurman & D. Kniskern (Eds), *Handbook of Family Therapy, Vol. 11*, 417-443. New York: Brunner-Mazel.

Colt, G.H. (1983). The enigma of suicide. *Harvard Magazine, 86*, 47-66.

Cooper, A. (1999). *The impact of police suicide on family and colleagues in selected Johannesburg Police Departments*. Unpublished Master's Dissertation. Johannesburg: Rand Afrikaans University.

De Jong, M. (1991). Attachment, individuation, and risk of suicide in late adolescence. *Journal of Youth and Adolescence, 21(3)*, 357-373.

Diekstra, R.F.W. (Ed.). (1989). *Suicide and its prevention: the role of attitude and imitation*. Leiden: E.J. Brill.

Diekstra, R.F.W. (1990). An international perspective on epidemiology and prevention of suicide. In S.J. Blumenthal & D.J. Kupfer (Eds.), *Suicide over the cycle: Risk factors, assessment and treatment of suicidal patients*, 253-302. Washington, DC: American Psychiatric Press.

Droge, A. (1992). *Noble death: suicide and martydom among Christians and Jews in antiquity*. New York: Harper Collins.

Dyer, C. (1995). *Beginning Research in Psychology: A Practical guide to Research Methods and Statistics*. U.S.A.: Blackwell Publishers.

Erikson, E.H. (1989). Foreword: A Dialogue with Erik H. Erikson. In D. Jacobs and H.N. Brown (Eds.), *Suicide: Understanding and Responding - Harvard Medical School Perspectives*, xi-xiv. Madison C.T: International Universities Press.

Fairbairn, W.D. (1952). *Psychoanalytic studies of personality*. London: Tavistock.

Feldman, D. (1987, March). A social work student's reaction to client suicide. *Social Casework: The Journal of Contemporary Social Work*, 184-187.

Forster, V.A. & McAdams III, C.R. (1999). The Impact of Client Suicide in Counsellor Training: Implications for Counsellor Education and Supervision. *Counsellor Education & Supervision, 39(1)*, 22-29.

Freeman, A. & Reinecke, M.A. (1993). *Cognitive therapy of suicide behaviour*. New York: Springer.

Freud, S. (1923). The ego and the id. In *The standard edition of complete psychological works* (trans, ed J Strachey). London: Hogarth Press.

Freud, S. (1940). An outline of psychoanalysis. In *The standard edition of complete psychological works* (trans, ed J Strachey). London: Hogarth Press.

Gergen, K. (1994). *Realities and Relationships. Soundings in Social Constructionism*. Cambridge, M.A: Harvard University Press.

Gilchrist, A. (1995). *Adolescent suicide and suicidal behaviour: a model of predictive risk factors*. Unpublished Master's Dissertation. Johannesburg: Randse Afrikaanse Universiteit.

Gilliland, B. (1997). *Crisis intervention strategies*. Pacific Grove, California: Brooks/Cole Publication Company.

Goldstein, L.S., & Buongiomo, P.A. (1984). Psychotherapists as suicide survivors. *American Journal of Psychotherapy, 38,* 392-398.

Green, R. (1999). *An exploratory study to identify the range of occupational stressors that occur among ambulance workers in Johannesburg*. Unpublished Master's Dissertation. Johannesburg: Rand Afrikaans University.

Hale, R., & Campbell, D. (1991). Suicidal acts. In J. Holmes (Ed.), *Textbook of Psychotherapy in Psychiatric Practice*. Edinburgh: Churchill Livingstone.

Hatton, C.L., & Valente, S.M. (1984). *Suicide: Assessment and Intervention* (2nd ed.). U.S.A: Appleton-Century-Crofts.

Henggeler, S., Schoenwald, S., Bordin, C., Rowland, M., & Cunningham, P. (1998). *Multisystemic Treatment of Antisocial Behaviour in Children and Adolescents.* New York: Guilford.

Hoffman, L. (1992). A Reflective Stance for Family Therapy. In S. McNamee and K.J. Gergen (Eds), *Therapy As Social Construction,* 7-24. London: Sage Publications.

Horowitz, M.J., Weiss, D.S., Kaltreider, N., Krupnick, J., Marmar, C., Wilner, N., & Dewitt, K. (1984). Reactions to the death of a parent: Results from patients and field subjects. *Journal of Nervous and Mental Disease, 172,* 383-392.

Hughes, S.L., & Neimeyer, R.A. (1990). A Cognitive Model of Suicidal Behaviour. In D. Lester (Ed.), *Current concepts of suicide,* 1-28. Philadelphia, PA: Charles Press.

Hughes, S.L., & Neimeyer, R.A. (1993). Cognitive predictors of suicide risk among hospitalised psychiatric patients: A prospective study. *Death Studies, 17,* 103-104.

Jackson, D. (1968a). *Human Communication, 1. Communication, Family and Marriage.* Palo Alto, CA: Science and Behaviour.

Jackson, D. (1986b). *Human Communication, 2. Therapy, Communication and Change.* Palo Alto, CA: Science and Behaviour.

Jacobs, D. & Brown, H.N. (Eds.) (1989). *Suicide: Understanding and Responding - Harvard Medical School Perspectives.* Madison, CT: International Universities Press.

Jacobs, D.G. (Ed.) (1999). *The Harvard Medical School Guide to Suicide Assessment and Intervention*. San Francisco: Jossey-Bass Publishers.

Kaplan, H.I. & Sadock, B.J. (1994). *Synopsis of Psychiatry: Behavioural Science Clinical Psychiatry.* U.S.A.: Williams & Wilkins.

Kernberg, O.F. (1966). Structural derivatives of object relationships. *Int J Psychonal, 47,* 236-253.

Kinsella, J. (1993). *The experience of persons close to suicide victims*. Unpublished Master's Dissertation. Johannesburg: Rand Afrikaans University.

Kleespies, P.M., Smith, M.R., & Becker, B.R. (1990). Psychology interns as patient suicide survivors: Incidence, impact, and recovery. *Professional Psychology: Research and Practice, 21,* 257-263.

Kleespies, P., Penk, W., & Forsyth, J. (1993). The stress of patient suicidal behaviour during clinical training: Incidence, impact, and recovery. *Professional Psychology: Research and Practice, 24,* 293-303.

Kleespies, P.M. (2000). Behavioural Emergencies and Crises: An Overview. *Journal of Clinical Psychology, 56 (9).* 1103-1108.

Kohler, L. (1984). On self object countertransference. *Annual of Psychoanalysis, 12,* 39-56.

Kohut, H. (1971). *The Analysis of the Self.* New York: International Universities Press.

Kohut, H. (1984). *How does analysis cure?* (A Goldber, Ed.). Chicago: University of Chicago Press.

Kolodny, S., Binder, R.L., Bronstein, A.A., & Friend, R.L. (1979). The working Through of patients' suicides by four therapists. *Suicide and Life Threatening Behaviour, 9,* 33-46.

Lester, D. (1988). *Suicide from a psychological perspective*. Springfield: Thomas.

Lester, D. (1994). *Emile Durkheim: le suicide, one hundred years later*. Philadelphia: Charles Press.

Lifton, R. (1989). Suicide: The Quest for a Future. In D. Jacobs & H. Brown (Eds.), *Suicide: Understanding and Responding,* 459-469. Madison, CN: International University Press.

Litman, R.E. (1965). When patients commit suicide. *American Journal of Psychotherapy, 19,* 570-576.

Malin, A. & Grotstein, J.S. (1966). Projective identification in the therapeutic process. *International Journal of Psycho-Analysis, 47,* 26-31.

Maltsberger, J.T. (1984-85). Consultation in a suicidal impass. *International Journal of Psychoanalytic Psychotherapy, 10,* 131-158.

Maltsberger, J.T. (1992). The Implications of Patient Suicide for the Surviving Psychotherapist. In D. Jacobs (Ed.), *Suicide and clinical practice,* 169-182. Washington, DC: American Psychiatric Press.

Maltsberger, J.T. (1999). The Psychodynamic Understanding of Suicide. In D.G. Jacobs (Ed.). *The Harvard Medical School Guide to Suicide Assessment and Intervention,* 72-82. San Francisco: Jossey-Bass Publishers.

Maltsberger, J.T., & Buie, D.H. (1974). Countertransference hate in the treatment of suicidal patients. *Arch Gen Psychiatry, 30,* 652-633.

Maltsberger, J.T., & Buie, D. (1989). Common Errors in the Management of Suicidal Patients. In D. Jacobs & H.N. Brown (Eds.), *Suicide: Understanding and Responding - Harvard Medical School Perspectives,* 285-294. Madison, CT: International Universities Press.

McAdams III, C.R. & Foster, V.A. (2000). Client Suicide: Its Frequency and Impact on Counsellors. *Journal of Mental Health Counselling, 22 (2).* 107-118.

McNamee, S. & Gergen, K. (Eds.). (1992). *Therapy as Social Construction*. London: Sage Publications Ltd.

Menninger, W. (1990). Anxiety in the psychotherapist. *Bulletin of the Menninger Clinic, 54,* 232-246.

Menninger, W.W. (1991). Patient suicide and its impact on the psychotherapist. *Bulletin of the Menninger Clinic, 55 (2).* 216-227.

Milch, W.E. (1990). Suicidal patients' psychological attacks on the therapist. *Bull Menninger Clin., 54 (3).* 384-390.

Miles, M. B., & Huberman, M.A. (1994) (2nd ed.). *An expanded source book: qualitative data analysis*. California: Sage.

Modestin, J. (1987). Counter-transference reactions contributing to completed suicide. *British Journal of Medical Psychology, 60,* 379-385.

