## *Chapter 7: Intentions and Questions when working Narratively in the Context of Suicidality*

Sections of transcript that highlight some of the questions and intentions the narrative informed therapists brought to the therapy room when working with people in the context appear in this chapter. As noted in previous chapters, assisting with connecting on a variety of levels was an intention of the narrative informed therapists, this is one of the key purposes that the research colleagues brought to the work. They also held other key intentions and the following poeticized extracts are like windows that reflect some of the ways of practising narrative informed therapy when working with people who are engaging with ideas of ending their lives. I have created some headings for this chapter, to assist the reader to feel like they are being led somewhere. You can decide where.

### *Hopeful Intentions*

> ***Hope***
>
> I would bring my own ***hopefulness***
> as a therapist
> as a human being.
>
> *Therapist 1*

I sensed that all the research colleagues were carrying hopefulness, into the therapy room when working to assist people who were engaging with suicide informed ideas. If someone has lost hope for living, I imagine that they may be able to take hold of the therapist's hope or take shelter in the therapist's optimism. If a therapist felt hopeless, this may inhibit effective therapeutic work. I wonder how we can sustain ourselves in this work? How can we keep holding and experiencing hope in the face of hopelessness? Questions worthy of consideration I think.

***Where to from hopelessness?***

We might be talking more about ***hopefulness*** than hopelessness,
hopelessness leads people
to do all sorts of things,
they are not necessarily life threatening
certainly things that are hurtful to people
and could have long-term consequences for people
that are negative,
death is just one of a range of things that people can do.

There is
self-sabotage
self-harm
self-degradation.

*Therapist 3*

The research colleague outlines some of the possible outcomes of hopelessness and says that she may talk more about hopefulness than hopelessness in a therapy session. The recurrent hope theme in relation to Narrative Therapy and suicidality reminds me of the book titled – *Narrative Therapy in Practice – The Archeology of Hope* (Monk et al., 1997), where Narrative Therapy is likened to finding hope within peoples stories through careful searching. The metaphors that we live and work by are many, the metaphor of archeology seems to fit for this enterprise.

***Optimism***

I am
fairly transparent about who
I am and what
I am
I think my optimism is fairly visible to people.

*Therapist 3*

Being transparent is a feature of narrative therapy generally (White, 1997) and an intention of the narrative informed therapists interviewed. It seems therapist 3 does

not hide who she is. The view she holds of herself is that she is optimistic when working with people in the context of suicidality. I wonder what effect this would have on the person who has come to consult with her? I imagine it would give a person (client) a sense of understanding where the therapist is coming from. This may help with the therapeutic connection and demystify the process of therapy.

> ***Hope Disconnection***
>
> Some people have a lot of
> ***hopefulness***
> but no sense of how to be
> connected
> to that
> ***hopefulness.***
>
> *Therapist 1*

The research colleagues felt that suicide-informed actions and thoughts arise when a person has lost all hope. This therapist appears to be saying that some people do have hope but need a helping hand to connect to the hope. This seems to be her intention and I am drawn to the idea of how we can find ways to reconnect a person to experiences of hopefulness, or a sense of hopefulness. It strikes me as an important part of a therapist's work, especially when working with someone who is in a suicidal context. I imagine it would be helpful to find ways of assisting a person to hold the connection and also to be noticing when that hold might be slipping.

***An Opportunity***

Even though I know
I've got to do the tick box thing
I've got to kind of pay lip service to those procedures and policies
and ways of working with people who are suicidal
I have had a similar experience like that
of being in the subject position
of being a clinical object
that experience reminds me of why I do what I do
why I don't want to work that way
I know how dehumanizing it is.
When someone is at that point of thinking of finishing their life
that is very serious

it is critical
it could be a turning
        point
***it is an opportunity***
it is kind of like someone has got as low as they can go
***it is an opportunity.***

*Therapist 3*

The hope of this research colleague is revealed. She views therapy as an opportunity. She spoke personally of a time when she herself experienced being put into a clinically subject position. I think we have all experienced this, I know that I have. From this experience, she knew, first hand, how 'dehumanizing' such an experience can be for people. It appears this may have strengthened her resolve to not work in that way. This research colleague has highlighted the dilemmas that many therapists face in relation to workplace protocol that does not always seem to fit best for the therapeutic situation.

***Standing in an inkling of understanding***

I try and understand
what that was about
that they had lost
***hope***
try to get some more
***understanding***
of
where they
are standing
with that now from
where they
have come from to
where they
are now.

I would be
looking to see if there was some
inkling
of something that had
***hope***
attached to it
that's what
I would be
looking out for
I would be
trying to
***understand***
what they meant by
what had happened in life
to get to that
point.
Some how to listen out for any
inkling
for something with
***hope***
attached to it

*Therapist 2*

On reflecting on this poem, I think of temporality, because in this poem the research colleague is intending to get an understanding across the domains of time. That is, an

understanding 'from where they have come from, to where they are now'. I am struck by the depth that therapist 2 is seeking to understand. Seeking to understand is a key theme arising out of this research. I wonder what the efforts of this narrative informed therapist, to understand, speaks to in the eyes of the person (client)? Narrative therapy has been likened to a 'narrative dance' (see Nicholson, 1995) where questions are asked about experiences and actions and where questions are asked about the meaning made of questions and actions in all the domains of time: past, present, present moment, future, recent past, distant past, near future and distant future.

***To Really Listen***

I intend
to do no harm,
which is the big one

An intention
to listen
To try to pick up the things that are not said
to be more intuitive
with an intention
really to listen.

