Chapter 1: Reflexively introducing the research

1.1 Introducing my reasoning for the research

The issue of suicide was chosen to research because it is widely acknowledged as an important and growing community health issue (Rayner & Warner, 2003). In Australia there are about 6 completed suicides every day and 180 suicide attempts, resulting in huge emotional and financial costs (Hassan, 1996). It is a health issue which we have few proven therapeutic approaches (Westefeld, Range, Rogers, Maples, Bromley, & Alcorn, 2000). Suicidality challenges practitioners' skills and sense of competence (Fox & Cooper, 1998) and training is often perceived as inadequate for dealing with this issue (Trimble, Jackson & Harvey, 2000; Kapoor, 2002). Psychologists have more than a 20% chance of having a client suicide (Kapoor, 2002). In an empirical study of Australian psychologists 90% said they had experienced clients with suicidal ideation and 76% had experienced their clients attempting suicide (Trimble et al., 2000).

Narrative Therapy has story telling at its centre and it is widely thought that telling and re-telling stories in particular ways are important for living a preferred authentic life (Morgan, 2000). After reviewing the existing literature on the effectiveness of narrative therapy, it was found that 'despite the apparent attraction to narrative therapy, research on its utility is sparse' (Etchison & Kleist, 2000, p.61). In addition, because of the high incidence of suicide in Australia there is an 'urgent need to think about differing views on such aspects as preferred interventions in managing high-risk clients' (Trimble, et al., 2000, p.228). Also, some literature suggests that 'tick-a-box' checklist approaches to assessment, when working with people who are experiencing suicidality, has not been found to be effective (Michel, Maltsberger, Jobes, Leenaars, Orbach, Stadler, Dey, Young, & Valach, 2002). In some cases it could even worsen the risk of suicide (Rogers & Soyka, 2004).

The coupling of narrative therapy and suicide was chosen because suicidality cannot genuinely be considered without exploring what it means to live life.

Narrative therapy concerns itself with what it means to live life relationally (Bird, 2000). Engaging with ideas to end one's life speaks to a disenchantment with life itself (O'Neill, 2004). McLeod and Lynch (2000) cite Taylor (1989, p.520), saying that the intention of the therapist is one of retrieval, meaning an attempt 'to uncover buried goods through rearticulation - and thereby to make these sources again empower, to bring the air back again into the half-collapsed lungs of the spirit'. I wondered if 'air is brought back into the half-collapsed lungs of the spirit', how might the spirit be affected? What will this mean for living life? My experience of narrative practice is that it is life enhancing. Although there isn't any conclusive evidence-based research to prove this, there is a huge and growing amount of cumulative evidence, detailing many stories, case studies and anecdotes of the effectiveness of narrative therapy, written up as articles in journals, books, and presented as workshops and papers at conferences (Speedy, 2004). I believe it is fair to say that if one gathered and recorded the accumulation of stories and case studies that suggest the effectiveness of narrative practices, one may be convinced that narrative practice opens up possibilities and therefore can 'bring air back into the half-collapsed lungs of the spirit'. The contribution of this research, is to explore the actual clinical practice of narrative informed therapists when they work in the area of suicidality, and draw out their wisdom about how narrative therapy practices can contribute to working with this difficult area.

1.2 Introducing the methodology for the Study

Using a bricolage methodology (Denzin & Lincoln, 2000) with narrative inquiry (Clandinin & Connelly, 2000) at its centre, and in-depth interviews, this research sought to understand more about N/narrative Therapy practice and how it links with suicidality. The narrative informed therapists were seen as the main actors, so this research is about their practice knowledges and experiences and the relationship between these knowledges, 'N/narrative therapy' and 'suicidality'. Of interest was how the narrative informed therapists give voice to and story the ways in which they work with people who are engaging with ideas of ending their life. The research contribution offers links that may foster a further understanding of narrative informed therapy; suicidality; and narrative therapy in relationship with suicidality.

In-depth interviews were used to draw out rich descriptions, stories and case studies of the ways that the narrative informed therapists practise therapy with this group of people. The research aimed to listen and record what experienced narrative informed therapists actually did in their clinical practice when consulting with people who are engaging with ideas of ending their life. Also, narrative informed therapists' knowledges about ways they thought therapists could be trained to work with people who are in a suicidal context, was added. The stories have been presented in poeticized form and can be found in Chapters Four to Eight.

This research is fluid in its application of narrative as a method and narrative as phenomenon. The boundaries of these areas simultaneously overlap and are infinite; this can be considered both a strength and a weakness of the research. I have experienced tensions at these boundaries, particularly in finding ways to compose the research in ways that necessarily are reductionist. The bricolage methodology assisted with this tension. Narrative has been viewed as a root metaphor in psychology and it has been suggested that it is impossible to 'draw clear boundaries around narrative as data, narrative as method and narrative as theory' (Kirkman, 2002, p.30). Chapter Three is devoted to the research methodology.

Key terms in this research will be elaborated upon in section 1.6 below, entitled 'Introducing the language chosen'.

1.3 The Research Question

The research question is: 'What stories do narrative informed therapists hold about actual ways of working with people who are engaging with ideas of ending their life?' Other components of the research question include: What is the meaning of suicidality to the narrative informed therapists? What are the actual intentions narrative informed therapists bring to the therapeutic work in this area? What are some of the ways in which narrative informed therapists take therapy beyond the therapy room? What ideas do narrative informed therapists hold about the issue of training new therapists?

1.4 Influence of my Personal Story in Development of the Research

Narrative therapy is an increasingly popular approach to therapy and currently of interest to many therapists, myself included. Over the past ten years, narrative therapy has been growing in popularity with scores of articles and books being written about it (Speedy, 2004). Narrative had become more than an interesting therapeutic approach for me, it had become a way of being and living in the world. As I looked at everything in life through a narrative lens, it seemed the most comfortable way for me to do the research.

> 'We might say that if we understand the world narratively, as we do, then it makes sense to study the world narratively. For us life – as we come to it and as it comes to others – is filled with narrative fragments, enacted in storied moments of time and space, and reflected upon and understood in terms of narrative unities and discontinuities' (Clandinin & Connelly 2000, p.17).

Some of the people I work with are engaging with ideas to end their lives, and so, out of concern and a desire to do the best practice, the research developed around suicidology, the study of suicide, and narratology, the study of story telling, which is central to narrative therapy. Thus, the work became a consideration of the links between suicidality and narrative therapy.