Myers, J.E., & Hutchinson, G.H. (1994). Dual role or conflict of interest? Clinics as mental health providers. In J.E. Myers (Ed.), *Developing and directing counselor education laboratories,* 107-114. Alexandria, VA: American Counselling Association.

National Center for Health Statistics (1996). Advance report of final mortality statistics, 1993. *NCHS Monthly Vital Statistics Report,* 44, (7, Suppl.).

Neuringer, C. (1988). The Thinking Processes in Suicidal Women. In D. Lester (Ed.), *Why Women Kill Themselves,* 43-52. Springfield, IL: Charles C. Thomas.

Pope, K. & Vasquez, M. (1991). *Ethics in psychotherapy and counselling*. San Francisco: Jossey-Bass.

Pretorius, H.W. (1992). *A study of cases of attempted suicide admitted to the H.F. Verwoerd Hospital*. Unpublished Master's Dissertation. Pretoria: University of Pretoria.

Read, G.F.H. (1996). *Trends in adolescent suicidal behaviour seen at William Slater centre for adolescents*. Centre for Adolescents.

Reiser, D.E. (1986). Self psychology and the problem of suicide. In A. Goldberg (Ed.), *Progress in psychology, 2.* 227-2241. New York: Guilford Press.

Richards, B.M. (1999). Suicide and internalised relationships: a study from the perspective of psychotherapists working with suicidal patients. *British Journal of Guidance & Counselling, 27(1).* 85-98.

Richards, B.M. (2000). Impact upon therapy and the therapist when working with suicidal patients: some transference and countertransference aspects. *British Journal of Guidance & Counselling, August 2000, 28,* 325-337.

Rosenthal, R. & Rosnow, R.L. (1991). *Essentials of Behavioural Research: Methods and Data Analysis* (2nd ed.). New York: McGraw-Hill Incorporated.

Ross, J.L. (1990). *An investigation into the causes of suicide among patients with schizophrenia*. Unpublished Master's Dissertation. Pretoria: University of Pretoria.

Sacks, M.H., Kibel, H.D., Cohen, A.M., Keats, M. & Turnquist, K.N. (1987). Resident response to patient suicide. *Journal of Psychiatric Education, 9,* 217-226.

Schafer, R. (1960). The loving and beloved superego in Freud's structural theory. *Psychoanal Study Child, 15,* 163-188.

Schnur, D.B. & Levin, E.H. (1985). The impact of successfully completed suicides on Psychiatric residents. *Journal of Psychiatric Education, 9,* 127-136.

Searls, H.F. (1979). *Countertransference and related subjects: Selected papers*. New York: International Universities Press.

Shea, S.C. (1999). *The practical art of suicide assessment: a guide for mental health Professionals and substance abuse counsellors*. New York: Wiley.

Shneidman, E. (1971). Suicide and suicidology: A brief etymological note. *Suicide & Life Threatening Behaviour 1: 4*: Human Sciences Press.

Silverman, D. (1993). *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*. London: Sage.

Silverman, D. (Ed.). (1997). *Qualitative Research: Theory, Method and Practice.* London: Sage Publications Ltd.

Singleton, R.A. (1993). *Approaches to Social Research* (2nd ed.). New York: Oxford University Press.

Smith, J.A. (1995). Semi-Structured Interviewing and Qualitative Analysis. In J.A. Smith, R. Harre & L. van Langenhove (Eds.), *Rethinking Methods in Psychology,* 9-26. London: Sage Publications.

Smith, J.A., Harre, R. & van Langenhove, L. (Eds.) (1995). *Rethinking Methods in Psychology*. London: Sage Publications.

Truter, J.F. (1994). *The Coloured para-suicide patient's perception of his family dynamics*. Department of Psychology: Potchefstroom University for Christian Higher Education.

Weber, R.P. (1985). *Basic Content Analysis.* Beverly Hills: Sage Publications.

Weishaar, M.E. & Beck, A.T. (1992). Hopelessness and suicide. *International Review of Psychiatry, 4,* 177-184.

Wertheimer, A. (1991). *A special scar: the experience of people bereaved by suicide.* London: Routledge.

Winnicott, D.W. (1949). Hate in the counter-transference. *International Journal of PsychoAnalysis, 30,* 69-74.

Wolf, E.S. (1979). Transferences and countertransferences in the analysis of disorders of the self. *Contemporary Psychoanalysis, 15,* 577-594.

Wolk-Wasserman, D. (1987). Some problems connected with the treatment of suicide attempt patients: transference and countertransference aspects. *Crisis, 8,* 69-82.

APPENDIX A

INTERVIEW SCHEDULE

Therapists' experiences of clients' suicide attempts

This interview schedule is in support of the semi-structured interview method of data collection, in a study that seeks to find out therapists' experiences in working with suicidal clients.

Your co-operation to participate fully in this interview is highly appreciated.

(a) Tell me about your exposure to suicidal clients, that is, under which circumstances.

(b) Tell me about how you perceive suicidal clients.

(c) How do you find your suicidal clients?

(d) What is your experience of therapy with a suicidal client?

(e) What are your feelings in working with suicidal clients?

(f) How do you find your therapy relationship with a suicidal client?

(g) What kind of discomforts have you had/experienced in working with suicidal clients?

(h) What kind of emotional impact does working with a suicidal client has on you?

(i) What stressors have you felt or experienced?

(j) What could be or are your feelings following a suicide attempt of a client that you may be or have been seeing for therapy?

THERAPIST CONSENT FORM

Dear Therapist/Trainee Therapist

This study seeks to find out how therapists experience working with suicidal clients.

You are invited and welcome to participate in this study. Your participation is purely voluntary, and you are free to withdraw at any time. Participation involves responding to a semi-structured interview that will not last more than an hour. A tape recorder will assist in recording all information. All information is very confidential and nothing will be revealed to identify you in any way.

If you decide to participate in this study, please sign below to show that you have consented voluntarily to participate.

Thank you.

_____

Interviewer

_____

Interviewee

LETTER OF PERMISSION

Dear Head of Psychology

I am an Intern Psychologist with Helen Joseph Hospital and with the Rand Afrikaans University. As part of my training I am conducting a research study on **Therapists' experiences of clients' suicide attempts**.

Hereby I request permission to conduct, as part of the study, interviews with therapists/trainee therapists of your institution/organisation. It is hoped that this study will at least explore as to how therapists find working with suicidal clients.

Participation of therapists/trainee therapists is purely voluntary and any participating individual may withdraw at any time should the person wish to. Participation involves semi-structured interviews that will happen at each participant's convenience. Each interview will not last more than an hour and will be tape recorded in order to facilitate with the transcribing of responses.

All information is strictly **confidential** and **nothing** will be revealed in order to identify each interview respondent.

Your co-operation is highly appreciated.

Thank you.

_____

Peddy Magagula

APPENDIX B

TRANSCRIBED INTERVIEWS

Interviewee A

Tell me about your exposure to suicidal clients, that is, under which circumstances
Ah , mainly in therapy, or otherwise in the wards through consults in the hospital, just … checking up on people who have been admitted to see if they are still suicidal or not, or a couple of people I have referred to go to the ward because the intention is quite high.

Is that the psychiatric ward?
Psychiatric ward, yeah. Yeah, …going to medical wards because they tried to harm themselves, and the medical people wanted to find out if they can discharge the patient or whatever, you know.
Maybe… have you had experience with self-referrals of suicidal clients?
Yeah, I think my first client ever in my internship was with a client who was very suicidal and he could not cope anymore, and he referred himself because he thought he was feeling he was going to kill himself.

Tell me about how you perceive your suicidal clients.
Ehmm. I don't know if there is one general perception. I just think I support the idea of somebody who does not have a lot of support. Ehm… I don't know, you know to be honest, a lot of people, say for example in the medical wards, I get the sense a lot of people especially from the Black culture, that they are angry! It's like an act of anger, they feel angry with somebody and they want that person to know they are angry, and I 'm not sure if they really want to kill themselves. And then other people…. Other people get the sense ehm…that the really have difficulties in their lives, like they don't have enough finance, and they don't have a job, and they don't have a proper place to stay, and it's just too much on top of all their emotional problems. Other people I get the sense I think they are tired, they… they seem to have very little coping skill, they seem they can't deal with things, they seem… they feel like they can't find a way out of their pain and they are tired. Very few clients… one of the clients I had who tried to commit suicide are very seriously… so actually he did want to die, but most of the time I get the sense that they don't want to die. It's a case of they want a way out or they don't know what else to do, you know.
So it sounds like it's more of an attempt to communicate something.
Mainly! It's mainly an attempt to say look I'm angry, and I need you hear that, you have gone too far with me or please help me I can't take this any more. On some occasions it’sn't that that person doesn’t want to live, you know, I find.

How do you find your suicidal clients?
In terms of…? *Generally, how do you find suicidal clients?* Ehm, I think again there is a distinction that on the medical wards… ehm… they have sort of recovered from the poisonous substance or whatever it is. Ehm, they seem mainly quite fine. Often, they seem like they regretted, they seem like, you know, people responded, and they are actually ready to go on now. And then others of them still seem quite weepy and

that they have accepted that they tried to kill themselves and regret or whatever. Eh… others of my suicidal patients I think, …. therapy clients…. I think some use it to get attention. I can think of a young boy who got a lot out of it and another client who… a borderline client who got a lot of attention from it. Ehm … some jut seem really lost, and distrought ehm…lost, just lost, you know! Like they need,…. Just lost their way, just lost and they try to hold on to what they got and into things, you know.