The intentions
are around really listening
That then gives you an idea around what you can connect on

And
to do no harm

And to be in a position of not knowing.

*Therapist 6*

I wonder if listening and taking on an unknowing stance are practices that lend themselves to curiosity? A non-expert stance and being curious are features of narrative therapy (Freeman & Combs, 1996). It seems that the intended practices outlined by Therapist 6, especially to really listen can bring forth ideas on 'what to connect on' in the therapy. Again, it is a seeking to understand. Understanding what is happening for a person (client) who is experiencing the suicidal tension is an important part of the therapeutic process. I imagine if a person (client) feels that they

have been understood, then they will experience a sense a connection with their therapist.

***In the looking***

I am interested in people
looking
at what they have not thought about before.
It is about
the minutiae
of their relationship
with
themselves and
with
the world

*Therapist 1*

The intention to get a person to 'look' and 'think' about 'something they haven't thought about before' speaks to me as a way for creating possibilities for difference. 'Sifting the minutiae' evokes an image of someone looking very powerfully, carefully, closely and patiently for something. This careful looking seems to be important when working with people who are in a suicidal context and has been spoken about by all the research colleagues. Is it the key to listening and understanding?

*Intentions to bring experience*

***I Bring***

I bring
my belief in integrity.
I know very little
when people come into my therapy room.
The ***position I take is that***
***I know very little***
about
their lives
I know a lot
about
my life,
they know a lot
about
their lives
we have a bit of a conversation
about
something
that they want to talk
about.
They have come to consult me
about
what they want to talk
about.
I bring
***my knowledges and beliefs,***
I bring
who I am,
my beliefs and ***experiences.***

*Therapist 4*

It appears that the intention is to be holding an unknowing position around a person's (client's) life in the therapy room, while simultaneously holding a knowing position of her own life operating in the therapy room. It seems the intention is that the two lives come together and a conversation is had. I am struck at how simple it sounds but I imagine this is quite complex and requires experience. Being hopeful is, once again, noted as important. How do we get to a position of knowing a lot about our lives,

what assists this knowing? It seems that ongoing conversations about life, beliefs, and experiences is important (McLeod & Lynch, 2000). Narrative theory speaks about professional culture and professional discourse, that sometimes distances therapists away from their own life experiences. Experiences that may shape intentions in the work and thus, when acknowledged and honoured, may assist in sustaining therapists (White, 2001; White, 1997). Is this where consultation with supervisors comes into play? There is more about this in the next chapter.

***Life Giving Energy***

I am quite liberal with my knowledges
that I have gained from my work with other people
the way that I preface that
people are the experts on their lives but they are often in positions
where they can't access all their knowledges about those things
so
where I think it is appropriate
I dispense knowledges
and wisdoms of things
that I have from other people who I have had conversations with about
these things.

People are sometimes amazed that other people might
have similar issues or have been through terrible times
or that some people also feel the same
not just big things like being suicidal
but even other things
people are amazed and eager to hear.

I can then talk about that sense of learning and
sense of listening and what that means
which is
a lot of life giving kind of energy.
I always find a very open reception to that.

*Therapist 6*

It appears this therapist is speaking about learnings from people (clients) previously in a suicidal context or maybe some other problematic situation. It is the 'life giving energy' that I am drawn to through what seems to be her 'dispensing of knowledges and wisdoms' gathered from similar contexts. I wonder if it is less isolating for people (clients) to know that others, known to the therapist, have been or are in similar

situations. I imagine this is her intention. I also wonder what those (clients) who have gone before and added to this research colleague's 'wisdom' would say or feel about her taking their knowledges and using them to assist others. Narrative therapy is known for creating communities to assist in engaging with problems in special ways for example the anti-anorexic leagues (Epston, 1994), and the *Power to our Journeys Group* (White, 1997). It is also known for 'taking it back practices' where therapists can let people know, the influence and contribution, their stories and lives (clients) have had on the life and work of therapists (White, 1997).

***Honouring***

Once we've ***established the wording*** that fits
we are in a good flow of conversation.
I am asking them a lot of questions about
what is happening in the run up
at that moment of sheer desperation
what is practically going on
what physically has been going on
what are they thinking
what they are feeling
what the conversation in their head is like between
their thoughts and their feelings
between the practicalities of what is going on
slowing
it
down
and looking at it in bits.
We have conversations about those bits in terms of
the practical side of things
how this idea of themselves is informed, in that run up
their beliefs about themselves.
It honours the history
it honours the reason why they feel so shocking
looking at the practicalities that brought them to that moment
understanding the beliefs and ideas that
operate behind that
seems to be important in helping people
***I want them to know I have heard***
I want to understand the complexity of what is yukky for them in their
lives

*Therapist 1*

In this poem, I am drawn to the honouring and the seeking to understand, multi-dimensionally and historically. This seems to be the way this therapist intends to 'honour' the context of suicidality. It reminds me that suicidality is complex, not simple or trite and that taking the complexity apart and looking 'at it in bits' is very honouring. This stands in contrast to jumping in with finding solutions, over concern about creating safety or trying to 'fix' things for the person (client). Language is

important, that is getting wording that fits. Also, listening in a way that is honouring and the person (client) feels heard.

***In Touch***

I like to ask people questions around
when you get to know who is important in their lives
if those people were in the room
What story that they would have about them?
What that would say about them?
I like those sorts of questions
I like to bring in other audiences
Those audience related questions.
Re-membering type questions .
If I was to say to your best friend
what stands out to them about you in the face of difficult situations
what do you think they would say?
And then have some conversations around that.
I like those kind of questions that put them in touch with their
community and also in touch with themselves.