My experience of Narrative Therapy, that is the Australian/New Zealand approach, goes back to the early 1990's. I began reading and studying the work of Michael White when I worked as a family support worker, in Newcastle, two hours drive North of Sydney. In 1996 I completed a year long professional development course in Narrative Therapy at Macquarie University and have continued to practise and study Narrative Therapy until the present day. I also visited Adelaide and attended two intensive courses with Michael White. I was interviewed by him and presented video tapes of my work to him and a team of narrative practitioners. I had the opportunity to be part of a 'reflecting team'. For the past 2 years, I have begun teaching a two-day introduction course on Narrative Therapy, with the Centre for Community Welfare and Training in Sydney. The course is run several times each year with a follow-up extension course. My knowledges of a more international approach to narrative therapy are slowly developing. I am currently very taken up

by the work of Johnella Bird (Bird, 2000; Bird, 2004) and her focus on relational meaning making.

1.5 Introducing the research colleagues

As mentioned the research focused on the experience and knowledges of six narrative informed therapists about their actual practice in relation to suicidality. The six narrative informed therapists became known as research colleagues. All have worked in various clinical settings in Sydney. The relationship of their ideas, knowledges, experiences and practice of narrative therapy to suicidality was of interest. All were women and had received training in Narrative Therapy, that is the narrative approach to therapy that is associated with David Epston of Auckland, New Zealand, Michael White of Adelaide, Australia, (White & Epston, 1990; Epston & White, 1992; White, 1992; White, 1995; White, 1997; White, 2002) and Johnella Bird of Auckland, New Zealand (Bird, 2000; Bird, 2004) and their colleagues.

The research colleagues were all asked the same question to begin with and subsequent questions were generally informed by their answer to the previous question. A question guide was followed. Chapter three details this much more.

1.6 Introducing some of the language chosen

- 'suicidality' – from a narrative perspective it was important that each research colleague came to their own naming of 'suicidality' and be given a space to speak about what that means to them (See Chapter 4).
- 'engaging with ideas of ending their life' – I found that expressing 'suicidality' as people who are engaging with ideas of ending their life, had appeal. This is because it reflects human agency, it is about ideas and a relationship with those ideas rather than a solid state or condition. This way of speaking reflects a poststructuralist way of speaking that fits with narrative. Similarly, 'suicidality' has also been referred to as phrases like 'suicide informed actions', or 'the suicidal context', or 'the experience of suicidality' throughout this research.

- 'narrative therapy' - it is difficult to give narrative therapy a definition. Hervern (1999) writes:

  > "The use of the term 'n/Narrative therapy' is problematic insofar as the phrase refers to both (1) a general perspective brought to bear by various constructivist approaches or epistemologies to the process of psychotherapeutic change ... and (2) a specific family of approaches to therapy frequently associated with the names of David Epston of New Zealand and Michael White of Australia."
  >
  > (See Epston & White, 1992; White, 1992; White, 1995; White & Epston, 1990; White, 1997).

Mostly, this research is referring to definition (2) above, however, when one defines narrative therapy as a model, approach or a framework, then anything that does not fit into the model might be construed as not being narrative therapy. Narrative therapy, is a poststructuralist therapy and it seems that in the very saying of this is a meaning of being inclusive, evolving and not wanting to be tied down to a particular set of ideas, or methods or techniques. When I am referring particularly to the Australian/New Zealand approach to narrative therapy I use capital letters – Narrative Therapy, and when I am referring to the more general perspective I will use lower case – narrative therapy.

- 'narrative informed therapists' – the research colleagues. I have chosen to use lower case because their knowledges are inclusive of both generalist narrative therapy and the Australian/New Zealand narrative therapy approach. As all the research colleagues have trained in Australia their knowledges are likely to lean more to the side of the Australian/New Zealand narrative therapy approach.
- 'people' not clients is seen as more respectful so 'client' is rarely used.

  As myself and one research colleague said:

  > 'and it is the time pressure that stops us from even having the ability to say 'the people that come to consult you' because it takes more time to be respectful than it does to say 'my client'.
  >
  > J: Yes, that's right, so even on that level, it is like I am trying to say things like 'people who are holding ideas about ending their life', I'd rather say it like that than just say 'people who are suicidal' it is more respectful

Therapist: yes, exactly

J: and in some of my putting together for the ethics report I just had to use those words because I know that that abbreviated way of speaking just fits for that culture

Therapist: yes because what you say might just look like ramblings'.

- 'voice' – 'The capacity to speak on one's own behalf, in terms that are not given by others'. (This has been taken from Monk et al., 1997, p.306).
- 'poem' – '*(1)* a composition in verse, characterised by the imaginative treatment of experience and a condensed use of language. (2) Any composition in verse' (This has been taken from 'Funk & Wagnalls' 1984, p.508). I wondered if the form that I had presented the data could be termed poems. After looking at the dictionary definition, I thought that it could.
- 'research colleague' - I felt research colleague is the most appropriate, respectful and best fitting name for the therapists who gave their stories for this research. They are more like colleagues than they are subjects, participants, or informants.
- 'Dual Diagnosis' is a term that has been given to people who have both a mental illness and substance use issue, sometimes the term implies substance abuse or misuse issue.

Chapters 2 through to 9 follow next, ending with the references and appendices. Throughout most of these chapters, more reflexivity is woven.

Chapter 2: A Literature Review

This chapter includes 2.1, a brief consideration of the broader context of suicide, 2.2 a review of key suicide research and includes the problems associated with researching suicide. 2.3 gives an overview of key ideas and insights from the research that may guide practitioners who are working with people who are in a suicidal context. 2.4 reviews literature in relation to theory and in relation to stories, narrative, living life and identity; and suggests that story-telling can assist people to live. 2.5 is an overview and review of the narrative therapy literature and research showing links with suicide. 2.6 reviews research and theory concerning connection and therapy, attachment theory and their links with suicide. Section 2.6 reviews connection and suicidality in the research and suggests that connecting can assist people to live their lives.