What is your experience of therapy with a suicidal client?
Eh I think it's different experiences. Eh.. one of the many experiences you find that is the exhaustion because this client kept on threatening and kept attempting suicide. And it was… it was very scary and very demanding and very painful. Ehm… and then I think… if I think of the other client… it was very scary and very tense. And because you have to make a judgement cause in a way about someone's life like do they need to go into the ward or should you make a suicide pact, and it sort of sit into your mind, you know. But I think …eh …also they ….people are very fragile, sometimes they seem very tender, …. very tender and very fragile and at the same time they seem to be very resilient. So I think, in terms of dealing with those variables is quite challenging, I think, it's quite challenging and there is an extra variable of… of really not wanting to get hurt yourself, or you really not want to stuff up because of huge implications, you know.

What are your feelings in working with suicidal clients?
I think my feelings are …like I said like …. ehm… anxiety over their safety a lot. Ehm, a lot of compassion and empathy I think. In a certain way a lot of tenderness, just feeling like… you know, are they alright, are they going to be okay. I don't know you get like there is a sense of fragility there. Sometimes I feel very tired, I get very tired, hoo, very demanded!

How do you find your therapy relationship with your suicidal clients?
Therapy relationships… if I think about my suicidal clients, with most of them, the relationship is quite difficult. Most of the suicidal clients are quite ambivalent, I find. It's like they desperately need you and really want you there, but then they sort of push you away, or think you don't care, you know, or test the boundaries, or …. If I think of those I worked with… it's kind of… there is ambivalence…. You know where there is a lot of closeness… I suppose it's difficult for them, you know they have to reveal their inner most… they sort of have to in a way. In order to get help then they have to reveal their inner most self to somebody else! And I think there is ambivalence, you know they are really needy, and they really need you, and they really … kind of … rely on you and you become very important, but then at the same time they want to push you away, or not wanting to be in that situation. So I often find the relationship to be quite ambivalent, and they are also demanding, mainly, yah.

What kind of discomforts have you had or experienced in working with suicidal clients?
Ehm… I think it's mainly ehh… for me ehh… just my one client kept on trying to commit suicide and she would phone me after she had taken pills or cut her wrist or something. I would almost have to take some responsibility to get her to the hospital or phone her dad, or phone the ambulance or something. And then… I mean … I didn't really get the pattern, I think the third or fourth time she did it I told her she must phone 911. And … and she did phone and she actually never tried it again. So, it

was very uncomfortable! I would be like very tense all of the time, like… whether this client would die or not (ha ha!), you know. And then only afterwards that I realised how much she kind of get met in her caring in a way, … like how much she did everything in her power to get me in that situation. I think it was her way of feeling like I was always in her mind or something. That was extremely uncomfortable! Ehm I think with my other client… ehm… discomfort is I think in feeling like I'm too much to them as a therapist, you know. With one particular lady it was like… I feel like I'm her family almost. You know, she does not really have anyone else and she's always playing a game of kind of seeming to always really need me but not wanting to be in that position, and yet at the same time I am, you know! It's very uncomfortable to try to maintain the therapeutic relationship appropriately and not take on too much or not take on nothing! Sometimes I think even… lately a lady I have seen in the medical ward… she's been there for some time, and no one has come to visit her, she does not have a tooth brush, she does not have a towel, she can't clean herself, and it's very painful, and there is a big pull, a lot of discomfort! I sort of have to ask myself why shouldn't I bring her a toothbrush and a towel, like knowing that that's not therapeutic, but the discomfort of what does this mean about me as a person, what does it mean about humanity, what does it mean about therapist if somebody… you know, is feeling dirty and horrible and they are suicidal and you can't really help?! You know what I mean, it's like this makes you think a lot of question about life and the meaning of life and about what makes you tick, what your role is, and what you should and shouldn't do, you know.

So it sounds like those are demands made on you on both the emotional and practical levels.
Yeah! I think, I mean I haven't brought this woman a tooth-brush or a towel because I thought… on a one hand I thought it's just not good, it's just not therapeutic, you know, and that's she would have to deal with it and that's what she would be dealing with. But on another hand there' something that's very inhumane!! You know when someone is in need and they feel dirty and they haven't been able to clean themselves for four days and they have just tried to commit… you know. Nobody is there for them, there's something very inhumane about not doing it and uncomfortable.

Hhm, hhm, emotionally, what kind of emotional impact does working with a suicidal client has on you?
Eh…you know I think emotional impact… ehm… it's more ….the discomforts of being this therapist and the issues that I have to deal with that in terms of the actual both emotional impact - like what do they need from me, how to work that balance of giving them the right things, making sure that I professionally take care of them and all that. Eh … I think eh ….really the emotional impact is really disturbing to me in some way, and in another way often time I see something positive because often suicidal clients… I think you find out that there's a new meaning, or seem to realise that they were important, or that they really did not want to die or…like my one client… I mean she is just changing the course of her life, she is changing the way her relationships are, she is changing the way she feels about this job, because she said she was so close to death and she suddenly realised what everything was about, you know. Often you see that with people who sort of have seen their anger and they sort of regret it, they shouldn't have let themselves…. So in terms of emotional impact there is sadness and also…. I don't know to me…it does not overwhelm me as much as other things sometimes because with some of these clients there is a positive step,

and I always remember what one lecturer said about this that some people when they actually come out of their suicidal actions is when they come out of their depression actually and they start to get better, and sometimes that suits for me, I don't know.

Mhhm. What stressors have you felt or experienced?
Eh… I think the main stressor is just whether they are going to die! Like this one lady who kept on trying to kill herself and she would phone me on my cell phone and I would only get the message like two hours later because I was in a movie, and then not being able to get hold of them and then wondering if she is dead! That's incredibly stressful, but I mean I ….and I mean…she's just become an inpatient but it does not really make a difference because I assume if she'll go out she'll try and commit it. So it does not make a difference… she tried it four times! And that is very stressful! Eh… and I do think feeling… sometimes, it's not always, sometimes it's feeling it has to do with having to do a good job. You, know, that you are doing a good therapeutic job because so much is relying on it, you know. I think that's the main stressor for me.

What may be or could be your feelings following a suicide attempt of a client that you are seeing or have been seeing for therapy?
Eh… I think the only time that this really happened was with this one particular girl, normally I would see somebody as a result of a suicide attempt because they wanted to, but she's the only one who has really been trying while I saw her. Eh … I think initially I felt dreadful, terrible, like I really have to help this person and I felt very responsible! Towards the end of the fourth attempt I felt angry! I felt like she is abusing me, you know, she… and I felt for her that that's the only way that she would get my care, even … I eventually sent her to Tara. She phoned me afterwards just to say "thank you it really helped so much, and she said I don't know if you remember me", and I just felt so sad! Like how could I not! I mean I don't forget my clients in any way, I just remember them just after two sessions, and here is somebody who tried to commit suicide four times and phone me, and how could you forget them, you know! Sometimes I just felt exasperated like, you know! Yah.

Okay, thanks very much!
Okay.

Interviewee B

Tell me about your exposure to suicidal clients, that is, under which circumstances.
Okay, suicidal clients - mostly were consults, regarded as para-suicides. So I have seen them upstairs, in the ward here, and also clients I work with in long-term, clients with personality problems and depression that attempted suicide during this year.

So you see them in the psychiatry ward and also in the medical wards.
Yeah, I have seen as outpatient the one, then she was admitted here and I have seen her in the ward and in the medical ward. *Okay.* Yeah.

Tell me about how you perceive your suicidal clients, your general perception.
Mhhm. Yah at the moment… in the beginning it was quite stressful because I felt like every overdose is going to be a potential suicide. But at the moment, it's the end of the

year now and I feel like ….ehm I had this patient this week and she overdosed fifteen times already. She is 35 years old, she has done it 15 times, she's now admitted here today, I expect her to do it more in her life time, and I can't take it seriously anymore. I know that they can potentially die but somehow they never do, they are just para-suicide. It has impact on me in a sense that I can never say what they are going to do. Like this S patient that we have seen today, you never know what she is going to do, and they also draw you into their ... it's like their manipulation thing and they draw you into that. It's like they want to elicit some reaction from you as well when you do long-term therapy with them. Mhm.

How do you find your suicidal clients, on a general level, yeah?
Ehm… I find them very sort of lost in their world. They don't know how to cope, maybe most of the time it's a matter of not knowing better than this is a way of how to resolve things, like a structured way to resolve things, and that's what they are doing. Ehm… they don't know any better, so sometimes I feel sorry for them because I can see they don't know any way. Sometimes I feel… I can feel their desperation, especially, we had another woman the other day - she jumped off the bridge, and I quite understand she is having a miserable life, she's young, she doesn't have a job, she's selling herself to earn money of any sort, she's feeling abused. She doesn't see any way out, and it elicits sort of motherly feelings from me but at the same time I am getting very exhausted. I do the same thing over and over and over. You would invite them for group therapy and they wouldn't come, and miraculously then they are better after this attempt. So it's something - to a some I feel motherly, to a some I feel more or less frustrated, yeah.

What is your experience of therapy with your suicidal clients?
Mhhm. Most of them I have seen as consults, others I have seen in groups, and then afterwards, one I have seen for long-term therapy and she had a suicide attempt right in the middle of therapy. L was the one, it was my long-term client and in the middle of therapy, just when she was about to …. Peddy to be most honest, to be intense, she started that suicide attempt. She actually did have education because she's a bit of a chemical depression, she takes tegretol for epilepsy as well. And it was so bad that she didn't want to come… she was so withdrawn she didn't want to come in to see a psychiatrist, and it's like I felt I must really spoon-feed her just to come in for help, but luckily she did. But she could have died. I remember her husband phoned me at home one night. Because we had a new system on the telephones they could not reach me, it was only the next evening, it was only the next day that I got these messages that I must please phone him because L is very difficult. But then she had three attempts, I could not get hold of her. So it's very frustrating, it feels like they are keeping you on a tight-rope and they want to draw you in all the time. And you going to be… I can't say you can prevent them from doing it. I am going to be liable, in a way. I feel like I am a bit responsible for the ones I'm really involved in. But for some you feel like, agh, you have to refer, you have to see that they are covered if they really need the help. Some come back for help, but it's like 10% who come back and really want to help themselves, so they are exhausting! Empathy for some, but exhaustion for others - more the personality disorders it's obviously the para-suicides. Yeah.