*Therapist 6*

The above shows some of the questions this research colleague might use in her practice when working with people who are in a suicidal context. Questions about connecting and community seem to be the intention here. 'Re-membering' questions are questions narrative therapists are likely to use, as well as looking out for an 'audience' and seeking friendship links (Russell & Carey, 2002). This sort of questioning can assist people to re-connect and reclaim relationships that may have been lost to them prior to the therapy conversation. It can be likened to storying a sense of belonging. It takes the therapy into the realm of the community.

***Less Blasé***

I have discovered some questions are going to be bloody terrible for some
but probably very good for others?
It has made me more sensitive to the questions.
I really wonder
I ask questions of myself
what it is about that?
what is that like for her?
I do check in quite a bit more
it has made me less blasé about how I think about these great questions Sussing each other out about whether this way of working is going to fit for them or not
checking out with people about how this sort of style of work is going for them
at the first session when someone is coming to you
am not sure where they have come from
what they are expecting.
continually checking out how useful this is
is this what they are wanting
I've often asked people about how they think they will go through the week with some of the things we have talked about and wondering how they will be sustaining that.

*Therapist 2*

Narrative therapy has some 'trademark' questions it seems, however I have always thought of it as more of a political therapy than a therapy of techniques (Freeman & Combs, 1996). Therapist 2 is careful about such questions, her intention is to check in, wonder and be sensitive. It seems that the intention is to not assume that the therapy is being effective, rather to find ways to check that the therapy is indeed being helpful. Negotiating the therapy is something narrative informed therapists are likely to practise (Bird, 2000). All the therapists talked about 'checking in' with people about how the therapy was going and allowing the people who come to consult with them to be in charge of the direction of the therapy. I wonder if this is the negotiating that narrative inquiry is known for? (Clandinin & Connelly, 2000). Also, this therapist is careful not to apply 'narrative questioning' if she feels it is not appropriate or fitting for herself or for the person (client).

***Smorgasbords and Scales***

When they first come in
I get them to do a scale of the depression or the sadness.
Whatever it is they name that they are feeling,
mainly it is sadness or depression,
they name depression or sadness or anger.

So we will scale that and where they are now.
Some of them are minus 2 or 3 or bla bla.

Has there been a time when you have been around 8, 9 or 10?
Some will say no,
some will say yeah,
so what is going on there?

We will start talking about
this depression.
Tell me about this depression?
It might be that they
have a broken relationship
failed something.

Whatever has triggered the depression?
Mum hates me
Life's fucked
I can't stand my dad,
I just don't want to be in the same room as him,
get him out of my life,
something like that.

So then I will map that out
what's that about?
That's when we get onto those things about
failure
not being good enough
not being able to please others.
Let me go back to the scaling
They put themselves at 1 and I will ask
where would you like to be?
And they might say up here at 8 or 9.
And then we will look at the times when they are up there
and they might say
when I am with my friends

when I am surfing.
And I might say, what catapulted you down to here?
I had this fight with mum and dad

my girlfriend left me.
So then it would be, 'tell me a bit about that?'

The story about that.

I start identifying stuff for them
So I might say
is it like you have to please your parents?
And they might say yes?
Is it like you feel you're not a good as others in the class?
And they might say,
I am never good enough I can never be as good as anyone else.
So, I start identifying themes if you like.

I'll say is it this or this or this.
Especially with young people who find it hard to speak.
You put it out like a smorgasbord
***so that they can choose.***
A lot of young people don't have the level of language
and I understand that.

So I put out a smorgasbord for them.
So when you have a fight with your mum and dad is it like they don't love you anymore?
Is it like you don't belong?
Or is it that the anger wells up in your tummy and you get this knot in your tummy?
And they'll say yeah it is like that.

So I just keep putting stuff out until they get it out.
I guess that is how I get to things,
I just keep questioning and getting them to identify things
so that I can get a
handle
on what is going on.
And I get a handle
on some of the themes of what is going on in their life.
They always tell you, the best thing they remember is the scale.
We have evaluation sessions
we call together a number of young people who have been through,
the thing they remember is

the scale,

it is something they can see.
It is a visual.
When you ask them at the end of the session,
what did you like best?

If they can tell you,
they will say
the scale,

because I can see it, you'll have it up on the whiteboard,
and they say the scale.

*Therapist 4*

Scaling questions are often used in solution focused therapy (Sharry et al., 2002). Therapist 4 spoke of using a solution focused approach to therapy as well as a narrative approach. The research colleague has found the 'smorgasbord' of ideas a useful way to work with young people who find describing/storying their context difficult for whatever reason. This research colleague has also highlighted a number of questions that she uses in her therapeutic practice. Although a lengthy illustration, I felt it gave a thorough explanation of the way this research colleague intends to proceed when working with people who are in a suicidal context.

***Intention of care and respect***

> ***A stream***
>
> Another big stream,
> I would be looking at,
> is around failure,
> ***not matching up in life,***
> a sense of not being worthwhile
>
> *Therapist 1*

Narrative therapy speaks about how problems can speak to people about their identity (White, 1992). I imagine a held identity of worthlessness or failure could inform suicide actions. Narrative therapy also speaks about the evaluative practices, comparative practices and normative practices that people often feel they are under (White, 2002). It seems that an intention of this therapist is to notice such things and bring them out into the open.