2.1 The broader context of suicide

We live in a life valuing society and culture. Embedded within this life-valuing society, is a culture that believes people who are unwell must get better (Rayner & Warner, 2003). It appears this life-valuing society is fueling research to save lives, to cure diseases and to lengthen lives. Thus, suicidal actions are generally viewed as irrational, to be understood and prevented (Rayner & Warner, 2004). Research communities and therapeutic communities are also part of the same culture (McLeod & Lynch, 2000). People who attempt suicide and self harm can be seen to be disrespectful of the efforts and ideals of health practitioners who are mostly devoted to saving lives (Michel et al., 2002). It has been suggested that this can lead to a pathologising, in a negative way, by health practitioners (Michel et al., 2002). As human life is culturally valued, suicidality is a major topic of interest. I have noticed that most people in my orbit have been affected by suicide in one way or another. Thus, the topic of suicide is of interest to families, researchers, teachers, scholars, governments, psychologists and sociologists. The field of suicidology is multi-disciplinary (Westefeld et al., 2000).

Most health care practitioners will meet with people who are engaging with ideas to end their lives at some time in their career. For example, it was found that out of 437 Australian psychologist respondents to a survey, 332 had experienced clients

who had attempted suicide, 170 had experienced a client complete suicide and 377 had clients who threatened suicide (Trimble et al., 2000). As mentioned, psychologists have a more than 20 per cent chance of having a client suicide (Kapoor, 2002). Counsellors at Kids Help Line, Australia, answer approximately 1800 calls annually from young people 'who call because of suicidal thoughts, intentions or behavours', 2% of all calls are suicidal related with this amount having doubled between 1994 and 2001. 13% of the suicide-related calls had immediate intention of attempting suicide, 8% were attempting suicide during the call, 49% had suicidal thoughts or fears, 20% were worried about others and 4% were seeking information (Suicide Sheet 11, p.1, Kids Help Line, 2002). These statistics suggest that health care practitioners could benefit from some training in suicidality.

Statistically suicide is actually a rare event, however it is a major cause of death of young men (Carr-Greg, 2003). In Australia, 2,320 people died from suicide in 2002, 503 were female and 1,817 were male. In 2001 the total number was 2,454. From 1991 to 2001 male suicides were four times higher than female suicides (AIHW National Morbidity Database, 2004). The World Health Organisation says suicide is one of the 'three leading causes of death for people aged 15–34 in many countries. Additionally, there has been a global increase in suicide rates between 1950 and 1995, from 10.1 in every 100,000 people to 16 per 100,000' (AIHW National Morbidity Database, 2004).

For Australia, in terms of age, it is young people, the 15 – 30 year olds; (especially young males) and the elderly, those over 65 years, who are more likely than other age groups to end their own lives. For young people suicide is the eighth leading cause of death, having slowly increased over the last decade (AIHW National Morbidity Database, 2004). Further, it is estimated that for every completed suicide in Australia there are another 30 attempts (AIHW National Morbidity Database, 2004). Young males are five times more likely to complete suicide than young females, however females are more likely to engage in suicidal ideation and attempt suicide (Zametkin, Alter, & Yemini, 2001).

Mental illness is a common characteristic of young people who commit suicide, as is a family history of suicide (Zametkin et al., 2001). SANE Australia, notes that 'suicide is the main form of premature death among people with mental illness'. More than 10% commit suicide within the first 10 years of being diagnosed (SANE Fact Sheet 14A, 2002).

It has been established that identifying a pattern common to those who suicide is difficult (Portes, 2002). However, characteristics of persons likely to suicide include: 'hopelessness/helplessness, a history of certain psychiatric diagnoses, a previous attempt, substance use/abuse, isolation, certain demographic patterns, family history and giving verbal intent' (Westefeld et al., 2000, p.475). Isolated clues are not thought to be very useful, so wide and comprehensive risk assessment is advocated (Westefeld et al., 2000).

2.2 Difficulties for Suicide Research

It appears that the tradition of suicide research has not been able to come up with any conclusive evidence about the effectiveness of suicide prevention, treatment and interventions (Zubrick & Silburn, 1996; Westefeld et al., 2000; Zametkin et al., 2001). This raises a dilemma for a society where life is valued highly and increases the challenge for practitioners. Treatment interventions are usually reported as effective but the suicide statistics continue to rise (Hoover and Paulson, 1999). For example, Glasser, Amdur & Backstrand's study (as cited in Cantor and Baume, 1999), noticed that despite increasing the number of psychiatrists and psychotherapists to an under-resourced area in the USA, the rate of suicide did not decrease.

Some of the difficulties in testing the effectiveness of suicide treatments relate to the fact that suicide is a rare event (Carr-Greg, 2003), hence sample sizes need to be large, and studies can be expensive to undertake. Also, there are problems with standardisation because of the need to consider several types of service centres. There are also ethical considerations and economic pressures. Ethics committees are likely to have concerns about grouping people into treatment versus no treatment groups (Zubrick & Silburn, 1996).

Randomised controlled trial research in relation to suicide treatment is problematic because generalisability is difficult. This leaves health practitioners with few, if any, evidence-based ways to proceed with people who are engaging with ideas about ending their lives (Zametkin et al., 2001). The effectiveness of treatment research is difficult to establish because of methodological issues such as, the lack of control groups, the uni-dimensionality of the studies, the lack of comparisons with other treatments and a lack of random design. Further, treatment practices are often fragmented with crisis intervention, suicidal behaviour management, treatment errors, and repeat episodes of suicidality; all of which make evaluation difficult. Therefore, conclusive evidence, showing that services and methods utilised to prevent suicide are effective, is lacking (Westefeld et al., 2000; Hoover & Paulson, 1999; Zubrick & Silburn, 1996). In addition, pharmacology has not been proven to be effective in lessening suicide risk (Sharry, Darmody, & Madden, 2000; Zametkin et al., 2001). More research is needed to work out the best types of treatment for assisting people who are experiencing suicidality (Trimble et al., 2000), across all the areas of suicidality, prevention, intervention, postvention and training (Westefeld et al., 2000).

Most suicide research targets prevention and reduction of suicide. Underlying most of this research is an urgency to find out why people act in suicidal informed ways. Research has not been able to predict who will complete suicide (Cantor & Baume, 1999). However, as mentioned, due to the complexities of suicidality, it is difficult to hold suicidality down as an independent variable because it is associated with many other issues. It is questionable whether there can even be a demarcation around suicidality as it is nearly always associated with a variety of different types of psychological disorders (Trimble et al., 2000). Also, the psychodynamic literature shows that suicide states have particular meanings for people depending on what has been internalised. The meanings can be simultaneously 'specific' and 'complex' (Richards, 1999). Hence, creative and innovative research methods have a place. Further, it is believed that reductionist quantitative research will never be able to get to an understanding of the complexities of suicidality and that more qualitative research is necessary (Michel et al., 2002).