Mhhm, okay. What are your feelings in working with suicidal clients?
Eh… if I bring it back to that immediate - yesterday, I had a group - two suicidal ones. I didn't want to do the groups, I wished they wouldn't come because it's such a big fuss that they want to die and I must try to help them in an hour's time and then send them out there again. So before the group I felt like, please, just don't come. I wished you wouldn't come, agh, just let me have peace, ha ha ha. But then afterwards I had two of them here - two young people - I felt so much empathy with them. Just to see them helping each other and trying to do something was very much uplifting for me in a way. But… you do get sort of desensitised for working with them, sometimes you just feel like just avoiding them, just do the job, do referrals, don't get involved because it's going to be messy. You are going to discover so much problems that you are not going to do anything about - socio-economical, long history, and you just not going to have the resources, they are not going to have the resources for coming in for therapy, anyway! So you are just going to get stuck, so just… say "hello and how was it, can you do it anywhere else", I have got this self-formula that you actually do it in five questions ha ha. Just do the thing, leave it up to them to come back to you, and see what happens because you know why they are doing it. Some are doing it because they are very desperate, some are doing it because there's no other way to get attention, for some it's more of a manipulation stuff and that's the worse, like this S patient at the moment.

So it looks like their context or background is very discouraging.
Yes! Very, very! Because, you can't, ….maybe they are desperate patients - how far must they go… how far must they go before people hear them, and worse of all is if a next of kin who can't handle it and they also start projecting their stuff, telling these patients like next time you must do it properly and stuff….what do you say to them? You try to rationalise, to explain to them that it's their way of handling their feelings of their next of kin. That is why they are so nasty with the patient. But how can you say that… you can't tell someone that you are utterly rejected, you wanted to die, you have this fantasy that they'll miss you after death. You wanted to die, and they don't even give a damn, and they even negotiate to do it again. So it's hard, you have to sit with that.

How do you find your therapy relationship with your suicidal clients?
Mhhm…. First, I am talking now…not about my long term. I had a good relationship with her. I could come very close to her, and I think she could benefit from it as well, and the therapy really went well. After her attempt she improved a lot! That sort of a crisis was over. Ehhm…there it was different - the relationship, I could come closer to her and help her through it, and support her where necessary and be with her because I know why, I understood what was happening in the therapy. But with the other ones it is sort of an ambivalent relationship. You….you hope you don't get consults, you hope you don't get a referral because you know it's going to be the same story, you know it's a desperate person who wants to get attention and needs something badly because she's not going to get it at home. It's like you don't want to get involved, but when you do get involved, when they do come back for group and stuff then you do get involved and you actually pick up their desperation and depression and what ever stuff and you work with it, then it's not so bad, I had one last week and she sat here. You still feel empathy for them, but most of them I feel I would rather avoid them, also because they are so many, and they are not compliant - they don't come back for

therapy and stuff like that. It feels like they don't really want to be helped, so for me to go into a relationship would mean rejection from them.

Okay, so there is a lot of rejection that you experience.
Yeah, it feels like! It's very… you are sort of prepared to give so much but because you know they are not going to come back either because of transport or that they feel better because the symptom has been functional in the family or what. You feel like…ehm…why then, why bother? They must sort of show that they are prepared to do something, and then you'll do that too. You'll help them if they are prepared to change, if they change something, yeah.

What kind of discomforts have you experienced in working with suicidal clients?
Yeah…there was one stage… but I think that it's also transference thing with this suicidal patient that I couldn't stop thinking of him, I went home I had obsessive thoughts about them, I couldn't …not only them but also the other patients, especially the one with violence thing, and the stuff that happened to them. I went home but it doesn't leave me when I went to sleep…I couldn't stop thinking about them as a way to control my feelings towards them. The suicidal ones are definitely having an impact due to you feel like you can't let go of them, they just stay with you all the time. So that's the discomfort in a sense that it feels like they are never leaving me, they stay my responsibility. Ehhm…whereas…and then I asked my supervisor about it. He said he once had a patient, the patient had phoned him and he was suicidal, and the patient said I have just taken stuff. And he said to the patient "then what must I do about it?" Sort of a hard attitude and …ehm…I feel like it is expected of me to have that attitude as well, and I could see…it's actually from an interpersonal perspective…I could see the function of his system because he does suicidal stuff because he wants to get attention. To get people closer to him and stuff. I could see the intention of my supervisor's reaction, but somehow I couldn't do it…I don't have the nerve to say that if someone is suicidal and say "then what I must do about it?" so it's also ambivalent in a sense that you are responsible, but you are also supposed to have… sort of a not so shallow attitude about it, if you are really going in therapy. So that was a rather a non comfortable space, and the transference situation, at one stage, I remember that I have a person in my close circulation of family, it's not my husband. He was dependent, borderline and also trying to commit and threatening with suicide in various stages of his life. In April when I was on leave, he would actually phone me, or sms me, when I was on my way to Kruger Park. He would phone me or send me an sms, "I don't want to live anymore. I'm going to die now. You won't see me after the weekend". And then I remember I sat there in the car. It was such a difficult situation, I was crying at the time. And I just sent him an sms back and I told him, "I am sorry if your life it's so bad. I still love you. If you need to do it then you can do it". And that was the last time he threatened me with suicide. After that, because of the transference, it was easier to deal with the patient who was suicidal. Now if I would get one…in the week we had a situation here with one who jumped out of the window, and everybody needed to check if it wasn't their patient. Now I feel like if they are going to do it they do it, I … I did my part. I can't do much more than that. I can offer support and give references, but I can't do much more than that. So that have sort of resolved the crisis for myself and for feeling responsible, and feeling like I have to hold on to them. It was like that earlier in the year, yeah.

It looks like your clients stayed with for a long time.
They did! But that cleared up. It somehow just disappeared.

Did you feel like they invaded your personal life?
Yeah because there was one stage that I actually made it a habit not to take on my suitcase into the bedroom because that's where…I leave it in the sitting room. I'm still doing the same thing, it's like a ritual. When I refused to look at certain stuff, it's very OCD. It would lead into a certain stuff, which would remind me of patients. But somehow the suicidal ones weren't the most upsetting, once you had violent experiences - they were more upsetting. But they do, you think about them a lot. At one stage when I know that this long-term one was suicidal I left my phone on all night. I just felt like…because I said to her, "you must phone me before you do it again". And I don't know if they contacted the hospital switchboard or something, they want that contact with you, you are the one pulling them through that. I just felt this exhausting. I had to keep my phone on next to my bed in case she wants to phone, so I must be there for her all the time.
It was a period in her therapy, but it still impacted. Now I don't do it anymore. And funny enough, when she really want to, then they couldn't get hold of me, through the system in the hospital, yeah.

What kind of emotional impact does working with a suicidal client has on you?
Ehh…ehh…one of the things is guilt. I feel like I must care for them, because they are so desperate. Because at late teenage-hood I was very depressed, and I had thoughts about…I never actually planned it. But I thought like…if I could just die. But I was more depressed more than just having a fantasy about getting away, I was never actually actively suicidal. Ehm…in a way I know how it feels like. I know how desperate they are, and I see that now I get so desensitised and blunt. It evokes a lot guilt. You sort of think how far are you prepared to go, this person needs so much. Are you going to stay after hours, are you going to be available, how much are you going to put into this patient? And …yeah, they might not return, and they might not bother to come back. They might not bother to follow up with therapy. So …I actually don't have the words for the emotional impact. I realise that some of it is guilt and exhaustion. At times then you just become blunt and desensitised, yeah.

What stressors have you felt or experienced?
Time…stressors have to do with time. You have an hour and you have to do consults. It's not always the case but you get seven at a time, then you have to do seven people all who wanted to kill themselves for all the bad reasons, all because of personality disorder or all these dynamics whatever. Then you can't assess or treat a person in that limited amount of time. So you do refer but you know they can't come back, or they tell you they can't come back, they tell you they don't have transport money and all stuff. And if they were suicidal you would refer them to the ward. Yeah…time was a big thing at times.
And stressors in terms of…you actually have the means… I had the suicide group, I could offer them something, but…then they won't come in because they don't have transport money. And I can understand that, it's part of their circumstances. So, that's quite a stressor because you know they going to come back, you know they are going to do it again, and you want to help them but you can't, they don't have the means to. And having to accept that it's hard, there were times when I felt like I would give them some transport money, but then that's the breaching of boundaries, and I can't

actually do that. Ehh…other stressors like….checking out that you really make sure that this patient is really not suicidal, and you rather refer. Also the ones who were very withdrawn. You can't come through to them, you don't have time to sit with them. You can't get through to them, so what they are telling you are they really telling you whatever they want to tell you, are they still going to do it? So yeah, the consult situation was difficult, yeah.