> ***Accepting***
>
> I suppose to me it is really about not pushing someone
> just accepting them
> sitting with that
> accepting.
>
> ***Really trying to understand***
> whatever she gives me
> which is not a lot.
>
> Rather than come in with all these judgements around dissassociation
> all these very powerful terms
> that suddenly put her in a very serious category
> it is not listening to that kind of stuff but really trying to understand
> what's happening for her at that time.
>
> *Therapist 2*

The research colleague is speaking about a woman where long silences made up part of the therapy. Her intention in this context is to 'sit' with it, to be 'accepting'. The

preference is to look for understanding. The therapist does not want to be controlling or imposing by 'pushing someone'. Again, I think about power in the therapeutic relationship and the way this research colleague manages it. I am drawn to the therapist's intention of letting go of judgements she might make that speak of pathology like 'disassociation'.

***The paths***

I am interested in why they believe in something
how they came to believe in it
more than what they believe in.
I am really interested in
I certainly wouldn't want to discount
or invalidate
or in anyway undermine the paths
that people have gone to.
I have talked to people with lots of different belief systems
some more new age kind of stuff
those ideas have actually been very sustaining
that it is their preferred way.

*Therapist 3*

Again, it seems like a deconstructing conversation is intended. Yet, the carefulness is apparent in that therapist 3 intends to engage in such a conversation in a way that does not 'invalidate', 'discount' or 'undermine'. I am drawn to the care and respect that the research colleague is referring to. I imagine, however, that it is important that therapists be careful when deconstructing in case they are pulling apart or unpacking things or ideas that are precious to the person (client) and leave the person (client) feeling undermined, discounted, not taken seriously or invalidated.

***It's on the table***

When I am starting to have externalising conversations
I am talking about the bigger picture stuff
I am asking about relational identity
I am putting the therapeutic relationship on the table

I feel like
chances are
this is such a different experience for someone
if they haven't had counselling before
haven't been to a narrative therapist before

People are not really used to being asked those sorts of questions
people I see have been to many counsellors
they have been struggling with problems for so long
they are a bit taken back by being asked those sorts of things
I give them a lot of information as to why I am asking them.

It really does seem to be quite baffling to them
'why is she asking me this kind of thing about what meaning I am having around the relationship and what I am thinking about the therapy?'
This is not done in a self-indulgent way
it is about being of service to the therapy.

I feel I should let them know why I speak the way I do
for the purposes of transparency
I know I do quite a bit of that with people

They're just not used to having therapists or professionals asking them that kind of question.
I find
as someone who is informed by narrative
that people who have been through a lot of different sorts of therapists
they are used to feeling like it is a one way street
they are used to questions that ask them to internalise things
to consider their essential self
I am inviting them into something else.
Something quite different.

*Therapist 3*

To summarise, this research colleague has highlighted a number of narrative intentions. They are intentions of all the research colleagues. She is looking to:

externalize the conversations, consider relational identity, checking in with people and negotiating the relationship, being transparent and collaborative, considering essentialist self ideas, and thinking of therapy as a two-way street. All of these are features of narrative theory (Freeman & Combs, 1996).

***Intention of being in the present moment***

> ***Drawn***
>
> Very drawn to
> narrative ideas
> very drawn to
> being in the ***present moment*** and working in the ***present moment***
> very drawn to
> non-pathologising ideas.
>
> *Therapist 2*

Therapist 2 is outlining what she views as some of the narrative ideas, that is, being and working in the present moment and non-pathologising ideas. I am taken by the distinction she makes of being both in the present moment and working in the present moment and would be interested in exploring her ideas around 'being' and 'working'.

> ***Breathing***
>
> It is about
> breathing
> it is about
> slowing your
> own breathing
> down
> and getting in touch with you're breathing
> and to be in ***the present moment***
> and noticing
> what is happening in your own body
> know your own early warning signs in your body.
>
> *Therapist 4*

This appears to be one of the ways that this research colleague is able 'to be in the present moment'. It is one of the practices she engages in so that she can be in the present moment with the people she is working with. I wonder what she does when she notices 'early warning signs', what are they alerting her too?

### *Intentions that challenge*

***Invitations to Jump***

I try to put myself into a not knowing position
which is often hard
There are invitations to jump ahead and
to think what they might be thinking or
what they might need,
that is a ***challenge*** for me continuously
that goes hand in hand with listening.
To listen properly I have to be in some ways not knowing
in order to
know from them.

*Therapist 6*

I am drawn to the way this research colleague is showing her practice in relation to understanding and listening. She brings to the therapy a 'not knowing position'. Similarly to another research colleague, therapist 6 says that she does this by trying not to jump in. I have found in my own experience that this takes discipline but I imagine that to know, understand, and connect it is necessary. To not let all of this get in the way of listening is the challenge.

***Something Lifting***

And it is a ***challenge*** I imagine
with this edge of the work
when you have the anxiety?
yes
which invites you to take in 'I know what's best for people who are suicidal'.
Even the idea that people are better off to be alive in this world
I always take a deep breath though when I talk to people
Because
they do have good reason to be sad
what a terrible to thing to have happened
I always take a bit of a breath
Because
you are actually saying
'well why wouldn't you feel miserable when all these terrible things have happened'.
I am always amazed
how you can have some sense of lifting in the other person
when they have somebody
really saying to them
it is not empathizing, I suppose it is empathizing
really saying
how bad it is,
I suppose that also it is like when you have an argument
to live or not to live
you're actually arguing in a sense
not to live
because
you are actually inflating that side
but
it always makes me marvel
the reaction I usually get
as though something is lifting from somebody.