Suicidality can be present across a range of therapeutic practice settings. For example, counselling rooms, hospitals and medical clinics, business and industrial contexts, community health centres, schools and universities, and psychiatric settings (Westefeld et al., 2000). The work of practitioners can be fragmented across a range of practice modalities such as: assessment, prevention, intervention, treatment, and postvention of suicidality, both within and between the various settings (Westefeld et al., 2000). Thus, research testing methods are challenged (Zubrick & Silburn, 1996) and the weight of the work can be quite difficult for practitioners who work in these various settings alongside people who are engaging with ideas to leave life (Kapoor, 2002). Research is context specific, however practitioners work across and within many varied settings using their preferred conceptual frameworks (Neimeyer, 2000).

2.3 Training in relation to working with people who are in a suicidal context

The challenge of the work may also be related to the fact that training received by health professionals is inadequate. For example, it has been found that many psychologists in Australia had not engaged in any training that related to working with people who are suicidal prior to becoming registered psychologists. However, since registering, most had undergone some further training (Trimble et al., 2000). Similarly, in the United States of America while new psychologists to the counselling field are becoming more exposed to people who are suicidal, training programs in the area of suicidology are also rare (Westefeld et al., 2000). Further, people with mental illness are at risk of making suicide informed decisions. 90% of completed suicides are by people with a psychiatric illness (Palmer, 2002). Should training for practitioners include this issue? It has been suggested, that realistically, training courses must include training in relation to this topic (Palmer, 2002).

It has been noted that trainees in suicidology are often disadvantaged because training is usually fragmented into areas such as 'risk assessment' or 'crisis management' which are disconnected from other important conceptual counselling and psychotherapy skills (Neimeyer, 2000). It is suggested a comprehensive treatment plan be taught, one that integrates evaluation and intervention for a person who is in a suicidal context. Also, it is important that trainees have an opportunity to 'bridge their preferred counselling theory and its associated

empirical based with the demands of their specific cases' (Neimeyer, 2000, p.557). It is strongly advocated that trainees are self-aware and have a supportive environment whereby they can reflect on their own unique and shared values, anxieties and concerns in relation to suicide, death and dying. As well as having a personal mentoring relationship (Sommers-Flanagan & Sommers-Flanagan, 1995; Neimeyer, 2000).

In terms of training, it seems to me, that it might be helpful for new therapists to read as many case studies and published transcripts as possible. This may assist in developing an understanding of the complexities and sensitivities that surround a person's experience of suicidality.

Literature and research, emphasizing case studies, can also give practitioners' guidelines in relation to working with people who are engaging with ideas to end their lives. After attempting suicide one woman writes of the 'pivotal moments' in psychotherapy treatment. Some examples include:

> "She continued to ask me why I felt like dying, and I kept replying that it was because of a 'swirl of things' ... She said ... unless we figure out what fears and anxieties comprise that 'swirl' I would always continue to live in a pattern of 'jumping to the dying part' .... never before had I realized that this was a pattern of mine ...Suicide had become a door that I needed to know could still be opened. But that didn't mean it was just okay to open or walk through it. ... In essence breaking down the 'swirl' led to talking about my feelings in more detail – feeling them and understanding them ... As a result of understanding myself better I was able to withstand a lot more of the difficult feelings I was having – so I didn't always 'jump to the dying part'." (Wise, 2004, p.91-92)

2.4 Ways of working with people experiencing suicidality

The literature shows that the most common element for approaching suicidality is diagnostic risk assessment (Westefeld et al., 2000) and that taking a proactive approach is viewed as beneficial (Palmer, 1995). Key issues for suicide assessment within the context of an intake interview may include the following:

- Evaluating for depression

- Exploring suicide ideation
- Assessing suicide plans
- Assessing patient self-control
- Using Standardised Suicide Assessment Devices

(Sommers-Flanagan & Sommers-Flanagan, 1995)

In addition, broadening social support for people in a suicidal context, following-up and assessing, intervening with problem-solving strategies, providing telephone numbers for after hours, and cognitive behavioural therapy have been rated as effective strategies by psychologists (Trimble et al., 2000).

However, it is suggested, in relation to working with people who are suicidal, that it is: 'a creative and collaborative response, such as that engendered by solution-focused therapy and other models, that is the most likely to facilitate change and re-empower clients to take back charge of their lives' (Sharry et al., 2002, p.383). It is believed that a solution-focused approach does not emphasize risk assessment. If a practitioner is too oriented towards risk assessment this may reduce therapeutic possibilities, probably for the people who are most at risk. Therefore, bringing together solution-focused therapy with risk assessment and using the solution-focused approach at the beginning stage of engagement is suggested (Sharry et al., 2002).

Using a solution-focused approach to working with people experiencing suicidality, the following interventions might include: 'listening for strengths, moving from problems to goals, finding exceptions, exploring how clients cope; and using scaling questions' (Sharry et al., 2002).

However, difficulties and challenges for practitioners' may be increased due to the uncertainty about what therapeutic methods to use with people who are in a suicidal context (Sharry et al., 2000). Recent therapies such as solution-focused therapy and narrative therapy are yet to create specific interventions for people who are suicidal (Palmer, 2002). Yet, it has been suggested that such collaborative and narrative approaches are promising (Michel et al., 2002; Sharry et al., 2000). However, it has

also been noted that one type of approach for all suicidal people is not an effective way to proceed (Rogers & Soyka, 2004).

Further, hypervigilance is an issue for practitioners who work in the context of suicidality. The research has shown that psychologists who have had a person (client) suicide become more vigilant in their attention to suicidal gestures and clues (Trimble et al., 2000; Rayner & Warner, 2003; Kapoor, 2002). The effects of being too vigilant may mean that the engagement process is thwarted (Sharry et al., 2000) leading to dissatisfaction for practitioners and clients.

As mentioned, it seems that there is a leaning to more traditional medical clinical approaches aiming at assessing and diagnosing suicidality. This is also where training in suicidality often rests (Michel et al., 2002). The effectiveness of this approach has been questioned (Sharry et al., 2002; Michel et al., 2002; Rogers & Soyka, 2004). For example, a team of clinician-researchers, observed interviews with people who had attempted suicide, in hospital emergency rooms, across Europe and in the United States of America. They all agreed that suicide risk assessment check lists, typically left patients feeling like their needs were unmet, and 'with little opportunity to contribute to any perspective on what actually happened' (Michel et al., 2002, p.425). They also found that it was uncommon for patients to return to follow-up appointments and they felt that an opportunity to help patients in distress was lost (Michel et al., 2002). Therefore, they advocated for an approach that embraced the idea that suicide was a 'culimination of life events with a developmental history' (Michel et al., 2002, p.429). Collaborating to share the story of the suicide experience was suggested as very likely to improve the clinical work (Michel et al., 2002).