What could be or are your feelings following a suicide attempt of a client that you could be or are seeing in therapy?
L my long-term client, I saw her initially, when I initially heard, initially I spent the next evening…ehm…and I was sort of shocked, because she said she would phone me whenever she wanted to do it, and she didn't phone me. I was angry with her for doing that! Not phoning me after contracting that she would do that! Desperate, because you still just don't want to let go. Especially with clients that you work with a lot! The consults are different because they come and go. With long-term ones ehm…yeah… a sense of desperation, and also rejection. You are available! Ultimately! You keep your phone on all night, and they wouldn't bother to give you a call, they would rather jump off a branch! Also frustration, like I said before, you know they need medication…because of depression she needed medication, and she wouldn't come to casualty. She wouldn't go to the psychiatrist just to get medication because last time they wanted to send her to Sterkfontein or something, and now she refuses to go. You know that she needs it! And…when you overcome your anger then it's like…I remember when I saw her here when before she was admitted, I actually…I took her hand and I said to her, "come on my darling you are going to be better", and I took her down to casualty myself. I could see that she was terribly depressed, and she's feeling awful. So…yeah something between anger stuff and rejection. Also a lot of empathy, yeah!

Do you feel like giving up on them at times?
Ahh…I don't know. The other day I sort of just…flew through to one of them, sort of, "hi, I heard you…the psychiatrist said I must come and see you. I heard you had a suicide attempt and it must be very hard for you, and we must try to help you…and blah blah blah…". It was sort of a five minutes thing and I left a pamphlet there because I had other stuff to do as well, then I brushed off. I sometimes do feel like giving up because agh, what the …they are going to do it again. They are going to end up in hospital again. It's like I know they are faking. There are some that I would take deadly serious like patients with underlying depression and stuff. But with the ones I say they are faking I know the previous attempts, and they have borderline personality disorder problems, and so on. You sort of know they are going to do it again. It's like I'm thinking of it as an institutionalised way of solving problems. It's part of their sculpture, when you don't feel well, when you are angry, when you fight with your boyfriend or with your parents or whatever, then the way to get out of it…you are really in trouble interpersonally your way to elicit reaction is to take overdose, because you know the ambulance is going to fetch you, and is going to be big trauma, and everybody is going to visit you in hospital, they'll send you flowers and food and cards, they'll have a lot of sympathy with you, and you'll forget it because how can they be so nasty with you - and …the symptom is really functional in a way that they return to the family, they integrate with the family again. And I feel like…well…you don't actually need that much from me, it's not that you really want to die. I don't say give up, I would like to see the family as well. I think I perceive

them to be more needy because my impression was like, "if you want to die, then you are terribly desperate, depressed and alone", because that's the way I felt when I fantasised about it before when I was a teenager.
Ehm…I won't say give up, I have come to perceive them as needy. It's their way of doing, and they are going to do it again and again unless they are going for long-term therapy, and chances that they'll have the frustration and tolerance is not good.
Ehm…I can't really say I've given up. So I treat them with less…some of them…less serious. With the ones who are depressed…have them admitted and medicated. But I can see that they are exhausting the hospital system. I think the are other ways of dealing with them, yeah.

Interviewee C

Can you tell me about your exposure to suicidal clients, that is, under which conditions or contexts?
Ehmm…most of them were in a hospital context, a government hospital that I worked at. In-patients largely, and I followed them-up after they were discharged from the hospital. Then I worked in the military…ehm…so in that context as well, you'll have people who come in who are in the military, due to trauma, due to family and marital problems, people resorting to para-suicide, just because they thought it's a way of coping, getting attention from their spouses and people who want to leave them, you know.
In the hospitals, it's largely teenagers ranging between the ages…I would say…15,16 up to 25,26, and a lot of them are primarily relationship problems, especially among the younger ones - their boyfriends and girlfriends had threatened to leave them or had ended off the relationship and they are with somebody else, or they have problems with families, those sorts of experiences. What was also quite interesting was the way in which they'll to attempt suicide. A lot of them would - depending on socio-economic circumstances, and what they could afford to take in order to attempt. For example, poor people may be able to get hold of jik or parrafin, or jayse-fluid, and make combinations of them or ingest stuff, as opposed to wrist cutting and other self - injurious behaviour
A lot of them would try to get tablets from their parents, somebody or an aunt, and they would take an overdose - panados as well as those they could get their hands on them. Ehm…yeah… I had a few cases where they would write notes, which would indicate that they had this planned, and they are kind of saying "good-bye", I had a few of those cases. And the more common para-suicide cases because of crisis, unlike those planned cases where somebody would lock their bedroom door so that nobody would come in and all those sorts of things, and it happened that the rope would give in, and then the person would fall down. It's very humiliating and depressing because they even failed committing suicide.

How do you perceive your suicidal clients, your general perception?
I usually look at them from the perspective of…it's a way of coping. It helps them cope if they go through that point in time. I think it varies, depending on what the diagnoses are, for example, if you have a borderline personality disorder, for example, with post-traumatic experience or history. I had such a case, a lady, when I was at King George, in Durban, she was classified as borderline with Axis I PTSD, and …eh, she would find any attempt to create injury on herself. She even tried, one day during time out, relaxing. She cut her wrist. But the dynamic there of self-injury is

different from the act of suicide, because in a borderline case like that there is a feeling of relief, that, "look I am alive, I have pain, I bleed". That's a different type of experience. Eh…in a more common cases that I have seen, like I mentioned earlier, where they would have some problem with family or relationships, eh… where there's like a crisis situation, that would be the first thing that comes to their minds. It's more impulsive, and that's for them their way of coping, a way of dealing with it. So what I found as my role, apart from being supportive in that environment, would be re-educative, where I would provide them with other options of coping. Sometimes I would get them to sign a document, saying that if you do feel like this again do you promise to either come to hospital first, or phone me first, or phone any other responsible or immediate family member, who is aware of that agreement. So the person would feel contained in that case of being in a crisis. They would find there are other options. So would be that kind of perception that I feel, eh…yeah.

Yeah, so it's mainly a way of coping of coping that people use.
Yeah, I also find that a lot of the environments that patients come from are mostly poor, working class, or both, if there is a difference, really, yeah…and had these experiences role modelled in a way. So they had either experiences of people in their families or who made the impression on them where …this is a way of coping, where…this is a way of getting out of the situation, by mentioning somebody talking about it, joking about it or whatever, or in cases where they tried other options and didn't receive any feedback. In that case now you need to go beyond and above just that person, and go to the significant others, and say "listen, how you respond to this person…", you need to do psycho-education work with the client.

What is your experience of therapy with suicidal clients?
Again it will depend on the diagnosis, eh…, for example, the axis II it's like a borderline personality disorder who presented underlying dynamics of the good object and the bad object. Sometimes you are perceived as the bad object, then to get back at you they may try to commit suicide, in an attempt to say you are failing. So you need…you need to always test and tap with that, eh…the thing to ….also to know, as every psychologist understanding the borderlines…eh…the prognosis for borderline personality disorder is poorer, because of the difficulty they have, you know, in terms of insight. They have no insight. I am talking about the real, real, severe borderlines. I have worked with a few of those and they are hard to work with. I found myself needing a lot of supervision after that, and containment myself, because basically they take you in this whirlwind with them…eh…where they are feeling if a particular way they want to drag you through the whole process, and you can't see what or where, or what the dynamics are, what's going like actually.
In terms of the other para-suicides that I mentioned earlier on, my experience of therapy has been brief in a sense that when patients were admitted to the hospital for overdoses, they were referred to us for discharge because we had to assess them to see if they are suitable for discharge, and it was compulsory that we set up a follow-up appointment so as to check once they have entered the traumatic environment again how are they coping. So you prepare them for that and the need for follow-up. And then after they come back for that follow-up appointment, we check now as to what are the issues, what are the sorts of things they would like to talk about, and if there is a need for a further follow-up, and in cases if there were then a few more sessions in dealing with a particular relationship, talking about learning other ways of coping, dealing with the emotions relating to that, and basically learning about feelings - that

it is okay to feel these things, but not necessarily act on them, and on that way, so that's a lot of what therapy would be. So it wouldn't be necessarily be a constructive and insightful stuff. It would be more re-educative, and psycho-educative.

So it sounds like clients do need a lot of that.
I think they…if they don't need a lot of it, they at least need to know that that is available to them, and by setting up follow-up appointments you are making it known that it is important that you are being here, because we would like to see how you are doing now that you have returned home from the hospital. Eh…I think it is an important message which says "I care about you, and what's happened, I have faith and hope that…that you'll cope in a healthier way, and by setting up this appointment, it communicates this message to them. So eh…it varies, but I think letting that open is important enough. Time…weeks or months later they will come back if they have a need to talk.

Yeah, how are your feelings in working with suicidal clients, on a general level?
I think on a personal level, eh…one of the things in working with people, generally, is that I came to learn a lot from them…ehm…I obviously haven't had all those experiences people come into sessions with, and sometimes when you sit and listen to what people go through, to how people respond to them, I actually learn that…oh gee there's another way that a person could possibly cope with situations, and that's another way that a person could possibly attempt suicide with or combine. So I learn, more specifically, for example, techniques of how people attempt suicide. So when I'm educating other people as well I bring in these new ideas, and suggest that oh well you might look at that, you might think about that and stuff like that. But I find it's a huge information gathering process for me, but it also teaches me or myself a lot of appreciation, I learn to appreciate life. 'Cause every time I talk about it ehm…it reminds me that life is special. Everybody is born with a survivor instinct, and eh…and when this instinct goes away for some or other reason, it's important to check. Everybody does something as well.

So there's a lot of taking in that you do during the process.
Yeah, I think that's one of the biggest experiences that I do get out of the work that I do, because as I say, personally I come from a much…much more stable family background in a sense that I was very protected and kept safe from things. Ehm…I was fortunate to have had parents who…who taught me ways of coping with stuff. When I had problems I felt like I had something to turn to, and I'm sure that had had an impact in making me who I am. I feel if I can pass that message, if those could establish this fit, then I'm kind of doing my bit in making stuff, and that helps, and that person can do their bit in helping another person, for their kids and their siblings.