*Therapist 6*

The question, at the beginning of this poem, was asked by me. I imagine that it would be wonderful for therapist and client alike to sense something lifting, especially in the face of experiencing the challenge of the work. It strikes me that working with people who are entertaining suicide is beyond empathizing. I sense that therapist 6 probably thinks this too. I wonder what one could call that? This research colleague is showing how change can happen in the moment, during the process of the therapy. It seems to be very delicate work. She is shying away from the dominant discourse that suggests people are better off living in this world and that suicide is bad. For me this is very challenging?

***Pressures and grapples***

I experience pressure.
The health department
particular protocols
check list stuff
when someone presents as suicidal.

You have to ask these set of questions,
you are supposed to make sure this is talked about,
it is in such a tick box way
it is so prescriptive.

Sometimes
I have made the decision to throw it out.
My narrative framework leads me to have other conversations
and not be so
'what have you done?'
you know the orientation of those questions.

I have been grappling with this dilemma
having to work within the health framework
I am a bit cynical.
I go with what I am comfortable with doing
with what I have experienced has been helpful for other people.

*Therapist 3*

Therapist 3 is noting how a narrative framework does not always fit with workplace systems. Most of the research colleagues made mention of this. It seems that

workplaces often have policies and procedures that are to be put in place when a person is in a suicidal context. This therapist grapples with this and will sometimes prefer to follow a narrative approach, she says she will go with what she feels comfortable with and what she has experienced as helpful for others. I can also relate to this. I find it personally tricky in my work, (with people [clients] who are viewed as very high risk [dual diagnosis]) to balance what I refer to as, 'not being an agent of social control' and 'duty of care'. It seems negotiating with workplaces and other workers around this is tricky but I have found can be achieved.

***The Package***

So
it is something about, what does it take to connect with the life that you are,
rather than the life that you now have?
or the identity of who you are?
Or something, rather than this dreamed of life.

Which is kind of complicated
because what we often say to people
and what I have heard a lot of narrative therapists say
is 'what are your dreams for relationships?'
'What are your hopes, plans or intentions?'
And yet if that takes people
further down a path
of pursuing a package
a product that they can never really achieve
then maybe that is a position lacking
ethics and substance
and that concerns me.

So
the kinds of things
I am beginning to think about
what does it mean to stop pursuing that product?
or stop pursuing that dreamed of life?
and instead being more actively engaging with
the current experience of life as it is
in the day
in the hour
in the minute
as it might be tomorrow
rather than this life that is based on reaching your dreams or something.

So
the sorts of things that might be
really helpful
to live in the minute
and I don't mean some new age idea of
living in the minute
or the moment
but maybe some kinds of ideas around living with
some acceptance of the now
or resisting the temptations
to solve the problems of the now.

*Therapist 5*

The research colleague appears to be thinking about the ethics of therapy in relation to working with people to achieve 'a lifestyle' or a 'product' that may be impossible for some to ever reach. I find this challenging. It has me wondering very seriously, the challenge is how do we know that dreams may never be reached, is this closing down possibilities, yet not wanting to jump in with a 'fix it' mentality. I guess I am curious about what is informing the dreams people are holding? What part does the broader culture have to play in these hopes and dreams?

> ***The trick part***
>
> I think the trick part is that the consumer world that we live in tricks us into believing that we will be able to arrive at, or consume or produce the life of our dreams if we only work hard enough, or are dedicated enough, or are good enough, or believe hard enough that it is possible and not give up on our hopes. If you just hold onto your hopes long enough then eventually you will be able to consume your life of your dreams, but that is a fallacy, it doesn't really evolve that way and so I have heard over and over again, people saying that this isn't the life that they thought they would have.
>
> Can acceptance of life as it is also contain some dreams and hopes, would that be a different type of relationship to dreams and hopes than the one that is produced through the searching for a product, searching for the perfect lifestyle product, or the perfect lifestyle, or the life that I imagined I would have? It seems like it could be different, there might be other possibilities with accepting life as it is and having dreams and hopes.
>
> *Therapist 5*

I am drawn to the way therapist 5 simultaneously places 'accepting life as it is' with having hopes and dreams. I find this profound and challenging. I wonder how this may affect us, if we can accept our lives as they are, while simultaneously holding and working towards our hopes and dreams? I wonder if exploring this with people in a suicidal context might be of help?

### *Conclusion*

In conclusion, there were a number of key themes that stood out, in relation to the actual intentions that the research colleagues bring into the therapy room. These shall be highlighted. The intention of finding hope, reconnecting with hope and being hopeful and optimistic stands out. Listening carefully with a view to understanding and finding thoughts that had not been thought about before, also stands out. Seeking to honour the suicidal despair through listening, deconstructing and finding ways to let the person (client) know that they have been heard and understood was another intention. This reminds me of CAMS, Collaborative Assessment and Management of Suicidality, (Jobes, 2000), whereby the most important factor in working with a person experiencing suicidality is deemed to be to thoroughly understand the person's experience.

Another intention of the research colleagues is to work in transparent ways and offer knowledges gleaned from life experiences and/or from what has been learned from working with others (clients). Yet, at the same time holding an intention to be in a position of not knowing, of not making assumptions, and for some, being intuitive in the way they worked. The research colleagues intended to assist people to find a sense of belonging and to be linked with communities of support. Re-membering conversations and questions were some of the actual ways the research colleagues practised. Other questions, carried the intention of deconstructing, especially questions that deconstructed ideas around failure and not measuring up, and also questions that sought to check and negotiate the direction of the therapy, and the fit of language. The whole notion of consumerism was an important topic when exploring the details that surround the suicidal context. The research colleagues intended for the work to be collaborative. Challenges of the work were raised in relation to working with government agencies where protocol did not always fit neatly with narrative informed practices.