The above research gives support to CAMS, which is the Collaborative Assessment and Management of Suicidality, (Jobes, 2000). Basically, CAMS is an empirical assessment tool that has collaboration and understanding between the client and practitioner as the main focus. The key tenet of CAMS is that the multidimensional experience of the person who is engaging with ideas to end life must be thoroughly understood by the practitioner. Then, a collaborative and co-authored plan can be

established. This way of working has been shown to increase compliance to the treatment plan and enhance the therapeutic relationship (Jobes, 2000).

Further ideas and insights for working with people experiencing a suicidal context have been generated by Stynes (1998). She closely followed and examined suicide narratives from three hundred and three therapy sessions in an in-depth qualitatively analysed study. From this empirical study, Stynes (1998, p.23-24) noted several ideas of how therapists need to position themselves in working with people who are potentially suicidal in the area of HIV and AIDS:

- therapists need to establish a strong therapeutic link with clients
- therapists working in the area of HIV and AIDS need to generate suicide-talk in order to make risk assessments and because clients sometimes need encouragement to talk about this subject
- therapists need to be able to sit back and listen without feeling compelled to take preventative action
- therapists need to find ways to address the inherent moral, ethical, legal and personal dilemmas arising when talking about suicide in therapy
- therapists need to feel comfortable about speaking about death
- therapists need to understand that suicide-talk does not always mean intent

Stynes is speaking particularly about suicide talk in therapy, not issues of general mental health when she notes the position that a therapist could take. She is speaking about working with suicidality in the context of HIV/AIDS, and the importance of bringing the issue to the fore to assess suicide risk during the therapy conversation. Her work on suicide, while focusing on HIV/AIDS emphasizes that suicidality or 'suicide talk' may be generated with most therapy problems.

Knowing some of the errors of treatment may be useful for health practitioners working in the context of suicidality. Psychotherapists, Paulson and Worth (2002) cited the following and labelled them treatment errors:

- Failure to develop an understanding of the individual (Kreiger, 1978)
- Practitioner anxiety about death (Birtchnell, 1983; Hendin, 1981)

- Practitioner difficulty in dealing with anger and hostility (Pope & Tabachnick, 1993)
- Failure to access the client's access to emotional support (Maltsberger & Buie, 1989)
- Failure to cope with clients' strong feelings (Neimeyer & Pfeffer, 1994)
- Failure to tolerate client dependency (Firestone, 1997)
- Maintaining an attitude that suicide was inevitable and the case hopeless (Krieger, 1978)
- Failure to confront, explore, and discuss the suicidal decision in order to take appropriate action (Neimeyer & Pfeffer, 1994)

It has been suggested that an intensive multidimensional approach may be helpful when working with people who are engaging with ideas to end their life. Aoun and Johnson (2002) studied a suicide intervention programme from a consumer's perspective in the Bunbury area, in the southwest region of Western Australia. They found that taking an approach that involved much effort and intensive work practices was helpful in diminishing the problem. The respondents felt that 'being able to talk and being listened to' was helpful, (47% of the sample), as well as the 'support, understanding and encouragement given and learning how to deal and cope with problems', (32.4% of the sample). Interestingly, 20.6% were not sure what was helpful. The return rate of the questionnaires was only 35 out of a potential 160. The 'being able to talk' and 'being listened to' is linked to a broader theme of connection, and implies that telling stories may assist people to live (Michel et al., 2002; Frank, 2002).

2.5 Stories, Narrative, Living and Identity

This section suggests ways that narrative therapy and suicidality have been linked together in the relevant literature. According to narratology (the study of story telling) people live their lives within the parameters of the stories that are available to them. These stories speak people into existence, people live by them and they are shaping of their lives, beliefs and identities (Kirkman, 2002).

This idea underpins narrative informed practice. For example, Narrative Therapist, David Epston, wrote to a woman after her first therapy session with him:

> 'I take it that telling me, a virtual stranger, your life story, which turned out to be a history of exploitation, frees you to some extent from it. To tell a story about your life turns it into a history, one that can be left behind, and makes it easier for you to create a future of your own design' (O'Hanlon, 1994, p.20).

In my opinion, these ideas in the above two paragraphs are central, when reviewing suicidality. In the exploring of suicidality it is essential to think about what it means to live life. Engaging with ideas to end one's life speaks of disenchantment with life itself (O'Neill, 2004). With this in mind, telling stories may assist people to live. When people have a dilemma to confront, they speak about it, they tell stories about their lives. It is not the contents of the story that matter as much as the understanding that the world is a place in which stories can be told, listened to and made sense of. The world is a narratable place, a place where life can be affirmed (Frank, 2002).

Stories need listeners to give the story recognition. The actual process of dialogical exchange is important for storytelling, as is re-telling, re-visioning or re-authoring (Frank, 2002). Stories that have a history of cultural tabooness, such as suicidality, may be reluctantly told or never told (O'Neill, 2004). Therefore, a person who lives with suicidal thoughts and ideas may not speak of this and may not be able to become fully known and understood, the culture may not give them a sense that their life and struggles are worthy of recognition and affirmation (Geddes & Porter, 2002). Perhaps if stories cannot be spoken about or aired, they may go underground and subversion may take place. Stories that may have gone underground, become hidden or lost and provide points of engagement for narrative therapy and an audience for these stories (White, 1995).

McLeod and Lynch (2000) write about the 'the good life' as a meta narrative, a narrative that people hold containing the spoken or unspoken beliefs about what constitutes the 'good life'. When one's life does not fit with one's beliefs, dreams or hopes of what the 'good life' constitutes, then a person may adopt a problematic position. I would therefore argue that some positions may become so problematic

that it informs suicidal acting and thinking, actions and thoughts that may become unspeakable and unstoryable. When the good life is more than fractured, suicide ideation becomes a real threat to a person's life. For example, suicide may become a solution, a way out, the only way, resistance, protest, or a rest. It is possible that people who are entertaining thoughts of suicide may be helped if space is created for a telling of life's events and circumstances in a particular way. Narrative informed practitioners make it their venture to engage in deconstructive conversations with the intention of unpacking some of the social discourse that might be informing problems and identity (White, 1995).