How do you find your therapy relationship with suicidal clients?
Again it would depend on personality types, and experiences that people come to…, I think it is important to tap into what you are working with, when the person comes in you try to find out their way. Sometimes a person comes in and very defensive. If you attack the defensive you are not helping the therapeutic environment and the relationship, if you are attacking the defensive. So don't! Ehm…rather work with them, work with the defence, try to make it feel like you have established rapport. Ehm…if you find a person coming in feeling very guilty and …or feeling very ashamed that he or she has attempted it. Eh…be careful about that and make it clear

that you are not there as a judge. You are not, for example as some religious leader, or a parental figure that will be "Hoo what were you thinking, are you stupid!", or "You know, why did you do that?" You are not in that position, that is not your role, and you are not helping the person. Ehmm…it's important…ehm…I think that goes across all clients, so I use that across clients, that's the reason I don't find it very different from some people who have maybe…major depressive episodes or who has sort of ehm…traumatic experiences, anxiety disorder.

So you don't see yourself as taking a very different role with suicidal clients.
No! I don't believe that you should be eh…a specific figure and draw it across all suicidal patients. I think each is different and should be treated as such. Each patient, a person comes in with a whole different set of circumstances, and need different things. But he had to come in because everybody is on his back about "you should do this and why you are not doing that, you should do that". If I'm going to be one more person doing that I am not helping. So you need to be very attentive to the person.

Does that role of yours function very, very efficiently in a medical setting 'cause what I find is that there is this expectation that you should talk this person out of his suicidal feelings, so he can be discharged or whatever?
Usually what happens is eh…what I find effective are the techniques that I use, they are very effective. Don't get me wrong, I 'm not going to sit in, if I'm with a teenager, for example, I'm not going to sit in and play teenager, and just be a pal to that teenager, then I'm not helping either. I'm just going to be an adult person…ehm who is able to empathise and hear what the person is experiencing, and perhaps give them options if they are ready to look at other options. But make them available to the person, something usually parents don't know how to do because they are so wrapped up in "I need to get this done, I need to get that done". So, you know, when you are in a position where you are an adult figure with life experience, as well as trained skills, and you can almost use decision making trees. It's where teenagers and young adults are, very much, they kind of need options to think about things. Oh, okay, there are different options to them, maybe you kind of need to look back to them, so what can I do, what can I choose, which is the best one. So you kind of teach them that skill. And I find that works, because you communicate to the person that "listen, you are old enough to make responsible decisions now", that's number one, number two, "I'm not going to make them for you, but I'm going to suggest, recommend based on my experiences, but the decision is still out to you". So you are kind of communicating…it's almost like you are a safety net. You kind of work as a safety net. They'll do all the stuff, but at the bottom there you have the skills to assess, and at the end there you say, "listen, you have these options, if you do this what do you think are the consequences? What are the consequences of that, and now choose behaviour that's best for you". It doesn't guarantee, but you are trying to give as much leeway as you can to this person, but at the same time just check to see if everything is okay.

So you invest a lot in the relationship.
I think so, you need to. I strongly believe the basis for any therapeutic relationship is in the establishment of trust in the relationship, and the establishment of rapport. Without that you don't have therapeutic relationship.

Okay, what kind of discomforts have you experienced in working with suicidal clients, these can be on a practical, environmental and emotional levels?

I don't think there's a general trend, because there's a lot of stuff that differs. But I recall when I saw a lot of…especially teens between the ages of seventeen to twenty one, and they were taking a whole lot of things of different combinations because of relationship problems. For me…I think my countertransference just filled up, where I was just "Hee! What's going on with these kids, you know why is it always about partners at this age, you know?". When I was at that age I was doing different things. I was just enjoying myself with friends and with meeting people, you know. There was this difficulty about…what are these combinations, what are… you keep thinking that they combine jik with paraffin, and a bit of jeysfluid, you know, really! So it was like a parent voice in me that was giving eh, irritated, like, man! How do you work with that? But it was also because I was seeing quite a few of them in a row…eh… so I had to check all of that with my own therapy and supervisor. It was important for me to feel in that way, and know that I was feeling that way, because I would then impose it on them and then act like I'm a parent.
Environmentally, I'll find sometimes the obvious difficulties - finances to come back for a follow up, transport, living far away. Which were real realistic themselves. Ehm…just quite inhibitory to the process. Then I can remember one thing which quite bothered me a few times. There were these teenagers who would come back, very well dressed, you know. Having all these trendy clothes on, and then not being able to follow up the sessions because they couldn't manage to…they couldn't afford to come. I would think to myself, "where are the priorities here?" Because…kids wearing Levi's! I don't even wear Levi's! Hah, hah, you know. Fancy outfits and costumes and jewellery, and just last week she had been drinking jik because her boyfriend hadn't…or just looked at another girl, you know, that she was pretty enough, for example. And say she comes in after having missed a previous session or something, and here she comes…I just wonder about that! But that's my own stuff, and I don't bring it in. Of course I haven't had the experience where I find people who would just not come for a session, or make them and cancel, make them and cancel. I haven't had that longer process of intervention eh…with the common para-suicides.

What kind of emotional impact does working with suicidal clients has on you?
Ehm…I think as you work with more of them…more people generally, not just suicidal cases, ehm…you kind of get used to it. I know it's a cold calculating thing to say. But…it seemed less seldom to me when somebody told me what they did, what their circumstances are. Because you learn as you go about different things that get people ehm…angry enough or desperate enough to consider an option like that. So you kind of as almost had what goes around that people resort to. Ehm…so the surprise element goes away after a while and you kind of use the basic principles of hearing the person, containment, the need to do the re-educative stuff, and follow up sessions. So it's kind of like that process.

So it starts initially as shock, which then goes away.
Initially when I was doing my internship, you say "Gee!". You say, "Okay, I'm a few years older than this person, and what this poor person is doing…". I mean really, me …years ago, you'll tell me jik, I would…okay, it's for the drain. That would be my association - to clean up drains! Drink! Fire, gas! You know. Here's somebody who thinks jik - drink. Oh, yeah, it was difficult to digest, but then it made me aware that you don't judge people based on your experiences, your circumstances, and life. That's where for me it's been a biggest learning experience. Because you just… you don't judge! You are not in that position. It gets easier because you kind of put your mind in

yourself, you are not in that position to prove or disprove, because it is that person's experience.

What are the stressors you have felt in working with suicidal clients?
It was very much the one that I mentioned…very much the parent voice in me, parental judgement that was going on in the beginning. Like man, how can you try to kill yourself for some weird character, because for the follow up session they'll would bring the boyfriend or the girlfriend along, just for company, and they would wait outside. Then you look at this person and you think, man! What is this weird… or in some way…because he'll be in some funky outfit or…just not caring…and here is this person who has tried to take their life to say, "you know what, do you care about me now, or whatever?" Again that…that's the experience that you go through in love, in relationships. It's just…yeah, I find it so extreme to kids or children at the age of fourteen eh…to feel that intenseness and wanting to die.

What could be your feelings following a suicide attempt of a client that you could be seeing in therapy?
I can honestly say at the point earlier, especially during my internship, I would have feelings of …I failed the person, or what did I miss….and …like a lot of self-blame…looking at…yeah…was I …did I do my job well enough? Could I have picked it up and missed it? Are there some technique of assessing that I missed out or something that I haven't covered? Those would be the initial feelings, until, you know I take them to supervision and speak to my supervisor, you know. And a lot of the time if I followed through everything I could possibly have, it comes down to, "look, you are human, you are not God. You are a therapist, you are a person trained with skills. The responsibility is not entirely yours to keep the person alive. The responsibility is with that person. You are helping him with skills. To do that more efficiently - if it was again depending on diagnosis, if it was a person who had a history throughout their lives of suicide attempts…ehm…and the coping mechanisms, then you'll have to look out for that, and you wouldn't be surprised, you wouldn't take it personally ehm… if it been a coping mechanism. You just take whatever, just as you could to prevent it, to keep reinforcing it. Remember, if you are feeling like this, if you're feeling that these are the triggers for when you are going to getting to think about suicide. Before the trigger…once you see that the trigger is coming on, these are the options that you can do. You kind of prepare them for it, and yeah, you teach them the basic stimulus-trigger-response, and they'll probably kind of say…"yeah, I was feeling like this, and I was feeling really down, and thinking about suicide". If that's the trigger, what is the response, the response is going to somebody. Is to change the patterns of thinking, and the person would do that, and you feel like the person is taking responsibility, and doing their part in the relationship, it's fifty-fifty. I give so much, and you give so much. I can't keep you alive. I can't fix you. You have to do it. You just have to.
Now I don't feel… I kind of assess the situation in terms of responsibility, and I try to access all the avenues in terms of my responsibility.

Does it not put pressure on you as a therapist to work more on the person - the client?
I don't think it's to work on the person, but for you to …and it makes me more alert… I need to check out, and make sure I have covered the different areas that I think could be dangerous in this person's life. That's when I think of things like the signing of the contract, like other options they didn't have before attempting. Giving them decision

trees, like making sure they have follow-up appointments that are convenient for them, otherwise they can't make it. So those sorts of things - signing the suicide contract, making sure you do appropriate counselling, checking out on the environment that causes or stimulates such behaviour, and then making sure that's dealt with as well. And if I need family to come in as well, may be parents need to be spoken to about different areas then I make sure that also happens. So I kind of do those different things.