## *Chapter 8: Training*

The following are some poems that relate to answers given about how new therapists might be trained to work narratively with a suicidal context? This was a component to the main research question. In some ways, the relationship between suicide and narrative therapy can be seen in the answers the research colleagues gave.

***Narrative - Not a deficit model***

One of the things that I never learned
which I would have liked to have learned
or been trained in
is that people have incredible resources
and to look for those resources.

Rather
than seeing people as empty in some ways
but to see those people with resources
that has been something that was absent from the training.

Rather
than seeing people,
because of their life circumstances
or the terrible things that have happened to them
or a drug or alcohol problem
or whatever
that they're diminished.

And I think that would make a huge difference
about having meaningful
open
less scary
conversations with people
if you didn't have that sense, or been trained in that way.

Just talking about it now
it is what I felt that I was trained in
that people are
diminished
inadequate
people who cannot access
resources.

*Therapist 6*

The above alerts me to thinking about the worldview or story that I carry about people who are experiencing problems. I wonder how the view I hold will affect the therapy? This research colleague is speaking about her undergraduate training whereby she thinks that she was trained to see people with problems as 'diminished'. It seems if she views people as being well 'resourced', then working in the context of suicidality is 'less scary' for her. It seems that psychologists and psychiatrists are trained into seeing people as having deficits. In order to give a person a diagnosis, deficits have to be found about the person. A straying from 'normality' as highlighted by a bell-shaped curve, is usually identified and from here a diagnosis is made. In society there is a lot of deficit thinking, by this I mean, looking at what is wrong. Practices within education tend to focus on mistakes and correction to enhance learning. White challenges this idea in his writings (White, 2002).

Narrative therapy says 'people are not the problem, the problem is the problem'. (O'Hanlon, 1994) Does this view have us less afraid when working with people in a suicidal situation? The literature does speak about higher therapist anxiety when working with people who are suicidal (Fox & Cooper, 1998) and hypervigilance if a practitioner has had an experience of someone completing suicide (Kapoor, 2002). It may be helpful in training people to work with people who are suicidal, that trainers assist practitioners to get in touch with qualities that speak about resilience and strength of the client. It may also be helpful to assist new therapists to get in touch with the worldview that they hold in relation to suicide. Further, to assist them to understand where their view comes from. Also, how this view has changed over time, and how this may affect the therapeutic conversations. There is opportunity for this to happen in supervision sessions but perhaps less opportunity in training. The literature also speaks of the importance of therapists being in touch with their own stories (Sommers-Flannagan, 1995; Stynes, 1998).

***Transparency?***

I think being able to identify
and really have thought through thoroughly
where you are coming from
makes you
  more accountable
then you can be
  more transparent
you can
  more respectfully
do some 'taking it back' practices with people
without imposing
or making it a really big issue
and talking about yourself in an exemplary way.
You can really make the most of your relationship
with that person
and be there
  as a human being.
But,
if you haven't thought about that
or thought about why
and done all that exploration
I get a bit concerned about how
  respectful
people are being and where they are positioning themselves as therapists.
I remember for myself
my own journey with the thinking
how long it took me to get that
the politics of it
that is fundamental
and how easy it is to be hypocritical basically.

Being really inconsistent and that leads to
disrespect,
doing practices that are
disrespectful
or potentially disrespectful,
marginalising and positioning people as other
all those sort of things that you don't want to be replicating, because it happens enough.

*Therapist 3*

The research colleague is saying that 'exploring' leads to 'accountability' leads to being able to be 'transparent' which in turn leads to respectful practices. I am drawn to this because the word respect is often spoken about. Breaking down what respect actually means, then considering how to practise respect is seldom noted. I think therapist 3 has highlighted her way to practise respect. Key themes for training new therapists that have emerged are around accountability, respect and transparency. I imagine transparency becomes easier the more one has explored their own experiences, emotions and stories. The idea of exploring links with the previous poem in relation to trainers giving space for new therapists to discuss their own stories, not only in relation to suicide, but to many other issues.

***To lose what is Precious***

Being comfortable with yourself
exploring your own life
so that you know about life and death,
I am sure there are some teachers out there
I think it has to be
experiential
it is about
loss
it is about
getting in touch with
loss
pain
and grief.
So if you would imagine
what it would be like to have lost everything
in the world
that is precious to you?
what would that be like to you?

*Therapist 4*

Again, the themes of exploring one's own life, being comfortable and experiential learning have emerged. I wonder how important it is for therapists to be in touch with 'pain', 'loss' and 'grief' when they take on therapeutic work with people who are in a suicidal context.

***Exploring***

I think it is to do
with being comfortable
with yourself
and exploring.

Having done narrative
we explore our own lives
whereas when you are operating from the expert
you've got your thing that you do with them
whatever that is
whether it is the CBT thing
the solution focused
even the narrative thing.

*Therapist 4*

For me narrative therapy tells me that I am not the expert on a person's life but I do have some expertise. I think becoming comfortable with your self is a lifetime project. Exploring our own lives is something that the research colleagues felt was important for training. The idea or discourse around education that says we receive our training and then go out into the world all knowing doesn't sit easily with me.

***What would it mean***

What would it mean
if more of our conversations were about
the pain
of trying to find the product
the pain of trying to find the perfect existence
the dreamed of existence
what if
more our conversations
went into the kind of painful
and ugly parts
of that not working
rather than our conversations going into the
***'I'm not measuring up'***
kind of speaking or conversations
how would that be for people?

*Therapist 5*

Yes, I wonder that too. It may mean that we, therapists, would get in touch with loss in our own lives.