> 'White developed strategies that assisted people to gain access to story lines previously subjugated ... in exposing the taken-for-granted "truths" that dictate how to live and behave, narrative therapists aim to liberate people from society's marginalizing practices that determine what is acceptable and unacceptable' (Monk & Gerhart, 2003, p.20).

In their study, McLeod and Lynch (2000) examined both the counsellor conceptions of the 'good life' and the clients' conceptions. Using a qualitative method of data analysis, Lynch, McLeod and a research team, narratively analysed a series of therapy sessions. They came to understand the essence of these sessions as a process of 'narrative repair of a fractured story of the good life' (p.389). It may be said that people present to therapy when their ideas of what 'the good life' is, have been fractured or disrupted in some way, or when their life is not what it was hoped to be, or when life has not turned out as expected. Stories of what the good life is, or what a successful life is, or what normal is, or what constitutes an acceptable identity are embedded in and generated by culture, the culture in which both the practitioner and the person seeking help dwell (McLeod & Lynch, 2000).

Concepts of the self are important in narrative therapy in terms of how they link with the living of life. The self is a metaphor, a metaphor that psychology, clinical psychology and psycho-dynamic theory have taken to mean the separate self or autonomous self (Jordan, 2000). Therefore, it is a common goal for therapy to work towards making people independent and self-sufficient (Jordan, 2000). The outcome of using this metaphor is that people are more easily pathologised as being deficient in some way. Because of the individualistic outlook that psychology

mostly adheres to, community, culture, relationships and context are usually given much less consideration. Therefore, therapeutic practices that emphasise the individual self, using an autonomous self metaphor, may place a burden on people to be over-responsible for problems. Inadvertently, the reflection on connection, culture and community, which seems so important in assisting people to live life may be undervalued in therapeutic work (Jordan, 2000).

The concept of the self is a structuralist concept and can be linked to structuralist ideas that have become fairly routine to most people. Ideas such as drives, needs, motives, growth, self-actualisation and the essentialist self, to name a few. Narrative Therapy views the 'self as a fluid social construct' (O'Hanlon, 1994, p.22) and it is the pursuit of Narrative Therapy to deconstruct taken-for-granted structuralist ideas that sometimes have eased people into problem saturated identity positions (Freeman & Combs, 1996). Social determinism is avoided within a post-structuralist positioning of selfhood. People are able to reflect on their selfhood and on their intentions, purposes and choices and commitments. They have the choice to story their lives in their own particular way, this gives an opportunity for revisioning or re-authoring stories which may provide possibilities for escape (Kirkman 2002, p.33). In relation to suicidality this may mean an escape from suicidal acting and thinking.

2.6 Narrative Therapy, Research, and Suicide

Briefly, Narrative Therapy can be described in the following way. Narrative therapy is a post-structuralist therapeutic practice that seeks to elicit stories from people, stories that have a history and a future possibility. Practitioners can act as co-authors with people to author their lives and re-author their lives (White, 1995). Narrative Therapy seeks to separate people from the problem so that they can view themselves as being in relationship to the problems. This is called externalization and is a linguistic separation of problems from the personal identities of people (O'Hanlon, 1994, p.22). People are centred as the experts on their own lives, not the practitioners. Emphasis is attributed to the stories that people tell and the differences that can be made through the tellings and retellings of stories (Morgan, 2000).

As previously mentioned, practitioners are attracted to Narrative Therapy, yet little is known empirically about the usefulness of narrative therapy (Speedy, 2004). It is reasoned that this is because narrative therapy is based on beliefs that are suitable for context-sensitive research methodologies that do not give emphasis to generalisability (Etchison & Kleist, 2000). Also, it seems that narrative therapists have been busying themselves developing and describing narrative practice rather than giving attention to outcome based research (Speedy, 2004). There is huge interest in narrative practice. According to Hervern (1999) there are over 2,000 articles, books and research documents about narrative therapy. I think that cumulative and anecdotal evidence would therefore suggest that narrative therapy has some utility as it has become so generative of books and articles. There are two narrative publications published monthly in Australia, *The Narrative Network News*, in Melbourne and *The International Journal of Narrative Therapy and Community Work* in Adelaide. It seems fair to say that narrative practitioners have been busily gathering cumulative outcomes rather than conclusive outcomes (Speedy, 2004).

Literature searches using key words 'narrative therapy' and 'suicide' reveal a few articles. Some of these are seasoned with stories about narrative therapy and suicide. The following are examples in the form of bite-size pieces of stories, that provide a taste of the way narrative therapy, research, and suicide relate with one another in the narrative therapy literature.

Narrative Therapy does engage in what is known as co-research. Co-research can be described as local context-sensitive research that often involves groups of people coming together to speak about ideas or issues from the position of the insider. The ideas are then documented and shared with others who are experiencing similar issues in similar situations (Nosworthy & Lane, 1995; White, 1997; Epston, 1999; O'Neill, 2004). One such co-research project has been published recently and researches suicidal thoughts of young people. Two Narrative Therapists archived information thought valuable about suicidal thinking that they had gathered from their clients who were at times engaging with suicidal thoughts (O'Neill, 2004). Three young people experienced in suicidal thinking gathered together to converse about particular knowledges they held about the way

suicidal thinking operated in their lives. The purpose of this was because the researchers thought it could be helpful to others. Parts of the conversation were published (see O'Neill, 2004) and I will quote some to give the reader a flavour of that work:

> 'Angela: ... Suicidal thoughts like to tell me that I am bad and that I don't fit into society...
> Brett ... Even though the suicidal person is going to feel that the decision is very personal, suicide isn't anything to do with individuality. It's more like a kind of soul destruction experience. It's like you feel that your soul, the whole fabric of life is wrong. Not just your own life, but life itself seems wrong...
> Jess: ...Being alone is the worst because then no other logic can come in and I become trapped ...' (O'Neill, 2004 p.41-42).

In a manual for health professionals entitled *Keeping Yourself Alive*, about intervening with suicidal young people from a narrative perspective it is written:

> '... for young people struggling with the idea of suicide and plagued by hopeless and worthless thinking, a story of self-destruction or giving away one's life, narrative therapy can help reconnect them with their experiences of competence, survival and hope. These reconnections can invite them into an alternative story of self-worth, courage and purpose so they can choose life and not feel compelled to respond to suicide's call to death.' (Stacey, 1997, p.42).