Interviewee D

Tell me about your exposure to suicidal clients, that is, under which circumstances. Okay, yeah. I'll speak about the most recent…ehm…I work in ward 6, Sterkfontein, and she was given to me as a patient. Actually before that she wasn't my patient, she was somebody else's but then she went into distress and the person she was seeing was on leave. So I hadn't seen her initially. So there was also an ethical way there…but the psychiatrist decided we had to do something. She was openly saying that she was suicidal, and she wanted to kill herself, and eh…so I decided to take the case on. I said yes I'll do it. So I sat down with her and I discussed her life story in brief, you know. She seemed to be very needy and attention seeking. Ehm…I also changed my style of therapy when I was with her, because in my second session that I had with her I decided sitting on a chair just….preventing the flow together, sort of informal with me facing her, you know. So I thought that I would create an informal context, and a little bit more intimate, you know. That did work to a degree because she started opening up quickly. However, she was this specific case, she had cut herself twice in the ward, and she was a long-term patient of psychiatric facility in Cape Town, every where, you know. Unfortunately she wanted to be more constrained, restrained and contained, than our unit could provide…than ward 6 could provide because it's an open ward. So she was then transferred to a closed ward…it was a lock up ward. I was going to continue therapy and seeing her, what happened was - her parents had signed her out and I lost control of the whole situation of my client, you know.

That other one that I would like to talk about was my first client, first borderline client that I had seen which, eh…she used to threaten me all the time, you know with the suicide, and so I think it was in our third or fourth session, I told her no, that she shouldn't black-mail me. She can make her choices, and I eh.. I can't remember so clearly right now. She stormed out…I had to close the session, it was four o'clock and that's when she started acting out, you know. I calmed her down and as soon as I had closed the door she said she is going to the bathroom now and she is going to cut her hand, right now. So because I had not worked with anybody like that before I started panicking, here was this woman now throwing a tantrum which she was well known for. I then walked to the bathroom with her. I wanted to calm her down saying that we'll sort it out tomorrow, that she mustn't…she's making me angry by going on like this, and it's not going to help her. So…although I was panicking I decided that no, this me running after her does not help, so I better stop now. I told the nursing sister to watch her and then I left …eh…I must say I was very, very angry because I don't want to be manipulated and the most of my borderline clients are the ones who try to manipulate the situation more than any other clients.

Was this client also in the lock up ward?
This client was on ward 6. She hadn't tried to cut herself before, she wasn't a self mutilator like the other one. She was more in there for depression and for having overdosed. So she was really merely acting out, and I was at the beginning of my time in ward 6 so I was truly not aware of this kind of behaviour. Ward 6 is an open ward. So you have to be at a certain level of functioning to take care of yourself. Be contained to a degree, you know, because we can't watch you the whole time.

Tell me about how you perceive your suicidal clients.
There is one, a male, my most recent client. There's one in particular, an Indian patient. I find that they run away all the time instead of making choices, especially with him. And I find that when you keep suicidal option open it drains in a lot, and I found that by just talking to him, and noticing how drained I was at a certain time when we started talking about his family and his suicidal nature, how drained I felt. However, when I was talking about the aspects of the other life I was getting more energetic.
I perceive them as being not wanting to take responsibility for life, and for running away all the time, you know. Yes I agree that they are tired, I can see that they are tired. Some of them…there's like differences between them. I don't see all of them in the same light. One I get irritated with because he's very manipulative, and…he has learnt self-helplessness to such a large degree, which is unbelievable. And he disqualifies everybody who tries to help him, including me. Maybe that's where my irritation comes from because he blocks me from helping him. I am aware of my own feelings when I do interact with him, and I try to make it overt by saying that this is how you make me feel all the time.
I perceive them as needing a lot of love, need a lot of attention, but as also selfish. I don't think that there's only one way that I see anybody. With regard to certain people certain points would be more salient than others. With some people the selfishness would be more…the anger… and in other people would be more the fear of themselves and them not succeeding and ehm…to some suicide is an option where they don't have to face themselves or face failure, and the others it's just an option out to get away from the pain. With all there is anger, so deep seated anger. I know I like most of my clients even though they are suicidal, it frustrates me, I think, because it's like why don't you give yourself a chance, you know. And I think a lot of people that land up in psychiatric units are actually quite good, decent people. I think with regard to my perception …I had had a friend whom I had to leave because of his drug abuse. I had to say to him, "well if you want to do that then go ahead and do that, I'm not going to try to save you anymore". Because I did that, last year, I think it has so much informed me, that instead of that panic you are feeling when trying to save I have realised that I have to let them go if that's what they want to do. I cannot take all that responsibility on myself. So in that way, there is not so much of that panic feeling because I have learnt to deal with that, you know, that I can't keep somebody alive, I can't make them to hold on to me, if they want to go they must. So my perception of them would be, I see them as having strengths, but being tired, but they must realise that they have to make a decision that they want to live or die. And I cannot make anybody want to live. That also has been a learning that helped me through this year

How do you find your suicidal clients, generally?
Very needy and attention seeking, manipulative…ehm…they can put on many faces, you know. Some of them can put on many faces. Like at one stage they'll be quite okay, and "I don't need any help", the next stage they'll put on the "I need help, everybody help me I am going to die right now", you see. And they'll talk to everybody. And then they can also withdraw, and put on the solitary "I just need my space" kind of thing. Which is true, I mean, the faces that we have, all of them function according to what we need at that time, or maybe in a sense of what we are hiding with happy faces, when they pretend to be on the high, you know, like the way men hide depression, that kind of thing. There was one of these who used to talk so rapidly as if she was manic, but she seemed like…she was trying to keep the suicidal thoughts away. But I found her to be very different from the other borderline clients. She didn't have the depths, or the seriousness of wanting to get out of what she was in, whereas the other patient of mine did have that depth. The other one seemed to ask for help continously, but almost seemed to thrive from that attention she was getting, as if she was a hypochondriac, that kind of thing, you know, as if she was being childish or something, you know. "Look at my suicidalness, look at this," you know, the openness was crude, and it made me worry less about the people that talked less about it. There were those that I was worried more about, than the one that was open about it, you know what I mean, so bragging about it, as if it was some kind of trophy. She wasn't actually my patient but I spoke to her because in ward 6 you can just speak, but I was not in therapy with her. This one was like a hypochondriac but she would always call me when I walk past to see her picture, and her pain, …and I just sometimes wonder, yeah.

What is your experience of therapy with suicidal clients?
Okay, you know I do the therapy but the suicidal stuff is at the back of my mind, because they are busy talking about themselves, how they interact with others, and their families, and it doesn't hit me until they bring it in. Then I look and say okay tell me about it, and I tend not to focus too much on it. Because there's a pull all the time from them to see the suicidal side. I sometimes feel I want to focus on other sides of their lives. Because it feels like they are contained - it depends which stage they are in. Say they are on that stage where they are like they are on the edge, then I obviously see that they need to speak about it, you know there is an urgency because there is that …for example, the cutters, they don't necessarily want to commit suicide, but they want to cut, and they have that urgency and I speak about it then. But with the others I try to like steer them, and make them look at life a bit more broadly. But I find that they are very negative, and they are so deep in their own stuff that they can't look out. They are like they want help, they are screaming for help but they are making no attempt to shift, and I think sometimes they'll speak about the suicide if they want, you know why, whatever, but I make it as part of everything, not as a focus all the time, because they are trying to focus on how they got there, how did they get to that low self-esteem, basically. A lot to do with suicide it has to do with low self-esteem, I could be wrong, but a lot of anger directed at other people, and I also think that suicide is internalised anger. And I try to also…ehm…make it less romantic, or less honourable, because certain of them…one guy I remember said he would take his children with him. I try to make it very direct sometimes, more so than others, more so with my other clients. I think I am more hard reaching sometimes, but still holding, and then they are at a good point where you can push them a little bit. I try to let them see the reality a little bit more, because I think they become very blind-sighted as to

what the options are. I say yes, suicide is an option, but then what are the other options. Yeah, I do more cognitive behavioural stuff with them also. Remember I have gone to ward 6 now, so I haven't had that much therapy experience as now, so …yeah…I try to do more cognitive stuff with them.

Is this to try to change their way of thinking?
Yes, whereas before, with my schizophrenic patients I would do more narrative stuff, you know, and look for meaning and stuff like that. Now I do more cognitive stuff.

What are your feelings in working with suicidal clients?
Frustration, …sadness, …irritation…but I think…it has lessened to a large degree over the time because I always had to watch myself because I would always go too close to a client and I would get affected by them more, and I have been told to like step back, so that's what I have been doing. When I feel it's too much then I'll step back and say okay what is this client making me feel, and then I would do an interactional analysis. It's not that I allow my feelings to override, but I am aware of what I feel, and of what I do. I then try to make use of them. I think with certain clients …it depends on their presentation to me, and how they interact with me. Certain clients I get on with, others I won't. Then I have to work much harder for myself to battle down my irritation and work with them, because like I described the guy would disqualify me. It's very hard after one and half hours of talking to this man he would still say he needs somebody else to talk to, and then he ran up to the dean of the hospital to say that he has no one to talk to, while I had spoken to him five minutes before that. So I was very angry at this man. I realised that that incident, because it gave me so much information because after that incident I could see his aggressiveness, I could see his manipulativeness. I could see so much that ordinarily could have taken a few sessions to come out. There is a lot people…you know when they are quite they tend to be very …especially as I noticed with my suicidal clients, they're very controlled by external circumstances, they have an external locus of control, so they are easily irritated, and easily made sad, and easily hurt, or angered or made happy by others. So that's one thing to work on, but their feelings…they used to make me feel very scared. I don't know if I have shut myself off, but I can shut my emotions down and close off. I think I have done that to a degree because I need to, because I work with people who cut themselves and might die, and I need a certain amount of distance. So for me I think I have shut down a little bit more than when I came to the ward. Not that I am not as open, it's just…I'm different. Maybe my realisation helps me. It always came to my head as to what would I do if I lost a client. What would I do, how would I make it through. And maybe I also watch the psychiatrist, and how when some people die and stuff, the doctors, they are just like…nobody goes and say sorry man…, they are taught in a very hard way to deal with it, and that has juxtaposed how we are trained and how they are trained, and it has made grow a bit hostile I think. To accept things a bit more…life is hard and some people are not going to make it. I think I have become more realistic now than before, yeah.