> ***Accountability***
>
> it is about teaching therapists
> to listen
> to themselves
> to notice
> if they are up to taking on that level of
> respecting someone else.
>
> And some days they are not going to be able to
> they need to know that before they just see somebody.
>
> To be accountable to the client
> unlike a lot of jobs
> people share very personal things about themselves
> and they just have to trust that you are going to be professional.
> It is important that professionalism
> is brought to the room,
> is well brought to the room.
>
> I don't think it is about
> whether you are good at therapy
> or bad at therapy
> it is around teaching therapists
> about practices of accountability.
>
> *Therapist 1*

It seems that accountable practices go hand in hand with respectful practices which go hand in hand with professionalism. The research colleague is saying that it is best not to see people (clients) if one is not able to be respectful and accountable. I do think that therapeutic work is 'unlike a lot of jobs' and I wonder if this can contribute to therapists feeling isolated at times. Accountability means, to therapist 1, having knowledge about yourself and recognising when you are not up to doing the work. I think this is very honourable, but what if a therapist, due to systems or workplace structural restraints cannot choose? It raises dilemmas, for example, what does a therapist do if they do not like a person (client)? I wonder if having a view 'the problem is the problem not the person' lessens the issue of liking or disliking the

person (client)? Is accountability about not working with people if we feel we are unable, uncomfortable, or not feeling up to it? I think it is.

***A Clear Framework***

Well I think,
to have a very clear framework in your head
that they have a very clear framework
about how they want to proceed with the conversation.

To be feeling that they are at a point,
in their skill level to feel comfortable
with speaking about some of those issues.

Not
the idea that,
I've done a bit of this and a bit of that
lets see how I go.
But
to have clear ideas in their head,
about how to proceed
clear ideas in their head
or something
about what does suicidality mean to them.
How does that all fit in terms of their life?
things like being ***curious*** about people in their lives
and being interested in people.
You can't really be trained in that.
But
I think you can train people in learning a framework.

There are all those other issues like pacing
sitting back
and really wondering
general wondering
curiosity
I don't know if that could be trained
I would have thought not.

*Therapist 2*

Having a 'framework' has been helpful for me, I think it gives me more courage as I face into the therapeutic work, especially when working with people who are engaging with ideas to end life. It is good to have ideas about how to proceed, but I

think the struggle here, when learning an approach or framework, is that listening needs to be paramount. Often, the thinking about ways to proceed or the next question can be become intrusive and get in the way of listening. This has been my experience. It is about teaching new therapists ways to hold the curiosity and listen well while simultaneously following some sort of process.

***Key advice?***

Be interviewed about
by someone who does have that framework
if you are interested in being a narrative therapist
or someone who is informed that way
being interviewed about
your own purposes and intentions and commitments.

I think
just trying to put them out there
articulate them say them
is really difficult
but it will come out of a conversation
it will come out of an interview.

So,
if you are a new therapist give yourself some opportunities whatever they are, where ever they come up, whether it is a narrative day, whether it is this kind of conversation, a research conversation, be part of a network, you can go to Dulwich, you can do Michael White's level 2 thing and have the experience of being asked about what is behind your purposes and intentions and commitments to this work and this way of working.

Because,
maybe this approach isn't for you,
because
if you are coming from a place where you are thinking this is a nice little trendy bag of tricks I can put in my kit of other things, you are not kind of there, you know what I mean?
And,
I have seen people do that and I think,
no they haven't really thought about it,
or maybe they haven't been asked about it,
there is something that is missing in their training or in what they do,
there is something that they haven't kind of got yet.
I remember for myself,
my own journey with the thinking,

how long it took me to get that,
the politics of it
that is fundamental
and how easy it is to be hypocritical.
Being really inconsistent and that leads to disrespect,
doing practices that are disrespectful or potentially disrespectful,
marginalising and positioning people as other,
all those sort of things that you don't want to be replicating, because it happens enough.
And
maybe some of this stuff has been influenced by
my psychodynamic training (laugh)
because that is something that still holds for me
if you are not willing to put yourself in the position
of the people you are working with
you are not going to be a very good therapist.

*Therapist 3*

Themes I am noticing include: politics, respect, marginalising, conversations, experiencing. 'The politics are fundamental' stands out. I wonder what the politics of narrative therapy really are? When I teach narrative therapy, I often say that the narrative approach to therapy speaks to me of a political therapy, a therapy for social justice. I wonder how suicidality fits with social justice and politics?

Also, what stands out is the importance of new therapists being aware of the 'purposes, intentions, and commitments' they hold. White also highlights this and the way purposes, intentions, and commitments can differ in relation to context (White, 2002).

***The Driving Seat***

If they are a really good therapist
what ever model you use
you use it in a way that fits for the person.

I think I definitely would use other ways of working
But
it is a fit between you and the person
which makes you a good therapist.
You create other ways of working.
If I work with suicidal people
which I often do
I do safety plans
I am sure that is a cognitive behavioural thing
But
I think it is how you introduce something
how you talk about it
how you approach it
that is more respectful for the person
than maybe other models
and puts you less in the driving seat.

*Therapist 6*

I am drawn to the way that this therapist is speaking about respectful practice that also takes in the using of safety plans. It seems she has found a way of working that is able to consider safety that is not imposing and that is respectful. I imagine she works collaboratively around this.