The above quote portrays one of Narrative Therapy's landmark features, 'externalising the problem', (White, 1995). In the above quote the Narrative Therapist uses externalising language, for example 'compelled to respond to suicide's call to death'. Using language this way enhances human agency (Freeman & Combs, 1996). Stacey's article gives a theoretical sample of working with young people who are suicidal from a narrative perspective.

'Hitting rock bottom' before one can get past a drug or alcohol problem is an example of a dominant story or taken-for-granted viewpoint. This meta-story is likely to be part of the discourse of some therapeutic practices in relation to drug

and alcohol treatment. Smith & Winslade (1997) consider this and other dominant ideas that surround treatment for alcoholism. They also give an overview of a case study about a young man named Patrick, age 23, who was 'struggling to resist the invitations of suicide'. His lifestyle had been entwined with alcohol use and suicidality.

> 'He [Patrick] even came to recognise that alcohol was becoming associated more and more often with suicidal thoughts. Such knowledge about the ways of alcohol, generated by Patrick from his own substantial experience, was used to help him turn the corner ... and follow the light at the end of the tunnel and begin his escape from the domain of alcohol. Rather than viewing Patrick's stand against alcohol as being due to 'hitting rock bottom', I understood it as being proof of the incomplete nature of alcohol's domination.' (Smith & Winslade, 1997, p.21).

Another example of Narrative Therapy and suicide in the literature is from Daphne Hewson, a Sydney based psychologist and teacher of Narrative Therapy. Hewson (1991, p.11) writes about prediction questions for reconstruction of the 'new-old' story. In writing about this, she recalls a female client whom she had contracted with around suicide. She states that she asks all her clients who are at risk of suicide to call her if they are going to end their life. She tells them that if they call she will want to talk to them about hopefulness. The woman client did ring to tell Daphne that she was about to commit suicide. She described her means and that she felt her children would be better off without her. Daphne's assessment was that the woman had 'reached utter hopelessness' and the only exception to this was that the woman had made the phone call. Daphne asked the following future prediction questions: 'if you were to decide that there was some small possibility of hope for your future, what processes would you have gone through to make that decision?' the woman replied 'an okay mother'. Daphne asked 'what else?' and the woman replied that she would have found a way out of her problems. Daphne asked 'which ones?' the woman listed out the problems. Daphne asked 'what else?' the woman replied 'that she would get free of her abusive husband and then be able to live the way she wanted' (Hewson, 1991, p.11).

It seems narrative therapists may re-search the therapy as the therapy progresses, in the moments of the therapy (Bird, 2000). The following is part of a 're-memembering conversation' and shows how the Narrative Therapist checks in with the person he is working with.

> "MW: Which realisation do you like best. This one or the one about you being a hopeless case?
> Judy: (laughing and crying) This one, this one, this one.
> MW: (also laughing with tears) I think I heard that.
> Judy: So did I. And I have to tell you. I am amazed to hear it!
> MW: Could we talk more about what you were saying about Aunt Clara and the theme of preservation, and about her commitment to partnership, and about her ways of being in life? I ask this because I think this could help us to clarify the manner in which you are linked to these values and principles in the way you live your life. It also might throw a different light on those conclusions you'd reached about being a dependent person, and about not being able to get done what any reasonably independent person might get done. That's if you want to do this, of course.
> Judy: It sounds good to me.
> MW: ... But before we get into this, could you tell me how this is going for you?
> Judy: I have to tell you that right now I am feeling a bit light for the first time since, well, since a very long time ago. I feel warmed too. I'm feeling this physically right now. My life has seemed such a dead ended and cold place in many ways.
> MW: In that case I guess it would be a good idea to continue in this direction ...." White (2002, p.51)

The above quotations have provided a taste of the way that the Narrative Therapy literature has linked with research and suicidality.

2.7 Connection and Research

In order to live well, being well connected, having positive relationships and not being isolated are all very important. It has been noted that the experience of

human suffering is linked to the effects of isolation and that healing can be experienced via connection with others. The first point of reconnection may have to begin with a therapist and then move outwards to others.

> 'In order for patients to relinquish strategies of disconnection and shift their negative expectations in relationships, they must actually experience a sense of relational efficacy, of having an impact on the other person, the therapist. This happens when the therapist is emotionally present, attuned, therapeutically authentic' (Jordan 2000, p.1005).

Literature on psychotherapy and suicide speaks about the importance of connection (Hoover & Paulson, 1999; Paulson & Worth, 2002). For example, a convincing phenomenological study explored the experiences of nine Canadian and European participants who were willing to share what the authors called their 'processes of becoming suicidal no longer' (Paulson & Worth, 2002). Thematically, the authors used the concepts of 'the journey away and the return to the self'. They found that when participants had support they became more open and were better able to reconnect to themselves and their experiences. They described three aspects of the reconnecting process. Firstly, a 'validating relationship' which provides a type of platform for reconnection. Secondly, moving from evaluations of the self to an understanding and trusting of self, and recognising that the conclusions drawn from 'emotional and cognitive processing' are interpretations. Thirdly, a dealing with and understanding of the underlying and past issues of disconnection to allow for a movement towards reconnection. The participants described the healing process as reconnection with the self and with others. They described the suicidal state as one of disconnection and isolation. The participants said that this state needed to be identified before reconnecting could take place. They described the disconnection as coming from conclusions that they held about their sense of self, rather than the context or situation. These conclusions about the self related to hopelessness and worthlessness (Hoover & Paulson, 1999).

Further research, in the area of psychotherapy and suicide, supportive of the importance of connection can be found in a study in which 41 therapists had experienced a client suicide. One participant responded: 'When suicidal patients have difficult times, stay as connected with them as possible' (Richards 2000,

p.327). In addition, the majority of the participants, 90% in fact, said that they dealt with the death of their clients by talking about this with their peers (Richards, 2000). This research supports the importance of staying connected to people who are in a suicidal context, as well as the importance of not being isolated in the work through being connected to supportive colleagues. Also, Cooper and Fox (1998, p.155) write about the importance for therapists working with people who are entertaining thoughts of suicide, to have supportive colleagues. They add that being aware of the emotions that come forth when working with people who are suicidal may give some protection for therapists becoming too 'overwhelmed'.