How do you find your therapy relationship with your suicidal clients?
Ahh the relationship…I found that they pull me in a lot. They want you to almost help them out of it and…you know, make you feel more responsible. But because I am aware of myself taking too much responsibility - which is one of my pitfalls - I tend to

be wary of that, but I must say I do give a lot of time to it, you know I will go and sit and talk more if I have a few free minutes somewhere, you know.
I'll talk about the first patient whom I said was manipulative. I think I was drawn to her from the first time I met her, and I tend to be drawn to borderlines for some reason. It's like I can see through this side that they put on, and I just saw the hurt behind her eyes although she was smiling and acting on as if everything was okay. She was in trouble with everybody from the beginning, and I was warned about her, nevertheless I took the case on. I liked her a lot, and I worked so hard in that case, and she kept on making me feel like I couldn't do enough. I got angry and despondent because it was like "why are you not happy with everything I do for you?". As I started getting to her it was a bit more comfortable but she made me go in-between people for her all the time. I tried to get closer but she would always stop me with some sort of action or something.

One day I had to put down the boundaries, you know. I think with the borderlines - but I didn't know at the time - you have to be very structured from the beginning, and you have to make sure that you…when you show them boundaries that you don't sort of reject them. She went ahead and she kept on challenging me in that week, which was also very difficult for me because at first our relationship was very close, and then she started being manipulative, and then it was almost like I couldn't stand going to work because this woman would just be very aggressive - verbally, you know, and being manipulative. She would always try and put me into a situation where…I thought my integrity would be compromised and my position as a therapist, and I had just gotten into the ward. So…I actually asked her after she had carried on with her behaviour about three times into the group. Instead of asking the group to comment on her behaviour which I should have done, I panicked when I asked if she might want to leave and she said yes, and that just set the relationship spiralling downwards.

Thereafter I was going to work with her but she wasn't….ehm…I think that hurt the most because that relationship I really wanted to work on, she just wasn't…. So I called in my supervisor, and then we sat down and then it was decided she should then go and work with my supervisor. And in that therapy we also modelled, like we sculpted how we felt about each other. I stood by the door, far away from her holding my hand out, and looking on, half looking at her and half looking away, which showed that I was still there, part of me was looking out. When she modelled she modelled like she was halfway out the door, and she's facing the door. I realised that…that was really over. For the first time I had to like say okay, the best thing for the patient is to work with somebody else, and I …I think that therapeutic relationship was very hard. But afterwards she came to me, and it became okay, we got on far better, ha ha ha. So in a way that had helped because she had somebody to go talk to but our relationship had somehow changed. Because I hadn't pushed her away totally I kept on saying it's okay, I'm still open, and I think you need somebody else and she agreed.
That had made her change too. I think it showed me that therapeutic relationships sometimes go through immense changes, and it hurts a lot because sometimes I felt I had not done the right thing, but just to see her later in very informal relationship do sort of therapy because she and I - the relationship could be existing without rejecting me still. There wasn't total abandonment which she was scared of. Even though she pushed me away I didn't abandon her. So from that side I think that taught me a lot about therapeutic relationships between suicidal clients and…the fact that the

suicidality might be at the back, the manipulative behaviour still continues. She was borderline…even if I put boundaries I had to be very holding and not to panic, yeah.

What discomforts have you experienced in working with suicidal clients?
That would be the discomforts, that would be, generally, yeah, especially with the one that I described now. She was the one running to the bathroom and she would always put me in-between people, so the discomforts would also be…like this client…she put me, ethically, into a difficult position between other patients and nurses, between herself and nurses, between other patients and nurses, between therapists and herself, and that's a difficulty!
The discomfort also is when they challenge me. I like being challenged but the way that I'm not a good therapist…but they do it in an underhanded way, because I'm always trying to work so hard and put so much in, that would feel bad, that was pointed out to me by my supervisor. Because that was actually me, because I'm working so hard for them, that I'm doing work for them more than they are doing in their own therapies. And that my expectations are higher. So what I learnt is that my discomfort is also my own doing. That it is my expectations which caused me great discomforts. So I orientated myself, I try to like let go of that too. To be more realistic and to see them as their own people, and that they have to do a lot of more work in therapy, and that I shouldn't be working so hard trying to pull them up. The discomfort is also wishing that I could make them better, to be altruistic, the sadness. The discomfort would also come when I don't know how much of self-disclosure, which level of self-disclosure is okay, yeah.

What emotional impact has working with suicidal clients had on you?
I think it angered me the first time I began to have contact with it - when this woman ran to the bathroom, and when she kept on manipulating me, saying she wants to kill herself and…the position she put me in, I didn't realise it, I got into the car and I was just fuming, and as we got closer to my house where I lived I realised I wanted to start crying, because it was out of frustration. At first it was total confusion, and I didn't realise what was going on. I was angry! Later on I realised my own need to control things and the realisation that I couldn't, and being put into that position. For somebody to be …I mean that's mean to actually do that to me, because I am there to help them and how can they want to hurt me, you know, and that sort of, "shame, me," position.
The impact was very great and I think that that's why I sort of not deal with it at the beginning. That sort of shut down and get at a distance. I think it took me about a week or two to actually let go of my own anger and irritation about how this woman was playing me. But my supervisor was there rather at times and I could speak openly about it so that was good. A lot of sorrow and sadness and helplessness that I feel, but intellectually I know that there is nothing that I can do about it. Sadness at some people who are very beautiful people who want to end their lives and also I sort of …I question myself why can't robbers, murderers and child rapists - why can't they put a gun on their heads and kill themselves, I sort of think to myself but why, why these people want to kill themselves. They're quite okay, they are nice. So I wonder about this side of people, but ehm…I am teaching myself to be comfortable with death and ehm…At the beginning of the year I lost two friends, that death seem to be close but I've a different view of life and death and a more spiritual view which also helps me. These people pull on your hard strengths, I think. So I think I need to be grounded at some time, coming back at my intellectualisation, spiritual thinking, and that kind of

stuff. Yeah, when it comes down to it I do get worried, and I think at night when I come home I think I do get a bit depressed, and energy seems to be sucked at times, and tired. The next day I'm back there and trying again, yeah.

Any stressors that you could have felt in working with suicidal people?
When that patient first did that to me I was stressed for two weeks, definitely. I just could not manage going to work, I mean I did go to work, but I was dragging it. I love going to work, the whole year even if it was difficult …In my life this one person managed to make me feel terrible. But…, yeah, I think working at ward 6 was incredibly stressful because it was like walking into a room full of webs, you know. Different relationships, relationships between the patients and who is aligned to who, and at times it was like so much around me, so much of information, and having to be disturbed like 24 hours a day just became too much for me. I was tired constantly. I still think that ehm…I think I'm more available than I should be, I'm always on the ward, always there for somebody to speak to, and I realised only about three weeks ago that my blood pressure was very low and I was feeling tired and I was ready to go home, and people just kept on speaking to me and they need this and they need that. I thought to myself, you know, when you are well you don't really realise how much you give to people. Then when you're ill then you do, the energy they take!
Then I realised I was allowing them to take too much. I wasn't saving anything for myself. I would get home, by eight o'clock I want to go to bed. I realised that I also need to have sometime for myself. I mean, I love being with my patients, I love the atmosphere in ward, you know you can just sit down and chat, I had a chat about anything with them, you know, and I find that I get to know them a bit more.

The stressor is also for me sometimes when I differ with the others on a patient, but I don't really account so much, I don't really stand up and say what I think because I know it's not going to go my way. Usually I am outspoken but sometimes I just feel like the system frustrates me. I like to do so much for people but you can't. I respect the people I work with and I think they are very hardworking, and I just think that we are overworked, and that some people really do…I mean Sterkfontein need more people than we got. But I also feel like the system and the structures that are in place are not listening to the people at the ground, and we could go so much further if they just did. Like if management could listen a bit more. Yeah, the system it's a stressor.

What could be your feelings following a suicide attempt of a client that you could be seeing in therapy?
I think I would feel terrible! My initial feelings would be that of total helplessness and inadequacy…that I hadn't done enough, and then I think anger because that's how I handle my feelings sometimes - I get angry first before I understand what's behind the anger. Then I think if it was just an attempt and not actual death, I think I would take it to supervision. But my feelings would be inadequacy, and…yeah…I'm dealing with…and holding people in hands almost. I actually don't have control over situations. I don't know how scarred I would be if somebody would die. My understanding now…if they do it now it's okay because they are the ones that have those feelings, they are the ones responsible for their own lives. I can't take that responsibility on. I understand that now. But I guess after that I'll be very scared, I'll have to have more supervision to make me feel okay. In therapy I'll ask them to

continue therapy, and probably make them sign certain papers. I respect that if somebody wants to do it then there's nothing I can do. So I think I would really feel inadequate, even though I know it's their responsibility. I would go through everything - what did I say, I'll probably check and what, and I'll probably be very careful for a while and not be as spontaneous as I am in therapy. So it will have an impact on me, yes.

Thank you very much.
Thanks.