***We Need to Grapple***

We shouldn't be training them (laughing)
I am an educator
I am a development co-ordinator
and trying to do it around areas of complexity
A lot of getting people to change practices
is not about training them
it is about
giving them opportunities
to have conversations about how they encounter the work
it is about
changing team and workplace cultures
it is about
subverting professional discourse in the way we train therapists.
That's where I am coming to in thinking about education.
Because I know a lot of the training has been in that prescriptive packaged way to people whose work is really really different from each others. And they are all invited into taking on the same factual based information, that's really divorced from people's lives.

I know it is just not sinking in and why is that?
Because the packages
don't encourage conversation,
don't encourage people to grapple with the dilemmas
don't encourage people to think about what they think.

And that's what training does, we are telling people how they should be thinking and we shouldn't be doing that. If you really want therapists to change practices towards suicidality or anything else is to introduce more opportunities for people to take the time to have those kind of deconstructive conversations and practices with each other and really get their heads into why they think the way they do.

I mean that is what I have learned a lot of in the last few months.
It is something that I have thought about for a long time
I am hearing it from a lot of different people who are coming to similar conclusions,
who have been delivering training for a long time,
practices aren't changing and why is that?

If you want people to change their thinking
you have to deliver it differently.
So even just that question about training makes me think about that stuff.
It is making the assumption
that they are a bit of a blank slate
and they are all the same slate before they start
and you can just imprint on it
and mould people to this idea of what a good therapist is.

*Therapist 3*

All of the words, in the above poem, were spoken by therapist 3. She was asking questions and what struck me is the idea of grappling with dilemmas, this I imagine would be important for any therapeutic approach, but I imagine particularly important when working with suicidality because of the life/death emotions that resonate. What would the grappling actually look like for the purpose of training? I think the research colleague is speaking of experience based learning through conversations. Do trainers and curriculum assume that people are a 'bit of a blank slate' beginning at the same place? It seems that giving new therapists opportunity to relay where they are up to in their learning and how any new learning may fit with past learning would be helpful. As well as how the new learning is fitting with held ideas, beliefs and life stories.

***Reflecting, gnitcelfeR***

In terms of what training might be like
I think a lot of the training that is on offer in narrative therapy
and maybe what Dulwich does is quiet good
because they have got that
experiential component
particularly stage 2 of Michael White.
There is a lot of that doing of it
and being in relation to other people while you are doing it
That is really important.

When you are reflecting,
You are getting in touch
with the fact that
as a therapist
you have a life in front of you.
You have a whole lot of purposes and intentions that you bring into it.
And so when you are developing that reflection
on someone else's life and then you reflect on your own
and then you get that chance to get to reflect back
in a reflecting team
and that is just so rich.

*Therapist 3*

Themes of 'purposes', 'intentions', 'being in relation' and 'reflecting' stand out for me. Does reflecting back really bring a richness? I wonder if reflecting can thicken and give a fuller understanding and appreciation to this research on the topics of suicidality and narrative therapy? Does reflecting 'train' us? For me, reflecting on a person's (clients) life and then reflecting on my life in light of that, and then reflecting that back, is a process that can be transformative.

***Reading is thin, Exposure and conversations are thicker***

What I have found really useful
is exposure to as
many different therapists' ways of thinking as possible.
Not just go into one person's
brand of narrative therapy
but
trying them all on
getting what I can
and learning from lots of different people
and in lots of different ways.

Being in conversation with people
that are inspired by the same kinds of thinking
and I think that's the way you learn too.
Even from your reading, it is thin
just to read is thin.
Because it is a journey
and it is with other people
I have found that most of the learning
that I have done mostly is more collaborative and with people
than I have done with solitary stuff.

*Therapist 3*

Therapist 3 is giving some ideas about what she has found useful – 'exposure to as many different therapists' ways of thinking as possible'. The way to do this is through collaborative conversations. I can only imagine that if a group of therapists were to be given some of these 'poems' and asked to have a reflective conversation, how much richer and fuller the descriptions and insights into narrative therapy and suicidality might be. Training is not a solitary journey, it seems important that new therapists engage in conversations with more experienced therapists as a valid way to learn. This means that experienced therapists will have to be open to sharing their experiences and showing the way they work. Therapist 3 is saying that there needs to be more than solitary reading. Telling the story of our learning journeys, and being reflexive is one way to learn. And, the final chapter, next, looks at this.

### *Conclusion*

In relation to training others to work with people who are suicidal, the research colleagues preferred training that is experiential. That is training that has a component that allows for conversations about the work the trainee is encountering. It was thought to be important that new therapists have an idea of what suicidality, life and death means to them. Training others to be in the moment and in touch with one's own bodily feelings and breathing was important to one of the research colleagues.

The conversations with the research colleagues revealed that exploring one's own beliefs and stories was important and helpful for trainees. One commented that research conversations, like the one they had engaged with, were helpful to developing their own understandings and that new therapists need to have opportunities that encourage conversation whereby they can reflect on their own views and ideas. She felt new therapists should not be 'trained', rather, 'they should be having conversations about how they encounter the work'. One research colleague spoke about the importance of having clear ideas of how to proceed with the therapy in line with how it fits with their own lives.

Most of the literature for training therapists to work with people who are suicidal focuses on suicide risk assessment and predicting suicide (Westefeld et al., 2000). Suicide risk assessment and predicting suicide was not an emphasis in this research and was not a theme to emerge from the interviews with the research colleagues. The research colleagues, mostly played down 'risk assessment' and preferred to emphasize the importance of joining well with the person seeking help and getting a good fit. It seems, that from the position of the narrative informed therapists, that the initial engagement is strengthened by listening to a person's story rather than putting them through some sort of tick-a-box style assessment process. The ability to engage well in the therapeutic relationship was as an important part of training new therapists.