Additionally, it seems when therapists reflect upon the stories and values they hold in relation to suicidality, they can connect with their client in an authentic way. It is important that the 'feelings, attitudes and opinions' held by psychologists, about people who are in a suicidal context, are given some thoughtful reflection. Psychologists who are aware of their beliefs have the capacity to work well with people who are suicidal (Sommers-Flanagan, 1995; Stynes, 1998). In many ways, this links to the value of therapists' supervision, a type of supervision that is able to create a space where therapists can effectively reflect upon their stories and values. I imagine the supervision would need to be a place where trainees felt safe, and where supervisors themselves, were in touch with their stories and feelings about the topic of suicidality.

The therapeutic relationship is an important site for connection when working with people who are engaging with ideas to end their life. If weight is placed on the importance of the therapeutic connection in keeping people alive, it is paramount to understand how such therapeutic connection can be maintained over time and what this connection would look like in its practical application. This goes not only for the connection with the therapist but also for connections on other levels. For genuine connection, stories need to be honoured and mutual empathy practiced in the therapeutic relationship (Jordan, 2000). Thus, theoretically speaking, engagement is a critical aspect of the therapeutic relationship and the foundation of all effective therapeutic practice. It is especially important when therapists are working with people who are in a suicidal context, that the therapeutic connection,

engagement or alliance works well for successful therapy (Jackson & Chable, 1985).

Attachment theorists suggest that even a threat of separation of parents from their children may mean a failure in the attachment relationship (Bowlby, 1980). Following from this idea, research on a sample of adolescent's who had attempted suicide and a non suicidal control group found that a threat of parental separation by adolescent's theoretically increases suicide attempt risk (Lyon et al., 2000). It seems that attachment theory may have ideas to offer the field of suicidology, but more research is needed to determine whether suicidality can be linked to insecure attachment (Lyon et al., 2000).

In Narrative Therapy, conversations that deliberately connect people in therapy with meaningful others have been named 're-membering' conversations by Michael White (White, 1997). Connection and emotional support are seen as important for helping people in a suicidal position (Paulson & Hoover, 1999; Paulson & Worth, 2002; Jordan, 2000; Bird, 2000). Re-membering conversations' are viewed as a way to connect people with others, to member them back to a preferred community of others. 'Re-membering' is a term coined by Barbara Myerhoffer (cited in Russell and Carey, 2002) and developed by Michael White for use in therapeutic conversations. Russell and Carey (2002, p.25) state: 'remembering practices are based on the post-structuralist understanding that our identities are forged through our relationship with other people.' Remembering conversations intentionally collect figures of support for people who are in a position of struggle (Russell and Carey, 2002). The Narrative Therapy literature does not directly state that 're-membering' is a way forward when working with people who are engaging with ideas to end their lives, but it seems, in my opinion, that it resonates with connection and re-connection, and hence may be helpful in assisting people to live.

Narrative therapy also seeks to connect and re-connect people with experiences. To quote Stacey (1997, p.42) again, 'narrative therapy can help reconnect them with their experiences of competence, survival and hope. These reconnections can invite them into an alternative story of self-worth, courage and purpose'.

A further study to support the point that connecting can assist with living life well is that conducted by Mills and Daniluk (2002). They conducted a qualitative study on five women who had all survived sexual abuse and had found dance therapy 'facilitative of their personal growth and healing'. Using a phenomenological approach six themes appeared, two of which related to connection and thus caught my attention. One of the themes was 'reconnection to their bodies' and another was 'sense of intimate connection'. Mills and Daniluk (2002, p.79) noted that all the women said that they had felt 'disconnected to varying degrees from their bodies'. While participating in dance therapy they mentioned that they had experienced 'a unique kind of emotional connection with others ... they remarked on how this intimacy was created without words, simply by moving together and at times physically connecting with each other'. Further, they spoke about a 'feeling of unity' and said that they felt 'honoured' 'supported' and 'accepted' by others. One of the women said that in 'talk therapy' she didn't feel as honoured as she did in 'dance therapy'. Although this study is not speaking about suicidality in particular, it does point to the therapeutic multidimensionality of the connecting.

Motto & Bostrom (2001) conducted a randomised-controlled trial of postcrisis suicide prevention. The method involved 3,005 people who had been hospitalised for being in a suicidal state. 843 people, the ones who refused follow-up treatment were divided into two randomised groups. One group received a letter at least four times a years for five years, the other group received no contact. The people in the contact group had a significantly lower suicide rate, leading the researchers to conclude that systematic contact for people not remaining in the health system 'appears to exert a signficant preventative influence for at least two years. Diminution of the frequency of contact and discontinuation of contact appear to reduce and eventually eliminate this preventative influence' (Motto & Bostrom, 2001, p.828). The researchers based their research on the hypothesis that for a person, who is suicidal, long-term and regular contact by another person may decrease the experience of isolation and increase a sense of connection. This other person was to have a concern for the patient's sense of well-being. They also felt that this contact should not make any demands on the patient (Motto & Bostrom, 2001). This is a study that tends to point to the possibility that connectedness is an important ingredient in treating suicidality.

2.8 Conclusion of literature review

Hence, in developing the rationale for my study it seemed that 'absent yet implicit' in suicidality is living life (White, 1997). It appears that life can be lived in and through stories – so I thought, perhaps narrative therapy has a place in a study of this kind (Michel et al., 2002). In 'attempting to understand suicide, it is difficult to specify a single pattern because those who commit suicide come from all walks of life and vary in background and motives' (Portes, 2002). Therefore, is it not important for therapists to hear about the unique patterns, backgrounds, life walks and stories that surround the experience of suicide? Narrative therapy seems like it could be poised to do this. Further, the randomised-controlled style of studies have many methodological issues to address (Cantor & Baume, 1999) so perhaps a randomised controlled trial style is not the best way for me to approach this topic. Attachment theory and ideas around connection seem fairly relevant to a study such as this but more research is needed about attachment and the relationship to suicidality (Lyon et al., 2000). Given the complexities of suicidality (Michel et al., 2002), the multidimensionality of the topic (Stynes, 1998) and the post-structural emphasis of narrative approaches to therapy, an inclusive methodology like the bricolage methodology appears to have a good fit. Narrative is an approach I currently have an interest in. Reflexivity, surely, has to be part of it. Reflexivity is certainly finding a place in qualitative research (McLeod & Balamoutsou, 2001; Etherington, 2001). The literature seems to be suggesting that collaborative ways of working may have a future as a valid and effective approach to choose when working with people who are experiencing suicidality. Also suggested is the desire for more research in relation to this (Michel et al., 2002; Sharry, et al., 2002). So, herewith is some more research. I hope you find links with your own experiences and held stories of suicidality that can further the sense you make of this complex, soul searching and often heart rendering topic.